GEORGIA FAMILIES PROGRAM

REPORT 17, PART B: HOSPITAL CLAIMS GLOBAL ANALYSIS

ANALYSES OF CLAIMS SUBMITTED BY HOSPITAL PROVIDERS (OTHER THAN CHILDREN'S HEALTHCARE OF ATLANTA) TO GEORGIA CARE MANAGEMENT ORGANIZATIONS

MARCH 1, 2011

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GLOSSARY

The following terms are used throughout this document:

- ***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.

- ***Affiliated Computer Systems, Inc. (ACS)*** – The State fiscal agent claims processor during the period of this analysis.

- ***Appeal*** – A formal process whereby a health care provider requests that a payor review the outcome of a claim previously submitted to the payor for reimbursement. This term is typically reserved for claims that were originally denied for payment or paid at a lower amount by the payor, and the provider believes a payment should be made or paid at a higher amount.

- ***Capitation Claim*** - A per Medicaid and/or PeachCare for Kids™ member fixed payment amount made by DCH 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 Kids™ 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 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.

- ***Centers for Medicare and Medicaid Services (CMS)*** – The federal agency under the Department of Health and Human Services responsible for the oversight and administration of the federal Medicare program, state Medicaid programs, and State Children's Health Insurance Programs.

- ***Centers for Medicare and Medicaid Services 1500 (CMS-1500 or "1500") Claim Form*** – Document most often required by payors to be utilized by physicians and other non-institutional providers for submission of a claim request for reimbursement to the health care payor.

- ***Clean Claim*** – A claim received by the CMO for adjudication in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment or alteration by the health care service provider in order to be processed and paid by the CMO. Per the DCH CMO model contract, the following exceptions apply: 1) A claim for payment of expenses incurred during a period of time for which premiums are delinquent; 2) A claim for which fraud is suspected; and 3) A claim for which a third party resource should be responsible.

- ***Credentialing*** –The process of establishing the qualifications of licensed health care providers, which may include the confirmation of their license, and confirmation of their education, and determining eligibility to participate in government health care programs.

- ***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.

- ***Explanation of Payment (EOP)*** – A statement from a payor to a patient and/or health care provider that includes information detailing the pricing and adjudication of a fee-for-service claim and/or claim detail. May also be referred to as the Explanation of Benefits (EOB).

- ***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.

- ***Filing Time Limit*** – The maximum amount of time a provider can utilize to submit a claim to a health plan.

- ***Georgia Families (GF)*** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids™ where 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.

- ***Implementation*** – For purposes of this report, the period of time from June 1, 2006 (or earlier, if applicable) through June 30, 2007.

- ***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.

- ***Outpatient Services*** – Medical procedures, surgeries, or tests that are done 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.

- ***Payor*** – An entity that reimburses a health care provider a portion or the entire health care expenses of a patient for whom the entity is financially responsible.

- ***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.

- ***Post-Implementation*** – For purposes of this report, the period of time beginning July 1, 2007.

- ***Prior Authorization (Authorization, PA, or Pre-Certification)*** – An approval given by a health care payor to a health care provider before a health care service is performed, that allows the provider to perform a specific health care service for a patient who is the financial responsibility of the payor with the understanding that the payor will reimburse the provider for the service.

- ***Provider Number (or Provider Billing Number)*** – An alphanumeric code utilized by health care payors to identify providers for billing, payment, and reporting purposes.

- ***Recoupment*** – Repayment of an overpayment, either by a payment from the provider or an amount withheld from the payment on a claim.

- ***Remittance Advice (RA)*** – A document provided by a health care payor to a health care provider that lists health care claims billed by the provider to the payor and explains the payment (or denial) of those claims.

- ***Revenue Codes*** – A listing of three or four 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).

- ***Triage*** – The process of reviewing a patient's condition to determine the medical priority and the need for emergency treatment.

- ***Triage Rate*** – The reimbursement rate paid to a provider when a patient enters the emergency room but is deemed to not be in need of emergency care. In some contracts, this is referred to as an Administrative Fee.

- ***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

Since implementation of the Georgia Families care management program in June 2006, the Department of Community Health (DCH) has been engaged in ongoing efforts to ensure the efficient operations and provision of health care services to the program's more than one million Georgia Medicaid and PeachCare for Kids^{TM} members. DCH 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.

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 included analyses focused on hospital payment and denial trends as well as the length of time required to complete contract loading and credentialing during the implementation of the program. The previously issued report is available online at http://dch.georgia.gov.

The analyses in this report include hospital claims that were paid or denied by the CMOs with paid dates from June 1, 2006 through June 30, 2010. It should be acknowledged that this period includes the implementation period of June 1, 2006 through June 30, 2007. Trends and issues identified during this period may vary significantly from the same analyses performed on data from the post implementation periods. When sufficient data was available, we attempted to analyze and compare the implementation and post implementation periods to identify trends, improvements, or other changes that may have been experienced by members and providers in the post implementation period. At the Department's request, the analyses were performed separately for Children's Healthcare of Atlanta and for all other hospitals. For clarity, the report is divided into two separate parts. This section, Part B, includes the analyses for all hospitals except Children's Healthcare of Atlanta. Results for Children's Healthcare of Atlanta are included in Report #17, Part A.

SCOPE OF REPORT

The scope of this report includes analyses of the Georgia Families program hospital claims experience (excluding Children's Healthcare of Atlanta) including adjudication and denial trends, as well as an analysis of the payment of triage rates and emergency room rates for emergency services, and an analysis of provider retention.

The initial Hospital Claims Analysis (Report #2) was performed in 2008 and included claims paid and denied between December 1, 2006 and August 31, 2007. This analysis includes claims paid or denied between June 1, 2006 and June 30, 2010. We have included the prior analysis period in an effort to identify trends and progression throughout implementation and post implementation of the Georgia Families Program.

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METHODOLOGY

The Department of Community Health requested that we analyze and report our findings by care management organization. We analyzed claims paid or denied from June 1, 2006 through June 30, 2010. The analyses included inpatient and outpatient hospital claims billed on the UB-04 claim form.

Myers and Stauffer has developed a data warehouse that includes encounter data from each CMO. The paid and denied claims utilized in these analyses were extracted from our data warehouse. When necessary, additional data was requested from the CMOs to supplement the data available in the data warehouse.

Based on monthly reconciliation reports prepared as part of a separate initiative, the Department has determined that the encounter data provided for certain CMOs is less than 100 percent complete. As of August 2010, the completion rate for the encounter claims was 99 percent for both Peach State and WellCare. The completion rate for AMGP was 100 percent. Although the rates indicate the encounter data is nearly complete, because the analyses were performed on a less than 100 percent complete set of encounter claims, there is a potential that the findings resulting from these analyses may reflect slightly inaccurate results.

In consultation with the Department of Community Health, 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 consistent with the ethics statements and policies of DCH".

A summary of findings from the following analyses are included in this report:

Analysis I: Claims Adjudication Trends – We performed various analyses of the claims data to determine the average number of days required to adjudicate claims.

Analysis II: Denied Claims Analysis – We performed analyses of the claims data to identify claim denial rates and reasons.

Analysis III: Emergency Room Services – We analyzed emergency room services to identify the frequency of which hospital emergency room claims were reimbursed at the triage rate by level of care. We identified the number of claims originally paid at the triage rate and later reprocessed at a higher rate after appeal. Note that, at DCH's request, additional in-depth analysis related to emergency room services is being performed and will be included in a separate report at a later date.

Analysis IV: Georgia Families Program Provider Retention – We analyzed the claims data and provider network information to determine whether any trends or potential provider retention concerns might exist for the Georgia Families program.

For reference, the following claim counts for each CMO were received and utilized in our analyses. These claims include inpatient and outpatient hospital claims paid or denied from June 1, 2006 through June 30, 2010 billed on the UB-04 claim form. *It should be noted that the claim counts and paid amounts cited herein may vary based on the whether the counts and paid amounts are from the claim header fields or claim detail fields. In some situations, there may be multiple EOP codes that are applicable to a single claim detail, which can cause minor variances in the counts and summaries. Minor differences may also be observed due to rounding.*

Non-CHOA Paid and Denied Claims by CMO, Based on Final Payment Status

	AMGP	PSHP	WellCare	Total
Number of Paid Claims	1,029,159	1,450,135	1,638,374	4,117,668
Percent of Total Claims	93.3%	96.2%	88.0%	92.1%
Number of Denied Claims	74,080	57,667	222,833	354,580
Percent of Total Claims	6.7%	3.8%	12.0%	7.9%
Total Claims	1,103,239	1,507,802	1,861,207	4,472,248
Percent	100.0%	100.0%	100.0%	100.0%

Limitations

The following limitations in the data should be taken into account when considering the findings identified:

1) Monthly reconciliation reports indicate that the encounter data provided by the CMOs is less than 100 percent complete. As of August 2010, the completion rate for the encounter claims was 99 percent for both Peach State and WellCare. The completion rate for AMGP was 100 percent. Although the rates indicate the encounter data is nearly complete, because the analyses were performed on a less than 100 percent complete set of encounter claims, there is a potential that the findings resulting from these analyses may reflect slightly inaccurate results.
2) WellCare has stated that the denied/paid dates reported on the encounters submitted by WellCare may not reflect the actual date the claim was paid or denied. This issue may limit the usefulness of trending information.
3) Certain claims may be rejected prior to entering the adjudication process with a CMO. These claims are not submitted by the CMOs in their encounter data submissions and are not included in the analyses in this report.
4) Changes to provider contracts from paying for emergency services at triage and emergency rates to instead include terms for reimbursement of emergency services at a negotiated rate based on level of care will impact any trending analyses related to frequency of triage payments.
5) In attempting to identify instances where a CMO paid a provider a triage payment for an ER visit, certain claims may potentially not be identified due to reduced reimbursement due to the deduction of co-payments or increased reimbursement due to the addition of interest or a combination of the two.

ANALYTICAL SUMMARIES AND FINDINGS

In addition to the findings by analysis type described below, please also refer to the findings summary presented at the end of this section. We have included additional detail of our analyses in the Exhibits to this report.

Unless otherwise noted, the analyses below are based on paid and denied encounter claims submitted by the CMOs to the fiscal agent and extracted from the Myers and Stauffer data warehouse, with adjudication dates from June 1, 2006 through June 30, 2010.

ANALYSIS I: CLAIMS ADJUDICATION

The DCH Contract with the CMOs:

The amended contract effective July 1, 2008 and all subsequent amendments between DCH and the CMOs contain the following language regarding the adjudication of claims.

4.16.1.1

> *The Contractor shall utilize the same time frames and deadlines for submission, processing, payment, denial, adjudication, and appeal of Medicaid claims as the time frames and deadlines that the Department of Community Health uses on claims its pays directly. The Contractor shall administer an effective, accurate and efficient Claims processing function that adjudicates and settles Provider Claims for Covered Services that are filed within the time frames specified by the Department of Community Health (see Part I. Policy and Procedures for Medicaid/PeachCare for Kids Manual) and in compliance with all applicable State and federal laws, rules and regulations.*

The original contract (effective June 1, 2006) contained only the second sentence of that contract requirement.

Section 4.16.1.8 of the original and amended contracts states:

> *Not later than the fifteenth (15th) business day after the receipt of a Provider Claim that does not meet Clean Claim requirements, the Contractor shall suspend the Claim and request in writing (notification via e-mail, the CMO plan Web Site/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all outstanding information such that the Claim can be deemed clean. Upon receipt of all the requested information from the Provider, the CMO plan shall complete processing of the Claim within fifteen (15) Business Days.*

In addition, as described in Analysis III, the contract amendment effective July 1, 2008 and all subsequent contract amendments between the CMOs and DCH now include the following:

4.9.7.5.4

For all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment

NOTE: The data analyzed in these claims analyses includes claims incurred prior to the contract amendment.

To complete the analysis of the time required to adjudicate claims, we used the CMO encounter data submitted by the CMOs to the fiscal agent contractor that are in the Myers and Stauffer data warehouse. Supplemental data was requested from the CMOs and/or their subcontractors for all hospital claims paid or denied with paid dates from June 1, 2006 through June 30, 2010. We used the date the claim was received by the health plan, as well as the adjudication date of the claim to determine the number of days required to adjudicate the claim.

Because of the difficulty associated with identifying the impact of weekends and holidays on the timely adjudication of individual claims, Myers and Stauffer included four additional calendar days in the timeliness determination. Therefore, if the number of calendar days between when the claim was received and when a CMO paid a claim is 19 calendar days or less, the claim will be considered timely adjudicated for purposes of this analysis. There may be isolated instances where a claim would be considered timely adjudicated when the number of calendar days exceeds 19. However, those instances should have minimal impact on the trend results of this analysis.

We analyzed the claims by period, considering the implementation period as June 1, 2006 through June 30, 2007 and the post implementation periods as SFY 2008, SFY 2009 and SFY 2010 with paid dates through June 30, 2010. This analysis relied on the final adjudication status of the claim. Therefore, the results of this analysis may differ from other analyses that use all denied claims, regardless of whether they were reprocessed or adjusted at a later date. Please also refer to Exhibit 1 for more information regarding this analysis.

AMERIGROUP Community Care (AMGP)

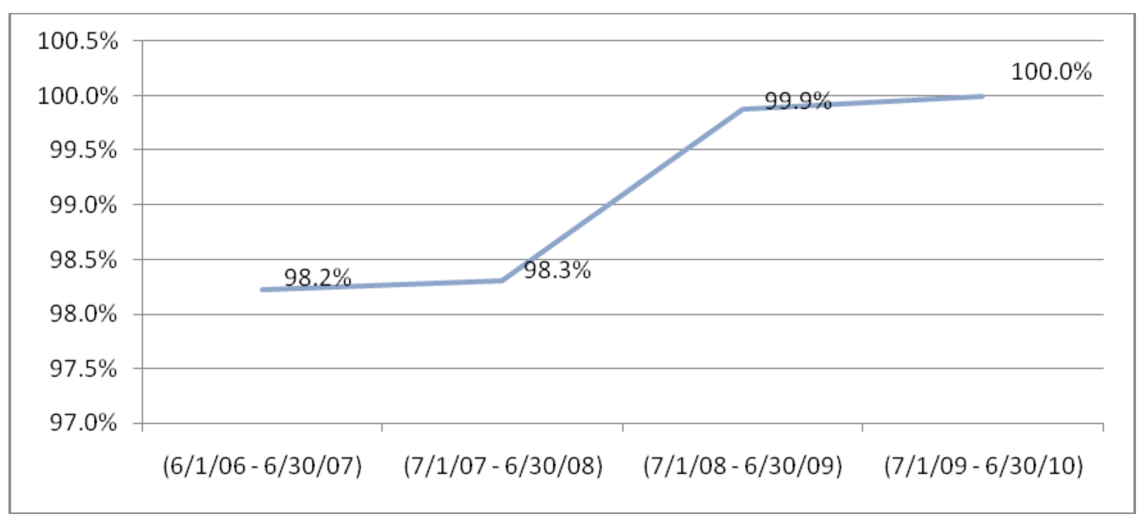
AMGP adjudicated approximately 1.1 million claims from implementation through June 30, 2010 for non-CHOA facilities. Of these claims, 99.2 percent were adjudicated in 19 days or less. The claims data suggests an improving trend in the processing of claims within the first 19 days after receipt. For the 0.8 percent of claims adjudicated at 20 days or more, AMGP reported paying $65,826 in interest. We noted that based on the encounter data submitted by AMGP, the adjudication rate in 19 days or less in SFY 2010 was 100 percent. However, by analyzing the data further, we also noted that during that time period the date that AMGP reported receiving the claim and the date AMGP reported the claim as being paid were identical. We have included a recommendation regarding these claims and confirming the validity of the reported information later in our report.

Table 1: Non-CHOA Claim Adjudication Statistics for AMGP, by Period

AMGP Non-CHOA	Implementation (6/1/06 - 6/30/07)	Post Implementation (7/1/07 - 6/30/08)	Post Implementation (7/1/08 - 6/30/09)	Post Implementation (7/1/09 – 6/30/10)	Total
Claims Paid	204,806	240,824	254,871	328,658	1,029,159
Percent Paid	94.5%	93.1%	92.2%	93.5%	93.3%
Claims Denied	11,940	17,730	21,466	22,944	74,080
Percent Denied	5.5%	6.9%	7.8%	6.5%	6.7%
Total Claims	216,746	258,554	276,337	351,602	1,103,239
Claims Adjudicated ≤ 19 Days	212,895	254,163	276,011	351,602	1,094,671
Percent Adjudicated ≤ 19 Days	98.2%	98.3%	99.9%	100.0%	99.2%
Claims Adjudicated > 19 Days	3,851	4,391	326	0	8,568
Percent Adjudicated > 19 Days	1.8%	1.7%	0.1%	0.0%	0.8%

In the figure below, we illustrate the percent of non-CHOA hospital claims adjudicated in 19 days or less by period. After the implementation period, the adjudication rate increased from 98.3 percent in SFY 2008 to 99.9 percent in SFY 2009. For SFY 2010, the encounter data for AMGP indicates that 100 percent of claims were paid on the day of receipt.

Figure 1: Non-CHOA Percent of Claims Adjudicated ≤ 19 Days, by Period, for AMGP



Peach State Health Plan (PSHP)

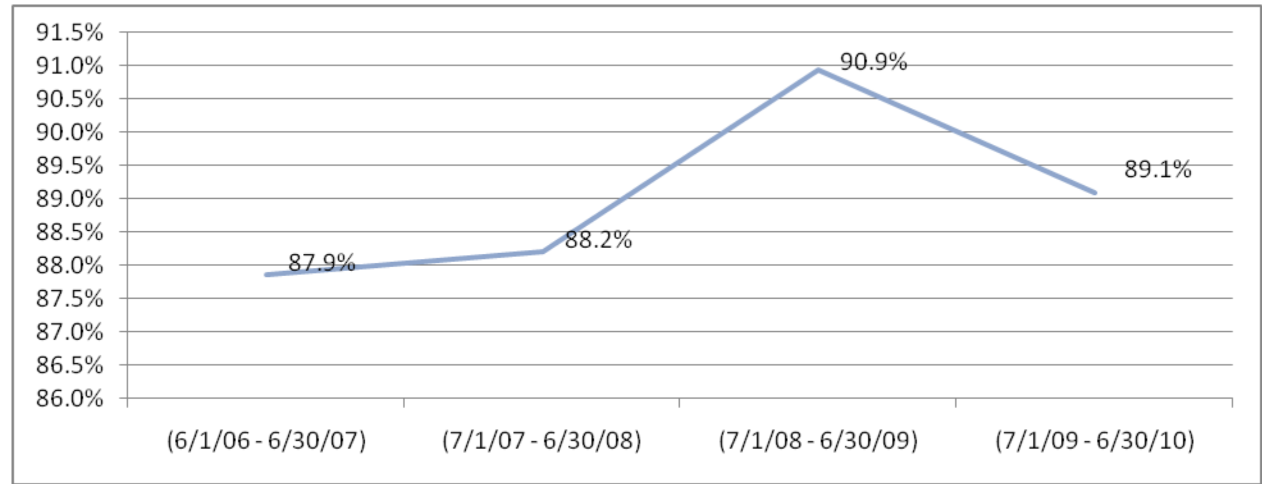
PSHP adjudicated approximately 1.5 million non-CHOA claims from implementation through June 30, 2010. Of these claims, 89.1 percent were adjudicated in 19 days or less. For the 10.9 percent of claims adjudicated at 20 days or more, PSHP reported paying $1,495,860 in interest.

Table 2: Non-CHOA Claim Adjudication Statistics for PSHP, by Period

PSHP Non-CHOA	Implementation (6/1/06 - 6/30/07)	Post Implementation (7/1/07 - 6/30/08)	Post Implementation (7/1/08 - 6/30/09)	Post Implementation (7/1/09 – 6/30/10)	Total
Claims Paid	304,072	340,910	375,369	429,784	1,450,135
Percent Paid	96.9%	95.9%	95.2%	96.7%	96.2%
Claims Denied	9,772	14,427	18,861	14,607	57,667
Percent Denied	3.1%	4.1%	4.8%	3.3%	3.8%
Total Claims	313,844	355,337	394,230	444,391	1,507,802
Claims Adjudicated ≤ 19 Days	275,762	313,448	358,547	395,975	1,343,732
Percent Adjudicated ≤ 19 Days	87.9%	88.2%	90.9%	89.1%	89.1%
Claims Adjudicated > 19 Days	38,082	41,889	35,603	48,416	164,070
Percent Adjudicated > 19 Days	12.1%	11.8%	9.1%	10.9%	10.9%

In the figure below, we illustrate the percent of non-CHOA hospital claims adjudicated in 19 days or less by period. After the implementation period, the adjudication rate increased from 88.2 percent in SFY 2008 to 90.9 percent in SFY 2009. For SFY 2010, the adjudication rate has decreased to 89.1 percent.

Figure 2: Non-CHOA Percent of Claims Adjudicated ≤ 19 Days, by Period, for PSHP



WellCare of Georgia (WellCare)

As stated earlier in this reports, WellCare has indicated that the denied/paid dates reported on the encounters submitted by WellCare may not reflect the actual date the claim was paid or denied. The denied/paid dates reported on the encounters may be affected by the movement of claims data from WellCare's adjudication system to their data warehouse. This issue may limit the usefulness of trending information and should be carefully considered when reviewing the results for this analysis.

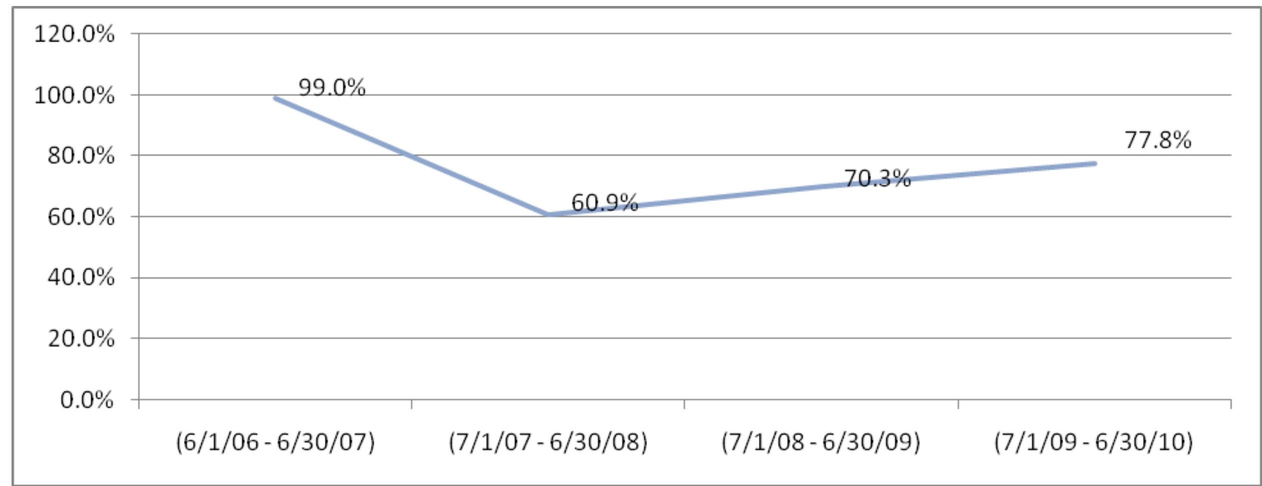
WellCare adjudicated over 1.8 million claims from implementation through June 30, 2010 for non-CHOA Providers. Of these claims, 73.4 percent were adjudicated in 19 days or less. For the 26.6 percent of claims adjudicated at 20 days or more, WellCare reported paying $165,432 in interest.

Table 3: Non-CHOA Claim Adjudication Statistics for WellCare

WellCare Non-CHOA	Implementation (6/1/06 - 6/30/07)	Post Implementation (7/1/07 - 6/30/08)	Post Implementation (7/1/08 - 6/30/09)	Post Implementation (7/1/09 – 6/30/10)	Total
Claims Paid	27,645	221,522	664,087	725,120	1,638,374
Percent Paid	58.2%	82.2%	87.9%	92.0%	88.0%
Claims Denied	19,880	48,047	91,710	63,196	222,833
Percent Denied	41.8%	17.8%	12.1%	8.0%	12.0%
Total Claims	47,525	269,569	755,797	788,316	1,861,207
Claims Adjudicated ≤ 19 Days	47,057	164,145	531,064	613,175	1,355,441
Percent Adjudicated ≤ 19 Days	99.0%	60.9%	70.3%	77.8%	72.8%
Claims Adjudicated > 19 Days	468	105,425	224,733	171,141	505,766
Percent Adjudicated > 19 Days	1.0%	39.1%	29.7%	22.2%	27.2%

In the figure below, we illustrate the percent of non-CHOA hospital claims adjudicated in 19 days or less by period. After the implementation period, the adjudication rate increased from 60.9 percent in SFY 2008 to 70.3 percent in SFY 2009. For SFY 2010, the adjudication rate increased to 77.8 percent. WellCare has indicated that the paid date reported in the encounter data may not accurately reflect the actual date the claim was paid.

Figure 3: Non-CHOA Percent of Claims Adjudicated ≤ 19 Days, by Period, for WellCare



ANALYSIS II: DENIED CLAIMS ANALYSIS

The DCH Contract with the CMOs:

The contract amendment effective July 1, 2008 and all subsequent contract amendments between the CMOs and DCH address claims that are inappropriately denied or underpaid with the following language:

4.9.7.5.4

> *For all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment.*

NOTE: The data analyzed in these claims analyses includes claims incurred prior to the contract amendment.

To complete the analysis of denied claims, we used the CMO encounter data submitted by the CMOs to the fiscal agent contractor and extracted from our data warehouse and we requested supplemental data from the CMOs and/or their subcontractors for all hospital claims paid or denied with paid dates from June 1, 2006 through June 30, 2010. We analyzed and summarized the denied claims by reason code listed on the claim. When applicable, we analyzed whether denied claims were later paid, and whether those payments included interest. We further analyzed the claims by period, considering the implementation period as June 1, 2006 through June 30, 2007 and the post implementation periods as SFY 2008, SFY 2009, and SFY 2010 with paid dates through June 30, 2010. This analysis was completed using all denied claims, regardless of whether they were reprocessed or adjusted at a later date. Therefore, the results from this analysis may differ from other analyses that use only the final adjudication status of the claim. Please also refer to Exhibit 2 for more information regarding this analysis.

AMERIGROUP Community Care (AMGP)

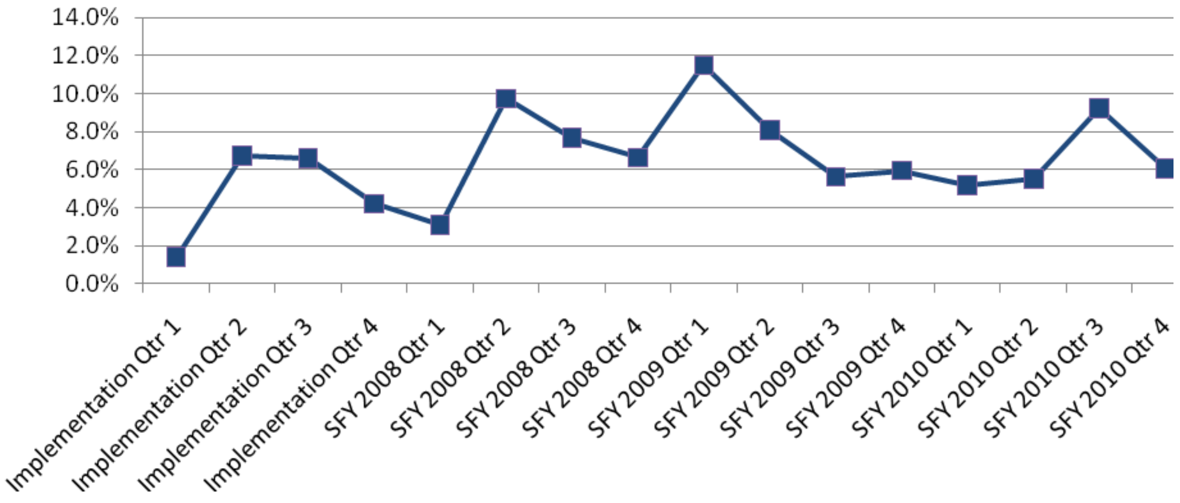
AMGP processed approximately 1.1 million non-CHOA hospital claims from June 1, 2006 through June 30, 2010. Approximately 6.7 percent of those claims were denied. In the table and figure below, we illustrate the variability of denied claims by period. During implementation, 5.5 percent of non-CHOA hospital claims were denied. In the post implementation periods, 6.9, 7.8 and 6.5 percent of claims denied, respectively.

Table 4: Non-CHOA Claim Denial Statistics, by Period for AMGP

	Implementation (6/1/06 - 6/30/07)	Post Implementation (7/1/07 - 6/30/08)	Post Implementation (7/1/08 - 6/30/09)	Post Implementation (7/1/09 - 6/30/10)	Total
Number of Claims Paid	204,806	240,824	254,871	328,658	1,029,159
Number of Claims Denied	11,940	17,730	21,466	22,944	74,080
Total Claims	216,746	258,554	276,337	351,602	1,103,239
Percent of Total Claims Denied	5.5%	6.9%	7.8%	6.5%	6.7%

The percentage of denied AMGP claims peaked in quarter one of SFY 2009 at 11.5 percent and declined to 6 percent by the last quarter of SFY 2009. The percentage peaked again at 9.2 percent for quarter three of SFY 2010 before dropping to 6.1 percent to finish out the fiscal year. The average denial rate for the period from June 1, 2006 to June 30, 2010 is 6.5 percent.

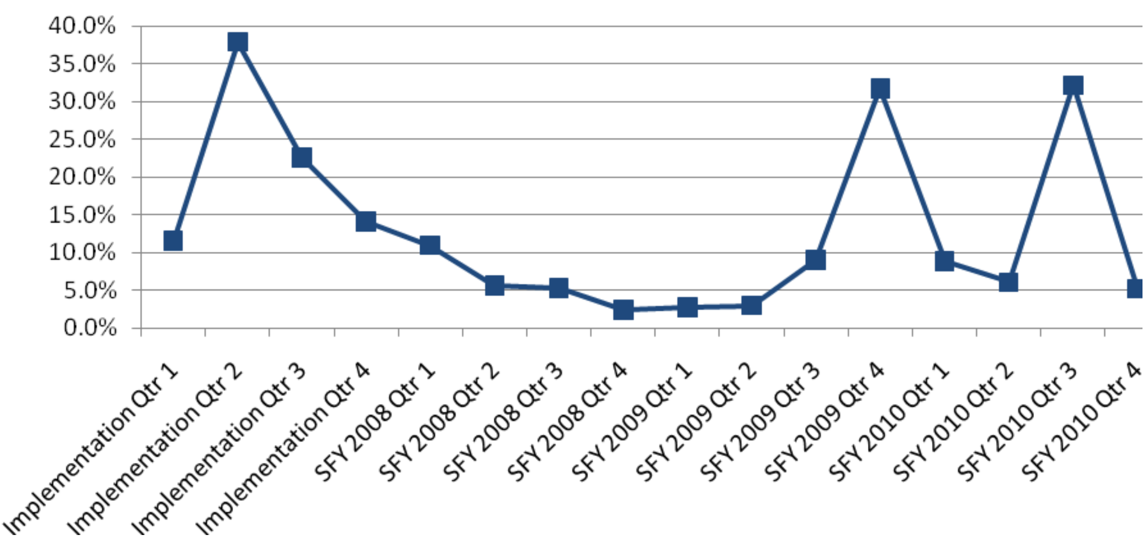
Figure 4: AMGP Percentage of Denied Non-CHOA Claims, By Quarter



AMGP reversed and later paid 9,928, or 13.1 percent of the non-CHOA hospital claims with an average of 117 days between the date of the denial and the payment. AMGP reported paying $125,918 in interest related to these claims. The figure below

illustrates the percentage of claim denials that were later paid, by quarter. The claims data suggests a decreasing trend in the need to reprocess previously denied claims through the second quarter of SFY 2009 followed by a spike in the fourth quarter of SFY 2009. SFY 2010 reflects wide variances from 32.1 percent in the third quarter to 5.2 percent in the fourth quarter of non-CHOA denials later paid to end the analysis period with an average rate of 13.1 percent.

Figure 5: AMGP Percentage of Denied Non-CHOA Claims Later Paid, By Quarter



In the table below, we present the number of denials by reason code category. For purposes of this analysis and for ease of reference, we developed the categories, mapping each denial reason code into a specific category. Of the eleven categories, only one ("Payment Issues") appears to be significantly increasing in the number of denials, from 2.4 percent during implementation to 22.5 percent during SFY 2010. The category "Payment Issues" includes denial descriptions such as "Reduced Allowable", "Paid at Contracted Rate" and "Agreement Discount".

Table 5: AMGP Non-CHOA Claim Denials by Reason Categories by Period

	Implementation (6/1/06 - 6/30/07)		Post Implementation (7/1/07 - 6/30/08)		Post Implementation (7/1/08 - 6/30/09)		Post Implementation (7/1/09 - 6/30/10)		All Periods	
Denial Reason Category	**Denials**	**Percent**	**Denials**	**Percent**	**Denials**	**Percent**	**Denials**	**Percent**	**Denials**	**Percent**
Coordination of Benefits	477	5.0%	951	4.8%	1,318	5.4%	1,633	7.3%	4,379	5.7%
Duplicate Submission	1,656	17.3%	2,661	13.4%	4,519	18.4%	1,940	8.6%	10,776	14.1%

	Implementation (6/1/06 - 6/30/07)		Post Implementation (7/1/07 - 6/30/08)		Post Implementation (7/1/08 - 6/30/09)		Post Implementation (7/1/09 - 6/30/10)		All Periods	
Non-Covered Benefit or Service	322	3.4%	1,011	5.1%	1,871	7.6%	3,246	14.5%	6,450	8.4%
Eligibility Issue	94	1.0%	35	0.2%	93	0.4%	64	0.3%	286	0.4%
Incorrect/Invalid Information	1,058	11.1%	1,501	7.6%	1,227	5.0%	1,353	6.0%	5,139	6.7%
Payment Issue	228	2.4%	326	1.6%	3,852	15.7%	5,061	22.5%	9,467	12.4%
Time Filing Limit	1,669	17.5%	5,355	27.0%	3,392	13.8%	2,078	9.3%	12,494	16.4%
Procedure Code Issue	293	3.0%	575	2.9%	404	1.7%	223	1.0%	1,495	2.0%
Included in Pricing	1,715	18.0%	4,134	20.8%	5,242	21.4%	3,806	17.0%	14,897	19.5%
Authorization Issue	1,866	19.5%	2,782	14.0%	2,214	9.0%	2,471	11.0%	9,333	12.2%
No Denial Reason/Non-Descript Reason	174	1.8%	511	2.6%	404	1.6%	570	2.5%	1,659	2.2%
TOTAL	**9,552**	**100.0%**	**19,842**	**100.0%**	**24,536**	**100.0%**	**22,445**	**100.0%**	**76,375**	**100.0%**

AMGP had 9,333 non-CHOA hospital claims, or 12.2 percent, that were denied for reasons related to prior authorization. During implementation, 19.5 percent of claims denied, and this figure decreased to 14.0 percent during the first post implementation period and 9.0 percent for the second post implementation period. For SFY 2010 the denials increased slightly to 11.0 percent.

Table 6: AMGP Non-CHOA Claims Denied for Prior Authorization, by Period

Denial Reason	SFY 2007	SFY 2008	SFY 2009	SFY 2010	All Periods
Dates of service are outside dates authorized	39	79	52	111	281
Deny preauth not obtained	1,782	2,668	2,111	2,036	8,597
Level of care not authorized	0	0	0	246	246
Units exceed UM authorization	43	31	49	68	191
Units reduced by UM authorization	2	4	2	10	18
TOTAL	**1,866**	**2,782**	**2,214**	**2,471**	**9,333**

Peach State Health Plan (PSHP)

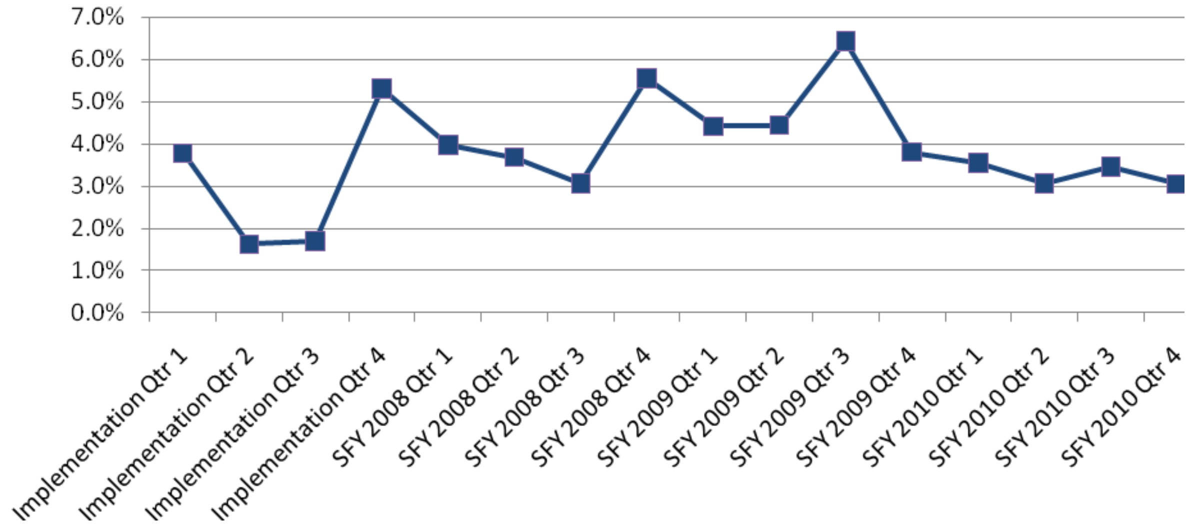
PSHP processed approximately 1.5 million non-CHOA hospital claims with paid dates from June 1, 2006 through June 30, 2010. Less than 4.0 percent of these claims were denied. In the table and figure below, we illustrate the variability of denied claims by period. During implementation, 3.1 percent of non-CHOA hospital claims were denied. In the post implementation periods, 4.1, 4.8 and 3.3 percent of claims denied, respectively.

Table 7: Non-CHOA Hospital Claim Denial Statistics, by Period for PSHP

	Implementation (6/1/06 - 6/30/07)	Post Implementation (7/1/07 - 6/30/08)	Post Implementation (7/1/08 - 6/30/09)	Post Implementation (7/1/09 - 6/30/10)	Total
Number of Claims Paid	304,072	340,910	375,369	429,784	1,450,135
Number of Claims Denied	9,772	14,427	18,861	14,607	57,667
Total Claims	313,844	355,337	394,230	444,391	1,507,802
Percent of Total Claims Denied	3.1%	4.1%	4.8%	3.3%	3.8%

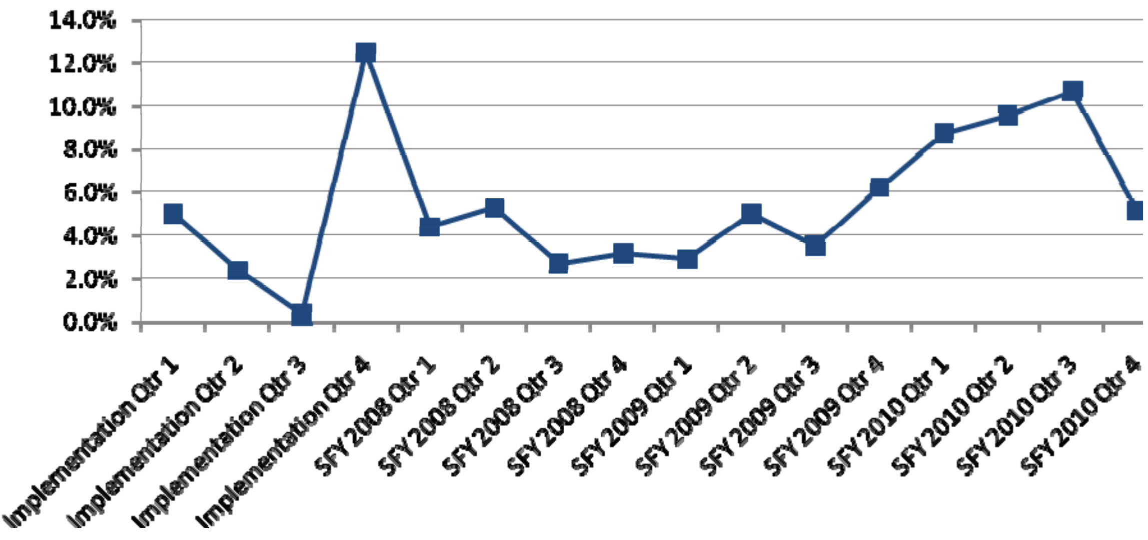
The percentage of denied PSHP non-CHOA hospital claims peaked in quarter three or four of each year but the percentage of denied claims decreased and, on average, remains at approximately 3.8 percent.

Figure 6: Percent of Non-CHOA Hospital Claims Denied, by Quarter for PSHP



PSHP reversed and later paid 3,439, or 5.9 percent, of non-CHOA hospital claims with an average of 145 days between the date of the denial and the payment. PSHP reported paying $67,390 in interest related to these claims. The figure below illustrates the percentage of claim denials that were later paid, by quarter. While the claims data suggests an increasing trend in the need to reprocess previously denied claims beginning in quarter three of SFY 2009, there was a marked decrease in this trend in quarter four of SFY 2010.

Figure 7: PSHP Percentage of Non-CHOA Denied Hospital Claims Later Paid, By Quarter



In the table below, we present the number of denials by reason code category. Of the eleven categories, only one ("Coordination of Benefits") appears to be significantly increasing in the number of denials, from 15.1 percent during implementation to 28.5 percent during SFY 2010. The category "Non-Covered Benefit or Service" decreased steadily from 15.6 percent during implementation to 6.8 percent for SFY 2010.

Table 8: PSHP Non-CHOA Claim Denials by Reason Categories by Period

	Implementation (6/1/06 - 6/30/07)		Post Implementation (7/1/07 - 6/30/08)		Post Implementation (7/1/08 - 6/30/09)		Post Implementation (7/1/09 - 6/30/10)		All Periods	
Denial Reason Category	**Denials**	**Percent**	**Denials**	**Percent**	**Denials**	**Percent**	**Denials**	**Percent**	**Denials**	**Percent**
Coordination of Benefits	1,463	15.1%	3,239	23.6%	4,495	27.1%	3,557	28.5%	12,754	24.3%
Duplicate Submission	968	10.0%	761	5.5%	601	3.6%	373	2.9%	2,703	5.2%
Non-Covered Benefit or Service	1,508	15.6%	449	3.3%	1,011	6.1%	592	4.8%	3,560	6.8%
Eligibility Issue	3	0.0%	10	0.1%	20	0.1%	36	0.3%	69	0.1%
Incorrect/Invalid Information	740	7.7%	145	1.1%	119	0.7%	421	3.4%	1,425	2.7%
Payment Issue	223	2.3%	324	2.4%	2,023	12.2%	406	3.3%	2,976	5.7%
Time Filing Limit	3,010	31.2%	7,030	51.3%	6,561	39.6%	3,993	32.0%	20,594	39.3%
Procedure Code Issue	122	1.3%	207	1.5%	285	1.8%	84	0.7%	698	1.3%
Included in Pricing	38	0.4%	6	0.0%	7	0.0%	1	0.0%	52	0.1%
Authorization Issue	1,582	16.4%	1,535	11.2%	1,463	8.8%	2,997	24.1%	7,577	14.5%
No Denial Reason/Non-Descript Reason	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
TOTAL	**9,657**	**100%**	**13,706**	**100%**	**16,585**	**100%**	**12,460**	**100%**	**52,408**	**100%**

PSHP had 7,577 non-CHOA hospital claims, or 14.5 percent, that were denied for reasons related to prior authorization. During implementation, 16.4 percent of claims denied, and this figure steadily decreased in SFY 2008 and SFY 2009 to 11.2 and 8.8 percent respectively. The percentage increased in SFY 2010 to 24.1 percent.

Table 9: PSHP Non-CHOA Claims Denied for Prior Authorization, by Period

Denial Reason	SFY 2007	SFY 2008	SFY 2009	SFY 2010	All Periods
DENY: AUTHORIZATION NOT ON FILE	1,211	1,054	1,158	2,656	6,079

Denial Reason	SFY 2007	SFY 2008	SFY 2009	SFY 2010	All Periods
DENY: AUTH DENIAL UPHELD - REVIEW PER CLP0700 PEND REPORT	1	3	2	0	6
DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH	10	30	3	4	47
DENY: CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING	56	43	33	27	159
DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING	160	258	45	49	512
DENY: CLAIM AND AUTH TREATMENT TYPE NOT MATCHING	29	39	59	24	151
DENY: DENIED BY MEDICAL SERVICES	66	64	112	141	383
DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT	49	44	51	96	240
TOTAL	**1,582**	**1,535**	**1,463**	**2,997**	**7,577**

WellCare of Georgia (WellCare)

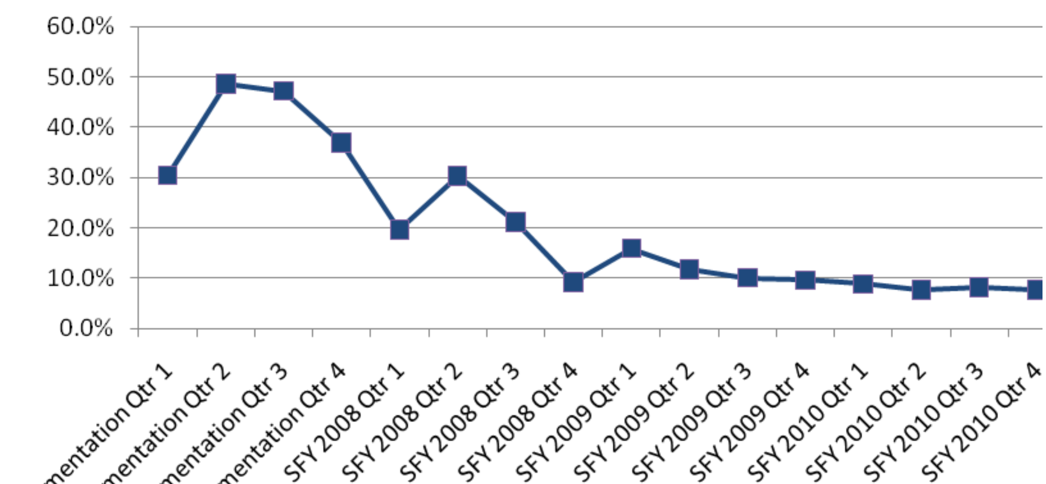
WellCare processed over 1.8 million hospital claims with paid dates from June 1, 2006 through June 30, 2010. Twelve percent of these claims were denied. It is important to note that WellCare has stated that the denied/paid dates reported on the encounters submitted by WellCare may not reflect the actual date the claim was paid or denied. While the total denial rates are accurate, this discrepancy limits the usefulness of the trend information displayed. Based on the dates reported on the encounters, we illustrate the variability of denied claims by period in the table and figure below. During implementation, 41.8 percent of hospital claims were denied. In the post implementation periods, 17.8, 12.1 and 8.0 percent of claims denied, respectively.

Table 10: Non-CHOA Hospital Claim Denial Statistics, by Period for WellCare

	Implementation (6/1/06 - 6/30/07)	Post Implementation (7/1/07 - 6/30/08)	Post Implementation (7/1/08 - 6/30/09)	Post Implementation (7/1/09 - 6/30/10)	Total
Number of Claims Paid	27,645	221,522	664,087	725,120	1,638,374
Number of Claims Denied	19,880	48,047	91,710	63,196	222,833
Total Claims	47,525	269,569	755,797	788,316	1,861,207
Percent of Total Claims Denied	41.8%	17.8%	12.1%	8.0%	12.0%

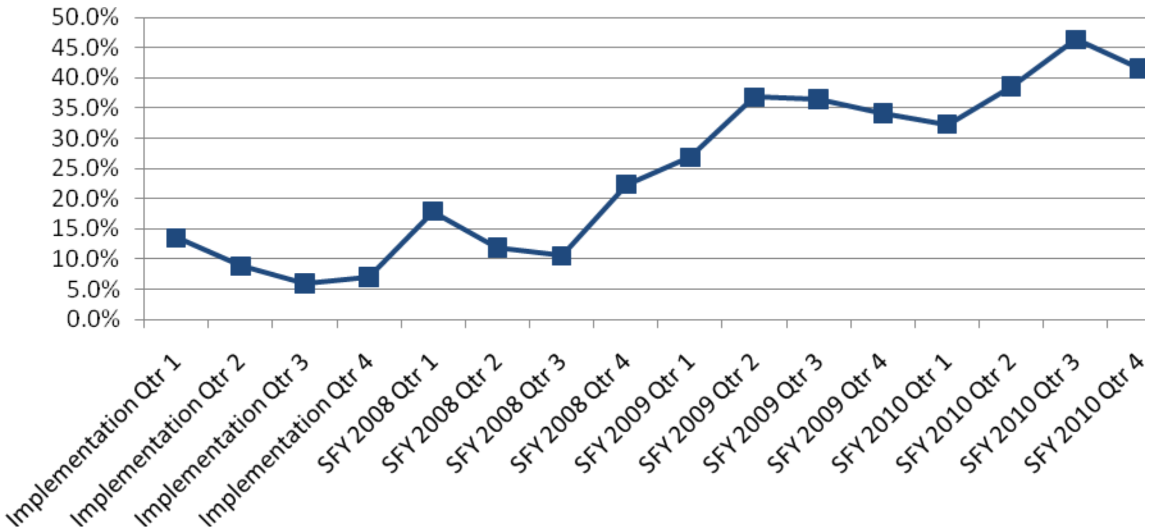
The percentage of denied WellCare claims, with the exception of SFY 2008 quarter two and SFY 2009 quarter one, has consistently decreased from a high of 48.5 percent during quarter two of implementation to its lowest level of 7.6 percent for quarter four of SFY 2010.

Figure 8: Percent of Claims Denied, by Quarter for WellCare



WellCare reversed and later paid 64,340, or 28.8 percent of hospital claims with an average of 28 days between the date of the denial and the payment. WellCare reported paying $25,034 in interest related to these claims. The figure below illustrates the percentage of claim detail line denials that were later paid, by quarter. The claims data suggests an increasing trend in the need to reprocess previously denied claims.

Figure 9: WellCare Percentage of Denied Claims Later Paid, By Quarter



In the table below, we present the number of denials by reason code category. Of the eleven categories, only one category ("No Denial Reason/Non-Descript Reason") appears to be significantly increasing in the number of denials, from 34.5 percent during implementation to 46.9 percent during SFY 2010. This category includes reason codes that were blank and codes such as "Claim Required Manual Intervention" and "High Dollar Threshold- Please Review". Other categories such as "Authorization Issue" decreased during the post implementation periods.

Table 11: WellCare Claim Detail Line Denials by Reason Categories by Period

	Implementation (6/1/06 - 6/30/07)		Post Implementation (7/1/07 - 6/30/08)		Post Implementation (7/1/08 - 6/30/09)		Post Implementation (7/1/09 - 6/30/10)		All Periods	
Denial Reason Category	**Denials**	**Percent**	**Denials**	**Percent**	**Denials**	**Percent**	**Denials**	**Percent**	**Denials**	**Percent**
Coordination of Benefits	18	0.3%	123	0.4%	329	0.5%	97	0.3%	567	0.4%
Duplicate Submission	1,879	30.1%	9,467	32.6%	18,800	27.1%	6,206	21.3%	36,352	27.2%
Non-Covered Benefit or Service	170	2.7%	1,781	6.1%	4,046	5.8%	3,025	10.4%	9,022	6.8%
Eligibility Issue	9	0.1%	15	0.1%	22	0.0%	3	0.0%	49	0.1%
Incorrect/Invalid Information	422	6.8%	885	3.1%	1,167	1.7%	1,566	5.4%	4,040	3.0%
Payment Issue	8	0.1%	9	0.0%	2	0.0%	0	0.0%	19	0.0%
Time Filing Limit	306	4.9%	2,477	8.5%	6,890	9.9%	3,341	11.5%	13,014	9.7%
Procedure Code Issue	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Included in Pricing	179	2.9%	185	0.6%	120	0.2%	844	2.9%	1,328	1.0%
Authorization Issue	1,092	17.5%	1,548	5.3%	592	0.9%	360	1.3%	3,592	2.7%
No Denial Reason/Non-Descript Reason	2,154	34.6%	12,604	43.3%	37,311	53.9%	13,640	46.9%	65,709	49.1%
TOTAL	**6,237**	**100%**	**29,094**	**100%**	**69,279**	**100%**	**29,082**	**100%**	**133,692**	**100%**

WellCare had 3,592 claims, or 2.7 percent, that were denied for reasons related to prior authorization. During implementation, 17.5 percent of claims denied. This number has decreased significantly to 1.2 percent for SFY 2010.

Table 12: WellCare Claims Denied for Prior Authorization, by Period

Denial Reason Provided by CMO	SFY 2007	SFY 2008	SFY 2009	SFY 2010	All Periods
AUTHORIZATION DENIED	5	23	4	7	39
Authorization expired - Date	3	1	0	0	4
Authorization expired - Date of Svc after Authorized dates	0	0	0	0	0
Authorization expired - Date of Svc of procedure is outside of what was Authorized	0	1	0	0	1
Date of Svc of procedure is ou	2	0	0	0	2
Date of Svc of procedure is outside of what was Authorized	0	2	0	0	2
Limit Reached-Authorization re	8	31	0	0	39
Limit Reached-Authorization required	0	44	20	5	69
NO VALID AUTHORIZATION ON FILE	56	23	0	1	80
Prior Authorization is require	872	1,265	28	0	2,165
Prior Authorization is required but was not obtained	0	31	513	336	880
Prior Authorization request wa	128	64	2	0	194
Prior Authorization request was denied	0	30	4	0	34
Prior Authorization request was denied, AUTHORIZATION DENIED	0	1	0	0	1
SERVICES NOT INCLUDED IN AUTHO	1	1	1	0	3
SERVICES NOT INCLUDED IN AUTHORIZATION	0	0	4	0	4
Svcs billed not consistent wit	17	27	1	0	45
Svcs billed not consistent with the Authorization on file	0	4	15	11	30
TOTAL	**1,092**	**1,548**	**592**	**360**	**3,592**

ANALYSIS III: EMERGENCY ROOM VISITS

The DCH Contract with the CMOs:

The contract amendment effective July 1, 2008 and all subsequent contract amendments between the CMOs and DCH address the payment of emergency services:

4.6.1.2

> *An Emergency Medical Condition shall not be defined or limited based on a list of diagnoses or symptoms. An Emergency Medical Condition is a medical or mental health Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:*
>
> - *Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
> - *Serious impairment to bodily functions;*
> - *Serious dysfunction of any bodily organ or part;*
> - *Serious harm to self or others due to an alcohol or drug abuse emergency;*
> - *Injury to self or bodily harm to others; or*
> - *With respect to a pregnant woman having contractions: (i) That there is adequate time to affect a safe transfer to another hospital before delivery, or (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.*

4.6.1.3

> *The Contractor shall provide payment for Emergency Services when furnished by a qualified Provider, regardless of whether that Provider is in the Contractor's network. These services shall not be subject to prior authorization requirements. The Contractor shall be required to pay for all Emergency Services that are Medically Necessary until the Member is stabilized. The Contractor shall also pay for any screening examination services conducted to determine whether an Emergency Medical Condition exists.*

All versions of the contract between the CMOs and DCH address emergency room visits with the following language:

4.6.1.4

> *The Contractor shall base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson.*

The contract amendment effective July 1, 2008 and all subsequent contract amendments between the CMOs and DCH address claims that are inappropriately denied or underpaid with the following language:

4.9.7.5.4

> *For all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment.*

To complete the analysis of emergency room visits claims, we used the CMO encounter data submitted by the CMOs to the fiscal agent contractor and extracted from our data warehouse and we requested supplemental data from the CMOs and/or their subcontractors for all hospital claims paid or denied with paid dates from June 1, 2006 through June 30, 2010. We identified claims as an emergency room visit if the claim type indicated outpatient and the revenue code billed on the claim was 450, 451, 452, 456 or 459 and the procedure code was 99281, 99282, 99283, 99284, 99285, 99291 or 99292. We noted that for each of the CMOs, certain hospital emergency room claims did not include a procedure code or indication of level of care. We have identified those encounters under the category “Level Not Provided”. When applicable, we analyzed whether denied claims were later paid, and whether those payments included interest. We further analyzed the claims by period, considering the implementation period as June 1, 2006 through June 30, 2007 and the post implementation periods as SFY 2008, SFY 2009 and SFY 2010 with paid dates through June 30, 2010.

It is important to note that the contracts between the CMOs and the hospital do not always contain provisions for triage payments, sometimes referred to as administrative fees, for services provided in the emergency room that are deemed non-emergency. An increasing number of contracts have been amended to include negotiated rates for the various levels of care and no longer include language allowing for the determination of an emergency status on the claims. For purposes of this analysis, a claim payment is classified as a triage payment if the amount paid was specifically referred to as such in the contract between the CMO and the provider or if the payment made for a claim included a level of care of 99283 or higher but was paid at the negotiated rate for procedures codes 99281 or 99282.

It is also important to note that the Department requested that Myers and Stauffer provide statistical data regarding the number of claims paid by each of the care management organizations (CMOs) at contractually defined non-emergency (triage) rates versus emergency rates. DCH did not request that Myers and Stauffer examine each claim and verify that the emergency/non-emergency determination was appropriate. The analysis includes the assumption that this determination was made appropriately by the CMO during the adjudication process and took into account the

factors cited in O.C.G.A. 33-21A-4b. Those factors include the age of the patient, the time and day of the week the patient presented for services, the severity and nature of the presenting symptoms, the patient's initial and final diagnosis and any other criteria prescribed by DCH, including criteria specific to patients under 18 years of age.

AMERIGROUP Community Care (AMGP)

AMGP paid 491,765 emergency room claims from June 1, 2006 to June 30, 2010. Of the 491,765 visits, 24,427 or five percent were paid at the triage rate. Ninety-nine percent of the claims paid at triage were classified as level three emergencies or higher. The procedure code/level of care was not provided for 3,524 emergency room claims.

Table 13: AMGP Non-CHOA Emergency Room Visits Paid at Triage Rate

	Count of ER Visits Paid at Non-Triage Rate	Count of ER Visits Paid at Triage Rate	Total ER Visits	Percent of ER Visits Paid at Triage Rate
Level 1 - 99281	46,407	0	46,407	0.0%
Level 2 - 99282	151,514	0	151,514	0.0%
Level 3 - 99283	187,758	17,951	205,709	8.7%
Level 4 - 99284	62,778	5,436	68,214	8.0%
Level 5 - 99285	14,506	798	15,304	5.2%
Trauma 1 – 99281	1,030	7	1,037	0.7%
Trauma 2 – 99282	56	0	56	0.0%
Level Not Provided	3,289	235	3,524	6.7%
TOTAL	**467,338**	**24,427**	**491,765**	**5.0%**

AGMP's percentage of emergency room visits paid at the triage rate has increased from zero percent at implementation to 14.6 percent for SFY 2010.

Table 14: Percent of AMGP Non-CHOA Emergency Room Visits Paid at Triage Rate by Period[1]

	Implementation (6/1/06 - 6/30/07)	Post Implementation (7/1/07 - 6/30/08)	Post Implementation (7/1/08 - 6/30/09)	Post Implementation (7/1/09 - 6/30/10)
Level 1 - 99281	0.0%	0.0%	0.0%	0.0%
Level 2 - 99282	0.0%	0.0%	0.0%	0.0%
Level 3 - 99283	0.0%	0.0%	1.8%	23.6%
Level 4 - 99284	0.0%	0.0%	1.5%	20.6%
Level 5 - 99285	0.0%	0.0%	1.0%	12.4%
Trauma 1 - 99281	0.0%	0.0%	0.3%	2.0%
Trauma 2 – 99282	0.0%	0.0%	0.0%	0.0%

Level Not Provided	0.0%	0.0%	1.4%	21.1%

[1] Percentages were determined by dividing the number of claims paid at the triage rate per level of care by the total number of claims billed with that code.

Peach State Health Plan (PSHP)

PSHP paid 606,309 emergency room claims from June 1, 2006 to June 30, 2010. Of the 606,309 visits, 226,237 or 37.3 percent were paid at the triage rate. Approximately 47.6 percent (107,604) of the claims paid at triage were classified as level three emergencies or higher. PSHP did not provide the procedure code/level of care for 7,937, or 1.3 percent, of the emergency room claims.

Table 15: PSHP Non-CHOA Emergency Room Visits Paid at Triage Rate

	Count of ER Visits Paid at Non-Triage Rate	Count of ER Visits Paid at Triage Rate	Total ER Visits	Percent of ER Visits Paid at Triage Rate
Level 1 - 99281	41,115	28,943	70,058	41.3%
Level 2 - 99282	111,987	87,153	199,140	43.8%
Level 3 - 99283	153,181	86,013	239,194	36.0%
Level 4 - 99284	55,680	18,994	74,674	25.4%
Level 5 - 99285	11,966	2,569	14,535	17.7%
Trauma 1 - 99281	656	28	684	4.1%
Trauma 2 – 99282	87	0	87	0.0%
Level Not Provided	5,400	2,537	7,937	32.0%
TOTAL	**380,072**	**226,237**	**606,309**	**37.3%**

The percentage of PSHP emergency room claims paid at the triage rate has increased from 31.3 percent at implementation to 52.5 percent for SFY 2010.

Table 16: Percent of PSHP Non-CHOA Emergency Room Visits Paid at Triage Rate by Period[1]

	Implementation (6/1/06 - 6/30/07)	Post Implementation (7/1/07 - 6/30/08)	Post Implementation (7/1/08 - 6/30/09)	Post Implementation (7/1/09 - 6/30/2010)
Level 1 - 99281	41.2%	35.1%	37.7%	56.3%
Level 2 - 99282	36.2%	35.3%	39.7%	61.6%
Level 3 - 99283	27.8%	25.3%	31.5%	51.2%
Level 4 - 99284	18.4%	15.6%	19.7%	40.0%
Level 5 - 99285	12.4%	10.0%	12.2%	29.9%
Trauma 1 - 99281	0.0%	0.0%	0.0%	16.1%
Trauma 2 - 99282	0.0%	0.0%	0.0%	0.0%

Level Not Provided	24.3%	12.0%	28.5%	49.8%

[1] Percentages were determined by dividing the number of claims paid at the triage rate per level of care by the total number of claims billed with that code.

WellCare of Georgia (WellCare)

WellCare paid 720,508 emergency room claims from June 1, 2006 to June 30, 2010. Of the 720,508 visits, 228,756 or 31.7 percent were paid at the triage rate. WellCare did not provide the procedure code/level of care for 382,831, or 53.1 percent of emergency room visits so we were unable to determine the actual level of care for the results identified under "Level Not Provided".

Table 17: WellCare Non-CHOA Emergency Room Visits Paid at Triage Rate

	Count of ER Visits Paid at Non-Triage Rate	Count of ER Visits Paid at Triage Rate	Total ER Visits	Percent of ER Visits Paid at Triage Rate
Level 1 - 99281	21,661	11,715	33,376	35.1%
Level 2 - 99282	67,173	32,711	99,884	32.7%
Level 3 - 99283	108,957	39,836	148,793	26.8%
Level 4 - 99284	37,123	9,197	46,320	19.9%
Level 5 - 99285	7,689	1,085	8,774	12.4%
Trauma 1 - 99281	446	38	484	7.9%
Trauma 2 – 99282	37	9	46	19.6%
Level Not Provided	248,666	134,165	382,831	35.0%
TOTAL	**491,752**	**228,756**	**720,508**	**31.7%**

WellCare's percentage of emergency room visits paid at the triage rate increased from 26.6 percent during implementation to 46.7 percent in the first year post implementation. The rate decreased to 29 percent in SFY 2010.

Table 18: Percent of WellCare Non-CHOA Emergency Room Visits Paid at Triage Rate by Period[1]

	Implementation (6/1/06 - 6/30/07)	Post Implementation (7/1/07 - 6/30/08)	Post Implementation (7/1/08 - 6/30/09)	Post Implementation (7/1/09 - 6/30/2010)
Level 1 - 99281	18.7%	51.7%	27.4%	10.4%
Level 2 - 99282	40.5%	51.1%	29.9%	2.4%
Level 3 - 99283	27.5%	50.7%	27.1%	5.0%
Level 4 - 99284	13.3%	31.6%	20.1%	8.7%

Level 5 - 99285	6.8%	20.4%	13.6%	1.1%
Trauma 1 - 99291	0.0%	11.3%	8.1%	0.0%
Trauma 2 - 99292	0.0%	0.0%	22.5%	0.0%
Level Not Provided	22.7%	40.9%	32.6%	36.0%

[1] Percentages were determined by dividing the number of claims paid at the triage rate per level of care by the total number of claims billed with that code.

ANALYSIS IV: GEORGIA FAMILIES PROGRAM PROVIDER RETENTION

The DCH Contract with the CMOs:

Both the original and amended contracts state in section 4.8 *"Provider Network"* that each CMO must have written selection and retention policies and procedures, however no specific retention requirements were found. The contracts also provide specific parameters regarding the providers that are required to be included in the network and, pursuant to section 2.8.1.5, in accordance with 42 CFR 438.204, DCH will monitor "The Contractor's policies and procedures for selection and retention of Providers".

We analyzed the claims data and provider network information to determine whether any trends or potential provider retention concerns might exist for the Georgia Families program.

AMERIGROUP Community Care (AMGP)

Twenty-eight (28) of the 133 hospitals contracted with AMGP have terminated their contract. Of that twenty-eight, five of the hospitals had no claim activity. In addition, six of the remaining 105 hospitals have no reported claim activity. The following table identifies the terminated hospitals and their respective claim encounters for the period June 1, 2006 through June 30, 2010.

Table 19: AMGP Disenrolled Providers with Reason and Claim Count

Provider Name	Date of Disenrollment	Reason for Disenrollment	Count of Claims Submitted
Atlanta Medical Ctr	4/5/2008	Term-Without Cause	8,424
Cartersville Medical Center	4/1/2010	Dismiss-Quit Contracted Group	9,118
Centennial Medical Ctr	11/1/2009	Dismiss-Without Cause	19
Coliseum Medical Ctr	4/1/2010	Dismiss-Without Cause	86
Coliseum Northside Hospital	4/1/2010	Dismiss-Quit Contracted Group	27
Doctors Hospital of Augusta	4/1/2010	Dismiss-Without Cause	24,920
DUP South Fulton Medical Center	4/6/2008	Term-Without Cause	9,515
Emory Dunwoody Medical Ctr	12/31/2006	Term-Retired or Closed	142
Emory Eastside Medical Center	4/1/2010	Dismiss-Quit Contracted Group	7,028
Fairview Park Hospital	4/1/2010	Dismiss-Credentialing Reason	743
Hendersonville Med Ctr	11/1/2009	Dismiss-Without Cause	0
Holy Cross Hospital	8/5/2009	Term-Wants Out of Network	7
North Fulton Regional Hospital	4/6/2008	Term-Without Cause	2,651

Provider Name	Date of Disenrollment	Reason for Disenrollment	Count of Claims Submitted
Northlake Medical Ctr	12/16/2006	Dismiss-Wants Out of Network	288
Parkridge East Hospital	11/1/2009	Dismiss-Without Cause	3,270
Parkridge Medical Ctr	11/1/2009	Dismiss-Without Cause	319
Polk Medical Center	4/1/2010	Dismiss-Without Cause	4,711
Portland Medical Ctr	11/1/2009	Dismiss-Without Cause	0
Redmond Regional Medical Ctr	4/1/2010	Dismiss-Quit Contracted Group	4,690
Skyline Medical Center	11/1/2009	Dismiss-Without Cause	8
South Fulton Medical Center	4/6/2008	Term-Without Cause	0
Southern Hills Medical Ctr	11/1/2009	Dismiss-Without Cause	0
Spalding Regional Hospital	4/5/2008	Term-Without Cause	3,297
StoneCrest Medical Center	11/1/2009	Dismiss-Without Cause	7
Summit Medical Ctr	11/1/2009	Dismiss-Without Cause	16
Sylvan Grove Hospital	4/6/2008	Term-Without Cause	1,138
Tampa General Hospital	6/1/2010	Dismiss-Wants Out of Network	0
The Doctors Hospital of Tattnall	6/1/2010	Dismiss-Quit Contracted Group	3,464

Peach State Health Plan (PSHP)

In the information provided to Myers and Stauffer by PSHP, thirteen hospitals were identified that appear to have terminated their contract with PSHP. Reasons were not provided by PSHP for the terminations, therefore we are unable to provide more detailed information regarding the number of provider-initiated and CMO-initiated terminations. Upon review of the initial findings, PSHP provided the following clarification.

> *"Of the thirteen (13) hospitals listed [as terminated from the network…], only three (3) have actually terminated from the network. After reviewing the data, we believe that the listing of terminated affiliations in the supplemental data may have given the impression that the associated hospitals were terminated from the provider network.*
>
> *The three (3) terminated hospitals were Ocala Regional Medical Center, Taylor Telfair Regional Hospital and Fulton DeKalb Hospital Authority d/b/a Grady Health System. The ten (10) remaining hospitals listed in the report continue to form a vital part of the PSHP provider network."*

The table below lists the original thirteen hospitals that were identified as well as highlights the clarification provided by PSHP.

Table 20: PSHP Disenrolled Providers and Claim Count

Provider Name	Date of Disenrollment	Count of Claims Submitted
BERRIEN COUNTY HOSPITAL	3/31/2009	5,667
CHILDRENS AT EGLESTON	6/30/2009	78,657
CHILDRENS AT HUGHES SPALDING	6/30/2009	64,489
DOCTORS HOSPITAL OF AUGUSTA	11/14/2008	1,028
DOCTORS HOSPITAL OF COLUMBUS	6/25/2009	10,909
EAST GEORGIA REGIONAL MED CTR	3/31/2009	223
FLOWERS HOSPITAL	4/30/2009	180
MCG HEALTH INC	6/30/2009	4,171
OCALA REGIONAL MED CTR	4/30/2009	8
ROCKDALE HOSPITAL	1/31/2009	18,830
TAYLOR TELFAIR REGIONAL HOSPITAL	9/30/2008	726
THE FULTON DEKALB HOSPITAL AUTHORITY DBA GRADY HEALTH SYSTEM	5/31/2009	66,885
WHEELER COUNTY HOSPITAL	2/18/2008	1,265

WellCare of Georgia (WellCare)

Two of the 146 hospitals contracted with WellCare terminated their contract. Seventeen of the remaining 144 hospitals had no claim activity.

Table 21: WellCare Disenrolled Providers with Reason and Claim Count

Provider Name	Date of Disenrollment	Reason for Disenrollment	Count of Claims Submitted
EMORY DUNWOODY MEDICAL CTR	12/31/2006	Physician Requested Termination	19
TAYLOR-TELFAIR REGIONAL HOSPITAL	10/31/2008	VOLUNTARY TERMINATION	267

HOSPITAL CLAIMS ANALYSIS FINDINGS SUMMARY:

Analysis	AMGP	PSHP	WellCare
I. Claims Adjudication ***(See also Exhibit 1)***	99.2% paid or denied within 19 days; Health plan reported interest payments of $65,826.	89.1% paid or denied within 19 days; Health plan reported interest payments of $1,495,860.	72.8% paid or denied within 19 days; Health plan reported interest payments of $165,432.
II. Denied Claims ***(See also Exhibit 2)***	▪ 6.7% claims denied ▪ SFY 2009 Quarter 1 highest level at 11.5% ▪ 13.1% of denied claims later paid in average of 117 days. Interest of $125,918 paid by plan. ▪ Denied claims related to "Payment Issues" and "Authorization Issues" continue to be problematic for providers	▪ 3.8% claims denied ▪ SFY 2009 Quarter 3 highest level at 6.4% ▪ 5.9% of denied claims later paid in average of 145 days. Interest of $67,390 paid by plan. ▪ Denials for Coordination of Benefits increased significantly from 15.1% during implementation to 28.5 percent for SFY2010.	▪ 12% claims denied ▪ Implementation Quarter 2 highest level at 48.5% ▪ 28.8% of denied claims later paid in average of 28 days. Interest of $25,034 paid by plan. ▪ Significant increase from 34.5% at implementation to 46.9% for SFY 2010 in denials with no denial reason or a non-descript reason
III. Emergency Room Visits	▪ 5% paid at triage rate ▪ 99% of claims paid at triage rate were classified as level 3 or higher ▪ Percentage of claims paid at triage rate increased from zero percent at implementation to 14.6% for SFY 2010	▪ 37.3% paid at triage rate ▪ 47.6% of claims paid at triage rate were classified as level 3 or higher ▪ Percentage of claims paid at triage rate increased from 31.3 percent at implementation to 52.5% for SFY 2010	▪ 31.7% paid at triage rate ▪ Procedure Code/Level of Care was not provided for approximately 53% of claims

Analysis	AMGP	PSHP	WellCare
IV. Provider Retention	28 Facilities terminated their contract	3 Facilities terminated their contract	2 Facilities terminated their contract

RECOMMENDATIONS

1) DCH may wish to require that the encounter data submitted by the CMOs contain complete and accurate data, including the actual dates the claims were paid or denied.
2) DCH may wish to have AMGP confirm the validity of the data submitted by AMGP which indicates that 100 percent of the hospital claims submitted were adjudicated in 19 days or less during SFY 2010.
3) DCH may wish to require WellCare to submit level of care information for emergency service claims in order to thoroughly evaluate triage payment trends.
4) DCH may wish to inquire to the CMOs concerning the apparent trend upward on the percentage of claims paid at the triage rate.
5) DCH may wish to ask AMGP to provide an explanation regarding the number of facilities which have terminated their contract with AMGP.
6) DCH may wish to request WellCare to provide an explanation regarding the number of hospitals not submitting claims.

EXHIBITS

Exhibit One – Claim Adjudication

AMERIGROUP Community Care (AMGP)

Claim Adjudication Statistics for AMERIGROUP Non-CHOA Hospital Claims

All Periods (6/1/06-6/30/10)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	1,029,159	74,080	1,103,239	$65,826
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	945,992	58,150	1,004,142	N/A
Number of Claims Adjudicated in 5-9 Days	54,205	8,629	62,834	N/A
Number of Claims Adjudicated in 10-14 Days	13,257	3,336	16,593	N/A
Number of Claims Adjudicated in 15-19 Days	8,936	2,166	11,102	N/A
Percent of Claims Adjudicated within 19 Days	**99.3%**	**97.6%**	**99.2%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	5,607	1,371	6,978	$19,925
Number of Claims Adjudicated in 35-64 Days	1,003	367	1,370	$35,056
Number of Claims Adjudicated in 65-94 Days	97	33	130	$5,384
Number of Claims Adjudicated in 95-124 Days	24	8	32	$548
Number of Claims Adjudicated in 125-184 Days	13	5	18	$1,318
Number of Claims Adjudicated in 185 + Days	25	15	40	$3,595

Claim Adjudication Statistics for AMERIGROUP Non-CHOA Hospital Claims

Implementation SFY 2007 (6/1/06 – 6/30/07)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	204,806	11,940	216,746	$31,692
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	170,163	7,517	177,680	N/A
Number of Claims Adjudicated in 5-9 Days	22,738	2,694	25,432	N/A
Number of Claims Adjudicated in 10-14 Days	4,737	825	5,562	N/A
Number of Claims Adjudicated in 15-19 Days	3,766	455	4,221	N/A
Percent of Claims Adjudicated within 19 Days	**98.3%**	**96.2%**	**98.2%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	3,024	363	3,387	$8,894
Number of Claims Adjudicated in 35-64 Days	324	73	397	$17,841
Number of Claims Adjudicated in 65-94 Days	35	4	39	$3,758
Number of Claims Adjudicated in 95-124 Days	10	5	15	$220
Number of Claims Adjudicated in 125-184 Days	5	3	8	$271
Number of Claims Adjudicated in 185 + Days	4	1	5	$710

Claim Adjudication Statistics for AMERIGROUP Non-CHOA Hospital Claims

Post Implementation SFY 2008 (7/1/07-6/30/08)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	240,824	17,730	258,554	$33,901
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	200,721	9,590	210,311	N/A
Number of Claims Adjudicated in 5-9 Days	24,525	3,552	28,077	N/A
Number of Claims Adjudicated in 10-14 Days	7,496	1,804	9,300	N/A
Number of Claims Adjudicated in 15-19 Days	4,894	1,581	6,475	N/A
Percent of Claims Adjudicated within 19 Days	**98.7%**	**93.2%**	**98.3%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	2,437	901	3,338	$10,854
Number of Claims Adjudicated in 35-64 Days	646	255	901	$17,161
Number of Claims Adjudicated in 65-94 Days	62	29	91	$1,627
Number of Claims Adjudicated in 95-124 Days	14	3	17	$328
Number of Claims Adjudicated in 125-184 Days	8	1	9	$1,047
Number of Claims Adjudicated in 185 + Days	21	14	35	$2,885

Claim Adjudication Statistics for AMERIGROUP Non-CHOA Hospital Claims

Post Implementation SFY 2009 (7/1/08-6/30/09)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	254,871	21,466	276,337	$232
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	246,450	18,099	264,549	N/A
Number of Claims Adjudicated in 5-9 Days	6,942	2,383	9,325	N/A
Number of Claims Adjudicated in 10-14 Days	1,024	707	1,731	N/A
Number of Claims Adjudicated in 15-19 Days	276	130	406	N/A
Percent of Claims Adjudicated within 19 Days	**99.9%**	**99.3%**	**99.9%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	146	107	253	$177
Number of Claims Adjudicated in 35-64 Days	33	39	72	$55
Number of Claims Adjudicated in 65-94 Days	0	0	0	$0
Number of Claims Adjudicated in 95-124 Days	0	0	0	$0
Number of Claims Adjudicated in 125-184 Days	0	1	1	$0
Number of Claims Adjudicated in 185 + Days	0	0	0	$0

Claim Adjudication Statistics for AMERIGROUP Non-CHOA Hospital Claims

Post Implementation SFY 2010 (7/1/09-6/30/10)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	328,658	22,944	351,602	$0
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	328,658	22,944	351,602	N/A
Number of Claims Adjudicated in 5-9 Days	0	0	0	N/A
Number of Claims Adjudicated in 10-14 Days	0	0	0	N/A
Number of Claims Adjudicated in 15-19 Days	0	0	0	N/A
Percent of Claims Adjudicated within 19 Days	**100.0%**	**100.0%**	**100.0%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	0	0	0	$0
Number of Claims Adjudicated in 35-64 Days	0	0	0	$0
Number of Claims Adjudicated in 65-94 Days	0	0	0	$0
Number of Claims Adjudicated in 95-124 Days	0	0	0	$0
Number of Claims Adjudicated in 125-184 Days	0	0	0	$0
Number of Claims Adjudicated in 185 + Days	0	0	0	$0

Peach State Health Plan (PSHP)

Claim Adjudication Statistics for Peach State Health Plans Non-CHOA Hospital Claims

All Periods (6/1/06-6/30/10)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	1,450,135	57,667	1,507,802	$1,495,860
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	842,765	27,832	870,597	N/A
Number of Claims Adjudicated in 5-9 Days	336,675	11,522	348,197	N/A
Number of Claims Adjudicated in 10-14 Days	85,543	3,990	89,533	N/A
Number of Claims Adjudicated in 15-19 Days	32,804	2,601	35,405	N/A
Percent of Claims Adjudicated within 19 Days	**89.5%**	**79.7%**	**89.1%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	36,437	2,461	38,898	$84,805
Number of Claims Adjudicated in 35-64 Days	27,812	1,743	29,555	$217,977
Number of Claims Adjudicated in 65-94 Days	13,732	1,382	15,114	$182,701
Number of Claims Adjudicated in 95-124 Days	7,922	805	8,727	$142,849
Number of Claims Adjudicated in 125-184 Days	13,325	1,082	14,407	$215,455
Number of Claims Adjudicated in 185 + Days	53,120	4,249	57,369	$652,074

Claim Adjudication Statistics for Peach State Health Plans Non-CHOA Hospital Claims

Implementation SFY 2007 (6/1/06 – 6/30/07)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	304,072	9,772	313,844	$466,813
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	197,999	5,798	203,797	N/A
Number of Claims Adjudicated in 5-9 Days	53,400	1,529	54,929	N/A
Number of Claims Adjudicated in 10-14 Days	11,351	613	11,964	N/A
Number of Claims Adjudicated in 15-19 Days	4,795	277	5,072	N/A
Percent of Claims Adjudicated within 19 Days	**88.0%**	**84.1%**	**87.9%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	5,879	478	6,357	$39,725
Number of Claims Adjudicated in 35-64 Days	5,685	352	6,037	$79,205
Number of Claims Adjudicated in 65-94 Days	4,027	178	4,205	$83,227
Number of Claims Adjudicated in 95-124 Days	4,146	168	4,314	$48,918
Number of Claims Adjudicated in 125-184 Days	8,672	245	8,917	$104,523
Number of Claims Adjudicated in 185 + Days	8,118	134	8,252	$111,216

Claim Adjudication Statistics for Peach State Health Plans Non-CHOA Hospital Claims

Post Implementation SFY 2008 (7/1/07-6/30/08)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	340,910	14,427	355,337	$556,249
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	164,237	5,424	169,661	N/A
Number of Claims Adjudicated in 5-9 Days	87,911	2,739	90,650	N/A
Number of Claims Adjudicated in 10-14 Days	35,390	1,567	36,957	N/A
Number of Claims Adjudicated in 15-19 Days	15,051	1,129	16,180	N/A
Percent of Claims Adjudicated within 19 Days	**88.8%**	**75.3%**	**88.2%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	17,789	1,058	18,847	$17,751
Number of Claims Adjudicated in 35-64 Days	3,709	503	4,212	$63,577
Number of Claims Adjudicated in 65-94 Days	3,327	521	3,848	$45,653
Number of Claims Adjudicated in 95-124 Days	1,346	299	1,645	$46,038
Number of Claims Adjudicated in 125-184 Days	1,825	365	2,190	$64,031
Number of Claims Adjudicated in 185 + Days	10,325	822	11,147	$319,199

Claim Adjudication Statistics for Peach State Health Plans Non-CHOA Hospital Claims

Post Implementation SFY 2009 (7/1/08-6/30/09)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	375,369	18,861	394,230	$354,048
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	201,377	7,439	208,816	N/A
Number of Claims Adjudicated in 5-9 Days	106,937	4,248	111,185	N/A
Number of Claims Adjudicated in 10-14 Days	28,719	1,289	30,008	N/A
Number of Claims Adjudicated in 15-19 Days	7,784	754	8,538	N/A
Percent of Claims Adjudicated within 19 Days	**91.9%**	**72.8%**	**90.9%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	9,739	686	10,425	$20,766
Number of Claims Adjudicated in 35-64 Days	9,156	534	9,690	$45,190
Number of Claims Adjudicated in 65-94 Days	3,752	533	4,285	$33,181
Number of Claims Adjudicated in 95-124 Days	1,152	231	1,383	$34,914
Number of Claims Adjudicated in 125-184 Days	1,076	357	1,433	$26,686
Number of Claims Adjudicated in 185 + Days	5,677	2,790	8,467	$193,311

Claim Adjudication Statistics for Peach State Health Plans Non-CHOA Hospital Claims

Post Implementation SFY 2010 (7/1/09-6/30/10)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	429,784	14,607	444,391	$118,750
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	279,152	9,171	288,323	N/A
Number of Claims Adjudicated in 5-9 Days	88,427	3,006	91,433	N/A
Number of Claims Adjudicated in 10-14 Days	10,083	521	10,604	N/A
Number of Claims Adjudicated in 15-19 Days	5,174	441	5,615	N/A
Percent of Claims Adjudicated within 19 Days	**89.1%**	**90.0%**	**89.1%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	3,030	239	3,269	$6,563
Number of Claims Adjudicated in 35-64 Days	9,262	354	9,616	$30,005
Number of Claims Adjudicated in 65-94 Days	2,626	150	2,776	$20,640
Number of Claims Adjudicated in 95-124 Days	1,278	107	1,385	$12,979
Number of Claims Adjudicated in 125-184 Days	1,752	115	1,867	$20,215
Number of Claims Adjudicated in 185 + Days	29,000	503	29,503	$28,348

WellCare of Georgia (WellCare)

Claim Adjudication Statistics for WellCare Non-CHOA Hospital Claims

All Periods (6/1/06-6/30/10)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	1,638,374	222,833	1,861,207	$165,432
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	381,402	45,744	427,146	N/A
Number of Claims Adjudicated in 5-9 Days	682,436	73,766	756,202	N/A
Number of Claims Adjudicated in 10-14 Days	123,449	17,755	141,204	N/A
Number of Claims Adjudicated in 15-19 Days	26,907	3,982	30,889	N/A
Percent of Claims Adjudicated within 19 Days	**74.1%**	**63.4%**	**72.8%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	254,699	39,060	293,759	$34,352
Number of Claims Adjudicated in 35-64 Days	24,143	6,234	30,377	$49,472
Number of Claims Adjudicated in 65-94 Days	15,559	4,141	19,700	$30,067
Number of Claims Adjudicated in 95-124 Days	15,932	3,643	19,575	$14,859
Number of Claims Adjudicated in 125-184 Days	25,517	6,440	31,957	$25,244
Number of Claims Adjudicated in 185 + Days	88,330	22,068	110,398	$11,437

Claim Adjudication Statistics for WellCare Non-CHOA Hospital Claims

Implementation SFY 2007 (6/1/06 – 6/30/07)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	27,645	19,880	47,525	$553
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	7,487	4,584	12,071	N/A
Number of Claims Adjudicated in 5-9 Days	15,474	13,411	28,885	N/A
Number of Claims Adjudicated in 10-14 Days	3,749	1,569	5,318	N/A
Number of Claims Adjudicated in 15-19 Days	622	161	783	N/A
Percent of Claims Adjudicated within 19 Days	**98.9%**	**99.2%**	**99.0%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	255	57	312	$336
Number of Claims Adjudicated in 35-64 Days	17	28	45	$35
Number of Claims Adjudicated in 65-94 Days	22	28	50	$46
Number of Claims Adjudicated in 95-124 Days	5	19	24	$29
Number of Claims Adjudicated in 125-184 Days	7	8	15	$41
Number of Claims Adjudicated in 185 + Days	7	15	22	$67

Claim Adjudication Statistics for WellCare Non-CHOA Hospital Claims

Post Implementation SFY 2008 (7/1/07-6/30/08)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	221,522	48,047	269,569	$34,777
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	49,020	11,462	60,482	N/A
Number of Claims Adjudicated in 5-9 Days	76,882	17,838	94,720	N/A
Number of Claims Adjudicated in 10-14 Days	6,485	1,686	8,171	N/A
Number of Claims Adjudicated in 15-19 Days	641	131	772	N/A
Percent of Claims Adjudicated within 19 Days	**60.1%**	**64.8%**	**60.9%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	2,985	649	3,634	$12,589
Number of Claims Adjudicated in 35-64 Days	5,654	1,651	7,305	$9,417
Number of Claims Adjudicated in 65-94 Days	7,727	1,481	9,208	$4,428
Number of Claims Adjudicated in 95-124 Days	9,785	1,898	11,683	$33
Number of Claims Adjudicated in 125-184 Days	14,771	2,685	17,456	$276
Number of Claims Adjudicated in 185 + Days	47,572	8,566	56,138	$8,034

Claim Adjudication Statistics for WellCare Non-CHOA Hospital Claims

Post Implementation SFY 2009 (7/1/08-6/30/09)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	664,087	91,710	755,797	$84,070
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	102,224	7,797	110,021	N/A
Number of Claims Adjudicated in 5-9 Days	336,442	29,524	365,966	N/A
Number of Claims Adjudicated in 10-14 Days	29,894	5,452	35,346	N/A
Number of Claims Adjudicated in 15-19 Days	17,150	2,581	19,731	N/A
Percent of Claims Adjudicated within 19 Days	**73.1%**	**49.5%**	**70.3%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	98,534	20,771	119,305	$13,143
Number of Claims Adjudicated in 35-64 Days	15,164	4,052	19,216	$14,305
Number of Claims Adjudicated in 65-94 Days	7,466	2,613	10,079	$18,162
Number of Claims Adjudicated in 95-124 Days	6,037	1,711	7,748	$12,870
Number of Claims Adjudicated in 125-184 Days	10,553	3,734	14,287	$22,638
Number of Claims Adjudicated in 185 + Days	40,623	13,475	54,098	$2,952

Claim Adjudication Statistics for WellCare Non-CHOA Hospital Claims

Post Implementation SFY 2010 (7/1/09-6/30/10)

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	725,120	63,196	788,316	$46,032
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	222,671	21,901	244,572	N/A
Number of Claims Adjudicated in 5-9 Days	253,638	12,993	266,631	N/A
Number of Claims Adjudicated in 10-14 Days	83,321	9,048	92,369	N/A
Number of Claims Adjudicated in 15-19 Days	8,494	1,109	9,603	N/A
Percent of Claims Adjudicated within 19 Days	**78.3%**	**71.3%**	**77.8%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	152,925	17,583	170,508	$8,285
Number of Claims Adjudicated in 35-64 Days	3,308	503	3,811	$25,715
Number of Claims Adjudicated in 65-94 Days	344	19	363	$7,432
Number of Claims Adjudicated in 95-124 Days	105	15	120	$1,927
Number of Claims Adjudicated in 125-184 Days	186	13	199	$2,289
Number of Claims Adjudicated in 185 + Days	128	12	140	$384

Exhibit Two – Denied Claims

AMERIGROUP Community Care (AMGP)

AMERIGROUP Non-CHOA Percent of Hospital Claims Denied by Quarter

Quarter/Year	Paid Claims	Denied Claims	Total Claims	Percent Denied
Implementation Qtr 1	13,291	191	13,482	1.4%
Implementation Qtr 2	47,697	3,438	51,135	6.7%
Implementation Qtr 3	74,611	5,264	79,875	6.6%
Implementation Qtr 4	69,207	3,047	72,254	4.2%
SFY 2008 Qtr 1	57,849	1,847	59,696	3.1%
SFY 2008 Qtr 2	57,454	6,202	63,656	9.7%
SFY 2008 Qtr 3	61,420	5,120	66,540	7.7%
SFY 2008 Qtr 4	64,101	4,561	68,662	6.6%
SFY 2009 Qtr 1	59,944	7,778	67,722	11.5%
SFY 2009 Qtr 2	64,069	5,647	69,716	8.1%
SFY 2009 Qtr 3	66,405	3,963	70,368	5.6%
SFY 2009 Qtr 4	64,453	4,078	68,531	6.0%
SFY 2010 Qtr 1	78,574	4,308	82,882	5.2%
SFY 2010 Qtr 2	77,775	4,557	82,332	5.5%
SFY 2010 Qtr 3	79,828	8,118	87,946	9.2%
SFY 2010 Qtr 4	92,481	5,961	98,442	6.1%
Total	1,029,159	74,080	1,103,239	6.7%

Based on final status of claim with paid date between 6/1/2006 and 6/30/2010

Excludes CHOA Hospitals - Children's Healthcare Egleston and Children's Healthcare Scottish Rite

AMERIGROUP Non-CHOA Percent of Hospital Denied Claims Later Paid by Quarter

Quarter/Year	Denied Claims	Overturned Claims	Percent Overturned
Implementation Qtr 1	191	22	11.5%
Implementation Qtr 2	3,440	1,303	37.9%
Implementation Qtr 3	5,262	1,189	22.6%
Implementation Qtr 4	3,047	429	14.1%
SFY 2008 Qtr 1	1,847	202	10.9%
SFY 2008 Qtr 2	6,202	349	5.6%
SFY 2008 Qtr 3	5,120	269	5.3%
SFY 2008 Qtr 4	4,562	110	2.4%
SFY 2009 Qtr 1	7,778	214	2.8%
SFY 2009 Qtr 2	5,647	168	3.0%
SFY 2009 Qtr 3	3,963	357	9.0%
SFY 2009 Qtr 4	4,175	1,325	31.7%
SFY 2010 Qtr 1	4,315	382	8.9%
SFY 2010 Qtr 2	4,557	276	6.1%
SFY 2010 Qtr 3	9,384	3,016	32.1%
SFY 2010 Qtr 4	6,114	317	5.2%
Total	75,604	9,928	13.1%

Based on final status of claim with paid date between 6/1/2006 and 6/30/2010

Excludes CHOA Hospitals - Children's Healthcare Egleston and Children's Healthcare Scottish Rite

Peach State Health Plan (PSHP)

Peach State Health Plans Non-CHOA Percent of Hospital Claims Denied by Quarter

Quarter/Year	Paid Claims	Denied Claims	Total Claims	Percent Denied
Implementation Qtr 1	32,163	1,262	33,425	3.8%
Implementation Qtr 2	75,102	1,240	76,342	1.6%
Implementation Qtr 3	97,154	1,682	98,836	1.7%
Implementation Qtr 4	99,653	5,588	105,241	5.3%
SFY 2008 Qtr 1	73,621	3,050	76,671	4.0%
SFY 2008 Qtr 2	90,295	3,449	93,744	3.7%
SFY 2008 Qtr 3	90,748	2,858	93,606	3.1%
SFY 2008 Qtr 4	86,246	5,070	91,316	5.6%
SFY 2009 Qtr 1	98,184	4,532	102,716	4.4%
SFY 2009 Qtr 2	84,471	3,922	88,393	4.4%
SFY 2009 Qtr 3	95,454	6,563	102,017	6.4%
SFY 2009 Qtr 4	97,260	3,844	101,104	3.8%
SFY 2010 Qtr 1	113,390	4,164	117,554	3.5%
SFY 2010 Qtr 2	117,200	3,698	120,898	3.1%
SFY 2010 Qtr 3	108,877	3,905	112,782	3.5%
SFY 2010 Qtr 4	90,317	2,840	93,157	3.0%
Total	1,450,135	57,667	1,507,802	3.8%

Based on final status of claim with paid date between 6/1/2006 and 6/30/2010

Excludes CHOA Hospitals - Children's Healthcare Egleston and Children's Healthcare Scottish Rite

Peach State Health Plans Non-CHOA Percent of Hospital Denied Claims Later Paid by Quarter

Quarter/Year	Denied Claims	Overturned Claims	Percent Overturned
Implementation Qtr 1	1,261	63	5.0%
Implementation Qtr 2	1,231	29	2.4%
Implementation Qtr 3	1,674	6	0.4%
Implementation Qtr 4	5,585	697	12.5%
SFY 2008 Qtr 1	3,038	133	4.4%
SFY 2008 Qtr 2	3,457	182	5.3%
SFY 2008 Qtr 3	2,854	76	2.7%
SFY 2008 Qtr 4	5,039	158	3.1%
SFY 2009 Qtr 1	4,504	130	2.9%
SFY 2009 Qtr 2	4,335	216	5.0%
SFY 2009 Qtr 3	6,216	218	3.5%
SFY 2009 Qtr 4	4,034	250	6.2%
SFY 2010 Qtr 1	4,048	353	8.7%
SFY 2010 Qtr 2	3,813	365	9.6%
SFY 2010 Qtr 3	3,900	417	10.7%
SFY 2010 Qtr 4	2,840	146	5.1%
Total	57,829	3,439	5.9%

Based on final status of claim with paid date between 6/1/2006 and 6/30/2010

Excludes CHOA Hospitals - Children's Healthcare Egleston and Children's Healthcare Scottish Rite

WellCare of Georgia (WellCare)

WellCare Non-CHOA Percent of Hospital Claims Denied by Quarter

Quarter/Year	Paid Claims	Denied Claims	Total Claims	Percent Denied
Implementation Qtr 1	3,812	1,667	5,479	30.4%
Implementation Qtr 2	5,360	5,053	10,413	48.5%
Implementation Qtr 3	7,585	6,777	14,362	47.2%
Implementation Qtr 4	10,888	6,383	17,271	37.0%
SFY 2008 Qtr 1	96,047	23,443	119,490	19.6%
SFY 2008 Qtr 2	22,062	9,597	31,659	30.3%
SFY 2008 Qtr 3	26,878	7,216	34,094	21.2%
SFY 2008 Qtr 4	76,535	7,791	84,326	9.2%
SFY 2009 Qtr 1	201,454	38,006	239,460	15.9%
SFY 2009 Qtr 2	142,772	18,889	161,661	11.7%
SFY 2009 Qtr 3	161,091	18,005	179,096	10.1%
SFY 2009 Qtr 4	158,770	16,810	175,580	9.6%
SFY 2010 Qtr 1	152,215	14,690	166,905	8.8%
SFY 2010 Qtr 2	206,359	17,213	223,572	7.7%
SFY 2010 Qtr 3	175,325	15,497	190,822	8.1%
SFY 2010 Qtr 4	191,221	15,796	207,017	7.6%
Total	1,638,374	222,833	1,861,207	12.0%

Based on final status of claim with paid date between 6/1/2006 and 6/30/2010

Excludes CHOA Hospitals - Children's Healthcare Egleston and Children's Healthcare Scottish Rite

WellCare Non-CHOA Percent of Hospital Denied Claims Later Paid by Quarter

Quarter/Year	Denied Claims	Overturned Claims	Percent Overturned
Implementation Qtr 1	1,670	225	13.5%
Implementation Qtr 2	5,061	446	8.8%
Implementation Qtr 3	6,784	405	6.0%
Implementation Qtr 4	6,392	447	7.0%
SFY 2008 Qtr 1	23,442	4,200	17.9%
SFY 2008 Qtr 2	9,613	1,143	11.9%
SFY 2008 Qtr 3	7,226	762	10.5%
SFY 2008 Qtr 4	7,819	1,747	22.3%
SFY 2009 Qtr 1	36,210	9,720	26.8%
SFY 2009 Qtr 2	19,742	7,264	36.8%
SFY 2009 Qtr 3	18,945	6,920	36.5%
SFY 2009 Qtr 4	17,577	5,999	34.1%
SFY 2010 Qtr 1	15,907	5,139	32.3%
SFY 2010 Qtr 2	15,995	6,171	38.6%
SFY 2010 Qtr 3	15,493	7,180	46.3%
SFY 2010 Qtr 4	15,795	6,572	41.6%
Total	223,671	64,340	28.8%

Based on final status of claim with paid date between 6/1/2006 and 6/30/2010

Excludes CHOA Hospitals - Children's Healthcare Egleston and Children's Healthcare Scottish Rite