Georgia Department of Audits and Accounts
Performance Audit Operations
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Medicaid Care Management Organizations (CMOs)

Limited Review of Financial and Operational Topics

Why we did this review

Our review of Medicaid Care Management Organizations (CMOs) was conducted in response to a request by the House Appropriations Committee. The Committee asked that we provide an overview of the performance of the CMOs. We agreed to review reports already obtained or produced by the Department of Community Health in key areas of interest, based on conversations with the House Budget Office staff. Our special examination includes a review of financial information, claims processing, prior authorization, and provider satisfaction.

While this examination covers several important aspects of operations, a more comprehensive review would include the quality of healthcare provided to members.

Who we are

The Performance Audit Operations Division was established in 1971 to conduct in-depth reviews of state programs. The purpose of these reviews is to determine if programs are meeting their goals and objectives; provide measurements of program results and effectiveness; identify other means of meeting goals; evaluate the efficiency of resource allocation; and assess compliance with laws and regulations.

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What we found

The Department of Community Health (DCH) contracts with three Care Management Organizations (CMOs) to provide healthcare for approximately 1.1 million individuals in Low-Income Medicaid, PeachCare, and several smaller Medicaid populations. Our review found that per capita spending on CMOs has slightly increased since 2008 and that CMOs are spending a reasonable amount of revenue on medical care for members. Regarding the CMOs' claims processing and prior authorization process, we found aspects in which performance has improved over time, as well as issues that still need to be addressed.

Collectively, the CMOs were paid approximately $2.7 billion in fiscal year 2010, an increase of about $400 million in two years. Nearly all of the increase is due to membership growth. Viewed per member, payments grew from $203.15 per month in fiscal year 2008 to $206.02 in fiscal year 2010, an increase of 1.4%. The increase is lower than other healthcare measures reviewed. Based on financial reports filed with the Georgia Department of Insurance, the CMOs had relatively small or negative profit margins in calendar year 2009 (none exceeded 1.6%). They also spent more than 85% of revenue on members' healthcare benefits in calendar years 2008 and 2009.

The operational areas reviewed – claims processing and prior authorizations – are two areas in which providers have frequent contact with the CMOs. According to surveys conducted for two CMOs, the percentage of providers satisfied with the performance in the two areas was higher in 2009 than two years earlier and similar to their satisfaction with other health plans in the market. Our review of the claims processing and prior authorizations processes also found areas of improved performance, but areas where issues still remain.

- Regarding claims processing, all three CMOs had lower denial rates for claims submitted in 2010 than for those submitted in 2008. They also meet expectations for processing claims within 15 days, as required by state law and the contract with DCH; the average number of days from service date to a claims decision has remained steady or dropped for most types of claims.

- Emergency room claims are still a point of contention between providers and CMOs. Our review of a sample of hospitals found wide variation in the portion of claims paid at a decreased rate, which occurs when a CMO deems the visit to be due to a non-urgent need. For example, one hospital received full payment for all 292 ER claims submitted to one CMO, while another CMO paid the hospital a decreased rate for 140 of 189 claims.

- The number of prior authorization requests received for each category of service (e.g., inpatient, outpatient, vision) varies by CMO. For example, Amerigroup has significantly more requests/member for medical inpatient authorizations than the other two CMOs, but WellCare's medical outpatient requests/member greatly exceeds the other companies. WellCare receives significantly more requests/member but has a higher approval rate than the other CMOs.

- During the April-June 2010 period, the CMOs approved or denied at least 99.9% of requests within 14 days, as allowed by the contract. No CMO met this time standard in December 2008. While the vast majority of requests were decided in a timely manner, the average number of days did vary by category of service and some CMOs did not meet the 14-day standard for each category.

The provider surveys conducted by the CMOs were not limited to claims processing and prior authorizations. Among other things, the surveys found that providers' overall satisfaction with the CMOs was higher than two years earlier but lower than their satisfaction with other health plans in the market.

It should be noted that this report provides only a partial picture of CMO performance and of the success of managed care. Managed care introduces administrative costs for providers that previously did not exist for the Medicaid/PeachCare population. This impact is likely to vary depending on provider type and the policies of each CMO, and we did not assess the cost of managed care for the providers. We also did not review the quality of the healthcare delivered to members, which is a principle argument for managed care and one often contested by providers. Quality can be viewed in several ways, including access to care through an adequate network of providers, the increased use of preventative and screening services, increased use of primary care providers, and numerous other measures.

DCH's Response: *DCH stated that the "review, in combination with the ongoing DCH oversight and other external reviews of the program, is highly instrumental to the Department's stewardship of this very important program." DCH also provided specific comments, located at the end of each section of this report, intended to provide "clarity and context." The comments reflected no significant disagreement with the report's analyses. DCH also stated that the report comments will be used to assist the agency during the forthcoming re-procurement of the CMO effort.*

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Purpose of Special Examination

Our review of Medicaid Care Management Organizations (CMOs) was conducted in response to a request by the House Appropriations Committee that we provide an overview of the performance of the CMOs. We agreed to review documents already obtained or produced by the Department of Community Health in key areas of interest, based on conversations with the House Budget Office staff. Our examination includes a review of financial information, claims processing, prior authorization, and provider satisfaction. A more comprehensive assessment of the CMOs would include a review of the quality of healthcare provided to members.

A description of the objectives, scope, and methodology used in this review is included in Appendix A on page 34. A draft of the report was provided to the Department of Community Health for its review, and pertinent responses were incorporated into the report.

Background

Managed Care

Georgia operates a comprehensive managed care model for a majority of Medicaid and PeachCare members. The current Medicaid managed care system began in the Atlanta and Central regions on June 1, 2006 and expanded to the four remaining regions (East, North, Southeast, and Southwest) on September 1, 2006. Managed care is a partnership between DCH and CMOs intended to improve the healthcare status of the member population; establish contractual accountability for access to and the quality of healthcare; lower costs through more effective utilization management; and result in budget predictability and administrative simplicity for the state. The CMOs under contract include AMGP Georgia Managed Care Company, Inc. (Amerigroup), Peach State Health Plan, Inc. (Peach State), and WellCare of Georgia, Inc. (WellCare). (See **Appendix B** on page 36 for CMO coverage by region.)

Prior to the implementation of managed care, healthcare expenses of Medicaid recipients were paid using a fee-for-service (FFS) system under which providers were paid directly by the state's Medicaid program for services rendered to Medicaid enrollees. Under managed care, DCH pays a negotiated rate to the CMOs for each enrolled member. The CMOs operate as fully insured entities, meaning that the CMOs assume the risk that the revenue from the state will cover the claims sent in by the providers. Paying the fixed rate per enrollee under the managed care system provides the state with more budget predictability for the Medicaid and PeachCare programs.

The managed care member population is defined as those enrolled in PeachCare and certain individuals, pregnant women, and women with breast or cervical cancer covered by Medicaid. Each managed care-eligible member has a choice in health plans (as at least two of the three CMOs operate in each of the six regions) and has at least 30 days to make that choice. If members do not choose a CMO, they are assigned to one based on past medical and physician history or, if that is unavailable, are auto-assigned based on a combination of quality measures and costs for the CMOs in the member's region. Until fully enrolled with a CMO, members are served under the FFS system.

Georgia's Medicaid Programs

Medicaid was enacted as Title XIX under the Social Security Act of 1965 and provides a variety of healthcare services. In Georgia, the Medicaid program is administered by DCH's Medicaid Division. Medicaid funding is budgeted by the General Assembly through two budget programs – Low Income Medicaid (LIM) and Aged, Blind, and Disabled (ABD). The ABD population continues to receive coverage in a traditional FFS system. Most individuals whose coverage is funded through the LIM Program are CMO members. According to DCH, the LIM budget category also includes funding for Right from the Start Medicaid (RSM), the Women's Health Medicaid Program for women with breast and cervical cancer, Refugee Medicaid, Foster Care Medicaid, and Adoption Assistance Medicaid. The relatively small numbers of individuals in the foster care and adoption assistance programs are not eligible to receive coverage through a CMO and continue to receive FFS coverage.

Information about each Medicaid category budgeted under LIM and eligible under the CMO system is given below:

- **Low Income Medicaid** provides medical coverage to eligible, underprivileged children up to the age of 18 and the adults who are legally responsible for them. Services covered by LIM include physician services, inpatient and outpatient hospital care, prescription drugs, emergency ambulance services, immunizations, medical equipment and supplies, and vision and preventative dental care for children. Eligibility for each enrollee is determined by the Department of Human Services' Division of Family and Children Services (DFCS) in the appropriate county.

- **Right from the Start Medicaid** covers medical care for pregnant women for up to 60 days after they give birth. Covered services include prenatal care and delivery, doctor visits, prescription drugs, and inpatient and outpatient hospital services. In order to qualify for RSM, a pregnant woman must not have an income that exceeds 200% of the federal poverty level. Children may qualify for RSM at various income levels depending on their age and family size. Qualified children are entitled to a range of Medicaid services including doctor visits, immunizations, dental care, vision care, and prescription drugs.

- The **Women's Health Medicaid Program** provides full Medicaid coverage, including cancer treatment services, to eligible women under 65 who have breast and/or cervical cancer and require treatment. Qualified applicants have incomes at or below 200% of the Federal Poverty Level, have no insurance or are underinsured, and are not otherwise eligible for Medicaid or Medicare.

- **Refugee Medicaid** provides cash and/or medical assistance to legal refugee adults and families to assist them in resettling and achieving economic self-sufficiency as quickly as possible.

The Medicaid eligibility categories under the LIM budget category are funded by a combination of state, federal, and other funds. The FY 2010 final expenditures for LIM were $2.95 billion, which was comprised of $700 million (23.7%) in state funds ($435 million in general funds and $265 million in tobacco funds), $2.2 billion (75.1%) in federal funds, and $35 million (1.2%) in other funds.

PeachCare for Kids

The State Children's Health Insurance Program (SCHIP) was created under Title XXI of the Social Security Act in 1997 to provide federal matching funds to states for uninsured infants, children, and adolescents. In Georgia, this program is called the PeachCare for Kids Program, which began in 1999. It provides healthcare benefits for uninsured children from birth through 18 years of age. Health benefits mirror those for Medicaid minus targeted case management and non-emergency transportation. A CMO is responsible for coordinating each child's healthcare under the PeachCare Program.

In order for a child to be eligible for PeachCare, the following criteria must be met:

- The income of the child's family must not exceed the family income cap of 235% of the federal poverty level (approximately $51,818 for a family of four);
- The child's family must not be eligible for health coverage under Medicaid, the State Health Benefit Plan (which covers state employees, teachers, and public school employees), the Board of Regents Health Plan, or any other insurer;
- The child must have been without health coverage for at least six months prior to PeachCare enrollment, unless coverage is involuntarily lost; and
- The child must be a United States citizen or a legal resident.

PeachCare is funded through state funds, federal funds, and premiums from families collected for children ages 6 through 18. Premium rates range from $10 to $35 per month for one child to a maximum of $70 for two or more children living in the same household, depending on family income. For federal fiscal year 2010, the federal financial participation rate for PeachCare was 75.6% and the state matching rate was 24.4% on the federal block grant. PeachCare is not an entitlement program and is subject to the availability of federal block grant funds that are specifically appropriated to the program. In fiscal year 2010, the PeachCare program expended $274.4 million, which was comprised of $66.9 million (24.4%) in state funds, $207.3 million (75.6%) in federal funds, and $142,515 (0.1%) in other funds.

CMO Membership

The number and distribution of members covered by CMOs has changed over the last two years. As shown in **Exhibit 1**, in June 2008, there were 926,000 members, of which about 77% were part of the Low Income Medicaid program and almost 23% in PeachCare. By June 2010, the population had grown to nearly 1,090,000, an increase of 17.5%. All of the increase was on the Medicaid side; the PeachCare population dropped 6.6% over two years. The age distribution also slightly changed, with the percentage of children under the age of one decreasing and the percentage of those under 14 increasing. Of the three CMOs, Amerigroup experienced the greatest membership growth and Peach State the least.

Exhibit 1
Membership by CMO and Category
June 2008, 2009, 2010

CMO	June 2008		June 2009		June 2010		Change	
	#	% of Total	#	% of Total	#	% of Total	#	%
Amerigroup	197,863	21.4%	221,928	21.8%	251,684	23.1%	53,821	27.2%
Peach State	276,767	29.9%	290,372	28.5%	293,267	26.9%	16,500	6.0%
WellCare	451,514	48.8%	507,775	49.8%	535,552	49.2%	84,038	18.6%
Total	926,144	100.0%	1,020,075	100.0%	1,088,503	100.0%	162,359	17.5%

Low-Income Medicaid	June 2008		June 2009		June 2010		Change	
	#	% of Total	#	% of Total	#	% of Total	#	%
0-2 months	9,486	1.0%	9,837	1.0%	9,829	0.9%	343	3.6%
3-11 months	74,674	8.1%	71,880	7.0%	71,269	6.5%	-3,405	-4.6%
1-5 years	206,866	22.3%	250,661	24.6%	274,402	25.2%	67,536	32.6%
6-13 years	207,342	22.4%	248,814	24.4%	279,083	25.6%	71,742	34.6%
Female 14-20 years	61,968	6.7%	70,974	7.0%	75,191	6.9%	13,223	21.3%
Female 21-44 years	91,933	9.9%	98,813	9.7%	101,904	9.4%	9,970	10.8%
Female 45 years and older	6,080	0.7%	6,641	0.7%	6,906	0.6%	826	13.6%
Male 14-20 years	44,815	4.8%	52,387	5.1%	58,081	5.3%	13,266	29.6%
Male 21-44 years	7,056	0.8%	9,364	0.9%	10,685	1.0%	3,629	51.4%
Male 45 years and older	1,629	0.2%	2,217	0.2%	2,455	0.2%	827	50.8%
Total Low Income Medicaid	711,849	76.9%	821,589	80.5%	889,806	81.7%	177,957	25.0%

PeachCare	June 2008		June 2009		June 2010		Change	
	#	% of Total	#	% of Total	#	% of Total	#	%
0-2 months	1	0.0%	0	0.0%	2	0.0%	1	100.0%
3-11 months	336	0.0%	344	0.0%	282	0.0%	-54	-16.1%
1-5 years	51,333	5.5%	43,396	4.3%	38,955	3.6%	-12,378	-24.1%
6-13 years	106,468	11.5%	100,746	9.9%	103,999	9.6%	-2,469	-2.3%
Female 14-20 years	25,348	2.7%	23,842	2.3%	25,850	2.4%	502	2.0%
Male 14-20 years	25,966	2.8%	24,525	2.4%	26,466	2.4%	500	1.9%
Total PeachCare	209,452	22.6%	192,853	18.9%	195,554	18.0%	-13,898	-6.6%

Breast and Cervical Cancer	June 2008		June 2009		June 2010		Change	
	#	% of Total	#	% of Total	#	% of Total	#	%
N/A	4,844	0.5%	5,633	0.6%	3,143	0.3%	-1,701	-35.1%

Total CMO Members	June 2008		June 2009		June 2010		Change	
	#	% of Total	#	% of Total	#	% of Total	#	%
Total CMO Members	926,144	100.0%	1,020,075	100.0%	1,088,503	100.0%	162,359	17.5%

Source: DCH Office of Planning and Fiscal Analysis

Requested Information

Cost of Managed Care

While managed care proponents also point to an opportunity to improve health outcomes, cost savings are often a key factor when states transition Medicaid members from fee-for-service to managed care. Managed care organizations are expected to decrease avoidable service utilization and adopt strategies to improve the health of their members. These objectives are not necessarily mutually exclusive, since more and costlier services may not improve health (e.g., using an emergency room for primary care instead of an established primary care provider).

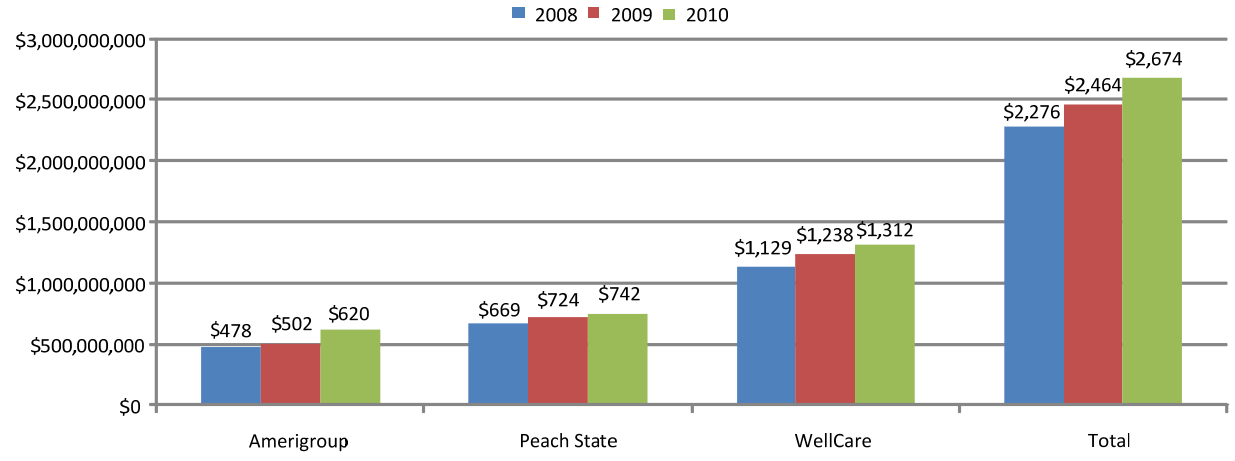
We calculated the growth in spending on the CMO population for the last three years and analyzed the components of the capitation rate for fiscal years 2008 through 2010. We also compared growth in the cost per CMO member to other measures of growth in healthcare spending.

CMO Payments[1]

In state fiscal years 2008-2010, adjusted payments to the three CMOs grew 17.5%, from $2.3 to $2.7 billion. As shown in **Exhibit 2**, the largest payments were to WellCare, which is the only CMO with members in all six regions. Amerigroup, which received the smallest amount each year, experienced the greatest growth in payments at nearly 30%.

The growth in payments was largely the result of an increase in members. In fiscal year 2008, CMO membership averaged about 933,000 per month. By fiscal year 2010, membership averaged more than 1,081,000 monthly, an increase of nearly 14%. An

Exhibit 2
CMO Payments, excluding QA Fees (in millions)



Source: Calculations based on data provided by DCH Office of Planning and Fiscal Analysis

[1] Adjusted payments are used throughout this section. Monthly payments have been adjusted in subsequent months for reasons such as identification of duplicate members and deaths of members. Payments also do not include the now-discontinued Quality Assurance Fee. The QA fee was similar to a premium tax paid by the CMOs directly to DCH. The fee was 6% from CMO inception to December 2007 and 5.5% from January 2008 through September 2009.

increase in members was responsible for $362.5 million of the $398.3 million increase in spending on CMOs. The remaining $35.8 million was due to growth in per capita spending.

Per Capita Payments to the CMOs

From fiscal year 2008 to 2010, per member per month (PMPM) payments to the CMOs increased 1.4% from $203.15 to $206.02. As shown in **Exhibit 3**, the PMPM increased in 2009 before slightly declining in 2010. The exhibit also shows that the CMOs' relative cost varies annually. In 2008 and 2009, WellCare's PMPM was the highest, but in 2010, its PMPM was the lowest. In 2010, the PMPM costs for the three CMOs were within a range of $5.50. Two years earlier, the PMPM varied by approximately $15.

The PMPM is comprised of several components, which are discussed below. The payment rates associated with these components must be supported by an actuary's certified rates, which are forwarded to the federal Centers for Medicare and Medicaid Services for approval.

- **Capitation Payment** – Approximately 85% of PMPM costs are from the monthly capitation paid for each member on a CMO's membership roll. The payment varies by eligibility category (i.e., PeachCare, Medicaid), member age, gender (those over 13), region, and CMO. For example, during the rate period that ended June 2010, a Low-Income Medicaid child between the ages of 1 and 5 had an associated monthly payment between $114.96 and $142.00. A PeachCare child of the same age cost $109.58 to $144.69.

- **Delivery Payment** – The CMOs receive a single payment for the delivery of each baby. The amount varies by region and CMO. The amounts were between $5,297 and $5,886 during the rate period that ended June 2010.

- **Neonatal Intensive Care Unit (NICU) Payment** – The CMOs receive a single payment for the admission of a baby to a NICU. This payment, which began in fiscal year 2010, is to be paid after the child is discharged from the hospital. The amount varies by region and was between $73,576 and $85,376 during the rate period that ended June 2010.

- **Member Merge Payment** – DCH paid the CMOs lump sum payments to account for capitation rates set too low in fiscal year 2009. According to DCH and its actuary, the fiscal year 2009 rates were initially set with data that included a significant number of duplicate members. Since the number of members was inflated but the health benefit expenditure information was not, the estimate of CMOs' expenditures per member were set too low, as were the corresponding rates paid to CMOs.

The relative stability of the PMPM was largely a result of the increase in capitation payments being offset by a decline in delivery payments. Capitation payments increased just over $9 over the two-year period. However, a decline in the delivery payment amounts and births reduced delivery payments from an average of $35.16 to $26.43 (24.8%) PMPM. From 2008 to 2010, the one-time delivery payment rate dropped more than 10% in most regions. In addition, the birth rate dropped from 5.6 per 1,000 members to 4.8. Had the birth rate remain unchanged, the PMPM would be

$4.65 higher than the actual 2010 rate. The drop in births also positively impacts the capitation payment, since it results in fewer members in the 0-2 months and 3-11 month rate categories, which have higher capitation rates than categories containing older children.

Exhibit 3
Per Capita Payments to CMOs (Excluding QA Fees)
Fiscal Years 2008-2010

Total (3 CMOs Combined)

	Per Member Per Month			Percentage Change		
Component	**FY08**	**FY09**	**FY10**	**FY08-09**	**FY09-10**	**FY08-FY10**
Capitation	$168.00	$175.68	$177.13	4.6%	0.8%	5.4%
Delivery Payments	$35.14	$31.27	$26.43	-11.0%	-15.5%	-24.8%
NICU Payments	$0.00	$0.00	$2.46	N/A	N/A	N/A
Member Merge	$0.00	$1.34	$0.00	N/A	N/A	N/A
PMPM Total	**$203.15**	**$208.19**	**$206.02**	**2.5%**	**-1.1%**	**1.4%**
Annual Total	$2,438	$2,498	$2,472	2.5%	-1.1%	1.4%

Amerigroup

	Per Member Per Month			Percentage Change		
Component	**FY08**	**FY09**	**FY10**	**FY08-09**	**FY09-10**	**FY08-FY10**
Capitation	$164.95	$169.31	$179.21	2.6%	5.8%	8.6%
Delivery Payments	$29.51	$27.37	$27.69	-7.2%	1.2%	-6.2%
NICU Payments	$0.00	$0.00	$3.00	N/A	N/A	N/A
Member Merge	$0.00	$1.09	$0.00	N/A	N/A	N/A
PMPM Total	**$194.46**	**$197.77**	**$209.90**	**1.7%**	**6.1%**	**7.9%**
Annual Total	$2,334	$2,373	$2,519	1.7%	6.1%	7.9%

Peach State

	Per Member Per Month			Percentage Change		
Component	**FY08**	**FY09**	**FY10**	**FY08-09**	**FY09-10**	**FY08-FY10**
Capitation	$164.55	$175.17	$175.43	6.6%	0.1%	6.6%
Delivery Payments	$34.78	$32.54	$27.57	-6.5%	-15.3%	-20.7%
NICU Payments	$0.00	$0.00	$2.67	N/A	N/A	N/A
Member Merge	$0.00	$1.58	$0.00	N/A	N/A	N/A
PMPM Total	**$199.33**	**$209.29**	**$205.67**	**5.0%**	**-1.7%**	**3.2%**
Annual Total	$2,392	$2,511	$2,468	5.0%	-1.7%	3.2%

WellCare

	Per Member Per Month			Percentage Change		
Component	**FY08**	**FY09**	**FY10**	**FY08-09**	**FY09-10**	**FY08-FY10**
Capitation	$171.53	$178.55	$177.12	4.1%	-0.8%	3.3%
Delivery Payments	$37.96	$32.21	$25.20	-15.2%	-21.8%	-33.6%
NICU Payments	$0.00	$0.00	$2.10	N/A	N/A	N/A
Member Merge	$0.00	$1.31	$0.00	N/A	N/A	N/A
PMPM Total	**$209.50**	**$212.07**	**$204.42**	**1.2%**	**-3.6%**	**-2.4%**
Annual Total	$2,514	$2,545	$2,453	1.2%	-3.6%	-2.4%

Source: Calculation based on data provided DCH Office of Planning and Fiscal Analysis

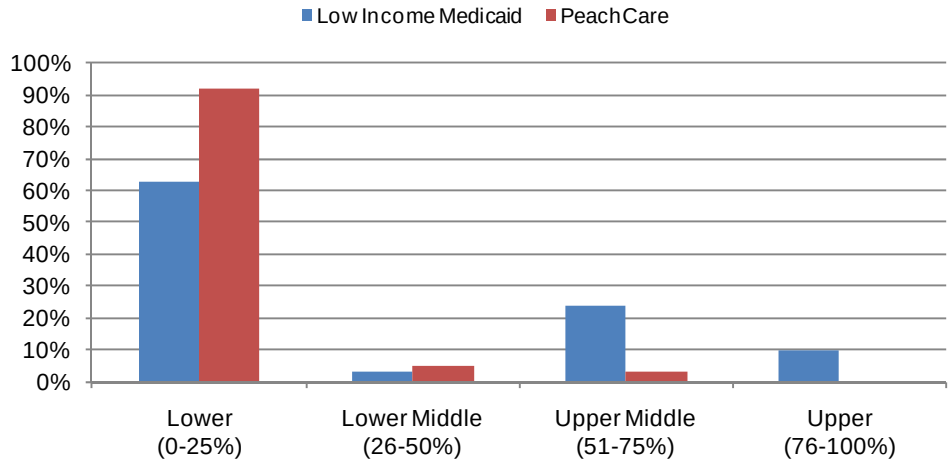
CMO Capitation Payments in Relation to Certified Rate Range

For the nine-month period ending June 2010, we found that DCH had frequently negotiated capitation rates for the CMOs at the low end of the actuary's rate range. This was true for a majority of Low Income Medicaid and PeachCare capitation rates reviewed.

Each year, DCH's contracted actuary establishes a payment range for each rate cell. The rate cells are based on eligibility category, age, gender, and region [see Exhibit 1 for categories (excluding regions)]. Using previous expenditures, medical inflation, projected membership, and other factors, the actuary projects a range for the CMOs' medical costs for each rate cell. An additional amount is allowed for administration. Within the rate range, DCH negotiates an actual rate with each CMO. Our review included those categories with the most members, including all Low Income Medicaid and PeachCare cells with members up to age 20, and Low Income Medicaid females 21-44. Each of the six regions was included in our analysis, resulting in a review of 169 rate cells. We divided the actuary's range for each rate into quartiles and determined into which quartile the negotiated rate fell.[2]

As shown in **Exhibit 4**, the vast majority of negotiated rates reviewed were in the lower quartile, meaning that DCH often paid near the lowest rate permitted by the actuarial analysis. This was especially true for the PeachCare cells, with more than 90% in the lower quartile. More than 60% of Low Income Medicaid rates were in the lower quartile. About 34% of Low Income Medicaid rates were in the top two quartiles.

Exhibit 4
Negotiated Rate in Relation to Actuarial Range
10/1/09 - 6/30/10 Period



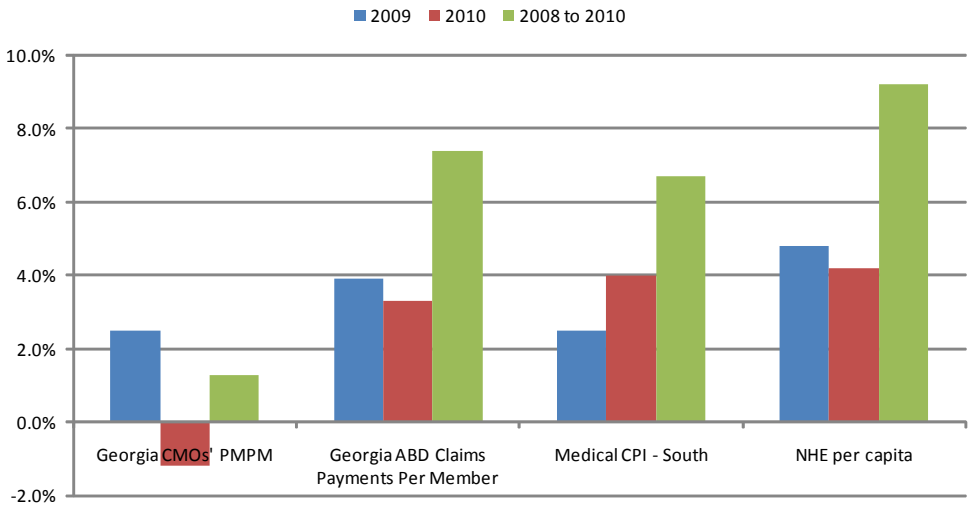
Source: Actuary reports and data from DCH Office of Planning and Fiscal Analysis

[2] A negotiated rate at the bottom of the range would be 0% and in the Lower quartile, while a negotiated rate at the top of the range would be 100% and in the Upper quartile. If the actuary's range was $110 to $120, a negotiated rate of $117 would be calculated at 70% ($7 of the $10 possible dollars) and the rate would be in the Upper Middle quartile.

CMO Cost Trend Compared to Other Measures

The change in per capita payments to the CMOs was lower than the other healthcare spending measures we reviewed. As shown in **Exhibit 5**, the change in per capita payments to the CMOs in fiscal years 2009 and 2010 was lower than the change in per capita claims for Georgia's Aged, Blind, and Disabled Medicaid population (covered under fee-for-service). The increase was also lower than the projected change in per capita national healthcare expenditures and the medical care inflation rate for the southern United States. It should be noted that the medical inflation rate shows the change in cost for a set of services and does not reflect changes in service utilization. The other measures show changes in the cost of spending per individual, which is influenced by both inflation and any change in the quantity or type of services used.

Exhibit 5
Changes in CMO Costs Compared to Other Measures



Note: The Georgia ABD population includes the non-Medicare population only.
Sources: CMO & ABD-Calculated from data provided by DCH Office of Planning and Fiscal Analysis; Medical CPI-U.S. Bureau of Labor Statistics; NHE-U.S. Centers for Medicare and Medicaid Services

Notable Issues Regarding Cost of Managed Care

1. **Spending Growth** – Increased spending on the CMO population is largely the result in the growth in membership. In fiscal year 2010, per capita spending was only slightly higher than two years earlier. The per capita growth was lower than the other measures reviewed.

2. **Impact on Providers** – Our review was focused on the costs to the state, not to health care providers. Nevertheless, it is important to note that a Medicaid managed care environment results in increased costs to providers. Managed care may save money through a focus on preventative care, but savings are also derived by placing additional controls over high-cost goods and services. These controls include additional requirements for prior authorizations and added scrutiny of certain claims. For the CMO, the costs of these controls are covered by the capitated rate paid by DCH. However, these controls require additional work – resulting in higher administrative costs – for the providers also. We did

not determine the extent to which providers are paid rates that are higher than rates paid through Medicaid FFS, which has lower administrative costs for the provider.

3. **Reviewing Service Utilization** – An opportunity exists for additional study that would provide a more complete explanation of managed care costs. We did not determine if managed care has resulted in a change in the mix of services utilized, with a reduction in higher cost services and an increase in lower cost, preventative services. Higher cost services that could be reviewed include emergency room usage rates, hospital admission and re-admission frequencies, average lengths of hospital stays, and the use of generic medication.

4. **Comparing CMO and FFS Cost** – While we did not independently estimate the cost savings or added cost resulting from the transition to managed care, in 2009 a DCH-contracted actuary did provide an estimate of cost avoidance. The contractor used Georgia FFS trend data from the period before CMOs, other states' FFS experiences, and medical inflation, and it made assumptions about what provider rate increases may have occurred under FFS. It reported that the use of CMOs resulted in savings of approximately $29.4 million in fiscal year 2007 and $35.0 million in 2008 (total funds). The contractor projected savings of $68.2 million in 2009 that grow to $134.6 million by 2010. These savings assume no increase in FFS provider rates. Greater savings were estimated if FFS providers received rate increases.

   We suggest caution when using these figures. While the contractor used a reasonable source for estimating healthcare cost changes, the source noted data limitations and a warning about the quality of projections. The Centers for Medicare and Medicaid Services' (CMS) 2008 Actuarial Report on the Financial Outlook for Medicaid stated that healthcare cost projections are "necessarily uncertain," and that "increases in Medicaid and other health care costs have often been relatively volatile, adding to the difficulty of correctly anticipating future trends." This is clearly demonstrated by the initial projections for savings to be generated by the move to managed care in Georgia. Originally projected to be $248 million, the 2009 contractor report puts the savings at $29.4 million.

   The CMS report also noted that state-level data was unavailable and that its projected cost changes were at the national level. Without Georgia data, the DCH contractor was forced to use national FFS trend data to estimate what would have happened to FFS spending in Georgia. If the state's growth was lower than the national rate, the projected savings from managed care would be lower (or disappear).

   While it would be ideal to determine actual savings (or added costs) resulting from the change to managed care, we did not identify a method that would provide an accurate figure in our reporting timeframe. The method discussed above – estimating FFS spending for the current population – was problematic for the reasons already noted. Another method for determining savings would be to compare spending on the managed care population to spending on a comparable population served under the Medicaid FFS model. Other states have adopted a similar managed care model as a pilot in a limited geographic area,

which allows researchers to compare changes in cost and quality for the FFS and managed care populations. However, Georgia's transition to managed care was statewide and mandatory for the entire population in certain eligibility categories, resulting in no significant, comparable population under the FFS model in the state.

DCH's Response: *In its response to the "Cost of Managed Care" section, DCH made the following points:*

- *Federal requirements mandate that Medicaid agencies pay managed care organizations at an actuarially sound capitation rate. The review accurately reflects the fact that the DCH pays the three contracted CMO plans at the lowest quartile of the actuarially sound rate.*

- *The percent increase in CMO costs compared to the percent increase in the [Medical] Consumer Price Index (CPI) for the southern region from 2008 to 2010 is particularly favorable in demonstrating the CMO efforts' ability to control spending growth (1.4% vs. 6.5%).*

- *The review accurately reflects the fact that Medicaid managed care may result in additional administrative costs to providers. Medicaid is by nature more administratively involved than most other commercial insurance plans. The source of this disparity is the fact that traditional commercial payers can address utilization issues to a large extent through changing member utilization behaviors – primarily through meaningful patient cost-sharing (e.g., co-payments, deductibles, co-insurances). Due to federal requirements regarding nominal cost-sharing, populations exempt from cost-sharing, and largely the inability to deny services based on an individual's inability to pay, greatly limits the use of this tool in the Medicaid environment.*

  However, the absence of a meaningful patient cost-sharing tool prompts Medicaid and the CMOs to work more closely with the provider community. The plans have an incentive to coordinate care, provide case management, disease management, and deliver better information to the provider at the point of care. The value of these enhancements is rarely acknowledged when discussing the value versus cost that managed care brings to the provider community.

- *While the review's caution of the preciseness of CMO savings estimates is prudent, the consistent fact from all analysis performed and scenarios considered reflects a net savings to the state.*

CMO Finances

All health insurance companies operating in Georgia must comply with state laws and regulations that are intended to ensure a company's solvency. The CMOs are no exception, subject to many of the same laws and regulations as well as oversight by the Georgia Department of Insurance (DOI). DOI reviews quarterly and annual financial reports from the CMOs and uses information from the National Association of Insurance Commissioners (NAIC) to assess the companies' solvency. Per state law, DOI also conducts a triennial "examination" of each CMO, similar to a financial audit, to ensure that previously reported financial statements are accurate.

DCH's contract with the CMOs also contains requirements related to the companies' solvency and maintenance of reserve funds. However, since the CMOs are contractors, paid with taxpayer funds to pay the covered medical costs for 1.1 million Georgians, DCH also has an interest in ensuring that a large portion of the CMOs' revenue is spent on members' medical care. To that end, the CMOs are required to submit financial information, including Medical Loss Ratio reports that show the portion of revenue going to medical care.

As part of our examination, we reviewed the financial statements provided to the Department of Insurance and NAIC by the CMOs, as well as financial analyses performed by DOI. We also reviewed the Medical Loss Ratio reports submitted by the CMOs and compared those to DOI-created MLRs. Finally, we calculated other common financial ratios associated with CMO operations.

Basic Financial Information

Exhibit 6 contains information from the CMOs' financial statements submitted for calendar years 2007-2009. The exhibit contains the components of the companies' net income or loss, including premium revenue, expenses related to paying health providers, and expenses associated with plan administration. It also contains investment gains (or losses) and federal and foreign taxes paid. It should be noted that WellCare's information is not limited to the Medicaid program; the company also participates in the Medicare Advantage Program in Georgia. However, Medicaid accounts for 96% of WellCare's stated[3] revenues and expenses for 2009 and an even greater percentage for the preceding two years.

The financial statements show that two of the three CMOs have reported net losses in at least one of the three years reviewed. Peach State reported a loss in each of the three years, while Amerigroup reported a loss in 2007. However, it is possible that the contracts with DCH are more profitable than they appear. Each of the CMO's administrative expenses includes payments to parent companies (or other subsidiaries) for the delivery of administrative services, and the portion of those payments that result in profit to the associated company is not known.

[3] Adjustments for taxes and investments are not reported separately for Medicare and Medicaid, so we could not remove Medicare's contribution to revenues and deductions.

Exhibit 6
CMO Revenues and Expenses[1] 2007-2009

	2007	2008	2009
Amerigroup			
Premium Revenues	$554,472,427	$490,845,189	$580,939,341
Less Expenses			
Hospital and Medical Expenses	465,394,358	401,112,107	486,840,640
Claims Adjustment Expenses	10,853,450	11,944,162	12,599,890
General Administrative Expenses	87,234,801	72,785,800	73,897,551
Total Underwriting Deductions	563,482,609	485,842,069	573,338,081
Net Underwriting Gain/Loss	-9,010,182	5,003,120	7,601,260
Plus Net Investment Gain/Loss	4,956,495	3,637,708	2,016,832
Less Federal and Foreign Income Taxes Paid/Recovered	-	-	-
Net Income/Loss	**-$4,053,687**	**$8,640,828**	**$9,618,092**
Peach State			
Premium Revenues	$697,824,047	$730,146,565	$751,986,499
Less Expenses			
Increase/Decrease in Reserves	6,057,139	-443,817	14,529,347
Hospital and Medical Expenses	594,769,830	616,628,341	661,385,574
Claims Adjustment Expenses	21,044,361	22,000,450	22,880,754
General Administrative Expenses	111,522,632	110,346,608	102,874,988
Total Underwriting Deductions	733,393,962	748,531,582	801,670,663
Net Underwriting Gain/Loss	-35,569,915	-18,385,017	-49,684,164
Plus Net Investment Gain/Loss	3,931,213	1,711,555	1,416,565
Less Federal and Foreign Income Taxes Paid/Recovered	14,197,697	1,198,548	11,925,615
Net Income/Loss	**-$17,441,005**	**-$15,474,914**	**-$36,341,984**
WellCare[2]			
Premium Revenues	$1,097,230,327	$1,273,183,620	$1,386,584,813
Less Expenses			
Hospital and Medical Expenses	887,530,002	1,023,014,466	1,160,073,153
Claims Adjustment Expenses	35,411,926	40,992,804	46,020,113
General Administrative Expenses	153,747,568	174,784,388	161,426,801
Total Underwriting Deductions	1,076,689,496	1,238,791,658	1,367,520,067
Net Underwriting Gain/Loss	20,540,831	34,391,962	19,064,746
Plus Net Investment Gain/Loss	7,393,859	4,335,521	1,270,092
Less Federal and Foreign Income Taxes Paid/Recovered	9,583,657	14,394,138	8,059,393
Net Income/Loss	**$18,351,033**	**$24,333,345**	**$12,275,445**

(1) The most recent triennial examination conducted by DOI on the three CMOs identified no material problems with the accuracy of the financial statements for the periods reviewed in the exam.
(2) WellCare's financial statements also include revenue and expenses from a Medicare Advantage program. In 2009, revenue from Medicare totaled $58 million, approximately 4% of total revenue. Similarly, Medicare-related expenses were approximately 4% of total underwriting expenses.
Source: 2007-2009 Annual Statements submitted to the Georgia Department of Insurance

Medical Loss Ratios

Medical loss ratios (MLR) represent the percentage of premiums an insurer uses to provide medical care. The ratio shows what is paid for medical care in contrast to administrative expenses and profit. Since 2007, the MLRs for each of the CMOs have generally been between 80% and 90%. **Exhibit 7** shows the MLRs as calculated by DOI and those reported to DCH by the CMOs. DOI's method places the three CMOs in the 80-86% range in 2007 and 2008, then rising in 2009. The CMO-calculated rates are all above 85%, exceeding 90% for Peach State in 2009.

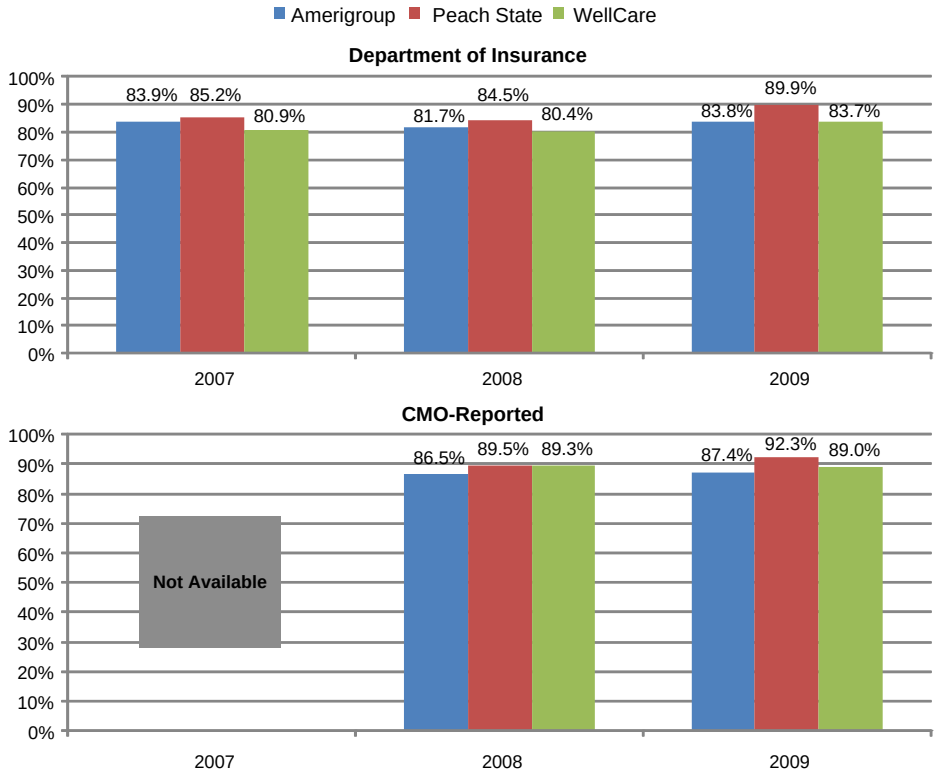
Medical Loss Ratio

$$\frac{\text{Medical Expenses}}{\text{Revenue}} \times 100$$

While MLR calculations compare medical expenses and premium revenue, the definition of each can vary. The differences in the ratios presented in Exhibit 7 can be attributed to adjustments to expenses or revenues. Using medical expenses, changes to reserves, and total revenues from each CMO's annual financial statement, DOI calculated the MLRs shown below. In their reports to DCH, the CMOs make adjustments to revenue prior to calculating the MLR, removing the quality assurance fee and revenue from re-insurance from total revenues. By lowering revenues, the MLR is increased. Either method is acceptable, as long as the method is known by those using the ratios and is the same for all entities being compared.

DCH does not currently set a minimum MLR that must be met by the CMOs. If the MLR is ever to be used as a performance requirement, as is true in some states and planned for most insurers under the new federal Patient Protection and Affordable

Exhibit 7
CMO Medical Loss Ratios



(1) WellCare's ratios, as calculated with information submitted to DOI, are impacted by the inclusion of Medicare revenue and expenses. Medicare represents approximately 4% of the corporation's reported revenues and expenses.

Sources: Annual statements submitted to Department of Insurance and reports submitted to DCH

Care Act, it is necessary to ensure that medical expenses and revenues are consistently classified. In response to the new federal law, the NAIC has developed a set of recommendations detailing the financial information that should be included in (or exempted from) the ratio calculation. The recommendations include a 3-page worksheet and 20+ pages of instructions for calculating the MLR.

Other Ratios Calculated by DOI

DOI uses several ratios as part of its assessment of health insurance companies' solvency. The ratios in **Exhibit 8** are based on the financial data in **Exhibit 6**.

Exhibit 8
Selected Financial Ratios for CMOs
2007-2009

	Amerigroup			Peach State			WellCare[1]		
Ratio	**2007**	**2008**	**2009**	**2007**	**2008**	**2009**	**2007**	**2008**	**2009**
Administrative Expense Ratio	17.7%	17.3%	14.9%	19.0%	18.1%	16.7%	17.2%	16.9%	15.0%
Combined Ratio	101.6%	99.0%	98.7%	105.1%	102.6%	106.6%	98.1%	97.3%	98.6%
Profit Margin Ratio	-0.7%	1.7%	1.6%	-2.5%	-2.1%	-4.8%	1.7%	1.9%	0.9%

(1) WellCare's ratios are calculated from financial statements that also include its Georgia-based Medicare business, which represents approximately 4% of both revenue and expenses.

Source: 2007, 2008, and 2009 financial statements submitted to the Georgia Department of Insurance

- **Administrative Expense Ratio** – This ratio reflects the percentage of total revenue used to administer the plan. Administrative expenses include the costs of claims processing, commissions, advertising and marketing, and other typical insurance plan activities. Theoretically, a company with a low administrative expense ratio operates more efficiently than one with a high ratio. However, beneficial activities such as a quality improvement and assurance program would increase the ratio. It should be noted that the administrative expense is increased by the inclusion of the state-mandated quality assurance fee. The fee was 6% in 2007 and 5.5% in 2008 and 2009 (until its federally mandated elimination on 9/30/09).

  The CMOs' administrative expense ratios were generally consistent within a given year, between 17% and 19% in 2007 and 2008 before dropping in 2009.

- **Combined Ratio** – This ratio compares underwriting deductions to premium revenue. A ratio under 100% indicates that the company is making "underwriting profit"; a ratio above 100% means that it is paying out more money in claims than it is receiving in premiums.

  The CMOs' combined ratios are all near or above 100% each year. Peach State's ratio exceeded 100% each year, while WellCare was always below 100%. Amerigroup had a ratio exceeding 100% in 2007, but it was slightly under 100% in 2008 and 2009.

- **Profit Margin Ratio** – The profit margin ratio compares net income to revenues. It is useful for comparing the relative profitability of companies within the same industry or one company's performance over time.

Peach State reported a loss of between 2% and 5% each year, while WellCare reported a 1%-2% profit each year. Amerigroup reported a small loss in 2007 and a profit of less than 2% in 2008 and 2009.

Notable Issues Regarding CMO Finances

1. **Limitations of CMO Financial Review** – The CMOs pay administrative expenses to their parent companies (and/or other subsidiaries), and these relationships impact the financial statements of the Georgia-based CMOs. Larger payments would shift profit to a non-Georgia company, while smaller payments would have the opposite effect. We did not assess the impact that the relationship has on the two organizations' financial performance. It should be noted that DOI, as part of its examination process, approves or requires modification of the administrative expense and tax-sharing agreements between CMOs and their affiliates.

DCH's Response: *In its response to the "CMO Finances" section, DCH made the following points:*

- *The discussion regarding Medical Loss Ratios (MLRs) in the review appropriately advises DCH that any future use of this ratio should be accompanied by consistently classified medical expenses and revenues. DCH agrees with this approach. However, DCH has not incorporated a minimum mandatory MLR at this point. An arbitrary minimum mandatory MLR in isolation is insufficient to monitor the appropriateness of medical expenses to administrative overhead and profit. For example, an increase in a plan's MLR can easily be accomplished by eliminating Emergency Room (ER) case management programs geared to decrease unnecessary ER utilization. Eliminating such programs can increase medical expenses (e.g., costly ER visits) while decreasing overhead (e.g., administrative cost associated with case management). Such a scenario may result in a plan compliant with a certain MLR, but this is not in the best interest of the member, the plan, or the State.*

- *While several other ratios are discussed in this review, DCH has no reason to be concerned or otherwise question the viability of the three CMO plans in the Georgia market at this time.*

CMO Claims Processing

Health care providers submit claims to the CMOs to receive payment for the services provided to CMO members. Like other insurance companies, when processing a claim, the CMOs ensure that the provider is in the network, that the member was eligible on the date of service, and that the particular service is covered by the member's benefit plan. The CMO may also determine if prior authorization was granted, if required for the service billed. If payment is approved, the rate agreed to in the contract with the provider must be determined. These steps must occur within 15 days, which is the maximum timeframe in which state law[4] and the contracts with DCH allow for claim adjudication.

Claims processing is a primary interaction between providers and CMOs. Processing problems were especially a concern of providers when the CMOs first began operations in Georgia. The problems reported by providers included a lack of timely processing, inaccurate or inconsistent payments, and frequent payment denials with an arduous appeals process. In addition, hospitals complained about CMO payment practices regarding emergency room claims.

Our limited review included analyzing claims information reported to DCH by the CMOs on a monthly basis. In addition, we met with staff of the Georgia Department of Insurance to discuss CMO claims processing as compared to other insurers in Georgia. Finally, we reviewed copies of relevant reports produced by Myers and Stauffer, an independent audit firm under contract with DCH, which was asked to evaluate specific aspects of CMO performance regarding claims processing. In a series of reports from January 2008 through September 2009 M&S made recommendations to providers, CMOs, and DCH to help resolve the identified problems.

Claims Processed

Exhibit 9 shows the total number of claims paid and denied by each of the CMOs for calendar years 2008 and 2009, as well as January through June 2010. The information was self-reported by the CMOs in the form of monthly reports to DCH. While we did not verify the reports' accuracy, we did correct obvious errors and confirm our changes with DCH officials. The reports show that the number of claims paid and denied in 2009 increased for Amerigroup and WellCare. The percentage of denied claims for all three CMOs has decreased since 2008. Through June of 2010, the CMOs denied approximately 10-12%, compared to denials of 13-18% in 2008.

Claims are denied for a variety of reasons. While the CMO monthly claims reports to DCH include lists of the top five reasons claims are denied, a precise comparison is difficult because the CMOs categorize denials differently. However, review of the reasons listed for June 2010 claims indicates that claims are generally denied because they may be duplicates of other claims or were not submitted in a timely manner, because authorization was not obtained in advance, or because another insurer is liable for the charge. Overall, these reasons are consistent with the patterns that M&S found in its earlier reviews of claims processing.[5]

[4] The Georgia Department of Insurance monitors the state-licensed insurance companies, including the CMOs, for compliance with the 15-day statutory requirement.

[5] These audits were done soon after CMO implementation so they also identified a number of claims denied because of implementation-related problems.

Exhibit 9
Claims Paid and Denied by CMO[1]
Calendar Years 2008-2010 (through June)

Amerigroup

	2008			2009			2010 (through June)		
	#	%	$	#	%	$	#	%	$
Paid	2,273,476	85.3%	$410,074,601	3,184,051	89.7%	$619,050,374	1,503,130	89.9%	$236,052,963
Denied	390,328	14.7%	$260,452,568	365,906	10.3%	$243,256,596	168,974	10.1%	$127,262,200
Paid/Denied	**2,663,804**	**100.0%**	**$670,527,169**	**3,549,957**	**100.0%**	**$862,306,970**	**1,672,104**	**100.0%**	**$363,315,163**

Peach State

	2008			2009			2010 (through June)		
	#	%	$	#	%	$	#	%	$
Paid	3,162,252	82.1%	$518,329,395	3,209,656	87.9%	$520,859,286	1,523,667	89.7%	$235,871,127
Denied	689,267	17.9%	$382,536,416	443,711	12.1%	$288,082,310	175,125	10.3%	$119,923,730
Paid/Denied	**3,851,519**	**100.0%**	**$900,865,811**	**3,653,367**	**100.0%**	**$808,941,596**	**1,698,792**	**100.0%**	**$355,794,857**

WellCare

	2008			2009			2010 (through June)		
	#	%	$	#	%	$	#	%	$
Paid	4,905,013	86.8%	$869,929,975	6,174,540	88.5%	$997,860,548	3,130,373	88.4%	$472,043,999
Denied[2]	744,657	13.2%	$132,476,465	801,954	11.5%	$144,373,279	411,566	11.6%	$77,349,183
Paid/Denied	**5,649,670**	**100.0%**	**$1,002,406,440**	**6,976,494**	**100.0%**	**$1,142,233,827**	**3,541,939**	**100.0%**	**$549,393,182**

(1)Does not include claims processed by CMO Pharmacy Benefit Management contractors; this information was not consistently reported across years or among CMOs.
(2) WellCare's 2008 "claims denied" dollar amount of $132,476,465 is an estimate based on the average dollar amount per denied claim in each of the two periods that followed. WellCare's December 2008 claims report erroneously listed $2.7 *billion* in denied claims for the month.

Source: Claims reports CMOs submitted to DCH

Timeliness

Like all health insurers, the CMOs must comply with state law that requires all claims to be paid, denied, or suspended pending further action within 15 days. DOI reported that, based on its review of claims data submitted, the CMOs demonstrate an acceptable level of compliance with state law regarding timeliness of action taken.

State law and DCH contracts with the CMOs also require that providers are paid 20% interest on claims adjudicated outside the required time frame. **Exhibit 10** contains reported information on the number and percentage of claims paid or denied late. WellCare paid or denied a smaller percentage of claims after the 15-day window than the other CMOs in 2008 and 2009, while both Amerigroup and Peach State reported late claims dropped to a comparable level by 2010. The exhibit also shows that denied claims are more likely than paid claims to occur after the deadline. Finally, the exhibit includes interest payments made by Amerigroup and WellCare over time (Peach State's reports did not include interest payments after 2008). Amerigroup paid less interest in 2009 than in 2008, while WellCare's interest payments increased.

In addition to paying or denying a claim, a CMO can comply with state law by suspending, or "pending," a claim within 15 days. According to an M&S report that reviewed claims processing, pended claims occurred for several reasons, including a claim potentially being a duplicate, lacking prior authorization for the service, containing coding problems, or requiring additional review by other CMO units.

Exhibit 10
Claims Paid or Denied Late[1]
Calendar Years 2008-2010 (through June)

	Amerigroup								
	2008			2009			2010 (through June)		
	Total	Late	% Late	Total	Late	% Late	Total	Late	% Late
Paid	2,273,476	46,529	2.0%	3,184,051	67,524	2.1%	1,503,130	13,137	0.9%
Denied	390,328	17,201	4.4%	365,906	15,646	4.3%	168,974	5,233	3.1%
Paid/ Denied	**2,663,804**	**63,730**	**2.4%**	**3,549,957**	**83,170**	**2.3%**	**1,672,104**	**18,370**	**1.1%**
Interest Penalties	$751,579			$557,146			$208,469		

	Peach State								
	2008			2009			2010 (through June)		
	Total	Late	% Late	Total	Late	% Late	Total	Late	% Late
Paid	3,162,252	122,163	2.3%	3,209,656	12,545	0.4%	1,523,667	19,641	1.3%
Denied	689,267	46,841	6.8%	443,711	3,716	0.8%	175,125	5,447	3.1%
Paid/Denied	**3,851,519**	**169,004**	**4.4%**	**3,653,367**	**16,261**	**0.4%**	**1,698,792**	**25,088**	**1.5%**
Interest Penalties	$423,009			Not Reported			Not Reported		

	WellCare								
	2008			2009			2010 (through June)		
	Total	Late	% Late	Total	Late	% Late	Total	Late	% Late
Paid	4,905,013	14,641	0.3%	6,174,540	10,676	0.2%	3,130,373	33,070	1.1%
Denied	744,657	6,304	0.8%	801,954	3,887	0.5%	411,566	13,714	3.3%
Paid/Denied	**5,649,670**	**20,945**	**0.4%**	**6,976,494**	**14,563**	**0.2%**	**3,541,939**	**46,784**	**1.3%**
Interest Penalties	$242,604			$524,720			$212,027		

(1)Does not include claims processed by CMO Pharmacy Benefit Management contractors; this information was not consistently reported across years or among CMOs.

Source: Claims reports CMOs submitted to DCH.

Unlike paid and denied claims, the total number of claims suspended in a period is not reported as part of the CMOs' standard claims processing reports. Instead, the CMOs report the number of claims in suspense on the last day of the month. As shown in **Exhibit 11**, variances exist among CMOs and for the time periods reviewed. At the end of December 2008, Amerigroup suspended the lowest percentage at 1.6%, while WellCare reported the highest number of suspensions, at 6.2%. In June 2010, all three CMOs suspended a smaller percentage of claims than 18 months earlier. Amerigroup and WellCare were under 1%, and Peach State was at 1.67%. It should be noted that the reports do not detail when the claims in suspend status were received. Some of these claims may have been received in an earlier period; a portion represents claims that will be paid or denied "late" in a subsequent month.

Exhibit 11
Percentage of Claims in Suspended Status(1)
End of 12/08, 6/09, 12/09, and 6/10

	12/08	6/09	12/09	6/10
Amerigroup				
Total Claims Received	245,932	247,726	324,258	281,918
Pended Status at End of Month	3,995	2,951	6,002	1,217
Total	1.62%	1.19%	1.85%	0.43%
Peach State				
Total Claims Received	281,177	298,918	326,970	264,354
Pended Status at End of Month	8,519	8,028	3,483	4,427
Total	3.03%	2.69%	1.07%	1.67%
WellCare				
Total Claims Received	552,654	613,788	791,388	679,619
Pended Status at End of Month	34,258	9,859	7,585	5,764
Total	6.20%	1.61%	0.96%	0.85%

(1)Does not include claims processed by CMO Pharmacy Benefit Management contractors; this information was not consistently reported across years or among CMOs. In addition, Myers and Stauffer reported that CMOs may pre-screen electronically submitted claims and reject those that don't meet certain requirements. These rejected claims would not be included in claims received figures.

Source: Claims reports CMOs submitted to DCH

Finally, the CMO reports provided information on the average number of days from the date of service to claims payment varies by CMO and provider type. **Exhibit 12** shows considerable variation among CMOs and provider types. In general, payments are occurring in less time than in December 2008, largely as a result of a decrease in days between service date and claim receipt by the CMO. Notable points include:

- **Inpatient/Outpatient** – For Amerigroup and Peach State, the average number of days has dropped from 5-6 weeks to 4 or less, with most of the change due to quicker submission by providers. WellCare's average time has remained unchanged, but it began much shorter than the other two CMOs.
- **Dental Services** – At the time of these reports, all three CMOs used the same subcontractor to process dental claims, resulting in little variation in the number of days to adjudicate a claim.

Exhibit 12
Average Number of Days to Claims Payment, by Provider Type
Four Selected Months

	Amerigroup[1]				Peach State[2]				WellCare			
	12/08	6/09	12/09	6/10	12/08	6/09	12/09	6/10	12/08	6/09	12/09	6/10
Inpatient/Outpatient Services												
Service Date to CMO	41	36	30	22	35	31	27	25	28	27	25	24
CMO to Payment	3	6	3	3	6	5	5	3	5	5	7	9
Total	44	42	33	25	41	36	32	28	33	32	32	33
Dental Services												
Service Date to CMO	13	8	15	12	17	N/R	11	N/R	12	8	11	10
CMO to Payment	10	10	10	10	7	N/R	11	N/R	10	10	10	10
Total	23	18	25	22	24	N/R	22	N/R	22	18	21	20
Vision Services												
Service Date to CMO	12	13	10	11	15	10	10	12	11	19	14	14
CMO to Payment	5	6	5	6	8	9	8	9	7	7	6	6
Total	17	19	15	17	23	19	18	21	18	26	20	20
Behavioral Health												
Service Date to CMO	N/R	N/R	N/R	N/R	30	25	31	26	26	20	26	21
CMO to Payment	N/R	N/R	N/R	N/R	6	6	6	7	3	4	3	3
Total	N/R	N/R	N/R	N/R	36	31	37	33	29	24	29	24

(1) According to DCH, unlike the other two CMOs, Amerigroup aggregates its reporting regarding inpatient/outpatient claims and its behavioral health claims because they are processed by the same claims system. The other two CMOs have separate subcontractors for behavioral health claims; therefore, those claims are reported separately.
(2) Peach State was in transition between dental providers in June 2009 and accurate data is not available. No dental claims lag information was reported for June 2010.
Source: Claims reports CMOs submitted to DCH

Appeals

Each CMO must provide a process by which a provider can appeal if it considers a claim to be erroneously denied or paid at a rate lower than is appropriate. **Exhibit 13** provides the number of claims decisions that were appealed and the outcomes of these appeals. As shown, about one quarter of one percent of Amerigroup's claims have been appealed in each period reviewed. Amerigroup denied a significant majority of the appeals. WellCare's 2008 appealed percentage was slightly lower and has dropped since then. WellCare was more likely to pay the claim as a result of the appeal. Peach State did not report appeals statistics in the periods under review.

Exhibit 13
Provider Appeals
2008, 2009, 2010 (through June)

	Amerigroup			Peach State			WellCare		
	2008	2009	2010 (through June)	2008	2009	2010 (through June)	2008	2009	2010 (through June)
Total Paid/Denied[1]	2,663,804	3,549,957	1,672,104	3,851,519	3,653,367	1,698,792	5,649,670	6,976,494	3,541,939
Paid on Appeal	1,828	2,202	1,185	N/R	N/R	N/R	6,307	3,584	1,490
Denied on Appeal	4,516	5,384	3,202	N/R	N/R	N/R	4,774	4,927	2,163
Total Appealed	6,344	7,586	4,387	N/R	N/R	N/R	11,081	8,511	3,653
% Appealed[2]	0.24%	0.21%	0.26%	N/R	N/R	N/R	0.20%	0.12%	0.10%

(1) The total number of claims paid or denied during the period, excluding pharmacy claims. The results of appeals decided during the period are included in the total. Therefore, if a claim was initially denied, appealed, and a decision was reached, the claim would be counted twice.
(2) The percentage appealed is the number of paid or denied appeals in the period in relation to the number of claims paid or denied in the period. However, an appeal decided in one period may have been from a claim originally processed in a prior period.

Source: Claims reports CMOs submitted to DCH

Emergency Room Claims

Claims adjudication decisions for emergency services are frequently appealed and, as acknowledged by DCH officials, have been an ongoing source of contention between hospital providers and CMOs. One of the arguments for using managed care practices such as contracting with CMOs is that there will be an emphasis on increasing use of primary care physicians and a decreased reliance on emergency rooms (ER) for non-emergency medical problems. In this context, DCH contracts allow the CMOs to pay reduced rates for ER visits deemed to be for non-urgent conditions.

The use of reduced or "triage" rates were the most frequently reported complaint when Myers and Stauffer was hired to mediate the concerns between hospitals and CMOs. In its 2008 review, M&S found that the three CMOs used different methods to define emergent conditions and to reimburse for emergent and non-emergent conditions. According to its report, "this variation has caused confusion on the part of hospitals and inconsistent treatment of hospitals across the state." The report recommended that DCH consider "significant changes used by the CMOs to identify, process, and pay emergency room claims." Since the M&S study, DCH has requested the CMOs report the number of ER claims submitted, the number paid at full and reduced rates, the time and day of service, and other relevant information.

While the ER reports submitted to DCH do not allow for a review of individual claim decisions, our review of the June 2010 reports indicates significant variation among the CMOs in the portion of ER claims paid at a reduced rate. As shown in **Exhibit 14**, we compared the percentage of ER claims paid at full and decreased rates by the three CMOs for 24 hospitals.[6] We found significant differences in the percentage of claims paid at a decreased rate from one CMO to another. For example, WellCare paid no claims from hospitals 1 and 2 at a decreased rate, while Peach State paid 83% of its claims at a decreased rate. Hospital 15, in contrast, received decreased

[6] Our analysis included any hospital that submitted at least 25 ER claims to each of the three CMOs. Many of the hospitals are in the Atlanta metropolitan region.

payments for 40% of claims to Amerigroup, while Peach State and WellCare paid every claim at the full rate.

We compared the percentage of decreased rates paid by each CMO to individual hospitals in an attempt to control for differences in member populations. Since each hospital serves a different population, we expected some variation among hospitals in the percentage of claims paid at a decreased rate. However, less variation would be expected for a single hospital filing claims with all CMOs. For example, we assumed that the healthcare needs of Peach State patients entering the ER at hospital 1 are not significantly different than the healthcare needs of WellCare patients at the same hospital.

Exhibit 14
ER Claims Paid at a Reduced Rate in June 2010
Hospitals with at least 25 Claims to Each CMO

0-33% of Claims Paid at Decreased Rate

67-100% of Claims Paid at Decreased Rate

	Amerigroup		Peach State		WellCare		Difference
Hospital	ER Claims Paid	Paid at Decreased Rate	ER Claims Paid	Paid at Decreased Rate	ER Claims Paid	Paid at Decreased Rate	(Highest and Lowest)
1	146	32%	180	83%	171	0%	83%
2	184	0%	120	83%	65	0%	83%
3	706	0%	819	40%	866	79%	79%
4	30	10%	59	88%	58	69%	78%
5	794	0%	760	0%	1,207	78%	78%
6	140	0%	124	77%	148	0%	77%
7	174	32%	189	74%	292	0%	74%
8	434	0%	876	0%	887	72%	72%
9	262	24%	241	88%	359	73%	64%
10	89	22%	110	84%	290	73%	61%
11	291	21%	641	78%	616	65%	57%
12	105	36%	142	84%	280	61%	48%
13	288	34%	373	81%	499	72%	47%
14	59	31%	101	71%	515	71%	41%
15	129	40%	58	0%	336	0%	40%
16	80	44%	73	84%	97	63%	40%
17	57	26%	31	65%	73	59%	38%
18	396	38%	224	0%	481	0%	38%
19	84	39%	60	77%	174	76%	37%
20	451	36%	297	0%	939	0%	36%
21	59	47%	188	81%	289	72%	33%
22	225	33%	116	0%	473	0%	33%
23	111	34%	142	67%	274	67%	33%
24	63	46%	40	68%	90	77%	31%
Total	**5,357**	**19%**	**5,964**	**43%**	**9,479**	**50%**	**27%**

Source: CMO ER claims reports submitted to DCH

Notable Issues Regarding Claims Processing

1. **Timeframe** – According to DOI, the CMOs are in compliance with state law regarding the 15-day timeframe for adjudicating claims. Since 2008, the percentage of claims paid or denied late has dropped for two CMOs and risen for the other.

2. **ER Claims** – Emergency room claims are still a point of contention between the hospitals and CMOs, and DCH officials are not confident that the current method of "triage rates" has been effective at reducing unnecessary ER visits by members.

3. **CMO Reporting** – The claims processing reports submitted to DCH contained numerous errors and inconsistencies that we identified with simple review and analysis. Some of the calculation errors had occurred for more than two years. DCH should consider adopting more thorough and formal analysis (e.g., comparing timeframes and CMOs) or removing the reporting responsibility from the CMO contracts.

4. **Additional Study** – The reviews of claims processing performed by M&S were useful in identifying implementation-related problems, but are (as noted at the time) limited because the data was in many cases preliminary. DCH should consider repeating key analyses with new, current datasets- perhaps even setting up a mechanism for some reviews to be done automatically for given periods.

DCH's Response: *In its response to the "Claims Processing" section, DCH made the following points:*

- *DCH acknowledges tension between some of the hospital providers and at least two of the three CMOs regarding the use of the emergency room triage rate. The original intent of the triage rate approach was to assist with steerage of non-emergent care to more appropriate treatment settings. DCH has solicited and received feedback from hospitals and the CMOs regarding alternative approaches that DCH may want to consider going forward.*

- *DCH staff spends significant time reviewing and reconciling CMO reports for claims processing statistics. Opportunities to streamline and more closely prescribe report content going forward are being explored as part of the upcoming CMO re-procurement effort. As suggested by the reviewers, unnecessary reports are candidates for elimination. However, it is important to emphasize that DCH staff do not accept CMO reports at face value. All reports are reviewed, scrutinized, and reconciled as required to ensure appropriate oversight of the program and the CMOs' activities.*

- *The Myers and Stauffer claims processing reviews have been an important component to DCH's oversight of the CMO program. Consistent with the reviewers' recommendation, DCH and Myers and Stauffer have developed a schedule to repeat selected CMO reviews previously conducted by Myers and Stauffer.*

Prior Authorization and Precertification[7]

Managed care organizations frequently require that providers obtain permission before delivering certain services to members. Prior authorization is intended to save costs by eliminating unnecessary services. A claim for a service delivered without prior authorization may be denied for payment.

DCH officials acknowledge that prior authorization is more frequently required for Medicaid managed care members than for those covered by private insurance. Unlike Medicaid members, individuals with private insurance often pay co-pays and deductibles, which provide a check on the necessity of the service. An individual with private insurance can also be held responsible for paying charges not covered by the insurance company. Medicaid members are not responsible for unreimbursed charges.

DCH contractual agreements with the CMOs prohibit prior approval requirements for emergency or urgent care services while requiring prior authorization for "all non-emergent and non-urgent inpatient admissions except for normal newborn deliveries." Standard (non-urgent) service authorization decisions must be communicated within 14 calendar days of request. The contracts also provide for expedited service authorizations, if the provider or the CMO determines the patient's life to be at risk if authorization is delayed. Expedited authorizations must be made within 24 hours[8]. The CMOs must provide 24/7 telephone support for prior authorization requests and submit quarterly reports to DCH regarding compliance with these stipulations.

We reviewed the prior authorization reports submitted by the three CMOs for the second quarter (April-June) of 2010 and for December 2008 and December 2009[9]. We also reviewed the M&S reports on claim processing that addressed prior authorization issues.

Frequency of Authorizations

Exhibit 15 shows the total number of authorizations processed, approved, and denied by the CMOs for the April to June 2010 time period, as well as the number of requests per 1,000 members. Amerigroup and Peach State both approved approximately 85% of authorization requests, while WellCare approved more than 95% of requests. In fact, WellCare approved more than 99% of requests for medical inpatient, outpatient, and behavioral health services. For each CMO, the approval rates were generally highest for medical inpatient and outpatient and lowest for dental. WellCare had a high denial rate for vision services, while Peach State reported no prior authorizations for vision and Amerigroup only 13.

Exhibit 15 also shows variation among the CMOs in the frequency of requests by type of service. Relative to the other CMOs, Amerigroup had a large number of requests per member categorized as medical inpatient, while WellCare had a large number for outpatient services. Overall, WellCare was more likely to receive

[7] DCH's contracts refer to precertification in relation to inpatient stays and to prior authorization for all other services requiring approval.

[8] Both standard and expedited limits can be extended for a particular request if the member or provider requests it, or if the CMO demonstrates to DCH that it is in the member's best interest.

[9] Authorization reports were monthly until January 2010.

requests for prior authorization. WellCare received 173 requests per 1,000 members during the three-month period. Amerigroup saw 91.3 requests and Peach State 81.6.

Exhibit 15
Prior Authorizations Submitted and Approved
April - June 2010

Amerigroup

	Approved		Denied		Total	Per 1,000 Members
	#	%	#	%	#	
Medical Inpatient	2,529	90.4%	270	9.6%	2,799	10.8
Medical Outpatient	11,609	91.2%	1,115	8.8%	12,724	48.9
Therapies	1,397	79.0%	371	21.0%	1,768	6.8
Behavioral Health	1,465	83.4%	292	16.6%	1,757	6.8
Vision	8	61.5%	5	23.1%	13	0.0
Dental	3,026	64.4%	1,674	35.6%	4,700	18.1
Total PA Requests	20,034	84.3%	3,725	15.7%	23,759	91.3

Peach State

	Approved		Denied		Total	Per 1,000 Members
	#	%	#	%	#	
Medical Inpatient	129	90.2%	14	9.8%	143	0.5
Medical Outpatient	11,241	96.0%	464	4.0%	11,705	39.0
Therapies	2,301	72.2%	884	27.8%	3,185	10.6
Behavioral Health	3,665	86.3%	581	13.7%	4,246	14.2
Vision	-	N/A	-	N/A	-	-
Dental	3,876	74.4%	1,331	25.6%	5,207	17.4
Total PA Requests	21,212	86.6%	3,274	13.4%	24,486	81.6

WellCare

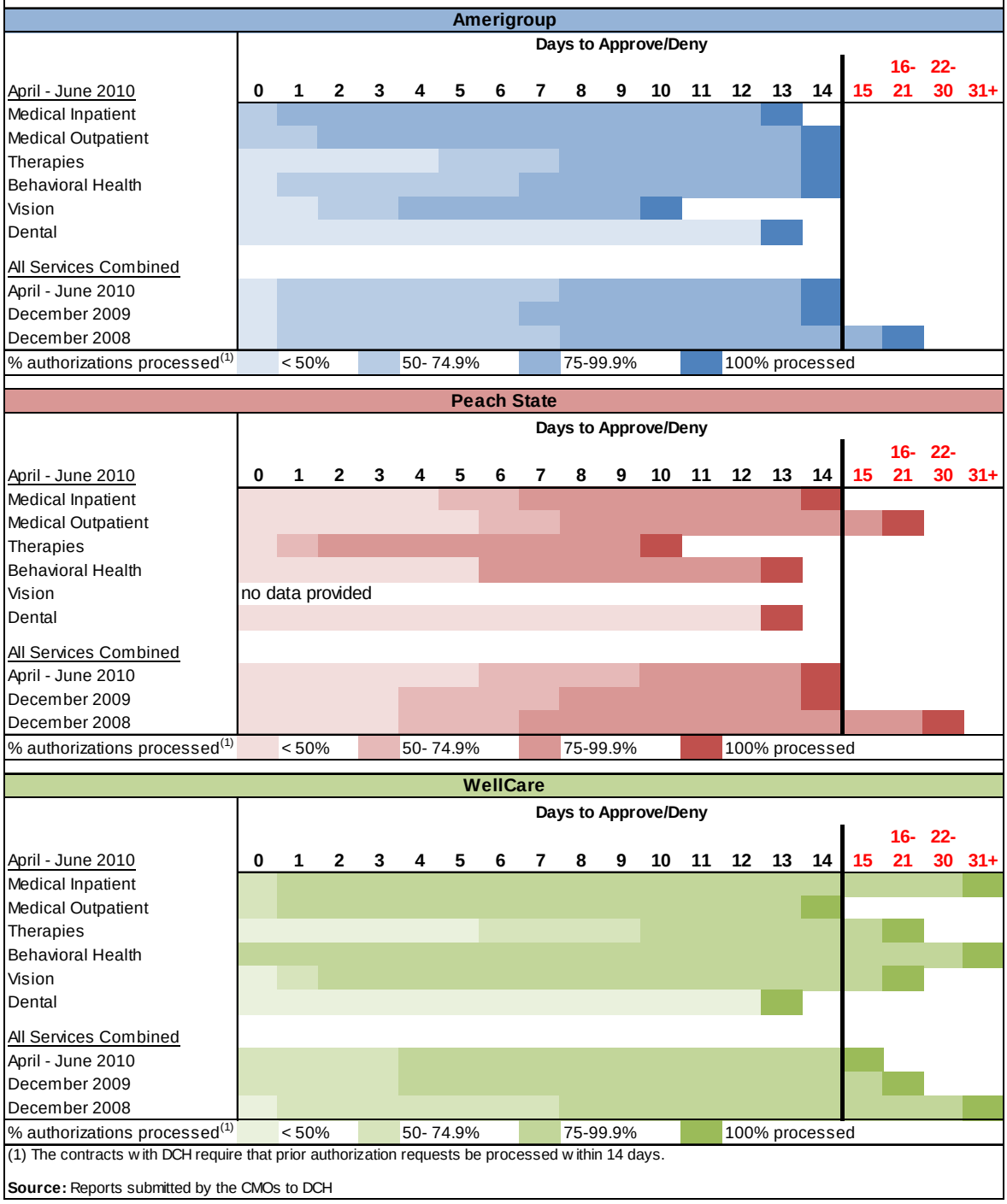
	Approved		Denied		Total	Per 1,000 Members
	#	%	#	%	#	
Medical Inpatient	815	99.4%	5	0.6%	820	1.5
Medical Outpatient	72,956	99.4%	440	0.6%	73,396	134.7
Therapies	6,624	94.9%	356	5.1%	6,980	12.8
Behavioral Health	584	100.0%	-	0.0%	584	1.1
Vision	1,372	73.5%	495	26.5%	1,867	3.4
Dental	7,497	70.3%	3,164	29.7%	10,661	19.6
Total PA Requests	89,848	95.3%	4,460	4.7%	94,308	173.1

Source: CMO reports submitted to DCH

Timeliness of Authorizations

Exhibit 16 shows the timeliness of authorization decisions for the three CMOs in the second quarter of 2010, as well as two earlier months – Decembers of 2008 and 2009. In accordance with the contracts with DCH, CMOs should process prior authorization requests within 14 days. According to that standard, all three CMOs exceeded the timeframe in December 2008. One year later, Amerigroup and Peach State met the standard. For the April-June 2010 period, all three CMOs processed 99.9% of requests within 14 days.

Exhibit 16
Timeliness of Prior Authorization Decisions
Selected Periods in 2008-2010



(1) The contracts with DCH require that prior authorization requests be processed within 14 days.

Source: Reports submitted by the CMOs to DCH

Variation exists in how quickly the CMOs process requests within the 14-day timeframe. For example, over half of Amerigroup and WellCare inpatient service requests were acted upon within 24 hours and more than 75% were processed by the end of the following day. It took Peach State five days to reach the 50% point and

seven days to reach 75%. On the other hand, Peach State data indicates it is much faster at making determinations[10] regarding "therapies" requests. Unlike Amerigroup and WellCare, which took five and six days, respectively, for half of the therapy requests to be processed, PeachState made 50% of decisions by the next day and 75% of decisions by the second. Dental requests are processed at relatively the same pace for all three CMOs. In each instance, more than 60% of authorizations are processed on the 13th day.

For those periods in which processing took more than 14 days, the magnitude and extent of delay varied considerably, and generally represents a handful of requests that took an extended time to approve or deny. For example, the delay in Peach State's medical outpatient decisions represents 9 of more than 11,700 requests that were received in the April- June 2010 reporting period. Similarly, 8 of 820 WellCare inpatient service requests took 15 days or more to process. It should also be noted that while 1.5% of WellCare's behavioral health requests took more than 14 days, 93% were answered within 24 hours.

In its 2007-2008 reviews of claim processing for various provider types, M&S noted that prior authorization "issues" were one of the reasons used for suspension and denial of claims. As a result of these findings, M&S suggested a number of changes that CMOs could initiate to improve prior authorization practices, including increased provider training and improved communication with provider staff, system changes to improve consistency, and more transparency about which services require prior authorization. M&S also suggested that DCH begin monitoring statistics such as authorization denial rates.

Notable Issues Regarding Prior Authorization

1. **Timeframe** – The CMOs appear to comply with contract timeframes in nearly 100% of cases, and timeliness has improved from earlier periods.

2. **CMO Reporting** – We identified unreliable data in the prior authorization reports submitted by the CMOs and inconsistent methods for completing the reports. For example, Amerigroup reduced its reported number of medical inpatient authorizations for this period significantly after we questioned why the quantity/rate was so much higher than the other two CMOs. Similar errors/inconsistencies could be minimized if the reports were subject to more thorough review by DCH. DCH should consider adopting more thorough and formal analysis (e.g., comparing timeframes and CMOs) or removing the reporting responsibility from the CMO contracts.

3. **Additional Study** – We did not review the complexity of the prior authorization process from the provider's perspective, or whether all types of authorizations are reasonable. Our review showed significant variation among the CMOs in the number of prior authorization requests for certain categories, especially medical inpatient and outpatient. Approval rates also differed among

[10] The speed at which authorization determinations are made does not appear to be related to the percentage of requests that are denied. For example, AMG denied 21% of therapy requests, PSHP 28%, and WC 5.1% in the April-June 2010 reporting period.

categories, with nearly all requests approved in some but less than 70% approved in others, and among CMOs when viewing a single service category. M&S has reviewed prior authorization, but those reports covered the time immediately after implementation of managed care and are now of limited value. DCH should consider repeating some of the key analyses from the M&S reports.

DCH's Response: *In its response to the "Prior Authorization and Precertification" section, DCH made the following points:*

- *DCH is pleased with the timeliness of the prior authorization reviews conducted by the CMOs and DCH's oversight of this critical function.*

- *Consistent with the claims processing recommendations noted in this review, DCH acknowledges the potential to improve the consistency in reporting requirements and the reporting process itself. This area is under close review by DCH as an area for improvement under the upcoming CMO re-procurement.*

- *The need for additional prior authorization studies is noted by the reviewer. DCH acknowledges the importance of reviewing key prior authorization statistics necessary to ensure the timely access to necessary health care services and products. These key indicators will be reviewed as Myers and Stauffer revisits some of the earlier analyses.*

- *DCH would expect the prior authorization approval percentage to vary widely depending upon the product or service requested. The appropriateness or inappropriateness of the percentage of requests approved or denied must be evaluated on a case-by-case basis.*

Provider Satisfaction Surveys

The DCH contracts with the CMOs require that provider satisfaction be measured each year. Each CMO uses a third-party vendor to conduct an annual satisfaction survey of a sample of providers. The surveys cover a variety of topics, such as provider relations, the provider network, quality management, finance issues, and pharmacy benefits.

We reviewed the most recent provider satisfaction survey reports. Peach State and WellCare, those reports included results of surveys completed in 2007, 2008, and 2009; Amerigroup's results included only 2009. We have included the results of all questions related to the topics covered in the report – claims processing and prior authorization/ precertification. We have also included the results of questions related to overall satisfaction. For the CMOs with 2007-2009 results, we included trend information.

Survey Result Trends

Peach State's and WellCare's favorable ratings increased from 2007 to 2009 in the pre-authorization and claims processing categories. As shown in **Exhibit 17**, we reviewed five questions related to pre-authorization and three questions related to claims processing. Measuring the percentage of favorable responses, Peach State had a statistically significant increase for 7 of 8 questions, while WellCare had a significant increase in 5 of 8. Amerigroup implemented a new survey tool in 2009; therefore, trend information is unavailable.

Regarding overall satisfaction, Peach State had significant increases in all three questions on the topic. WellCare had a significant increase in the percentage of providers that would recommend the plan to other physician practices, but increases in the other two questions were not deemed significant.

Each CMO used a different method for selecting its sample of providers; therefore, direct comparisons of CMO results are not appropriate. One CMO sample included all types of providers, another sampled only primary care providers, and the third sampled only high-volume providers.

CMOs Compared to Other Plans

The CMOs did not measure their performance against other plans in a consistent manner. The CMOs asked different questions and compared themselves to different plans. Amerigroup asked respondents how it compared to other Medicaid plans. Instead of the provider making a direct comparison, Peach State and WellCare asked providers to respond to each question twice – once considering their experience with the CMO and then considering their experience with all other plans in the market (e.g., private insurance, FFS Medicaid, and/or Medicaid).

As shown in **Exhibit 18**, Amerigroup reported that one-third of providers responded favorably when comparing its claims processing and utilization management (pre-authorization) to other Medicaid plans. Overall provider satisfaction was not measured against other plans.

Exhibit 17
Provider Satisfaction Surveys
Favorable Responses, 2007 - 2009

	2007	2008	2009	Statistical Significance (2007 to 2009)
Amerigroup[1][2]				
Pre-Authorization				
Process for obtaining pre-certification/authorization	N/A	N/A	35%	
Efficiency of pre-certification/authorization process	N/A	N/A	34%	No Trend Data
Timeliness of Medical Director's response to concerns	N/A	N/A	31%	
Claims Processing				
Accuracy of claims processing	N/A	N/A	36%	
Timeliness of claims processing	N/A	N/A	44%	No Trend Data
Responsiveness during claims payment dispute process	N/A	N/A	24%	
Overall Satisfaction				
Recommend CMO to other providers	N/A	N/A	79%	No Trend Data
Overall satisfaction with CMO	N/A	N/A	74%	
Peach State[2]				
Pre-Authorization				
Process of obtaining pre-certification/referral/ authorization information	17.2%	20.2%	26.2%	Significant Increase
Timeliness of UM's pre-certification process	14.3%	18.1%	25.5%	Significant Increase
Availability to request authorizations by phone, fax or web portal	N/A	25.2%	31.4%	N/A
Extent to which UM staff share review criteria and reasons for adverse determinations	10.0%	17.0%	22.7%	Significant Increase
Consistency of review decisions	8.6%	20.3%	23.5%	Significant Increase
Claims Processing				
Accuracy of claims processing	12.1%	16.0%	28.8%	Significant Increase
Timeliness of claims processing	14.6%	19.7%	32.6%	Significant Increase
Resolution of claims payment problems or disputes	8.7%	16.4%	21.2%	Significant Increase
Overall Satisfaction				
Recommend CMO to other physicians practices	58.1%	72.0%	80.3%	Significant Increase
Recommend CMO to other patients	59.7%	72.0%	77.9%	Significant Increase
Overall satisfaction with CMO	42.2%	60.2%	67.3%	Significant Increase
WellCare[2]				
Pre-Authorization				
Process of obtaining pre-certification/referral/ authorization information	25.7%	27.9%	33.0%	Significant Increase
Timeliness of UM's pre-certification process	22.5%	25.5%	29.3%	Significant Increase
Phone access to UM staff	23.2%	26.3%	28.4%	Not Significant
Extent to which UM staff share review criteria and reasons for adverse determinations	17.0%	18.9%	24.3%	Significant Increase
Consistency of review decisions	15.7%	19.6%	23.0%	Significant Increase
Claims Processing				
Accuracy of claims processing	20.2%	26.4%	20.1%	Not Significant
Timeliness of claims processing	24.8%	31.9%	30.8%	Significant Increase
Resolution of claims payment problems or disputes	13.0%	18.6%	17.3%	Not Significant
Overall Satisfaction				
Recommend CMO to other physicians practices	61.8%	73.2%	72.7%	Significant Increase
Recommend CMO to other patients	65.0%	74.8%	70.5%	Not Significant
Overall satisfaction with CMO	53.4%	63.0%	58.0%	Not Significant

(1) Amerigroup re-designed their survey in 2009; therefore, no trend data is available.
(2) Percentages for pre-authorization and claims processing questions are for respondents answering "excellent" or "very good." Within Overall Satisfaction category, percentages are for respondents answering "definitely" or "probably yes" to the question about recommending the CMO to other providers; for the question about overall satisfaction, the percentage are for respondents answering "very satisfied" or "somewhat satisfied."

Source: Provider survey results submitted by CMO vendors

Exhibit 18
Provider Satisfaction Surveys
Favorable Responses Compared to Other Plans

	Amerigroup[1]
Pre-Authorization	
How utilization management compares to other plans	33%
Claims Processing	
How claims processing compares to other plans	33%

	Peach State		
	2009 CMO	**2009 - All Other Plans in Market[2]**	**Statistical Significance (Compared to Other Plans)**
Pre-Authorization			
Process of obtaining pre-certification/referral/ authorization information	26.2%	24.2%	Not Significant
Timeliness of UM's pre-certification process	25.5%	24.4%	Not Significant
Availability to request authorizations by phone, fax or web portal	31.4%	30.7%	Not Significant
Extent to which UM staff share review criteria and reasons for adverse determinations	22.7%	24.6%	Not Significant
Consistency of review decisions	23.5%	25.0%	Not Significant
Claims Processing			
Accuracy of claims processing	28.8%	26.0%	Not Significant
Timeliness of claims processing	32.6%	27.6%	Not Significant
Resolution of claims payment problems or disputes	21.2%	20.8%	Not Significant
Overall Satisfaction			
Recommend CMO to other physicians practices	80.3%	N/A	N/A
Recommend CMO to other patients	77.9%	N/A	N/A
Overall satisfaction with CMO	67.3%	80.8%	Significantly Lower

	WellCare		
	2009 CMO	**2009 - All Other Plans in Market[2]**	**Statistical Significance (Compared to Other Plans)**
Pre-Authorization			
Process of obtaining pre-certification/referral/ authorization information	33.0%	34.1%	Not Significant
Timeliness of UM's pre-certification process	29.3%	29.6%	Not Significant
Phone access to UM staff	28.4%	26.4%	Not Significant
Extent to which UM staff share review criteria and reasons for adverse determinations	24.3%	27.4%	Not Significant
Consistency of review decisions	23.0%	22.9%	Not Significant
Claims Processing			
Accuracy of claims processing	20.1%	21.4%	Not Significant
Timeliness of claims processing	30.8%	24.9%	Not Significant
Resolution of claims payment problems or disputes	17.3%	19.1%	Not Significant
Overall Satisfaction			
Recommend CMO to other physicians practices	72.7%	N/A	N/A
Recommend CMO to other patients	70.5%	N/A	N/A
Overall satisfaction with CMO	58.0%	80.2%	Significantly Lower

(1) Amerigroup asked respondents how its claims processing/utilization management compares to other Medicaid plans. The percentage represents the top two favorable responses – those that responded "much better" and "better."
(2) In addition to the CMO, the respondents were asked to rate all other health plans in the market. The percentage represents the top two favorable responses, as noted in Exhibit 17.
Source: Provider survey results submitted by CMO vendors

For Peach State and WellCare, providers reported overall satisfaction to be lower than with other plans in the market. For the eight pre-authorization and claims processing questions, the two CMOs have favorable responses at a rate similar to the other plans. There was no significant difference in the percentage of favorable responses for the CMO when compared to the other plans.

As noted above, because the CMOs used different methods for selecting their providers to be surveyed, it is not appropriate to compare the CMOs to one another on these measures.

Notable Issues Regarding Provider Satisfaction Surveys

1. **Comparing CMO Results** – Survey results are not comparable because the CMOs have used different methods to select providers to be surveyed and because they do not use the same survey questions.

2. **Trend** – One CMO used a new survey instrument in 2009, meaning that trend information is unavailable. For the two CMOs that have three years' worth of results, satisfaction with claims processing and prior authorization has increased. For one of the CMOs, overall satisfaction has increased. For those two CMOs, overall satisfaction trails other market plans.

DCH's Response: *In its response to the "Provider Satisfaction Surveys" section, DCH made the following points:*

- *DCH acknowledges that comparability of provider satisfaction surveys across CMOs as well as individual CMO provider satisfaction trending is important. DCH recognizes the need to be more prescriptive in the provider satisfaction tools utilized by the CMOs going forward to accomplish this type of comparison. However, DCH must point out that prior to the CMO effort, there was no such effort to measure provider satisfaction in the traditional FFS program. The introduction of provider satisfaction reporting in general shows a level of accountability the program has not been held to in the past.*

- *Despite the limitations in the comparability of the provider satisfaction tools, DCH is pleased that the percentage of providers satisfied with the claims processing and prior authorization areas was significantly higher in 2009 versus two years prior and similar to their satisfaction with other health plans in the market.*

Appendix A
Objectives, Scope, and Methodology

We conducted this special examination in response to a request from the House Appropriations Committee. The Committee asked that we review Care Management Organizations (CMOs) under contract with the Department of Community Health. After consultation with the House Budget Office, we determined that the report would provide an overview in the following areas: (a) cost of managed care/payments to the CMOs, (b) CMO finances, (c) claims processing, (d) prior authorization/pre-certification, and (e) provider satisfaction. We also agreed that, in addition to summarizing available information in these areas, we would offer any observations regarding oversight weaknesses or areas for additional study. These observations are included as "notable issues" within each relevant section of the report.

Our review was limited to already available information, often in the form of reports submitted to DCH by the CMOs or other entities, but in other cases, data created and maintained by DCH. We did not verify the accuracy of the information, but we did review it for reasonableness. These reviews included comparing the information to other available sources, comparing the data over time, and verifying spreadsheet calculations. For each subject area, we also interviewed DCH personnel to gain a better understanding of CMO responsibilities, CMO and DCH reports, and DCH methods for reviewing CMO performance.

Our review of the cost of managed care included reviewing financial data used by DCH's Office of Financial Analysis. CMO payment information maintained by the Office was checked against reports from the payments system. We also reviewed reports from DCH's contracted actuaries, including those that serve as the basis for establishing capitation rates. Finally, we obtained cost trend information from sources such as the Bureau of Labor Statistics (CPI), the Centers for Medicare and Medicaid Services (national health expenditures), and Georgia's Budgetary Compliance Reports (Medicaid ABD spending).

CMO financial information was obtained from calendar year 2007, 2008 and 2009 financial statements provided to the Georgia Department of Insurance (DOI). We also reviewed the triennial examinations of each CMO that were conducted by a DOI contractor. Finally, interviews with and information from personnel with DOI helped inform the ratio analyses conducted.

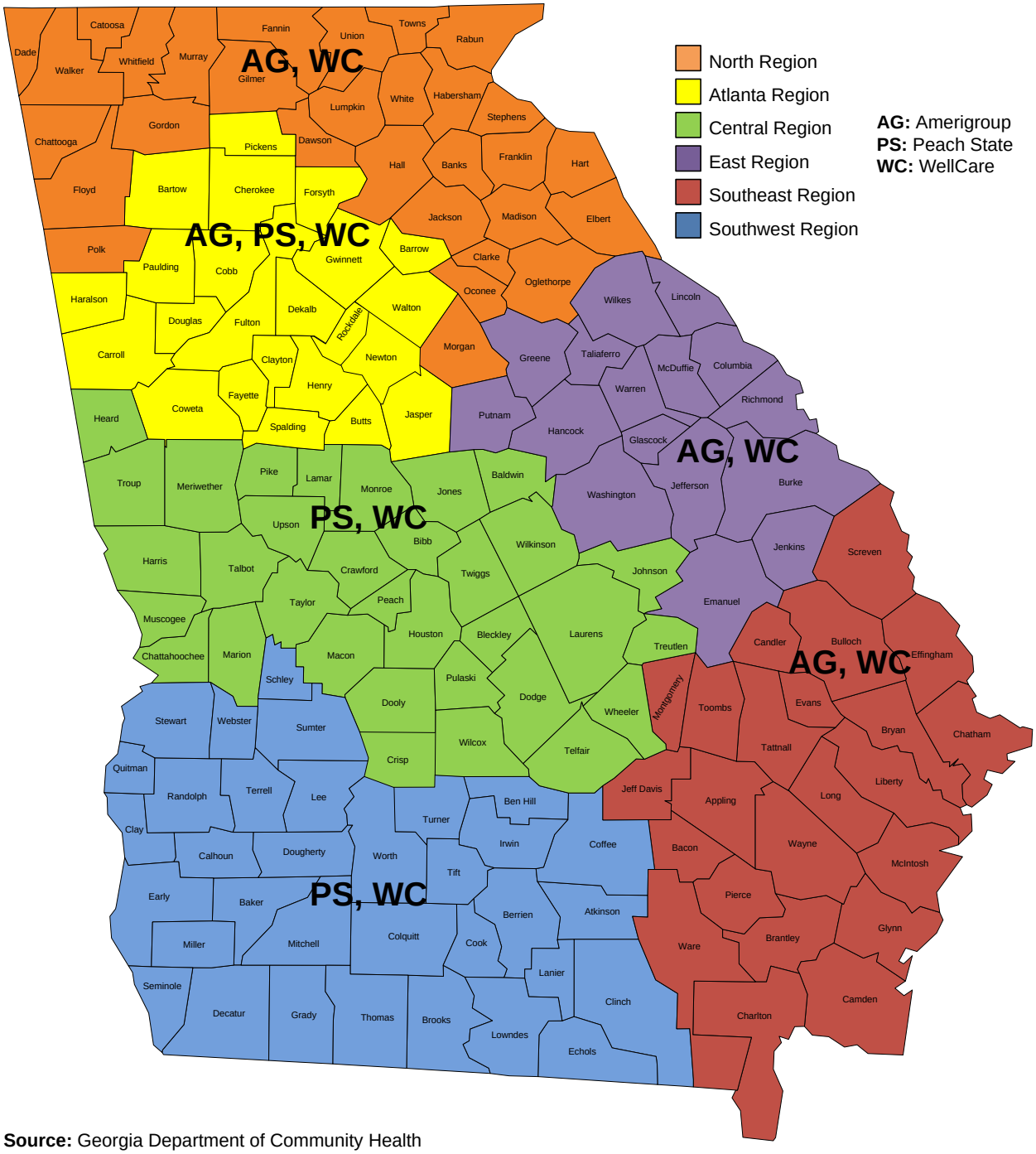
The review of claims processing included reviews of the claims processing reports submitted to DCH by the CMOs. We reviewed cumulative reports for calendar years 2008 and 2009, as well as the first six months of 2010. We also interviewed personnel with DOI to determine that agency's findings related to the timeliness of the CMOs' claims processing. Finally, we reviewed claims processing reports conducted by Meyers and Stauffer, a certified public accounting firm under contract with DCH.

The prior authorization review consisted of analysis of the monthly reports submitted to DCH by the CMOs, as well as review of the Meyers and Stauffer reports that covered the subject.

Regarding provider satisfaction, we reviewed the results of the surveys conducted during 2009.

The project was not conducted in accordance with generally accepted government auditing standards (GAGAS), given the timeframe in which the report was needed. However, it was conducted in accordance with Performance Audit Division policies and procedures for non-GAGAS engagements. These policies and procedures require that we plan and perform the engagement to obtain sufficient, appropriate evidence to provide a reasonable basis for the information reported and that data limitations be identified for the reader.

Appendix B
CMO Regions



Source: Georgia Department of Community Health

For additional information or for copies of this report call 404-657-5220.
Or see our website:
http://www.audits.ga.gov/rsaAudits/