GEORGIA FAMILIES PROGRAM

REPORT 17, PART A: HOSPITAL CLAIMS GLOBAL ANALYSIS

ANALYSES OF HOSPITAL CLAIMS SUBMITTED BY 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's 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™ 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 A, includes the analyses for Children's Healthcare of Atlanta only. Results for all other hospitals are included in Report #17, Part B.

SCOPE OF REPORT

The scope of this report includes analyses of the Georgia Families program Children's Healthcare of Atlanta (CHOA) hospital claims experience including adjudication and denial trends, as well as an analysis of the payment of triage rates (also referred to as administrative fees) and emergency room rates for emergency services. For purposes of this report, "CHOA" refers to Children's Healthcare Egleston and Children's Healthcare Scottish Rite.

The initial Hospital Claims Analysis (Report #2) was performed in 2008 and included claims paid and denied between June 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 analysis related to emergency room services is being performed and will be reported at a later date.

For reference, the following claim counts for each CMO were utilized in our analyses. These claims include inpatient and outpatient Children's Healthcare of Atlanta hospital claims paid or denied from June 1, 2006 through June 30, 2010 billed on the UB-04 claim form. *Please note that the claim counts and paid amounts cited herein may vary based on 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.*

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

	AMGP	PSHP	WellCare	Total
Number of Paid Claims	126,044	186,334	85,261	397,639
Percent of Total Claims	95.4%	97.4%	89.8%	95.1%
Number of Denied Claims	6,090	4,934	9,642	20,666
Percent of Total Claims	4.6%	2.6%	10.2%	4.9%
Total Claims	132,134	191,268	94,903	418,305
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)

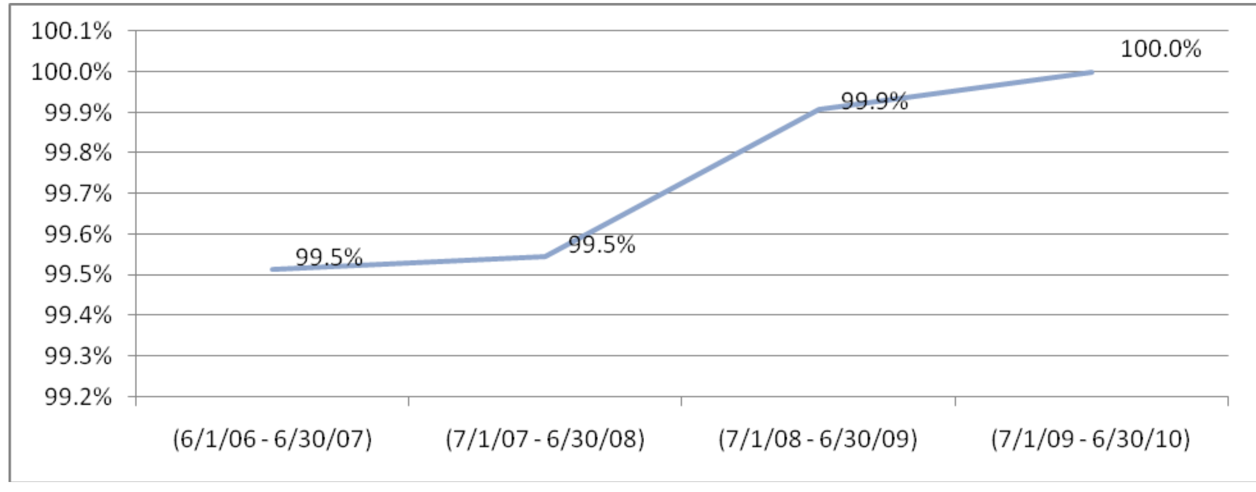
AMGP adjudicated 132,134 claims from implementation through June 30, 2010 for CHOA facilities. Of these claims, 99.8 percent were adjudicated in 19 days or less. For the 0.2 percent of claims adjudicated at 20 days or more, AMGP reported paying $13,953 in interest. We noted that based on the encounter 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: CHOA Claim Adjudication Statistics for AMGP, by Period

AMGP 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	24,373	27,750	31,970	41,951	126,044
Percent Paid	94.7%	96.0%	93.5%	96.9%	95.4%
Claims Denied	1,377	1,146	2,207	1,360	6,090
Percent Denied	5.3%	4.0%	6.5%	3.1%	4.6%
Total Claims	25,750	28,896	34,177	43,311	132,134
Claims Adjudicated ≤ 19 Days	25,625	28,765	34,146	43,311	131,847
Percent Adjudicated ≤ 19 Days	99.5%	99.5%	99.9%	100.0%	99.8%
Claims Adjudicated > 19 Days	125	131	31	0	287
Percent Adjudicated > 19 Days	0.5%	0.5%	0.1%	0.0%	0.2%

In the figure below, we illustrate the percent of claims adjudicated in 19 days or less by period. After the implementation period, the adjudication rate increased from 99.5 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 date of receipt.

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



Peach State Health Plan (PSHP)

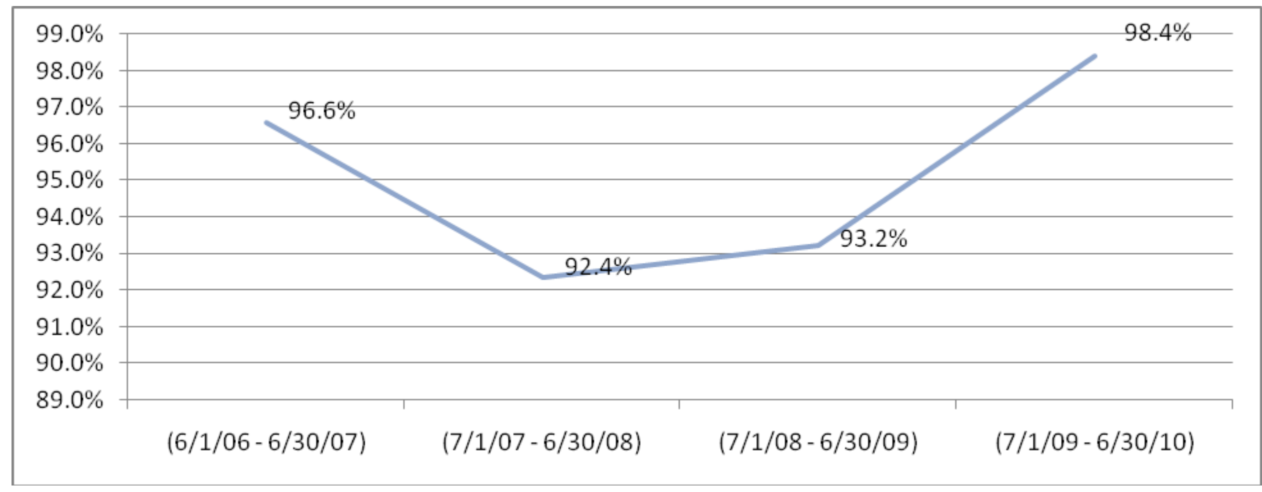
PSHP adjudicated 191,268 CHOA claims from implementation through June 30, 2010. Of these claims, 95.3 percent were adjudicated in 19 days or less. For the 4.7 percent of claims adjudicated at 20 days or more, PSHP reported paying $152,258 in interest.

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

PSHP 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	49,854	42,419	44,178	49,883	186,334
Percent Paid	97.7%	96.8%	96.8%	98.2%	97.4%
Claims Denied	1,178	1,416	1,442	898	4,934
Percent Denied	2.3%	3.2%	3.2%	1.8%	2.6%
Total Claims	51,032	43,835	45,620	50,781	191,268
Claims Adjudicated ≤ 19 Days	49,298	40,482	42,529	49,971	182,280
Percent Adjudicated ≤ 19 Days	96.6%	92.4%	93.2%	98.4%	95.3%
Claims Adjudicated > 19 Days	1,734	3,353	3,091	810	8,988
Percent Adjudicated > 19 Days	3.4%	7.6%	6.8%	1.6%	4.7%

In the figure below, we illustrate the percent of CHOA claims adjudicated in 19 days or less by period. After the implementation period, the adjudication rate increased from 92.4 percent in SFY 2008 to 93.2 percent in SFY 2009. For SFY 2010, the adjudication rate increased to 98.4 percent.

Figure 2: 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 94,903 claims from implementation through June 30, 2010 for CHOA facilities. Of these claims, 73.1 percent were adjudicated in 19 days or less. However, it is important to reiterate that WellCare has indicated that the paid date reported in the encounter data may not accurately reflect the actual date the claim was paid and the results of this analysis may not accurately reflect the actual length of time required to adjudicate claims.

For the 26.9 percent of claims adjudicated at 20 days or more, WellCare reported paying $37,490 in interest.

Table 3: CHOA Claim Adjudication Statistics for WellCare, by Period

WellCare 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	82	6,302	43,445	35,432	85,261
Percent Paid	10.8%	84.4%	91.4%	90.5%	89.8%
Claims Denied	675	1,164	4,105	3,698	9,642
Percent Denied	89.2%	15.6%	8.6%	9.5%	10.2%
Total Claims	757	7,466	47,550	39,130	94,903
Claims Adjudicated ≤ 19 Days	757	6,559	28,874	33,143	69,333
Percent Adjudicated ≤ 19 Days	100.0%	87.9%	60.7%	84.7%	73.1%
Claims Adjudicated > 19 Days	0	907	18,676	5,987	25,570
Percent Adjudicated > 19 Days	0.0%	12.1%	39.3%	15.3%	26.9%

In the figure below, we illustrate the percent of CHOA claims adjudicated in 19 days or less by period. After the implementation period, the adjudication rate decreased from 87.9 percent in SFY 2008 to 60.7 percent in SFY 2009. For SFY 2010, the adjudication rate increased to 84.7 percent. As stated previously, WellCare has indicated that the

paid date reported in the encounter data may not accurately reflect the actual date the claim was paid and the results of this analysis may not accurately reflect the actual adjudication rates.

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

Period	Percent
(6/1/06 - 6/30/07)	100.0%
(7/1/07 - 6/30/08)	87.9%
(7/1/08 - 6/30/09)	60.7%
(7/1/09 - 6/30/10)	84.7%

ANALYSIS II: <u>DENIED CLAIMS ANALYSIS</u>

<u>The DCH Contract with the CMOs:</u>

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 132,134 CHOA hospital claims from June 1, 2006 through June 30, 2010. Approximately 4.6 percent of those claims were denied. In the table and figure below, we illustrate the variability of denied claims by period. During implementation, 5.3 percent of hospital claims were denied. In the post implementation periods, 4.0, 6.5 and 3.1 percent of claims denied, respectively.

Table 4: 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	24,373	27,750	31,970	41,951	126,044
Number of Claims Denied	1,377	1,146	2,207	1,360	6,090
Total Claims	25,750	28,896	34,177	43,311	132,134
Percent of Total Claims Denied	5.3%	4.0%	6.5%	3.1%	4.6%

The percentage of denied AMGP claims peaked in quarter two of SFY 2009 at 13.5 percent and declined to the lowest level of 1.7 percent by quarter four of SFY 2009.

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

AMGP reversed and later paid 1,360, or 22.1 percent of denied claims with an average of 98 days between the date of the denial and the payment. AMGP reported paying $16,021 in interest related to these claims. The figure below illustrates, by quarter, the percentage of claim denials that were later paid. The claims data suggests a decreasing trend in the need to reprocess previously denied claims through the first quarter of SFY 2009 followed by a spike in the second quarter of SFY 2009. SFY 2010 reflects a gradual increase in the number of CHOA denials later paid to end the analysis period with an average rate of 15.6 percent.

Figure 5: AMGP Percentage of Denied 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 .5 percent during implementation to 32.7 percent during SFY 2010. The category "Payment Issues" includes denial descriptions such as "Reduced Allowable", "Paid at Contracted Rate" and "Agreement Discount". The category "Time Filing Limit" has decreased significantly from 42.9 percent during implementation to 0.7 percent in SFY 2010. The category "No Denial Reason/Non-Descript Reason" includes claims with denial reasons such as "Not Assigned", "Deny All Claim Lines" and "No Fault".

Table 5: AMGP 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	28	3.4%	58	4.9%	77	3.9%	247	19.5%	410	7.8%
Duplicate Submission	153	18.5%	148	12.4%	601	30.7%	108	8.5%	1,010	19.2%
Non-Covered Benefit or Service	37	4.5%	119	10.0%	307	15.7%	102	8.0%	565	10.8%
Eligibility Issue	3	0.4%	2	0.2%	3	0.2%	1	0.1%	9	0.2%
Incorrect/Invalid Information	44	5.3%	61	5.1%	148	7.6%	28	2.2%	281	5.4%
Payment Issue	4	0.5%	13	1.1%	344	17.6%	415	32.7%	776	14.8%
Time Filing Limit	355	42.9%	492	41.2%	94	4.8%	9	0.7%	950	18.1%
Procedure Code Issue	18	2.2%	14	1.2%	34	1.7%	25	2.0%	91	1.7%
Included in Pricing	55	6.6%	89	7.5%	215	11.0%	67	5.3%	426	8.1%
Authorization Issue	102	12.3%	141	11.8%	32	1.6%	157	12.4%	432	8.2%
No Denial Reason/Non-Descript Reason	29	3.4%	57	4.6%	105	5.2%	110	8.6%	301	5.7%
TOTAL	**828**	**100%**	**1,194**	**100%**	**1,960**	**100%**	**1,269**	**100%**	**5,251**	**100%**

AMGP had 432 CHOA hospital claims, or 8.2 percent, that were denied for reasons related to prior authorization. During implementation, 12.3 percent of claims denied, and this figure decreased to 11.8 percent during the first post implementation period and 1.6 percent for the second post implementation period. For SFY 2010 the denials increased to 12.4 percent.

Table 6: AMGP 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 of authorization	7	4	0	9	20
Deny preauth not obtained	83	132	31	100	346
Level of care not authorized	0	0	0	36	36
Units exceed UM authorization	12	5	1	12	30
Units reduced by UM authorization	0	0	0	0	0
TOTAL	**102**	**141**	**32**	**157**	**432**

Peach State Health Plan (PSHP)

PSHP processed 191,268 CHOA hospital claims with paid dates from June 1, 2006 through June 30, 2010. Less than three percent of these claims were denied. In the table and figure below, we illustrate the variability of denied claims by period. During implementation, 2.3 percent of CHOA hospital claims were denied. In the post implementation periods, 3.2, 3.2 and 1.8 percent of claims denied, respectively.

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

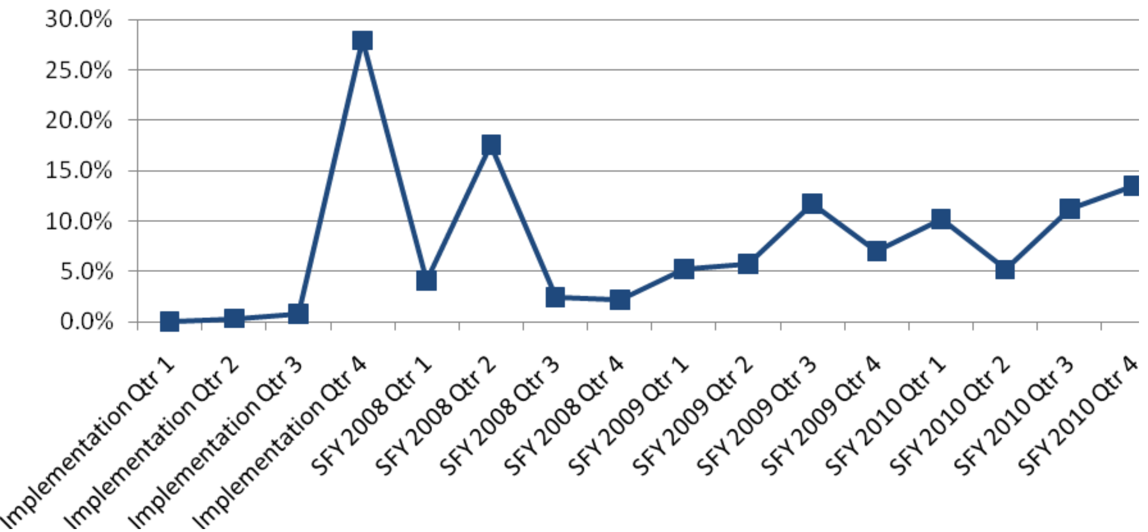
	Implementation (6/1/06 - 6/30/07)	Post Implementation (7/1/07 - 6/30/08)	Post Implementation (7/1/08 - 6/30/09)	Post Implementation (7/1/09 - 6/30/10)	Total
Number of Claims Paid	49,854	42,419	44,178	49,883	186,334
Number of Claims Denied	1,178	1,416	1,442	898	4,934
Total Claims	51,032	43,835	45,620	50,781	191,268
Percent of Total Claims Denied	2.3%	3.2%	3.2%	1.8%	2.6%

The percentage of denied PSHP CHOA hospital claims peaked in quarter two of SFY 2008 at 4.9 percent. Since that time, the percentage of denied claims decreased and, on average, remains at approximately 2.6 percent.

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

PSHP reversed and later paid 447, or 8.9 percent, of CHOA hospital claims with an average of 104 days between the date of the denial and the payment. PSHP reported paying $8,209 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 a gradual increase in the need to reprocess previously denied claims.

Figure 7: PSHP Percentage of 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 52.8

percent during SFY 2010. The category “Non-Covered Benefit or Service” decreased steadily from 25.3 percent during implementation to 1.7 percent for SFY 2010.

Table 8: PSHP 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	148	15.1%	244	20.7%	286	24.4%	411	52.8%	1,089	26.5%
Duplicate Submission	80	8.1%	50	4.2%	37	3.2%	57	7.3%	224	5.5%
Non-Covered Benefit or Service	248	25.3%	9	0.8%	29	2.5%	13	1.7%	299	7.3%
Eligibility Issue	1	0.1%	0	0.0%	4	0.3%	2	0.3%	7	0.2%
Incorrect/Invalid Information	1	0.1%	2	0.2%	4	0.3%	30	3.9%	37	0.9%
Payment Issue	3	0.3%	65	5.5%	382	32.6%	76	9.8%	526	12.8%
Time Filing Limit	51	5.2%	257	21.8%	184	15.7%	60	7.7%	552	13.4%
Procedure Code Issue	2	0.2%	3	0.3%	5	0.4%	5	0.6%	15	0.3%
Included in Pricing	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Authorization Issue	448	45.6%	547	46.5%	242	20.6%	124	15.9%	1,361	33.1%
No Denial Reason/Non-Descript Reason	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
TOTAL	**982**	**100.0%**	**1,177**	**100.0%**	**1,173**	**100.0%**	**778**	**100.0%**	**4,110**	**100.0%**

PSHP had 1,361 CHOA hospital claims, or 33.1 percent, that were denied for reasons related to prior authorization. During implementation, 45.6 percent of claims denied, and this figure increased slightly to 46.5 percent during the first post implementation period and decreased to 20.6 percent for the second post implementation period. For SFY 2010 the denials further decreased to 15.9 percent.

Table 9: PSHP 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	341	321	146	106	914
DENY: AUTH DENIAL UPHELD - REVIEW PER CLP0700 PEND REPORT	0	22	11	0	33
DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH	0	7	5	3	15
DENY: CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING	3	15	6	0	24
DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING	5	73	10	2	90
DENY: CLAIM AND AUTH TREATMENT TYPE NOT MATCHING	0	1	3	0	4
DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT	82	95	42	11	230
DENY: DENIED BY MEDICAL SERVICES	17	13	19	2	51
TOTAL	**448**	**547**	**242**	**124**	**1,361**

WellCare of Georgia (WellCare)

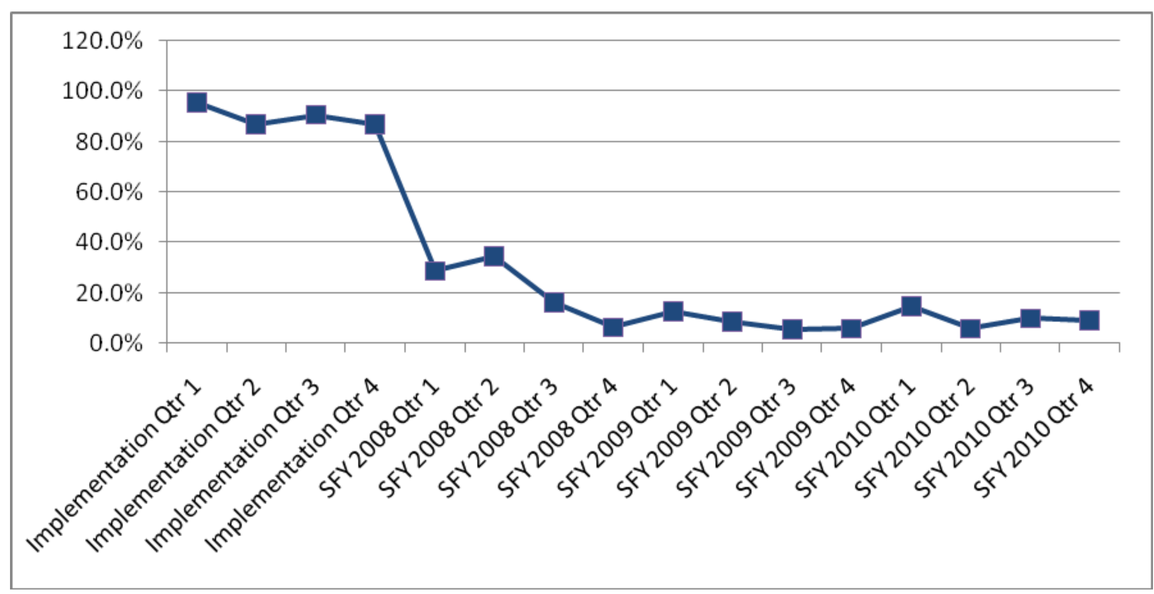
WellCare processed 94,903 CHOA hospital claims with paid dates from June 1, 2006 through June 30, 2010. Approximately ten percent of these claims were denied. In the table and figure below, we illustrate the variability of denied claims by period. It is important to note that WellCare has stated that 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, during implementation 89.2 percent of CHOA hospital claims were denied. In the post implementation periods, 15.6, 8.6 and 9.5 percent of claims denied, respectively.

Table 10: 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	82	6,302	43,445	35,432	85,261
Number of Claims Denied	675	1,164	4,105	3,698	9,642
Total Claims	757	7,466	47,550	39,130	94,903
Percent of Total Claims Denied	89.2%	15.6%	8.6%	9.5%	10.2%

The post implementation percentage of denied WellCare claims peaked in quarter two of SFY 2008 at 34.4 percent. Since that time, the percentage has decreased to 9.1 percent by the end of SFY 2010.

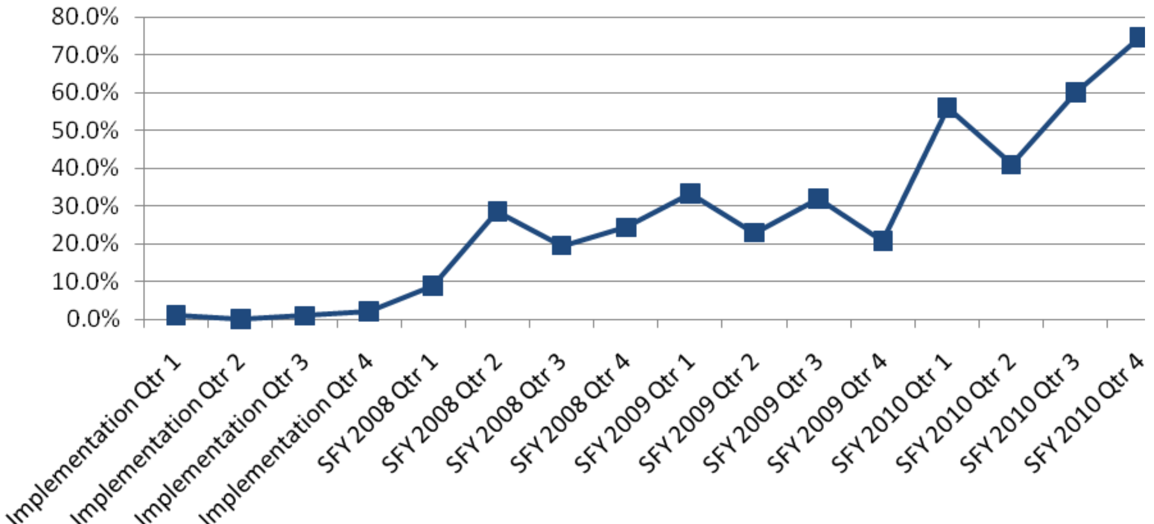
Figure 8: Percent of Claims Denied, by Quarter for WellCare



WellCare reversed and later paid 3,757, or 38.7 percent with an average of 52 days between the date of the denial and the payment. WellCare reported paying $12,719 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 24.1 percent during implementation to 54 percent during SFY 2009. 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" and "Incorrect/Invalid Information" have decreased during the post implementation periods.

Table 11: WellCare 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	0	0.0%	6	0.8%	42	1.3%	1	0.1%	49	1.0%
Duplicate Submission	17	21.5%	201	26.2%	1,149	36.7%	615	56.6%	1,982	39.1%
Non-Covered Benefit or Service	0	0.0%	59	7.7%	41	1.3%	20	1.8%	120	2.4%
Eligibility Issue	0	0.0%	0	0.0%	3	0.1%	3	0.3%	6	0.1%
Incorrect/Invalid Information	6	7.6%	17	2.2%	8	0.3%	6	0.6%	37	0.7%
Payment Issue	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Time Filing Limit	3	3.8%	74	9.6%	174	5.5%	26	2.4%	277	5.5%
Procedure Code Issue	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Included in Pricing	1	1.2%	2	0.3%	1	0.0%	2	0.2%	6	0.1%
Authorization Issue	33	41.8%	54	7.0%	25	0.8%	3	0.3%	115	2.3%
No Denial Reason/Non-Descript Reason	19	24.1%	355	46.2%	1,692	54.0%	410	37.7%	2,476	48.8%
TOTAL	**79**	**100%**	**768**	**100%**	**3,135**	**100%**	**1,086**	**100%**	**5,068**	**100%**

WellCare had 115 claims for all periods, or 2.3 percent, that were denied for reasons related to prior authorization. During implementation, 41.8 percent of claims denied. This number has decreased significantly to 0.3 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	0	0	0	1	1
Authorization expired - Date o	0	1	0	0	1
Authorization expired - Date of Svc after Authorized dates	0	0	1	0	1
Authorization expired - Date of Svc after Authorized dates, Date of Svc of procedure is outside of what was Authorized	0	0	0	0	0
Date of Svc of procedure is ou	0	0	0	0	0
Date of Svc of procedure is outside of what was Authorized	0	0	0	0	0
Limit Reached-Authorization re	0	0	0	0	0
Limit Reached-Authorization required	0	0	0	0	0
NO VALID AUTHORIZATION ON FILE	0	0	1	0	1
Prior Authorization is require	26	48	3	0	77
Prior Authorization is required but was not obtained	0	1	18	1	20
Prior Authorization request wa	7	2	1	0	10
Prior Authorization request was denied	0	1	0	0	1
Prior Authorization request was denied, AUTHORIZATION DENIED	0	0	0	0	0
SERVICES NOT INCLUDED IN AUTHO	0	0	0	0	0
SERVICES NOT INCLUDED IN AUTHORIZATION	0	0	1	0	1
Svcs billed not consistent wit	0	1	0	0	1
Svcs billed not consistent with the Authorization on file	0	0	0	1	1
TOTAL	**33**	**54**	**25**	**3**	**115**

ANALYSIS III: EMERGENCY ROOM VISITS

<u>The DCH Contract with the CMOs:</u>

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 visit 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 approximately three percent of PSHP CHOA hospital emergency room claims and 99.9 percent of WellCare CHOA hospital emergency room claims did not include a procedure code. 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 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 45,565 emergency room claims from June 1, 2006 to June 30, 2010. The original contract between AMGP and CHOA included negotiated rates for each level of care as well as language that indicated that only CPT codes 99283, 99284 and 99285

were considered "emergency conditions." The contract did not include language that would indicate that AMGP would evaluate each claim to make a determination of whether the claim was for services provided for an "emergency condition". Later amendments to the contract continue to allow for negotiated rates for each level of care but no longer include language regarding what will be treated as an "emergency condition." In addition, negotiated rates for trauma CPT codes 99291 and 99292 were added to the contract effective December 1, 2008. Therefore, for purposes of this analysis, an ER visit is only considered as being reimbursed at a triage rate if the payment made by AMGP was the negotiated amount for CPT codes 99281 and 99282 on a claim billed with a CPT code of 99283 or higher. Of the 45,565 visits, only 4 ER claims billed with a CPT code of 99283 or higher were paid at the negotiated 99281 or 99282 CPT code rates in effect for the date of service on the claim.

Table 13: AMGP 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	48	0	48	0.0%
Level 2 - 99282	6,295	0	6,295	0.0%
Level 3 - 99283	21,716	3	21,719	0.0%
Level 4 - 99284	7,995	1	7,996	0.0%
Level 5 - 99285	7,962	0	7,962	0.0%
Trauma 1 - 99291	424	0	424	0.0%
Trauma 2 - 99292	8	0	8	0.0%
Level Not Provided	1,113	0	1,113	0.0%
TOTAL	**45,561**	**4**	**45,565**	**0.0%**

Table 14: Percent of AMGP 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%	0.0%	0.0%
Level 4 - 99284	0.0%	0.0%	0.0%	0.0%
Level 5 - 99285	0.0%	0.0%	0.0%	0.0%
Trauma 1 - 99291	0.0%	0.0%	0.0%	0.0%

Trauma 2 - 99292	0.0%	0.0%	0.0%	0.0%
Level Not Provided	0.0%	0.0%	0.0%	0.0%

[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 level of care.

Peach State Health Plan (PSHP)

The original contract between PSHP and CHOA contained language that allowed for each ER claim to be evaluated as to whether or not the claim met the definition of emergency care. In the event an ER claim did not meet this definition, then the contract allowed for an administrative fee to be paid to CHOA. Effective November 1, 2008, the contract was amended to include negotiated rates for each level of care and to remove the emergency care determination. In addition, the contract no longer contained a provision for an administrative fee for ER claims. Also, negotiated rates for trauma CPT codes 99291 and 99292 were added to the contract. Therefore, for purposes of this analysis, after November 1, 2008 an ER visit is only considered as being reimbursed at a triage rate if the payment made by PSHP was the negotiated amount for CPT codes 99281 and 99282 on a claim billed with a CPT code of 99283 or higher.

PSHP paid 66,364 emergency room claims from June 1, 2006 to June 30, 2010. Of the 66,364 visits, 4,552 or 6.9 percent were paid at the triage rate. Approximately sixty-six percent (3,008) of the claims paid at triage were classified as level three emergencies or higher.

Table 15: PSHP 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	66	15	81	18.5%
Level 2 - 99282	9,141	1,529	10,670	14.3%
Level 3 - 99283	30,757	2,191	32,948	6.6%
Level 4 - 99284	11,022	510	11,532	4.4%
Level 5 - 99285	10,005	307	10,312	3.0%
Trauma 1 - 99291	520	0	520	0.0%
Trauma 2 - 99292	15	0	15	0.0%
Level Not Provided	286	0	286	0.0%
TOTAL	**61,812**	**4,552**	**66,364**	**6.9%**

Table 16: Percent of PSHP 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	42.3%	0.0%	30.8%	0.0%
Level 2 - 99282	35.7%	0.0%	4.3%	0.0%
Level 3 - 99283	27.1%	0.0%	5.2%	0.0%
Level 4 - 99284	19.9%	0.0%	2.7%	0.0%
Level 5 - 99285	13.2%	0.0%	2.0%	0.1%
Trauma 1 - 99291	0.0%	0.0%	0.0%	0.0%
Trauma 2 - 99292	0.0%	0.0%	0.0%	0.0%
Level Not Provided	0.0%	0.0%	0.0%	0.0%

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 level of care.

Our analysis of the PSHP claims data does not provide a clear indication of why there are no ER visits paid at the triage rate during the first post-implementation period, 7/1/07 through 6/30/08. However, as stated earlier, 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.

WellCare of Georgia (WellCare)

The original contract between WellCare and CHOA contained language that allowed for each ER claim to be evaluated as to whether or not the claim met the definition of emergency care. In the event an ER claim did not meet this definition, then the contract allowed for an administrative fee to be paid to CHOA. These provisions have been consistent through each subsequent amendment to the contract. Therefore, for purposes of this analysis, any ER claim paid at the administrative fee is considered a triage payment.

WellCare paid 34,824 emergency room claims from June 1, 2006 to June 30, 2010. Of the 34,824 visits, 20,285 or 58.3 percent were paid at the triage rate. WellCare provided the procedure code/level of care for only 29.1 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 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	6	9	15	60.0%
Level 2 - 99282	245	938	1,183	79.3%
Level 3 - 99283	1,778	3,575	5,353	66.8%
Level 4 - 99284	964	950	1,914	49.6%
Level 5 - 99285	921	664	1,585	41.9%
Trauma 1 - 99291	52	21	73	28.8%
Trauma 2 - 99292	1	0	1	0.0%
Level Not Provided	10,572	14,128	24,700	57.2%
TOTAL	**14,539**	**20,285**	**34,824**	**58.3%**

Table 18: Percent of WellCare 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%	100.0%	50.0%	0.0%
Level 2 - 99282	0.0%	90.2%	75.1%	0.0%
Level 3 - 99283	0.0%	87.3%	63.6%	100.0%
Level 4 - 99284	0.0%	56.8%	48.5%	0.0%
Level 5 - 99285	0.0%	46.8%	41.2%	0.0%
Trauma 1 - 99291	0.0%	25.0%	30.6%	0.0%
Trauma 2 - 99292	0.0%	0.0%	0.0%	0.0%
Level Not Provided	14.3%	39.0%	56.7%	58.2%

[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 level of care.

Hospital Claims Analysis Findings Summary:

Analysis	AMGP	PSHP	WellCare
I. Claims Adjudication ***(See also Exhibit 1)***	99.8% paid or denied within 19 days; Health plan reported interest payments of $13,953	95.3% paid or denied within 19 days; Health plan reported interest payments of $152,258	73.1% paid or denied within 19 days; Health plan reported interest payments of $37,490
II. Denied Claims ***(See also Exhibit 2)***	▪ 4.6% claims denied ▪ SFY 2009 quarter 2 highest level at 13.5% ▪ 22.1% of denied claims later paid in average of 98 days. AMGP reported paying $16,021 in interest on these claims ▪ Denied claims related to “Payment Issues” continues to be problematic for providers ▪ Denied claims related to timely filing decreased from 42.9% at implementation to 0.7% for SFY 2010	▪ 2.6% of claims denied ▪ SFY 2008 quarter 2 highest level at 4.9% ▪ 8.9% of denied claims later paid in average of 104 days. PSHP reported paying $8,209 in interest on these claims ▪ Significant increase from 15.1% at implementation to 52.8% for SFY 2010 in denials related to Coordination of Benefits ▪ Significant decrease from 25.3% at implementation to 1.7% for SFY 2010 in denials related to Non-Covered Benefits	▪ 10.2% claims denied ▪ Implementation denial rate averaged 90.0%. SFY 2008 quarter 2 highest level for post-implementation at 34.4% ▪ 38.7% of denied claims later paid in average of 52 days. WellCare reported paying $12,719 in interest on these claims ▪ Significant increase from 24.1% at implementation to 54% for SFY 2009 in denials with no denial reason or a non-descript reason ▪ Significant decrease from 41.8% at implementation to 0.3% in SFY2010 for denials related to authorization issues

Analysis	AMGP	PSHP	WellCare
III. Emergency Room Visits	▪ No contract provisions for administrative fee. Contract includes negotiated rates for each level of care. ▪ Four claims paid at triage rate were classified as level 3 or higher	▪ 6.9% paid at triage rate ▪ 66% of claims paid at a triage rate were classified as level 3 or higher ▪ Emergency care determination and administrative fee language removed from contract effect November 1, 2008	▪ 58.3% paid at triage rate ▪ Procedure Code/Level of Care was not provided for 70.9% of claims

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 less than 20 days during SFY 2010.
3) DCH may wish to require PSHP to provide additional information regarding the payment of triage payments during the first post-implementation period.
4) DCH may wish to require WellCare to submit level of care information for emergency service claims in order to thoroughly evaluate triage payment trends.
5) DCH may wish to request an explanation from AMGP and WellCare regarding their denials and high overturn percentages. This practice appears to be resource-intensive for providers.

EXHIBITS

Exhibit One – Claim Adjudication

AMERIGROUP Community Care (AMGP)

Claim Adjudication Statistics for AMERIGROUP CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	126,044	6,090	132,134	$13,953
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	120,057	4,892	124,949	N/A
Number of Claims Adjudicated in 5-9 Days	4,411	773	5,184	N/A
Number of Claims Adjudicated in 10-14 Days	760	246	1,006	N/A
Number of Claims Adjudicated in 15-19 Days	606	102	708	N/A
Percent of Claims Adjudicated within 19 Days	**99.8%**	**98.7%**	**99.8%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	189	66	255	$1,115
Number of Claims Adjudicated in 35-64 Days	17	9	26	$534
Number of Claims Adjudicated in 65-94 Days	2	0	2	$69
Number of Claims Adjudicated in 95-124 Days	1	0	1	$12,235
Number of Claims Adjudicated in 125-184 Days	1	0	1	$0
Number of Claims Adjudicated in 185 + Days	0	2	2	$0

Claim Adjudication Statistics for AMERIGROUP CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	24,373	1,377	25,750	$12,621
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	22,626	1,090	23,716	N/A
Number of Claims Adjudicated in 5-9 Days	1,269	201	1,470	N/A
Number of Claims Adjudicated in 10-14 Days	240	51	291	N/A
Number of Claims Adjudicated in 15-19 Days	125	23	148	N/A
Percent of Claims Adjudicated within 19 Days	**99.5%**	**99.1%**	**99.5%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	106	9	115	$269
Number of Claims Adjudicated in 35-64 Days	4	3	7	$54
Number of Claims Adjudicated in 65-94 Days	1	0	1	$63
Number of Claims Adjudicated in 95-124 Days	1	0	1	$12,235
Number of Claims Adjudicated in 125-184 Days	1	0	1	$0
Number of Claims Adjudicated in 185 + Days	0	0	0	$0

Claim Adjudication Statistics for AMERIGROUP CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	27,750	1,146	28,896	$1,326
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	24,316	735	25,051	N/A
Number of Claims Adjudicated in 5-9 Days	2,407	213	2,620	N/A
Number of Claims Adjudicated in 10-14 Days	488	107	595	N/A
Number of Claims Adjudicated in 15-19 Days	451	48	499	N/A
Percent of Claims Adjudicated within 19 Days	**99.7%**	**96.2%**	**99.5%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	74	36	110	$841
Number of Claims Adjudicated in 35-64 Days	13	5	18	$479
Number of Claims Adjudicated in 65-94 Days	1	0	1	$6
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	2	2	$0

Claim Adjudication Statistics for AMERIGROUP CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	31,970	2,207	34,177	$5
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	31,164	1,707	32,871	N/A
Number of Claims Adjudicated in 5-9 Days	735	359	1,094	N/A
Number of Claims Adjudicated in 10-14 Days	32	88	120	N/A
Number of Claims Adjudicated in 15-19 Days	30	31	61	N/A
Percent of Claims Adjudicated within 19 Days	**100.0%**	**99.0%**	**99.9%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	9	21	30	$5
Number of Claims Adjudicated in 35-64 Days	0	1	1	$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

Claim Adjudication Statistics for AMERIGROUP CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	41,951	1,360	43,311	$0
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	41,951	1,360	43,311	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 CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	186,334	4,934	191,268	$152,258
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	129,803	2,580	132,383	N/A
Number of Claims Adjudicated in 5-9 Days	36,901	790	37,691	N/A
Number of Claims Adjudicated in 10-14 Days	9,347	264	9,611	N/A
Number of Claims Adjudicated in 15-19 Days	2,449	146	2,595	N/A
Percent of Claims Adjudicated within 19 Days	**95.8%**	**76.6%**	**95.3%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	2,922	141	3,063	$8,048
Number of Claims Adjudicated in 35-64 Days	1,945	118	2,063	$31,314
Number of Claims Adjudicated in 65-94 Days	553	75	628	$19,576
Number of Claims Adjudicated in 95-124 Days	636	76	712	$19,174
Number of Claims Adjudicated in 125-184 Days	838	91	929	$40,881
Number of Claims Adjudicated in 185 + Days	940	653	1,593	$33,265

Claim Adjudication Statistics for Peach State Health Plans CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	49,854	1,178	51,032	$62,188
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	38,461	823	39,284	N/A
Number of Claims Adjudicated in 5-9 Days	8,165	153	8,318	N/A
Number of Claims Adjudicated in 10-14 Days	1,375	80	1,455	N/A
Number of Claims Adjudicated in 15-19 Days	205	36	241	N/A
Percent of Claims Adjudicated within 19 Days	**96.7%**	**92.7%**	**96.6%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	483	24	507	$2,625
Number of Claims Adjudicated in 35-64 Days	431	9	440	$13,315
Number of Claims Adjudicated in 65-94 Days	133	7	140	$9,264
Number of Claims Adjudicated in 95-124 Days	106	12	118	$15,888
Number of Claims Adjudicated in 125-184 Days	432	14	446	$15,916
Number of Claims Adjudicated in 185 + Days	63	20	83	$5,180

Claim Adjudication Statistics for Peach State Health Plans CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	42,419	1,416	43,835	$41,484
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	22,618	563	23,181	N/A
Number of Claims Adjudicated in 5-9 Days	11,549	324	11,873	N/A
Number of Claims Adjudicated in 10-14 Days	3,661	106	3,767	N/A
Number of Claims Adjudicated in 15-19 Days	1,579	82	1,661	N/A
Percent of Claims Adjudicated within 19 Days	**92.9%**	**75.9%**	**92.4%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	1,417	58	1,475	$1,059
Number of Claims Adjudicated in 35-64 Days	281	22	303	$4,030
Number of Claims Adjudicated in 65-94 Days	216	25	241	$3,125
Number of Claims Adjudicated in 95-124 Days	420	29	449	$1,027
Number of Claims Adjudicated in 125-184 Days	254	27	281	$17,588
Number of Claims Adjudicated in 185 + Days	424	180	604	$14,655

Claim Adjudication Statistics for Peach State Health Plans CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	44,178	1,442	45,620	$39,893
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	29,752	547	30,299	N/A
Number of Claims Adjudicated in 5-9 Days	8,701	193	8,894	N/A
Number of Claims Adjudicated in 10-14 Days	2,824	66	2,890	N/A
Number of Claims Adjudicated in 15-19 Days	425	21	446	N/A
Percent of Claims Adjudicated within 19 Days	**94.4%**	**57.4%**	**93.2%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	820	47	867	$3,230
Number of Claims Adjudicated in 35-64 Days	1,118	78	1,196	$11,330
Number of Claims Adjudicated in 65-94 Days	156	35	191	$4,252
Number of Claims Adjudicated in 95-124 Days	77	31	108	$1,709
Number of Claims Adjudicated in 125-184 Days	96	49	145	$6,592
Number of Claims Adjudicated in 185 + Days	209	375	584	$12,780

Claim Adjudication Statistics for Peach State Health Plans CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	49,883	898	50,781	$8,693
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	38,972	647	39,619	N/A
Number of Claims Adjudicated in 5-9 Days	8,486	120	8,606	N/A
Number of Claims Adjudicated in 10-14 Days	1,487	12	1,499	N/A
Number of Claims Adjudicated in 15-19 Days	240	7	247	N/A
Percent of Claims Adjudicated within 19 Days	**98.6%**	**87.5%**	**98.4%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	202	12	214	$1,133
Number of Claims Adjudicated in 35-64 Days	115	9	124	$2,638
Number of Claims Adjudicated in 65-94 Days	48	8	56	$2,936
Number of Claims Adjudicated in 95-124 Days	33	4	37	$551
Number of Claims Adjudicated in 125-184 Days	56	1	57	$785
Number of Claims Adjudicated in 185 + Days	244	78	322	$650

WellCare of Georgia (WellCare)

Claim Adjudication Statistics for WellCare CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	85,261	9,642	94,903	$37,490
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	29,799	3,003	32,802	N/A
Number of Claims Adjudicated in 5-9 Days	26,813	2,311	29,124	N/A
Number of Claims Adjudicated in 10-14 Days	5,157	543	5,700	N/A
Number of Claims Adjudicated in 15-19 Days	1,508	199	1,707	N/A
Percent of Claims Adjudicated within 19 Days	**74.2%**	**62.8%**	**73.1%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	14,208	1,846	16,054	$9,442
Number of Claims Adjudicated in 35-64 Days	1,261	203	1,464	$12,276
Number of Claims Adjudicated in 65-94 Days	805	80	885	$2,183
Number of Claims Adjudicated in 95-124 Days	638	80	718	$7,130
Number of Claims Adjudicated in 125-184 Days	1,188	133	1,321	$6,331
Number of Claims Adjudicated in 185 + Days	3,884	1,244	5,128	$128

Claim Adjudication Statistics for WellCare CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	82	675	757	$0
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	39	122	161	N/A
Number of Claims Adjudicated in 5-9 Days	35	519	554	N/A
Number of Claims Adjudicated in 10-14 Days	7	32	39	N/A
Number of Claims Adjudicated in 15-19 Days	1	2	3	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

Claim Adjudication Statistics for WellCare CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	6,302	1,164	7,466	$12,042
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	1,340	216	1,556	N/A
Number of Claims Adjudicated in 5-9 Days	3,792	682	4,474	N/A
Number of Claims Adjudicated in 10-14 Days	451	61	512	N/A
Number of Claims Adjudicated in 15-19 Days	11	6	17	N/A
Percent of Claims Adjudicated within 19 Days	**88.8%**	**82.9%**	**87.9%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	17	3	20	$1,109
Number of Claims Adjudicated in 35-64 Days	23	15	38	$5,296
Number of Claims Adjudicated in 65-94 Days	6	15	21	$0
Number of Claims Adjudicated in 95-124 Days	23	12	35	$5,636
Number of Claims Adjudicated in 125-184 Days	70	29	99	$0
Number of Claims Adjudicated in 185 + Days	569	125	694	$1

Claim Adjudication Statistics for WellCare CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	43,445	4,105	47,550	$17,191
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	6,933	349	7,282	N/A
Number of Claims Adjudicated in 5-9 Days	17,832	857	18,689	N/A
Number of Claims Adjudicated in 10-14 Days	1,628	211	1,839	N/A
Number of Claims Adjudicated in 15-19 Days	953	111	1,064	N/A
Percent of Claims Adjudicated within 19 Days	**62.9%**	**37.2%**	**60.7%**	**N/A**
Number of Claims Adjudicated in 20-34 Days	9,060	1,075	10,135	$4,043
Number of Claims Adjudicated in 35-64 Days	1,197	147	1,344	$4,641
Number of Claims Adjudicated in 65-94 Days	795	64	859	$555
Number of Claims Adjudicated in 95-124 Days	615	68	683	$1,494
Number of Claims Adjudicated in 125-184 Days	1,117	104	1,221	$6,331
Number of Claims Adjudicated in 185 + Days	3,315	1,119	4,434	$127

Claim Adjudication Statistics for WellCare CHOA Hospital Claims

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

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	35,432	3,698	39,130	$8,258
Number of Claims Adjudicated Up to 4 Days After Day of Receipt	21,487	2,316	23,803	N/A
Number of Claims Adjudicated in 5-9 Days	5,154	253	5,407	N/A
Number of Claims Adjudicated in 10-14 Days	3,071	239	3,310	N/A
Number of Claims Adjudicated in 15-19 Days	543	80	623	N/A
Percent of Claims Adjudicated within 19 Days	85.4%	78.1%	84.7%	N/A
Number of Claims Adjudicated in 20-34 Days	5,131	768	5,899	$4,290
Number of Claims Adjudicated in 35-64 Days	41	41	82	$2,340
Number of Claims Adjudicated in 65-94 Days	4	1	5	$1,628
Number of Claims Adjudicated in 95-124 Days	0	0	0	$0
Number of Claims Adjudicated in 125-184 Days	1	0	1	$0
Number of Claims Adjudicated in 185 + Days	0	0	0	$0

Exhibit Two – Denied Claims

AMERIGROUP Community Care (AMGP)

AMERIGROUP CHOA Percent of Hospital Claims Denied by Quarter

Quarter/Year	Paid Claims	Denied Claims	Total Claims	Percent Denied
Implementation Qtr 1	2,614	57	2,671	2.1%
Implementation Qtr 2	5,235	367	5,602	6.6%
Implementation Qtr 3	9,078	702	9,780	7.2%
Implementation Qtr 4	7,446	251	7,697	3.3%
SFY 2008 Qtr 1	7,397	288	7,685	3.7%
SFY 2008 Qtr 2	7,181	445	7,626	5.8%
SFY 2008 Qtr 3	7,086	165	7,251	2.3%
SFY 2008 Qtr 4	6,086	248	6,334	3.9%
SFY 2009 Qtr 1	6,792	679	7,471	9.1%
SFY 2009 Qtr 2	7,409	1,154	8,563	13.5%
SFY 2009 Qtr 3	8,561	215	8,776	2.4%
SFY 2009 Qtr 4	9,208	159	9,367	1.7%
SFY 2010 Qtr 1	10,154	332	10,486	3.2%
SFY 2010 Qtr 2	9,845	263	10,108	2.6%
SFY 2010 Qtr 3	10,825	307	11,132	2.8%
SFY 2010 Qtr 4	11,127	458	11,585	4.0%
Total	126,044	6,090	132,134	4.6%

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

Includes only CHOA Hospitals - Children's Healthcare Egleston and Children's Healthcare Scottish Rite

AMERIGROUP CHOA Percent of Hospital Denied Claims Later Paid by Quarter

Quarter/Year	Denied Claims	Overturned Claims	Percent Overturned
Implementation Qtr 1	57	5	8.8%
Implementation Qtr 2	367	59	16.1%
Implementation Qtr 3	703	302	43.0%
Implementation Qtr 4	251	42	16.7%
SFY 2008 Qtr 1	288	23	8.0%
SFY 2008 Qtr 2	445	46	10.3%
SFY 2008 Qtr 3	165	8	4.8%
SFY 2008 Qtr 4	251	1	0.4%
SFY 2009 Qtr 1	679	6	0.9%
SFY 2009 Qtr 2	1,154	552	47.8%
SFY 2009 Qtr 3	215	13	6.0%
SFY 2009 Qtr 4	159	9	5.7%
SFY 2010 Qtr 1	332	66	19.9%
SFY 2010 Qtr 2	264	40	15.2%
SFY 2010 Qtr 3	316	67	21.2%
SFY 2010 Qtr 4	502	121	24.1%
Total	6,148	1,360	22.1%

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

Includes only CHOA Hospitals - Children's Healthcare Egleston and Children's Healthcare Scottish Rite

Peach State Health Plan (PSHP)

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

Quarter/Year	Paid Claims	Denied Claims	Total Claims	Percent Denied
Implementation Qtr 1	9,256	286	9,542	3.0%
Implementation Qtr 2	12,809	288	13,097	2.2%
Implementation Qtr 3	15,414	252	15,666	1.6%
Implementation Qtr 4	12,375	352	12,727	2.8%
SFY 2008 Qtr 1	9,432	72	9,504	0.8%
SFY 2008 Qtr 2	13,676	700	14,376	4.9%
SFY 2008 Qtr 3	10,254	247	10,501	2.4%
SFY 2008 Qtr 4	9,057	397	9,454	4.2%
SFY 2009 Qtr 1	10,786	407	11,193	3.6%
SFY 2009 Qtr 2	10,621	354	10,975	3.2%
SFY 2009 Qtr 3	11,544	387	11,931	3.2%
SFY 2009 Qtr 4	11,227	294	11,521	2.6%
SFY 2010 Qtr 1	11,461	293	11,754	2.5%
SFY 2010 Qtr 2	11,103	157	11,260	1.4%
SFY 2010 Qtr 3	12,997	196	13,193	1.5%
SFY 2010 Qtr 4	14,322	252	14,574	1.7%
Total	186,334	4,934	191,268	2.6%

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

Quarter/Year	Denied Claims	Overturned Claims	Percent Overturned
Implementation Qtr 1	301	0	0.0%
Implementation Qtr 2	320	1	0.3%
Implementation Qtr 3	269	2	0.7%
Implementation Qtr 4	351	98	27.9%
SFY 2008 Qtr 1	74	3	4.1%
SFY 2008 Qtr 2	705	124	17.6%
SFY 2008 Qtr 3	249	6	2.4%
SFY 2008 Qtr 4	408	9	2.2%
SFY 2009 Qtr 1	343	18	5.2%
SFY 2009 Qtr 2	403	23	5.7%
SFY 2009 Qtr 3	410	48	11.7%
SFY 2009 Qtr 4	301	21	7.0%
SFY 2010 Qtr 1	295	30	10.2%
SFY 2010 Qtr 2	155	8	5.2%
SFY 2010 Qtr 3	196	22	11.2%
SFY 2010 Qtr 4	252	34	13.5%
Total	5,032	447	8.9%

WellCare of Georgia (WellCare)

WellCare CHOA Percent of Hospital Claims Denied by Quarter

Quarter/Year	Paid Claims	Denied Claims	Total Claims	Percent Denied
Implementation Qtr 1	4	87	91	95.6%
Implementation Qtr 2	33	216	249	86.7%
Implementation Qtr 3	23	225	248	90.7%
Implementation Qtr 4	22	147	169	87.0%
SFY 2008 Qtr 1	731	293	1,024	28.6%
SFY 2008 Qtr 2	823	432	1,255	34.4%
SFY 2008 Qtr 3	943	184	1,127	16.3%
SFY 2008 Qtr 4	3,805	255	4,060	6.3%
SFY 2009 Qtr 1	14,605	2,095	16,700	12.5%
SFY 2009 Qtr 2	9,071	847	9,918	8.5%
SFY 2009 Qtr 3	10,682	611	11,293	5.4%
SFY 2009 Qtr 4	9,087	552	9,639	5.7%
SFY 2010 Qtr 1	4,587	783	5,370	14.6%
SFY 2010 Qtr 2	6,796	421	7,217	5.8%
SFY 2010 Qtr 3	9,795	1,068	10,863	9.8%
SFY 2010 Qtr 4	14,254	1,426	15,680	9.1%
Total	85,261	9,642	94,903	10.2%

WellCare CHOA Percent of Hospital Denied Claims Later Paid by Quarter

Quarter/Year	Denied Claims	Overturned Claims	Percent Overturned
Implementation Qtr 1	88	1	1.1%
Implementation Qtr 2	216	0	0.0%
Implementation Qtr 3	224	2	0.9%
Implementation Qtr 4	147	3	2.0%
SFY 2008 Qtr 1	293	26	8.9%
SFY 2008 Qtr 2	436	124	28.4%
SFY 2008 Qtr 3	185	36	19.5%
SFY 2008 Qtr 4	259	63	24.3%
SFY 2009 Qtr 1	1,970	654	33.2%
SFY 2009 Qtr 2	948	217	22.9%
SFY 2009 Qtr 3	634	202	31.9%
SFY 2009 Qtr 4	620	128	20.6%
SFY 2010 Qtr 1	845	473	56.0%
SFY 2010 Qtr 2	423	173	40.9%
SFY 2010 Qtr 3	1,068	642	60.1%
SFY 2010 Qtr 4	1,359	1,013	74.5%
Total	9,715	3,757	38.7%