

DEPARTMENT OF COMMUNITY HEALTH

GEORGIA FAMILIES

REPORT #16: NEWBORN ANALYSIS

**MEDICAID CARE MANAGEMENT ORGANIZATION ACT
COMPLIANCE MONITORING**

AUGUST 2, 2010

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REPORT GLOSSARY

The following listing of terminology and references may be used throughout this report:

- **Affiliated Computer Services, Inc. (ACS)** – State fiscal agent claims processor.
- **Care Management Organization (CMO)** – An organization that has entered into a risk-based contractual arrangement with the Department to obtain and finance care for enrolled Medicaid and PeachCare for Kids™ members. CMOs receive a per capita or capitation claim payment from the Department for each enrolled member. Three Care Management Organizations currently operate in Georgia. These organizations include AMERIGROUP Community Care (AMERIGROUP), Peach State Health Plan (PSHP), and WellCare of Georgia (WellCare).
- **Department of Community Health (DCH or Department)** – the Department within the state of Georgia that oversees and administers the Medicaid and PeachCare for Kids™ programs.
- **Fiscal Agent Contractor (FAC)** – The entity contracted with the Department to process Medicaid and PeachCare for Kids™ claims and other non-claim specific payments. With the exception of pharmacy claims, Affiliated Computer Services, Inc. is the FAC for the Department.
- **Georgia Families (GF)** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids™ where the Department contracts with Care Management Organizations to manage and finance the care of eligible members.
- **Member** – An individual who is eligible for Medicaid or PeachCare for Kids™ benefits. An individual who is eligible for Medicaid or PeachCare for Kids™ benefits might also be eligible to participate in the Georgia Families program.
- **PeachCare for Kids™ Program (PCK)** – The Children’s Health Insurance Program (CHIP) funded by Title XXI of the Social Security Act, as amended.
- **Traditional Medicaid and PeachCare for Kids™** – For purposes of this analysis, the portion of the Medicaid and PeachCare for Kids™ program that provides benefits to eligible members who are not participants in the Georgia Families program.

PROJECT BACKGROUND AND OBJECTIVE

Myers and Stauffer LC was engaged by the Department of Community Health (DCH) to assist in studying and reporting on specific aspects of the Georgia Families (GF) program, including certain issues presented by providers, selected claims paid or denied by Care Management Organizations (CMOs), and selected GF policies and procedures. Initial phases of the engagement focused on hospital and physician provider subjects. Since that time, the Department has also requested analyses of Dental providers and CMO compliance with the Medicaid Care Management Organizations Act (“the Act”). Completed reports, available online at <http://dch.georgia.gov>, have assessed payment and denial trends of hospital, physician, and dental providers; the payment accuracy of hospital, physician, and dental provider claims; compliance with the Act, analysis of certain CMO policies and procedures, and a survey of member satisfaction with dental benefits.

The objective of this analysis was to confirm that the CMOs are in compliance with certain provisions of the Medicaid Care Management Organizations Act, formerly referred to as House Bill 1234, Section 33-21A-6, pertaining to coverage and payment for newborns. The Act was signed into law in May 2008 and became effective on July 1, 2008. The newborn coverage and payment portion of the Act states:

- (a) Each care management organization shall pay for health care services provided to a newborn infant who is born to a mother who is a member currently enrolled with that care management organization until such time that the newborn is finally discharged from all inpatient care to a home environment subject to approval by the federal Centers for Medicare and Medicaid Services. For a newborn infant whose mother is enrolled in a Medicaid program under which she receives Medicaid benefits directly from the Department of Community Health, the Department of Community Health shall pay for health care services provided to the newborn until such time as the newborn is finally discharged from all inpatient care to a home environment.*
- (b) In the event a newborn is disenrolled from a care management organization and re-enrolled into the Medicaid fee-for-service program conducted directly by the Department of Community Health, the care management organization shall ensure the coordination of care for that child until the child has been appropriately discharged from the hospital and placed in an appropriate care setting.*

This report describes the analysis, findings, and recommendations of the CMOs’ compliance with these provisions of the Act.

METHODOLOGY

Data Required:

The Medicaid Care Management Organizations Act was signed into law in May 2008 and was effective on July 1, 2008. For the purpose of this analysis, Myers and Stauffer selected claims for only those newborns with a date of birth during calendar year 2009. This period was selected to provide a more accurate determination of the current status of compliance with the Act and to eliminate any issues related to implementation of the provisions of the Act. The following information was utilized for the period effective January 1, 2009 through December 31, 2009.

- Member Eligibility Files
- CMO Paid and Denied Medicaid and PeachCare for Kids™ Claims
- Georgia Families Capitation Payments
- Traditional Medicaid and PeachCare for Kids™ UB04 Claims paid by the Department of Community Health (DCH)

Note that Myers and Stauffer has developed a data warehouse that includes encounter data from each CMO, as well as Traditional Medicaid and PeachCare for Kids™ data from the fiscal agent contractor (FAC). The FAC provides Myers and Stauffer with updated member eligibility, reference files, encounter data, and claims data monthly in a standardized extract. When necessary, additional data is requested from the CMOs and the Department's FAC to supplement the data available in the data warehouse.

Analytical Process:

- 1) We requested the required data from the CMOs to supplement the data in our data warehouse. Quality assurance procedures were performed to identify potential data quality issues.
- 2) Utilizing the eligibility files provided by the FAC, we identified Traditional Medicaid and PeachCare for Kids™ members born on or after January 1, 2009, but prior to January 1, 2010, having a Medicaid or PeachCare for Kids™ eligibility span that began on the member's date of birth. If the newborn was enrolled with a CMO during their birth month, we identified the CMO responsible for payment of the inpatient hospital newborn claim.
- 3) We attempted to link the newborn to the mother via the FAC-provided eligibility file. Since the mother was not always indicated in the eligibility file, we also utilized the "Head of Household" field that is included in the member eligibility file and any other data that might allow us to link the newborn to the mother such as Social Security Numbers and Case Numbers. We also determined the Payor

that should have been financially responsible for each inpatient hospital newborn claim based on the provisions of the Act. Pursuant to the Act, this determination was based on the mother's CMO enrollment status at the time of the newborn's birth.

- 4) Utilizing the claims and encounter files provided by the FAC, we identified inpatient hospital claims containing diagnosis and procedure codes indicating that services were provided to newborns. The analyses included claims beginning at the newborn's date of birth through the date of discharge from inpatient care to a home environment. "Home environment" was identified using the Patient Status code on the claim. The Patient Status code provided on the claim was assumed to be accurate for purposes of this analysis.
- 5) We segregated the claims data based on the Payor we determined should have been financially responsible for the cost of the inpatient hospital newborn claim. Next, we compared the actual Payor and the entity we determined should have been financially responsible for the cost of the inpatient hospital newborn claim to confirm whether the inpatient hospital claim was paid in accordance with Section 33-21A-6 of the Medicaid Care Management Organizations Act.

Assumptions and Limitations:

- Based on monthly reconciliation reports prepared as part of a separate initiative, the Department has determined that the encounter data provided by the CMOs is less than 100 percent complete. The claim encounter data provided by the CMOs is reconciled each month against the cash disbursement journals submitted by the CMOs. As of January 1, 2010, the reconciliation indicated AMERIGROUP had submitted approximately 99 percent of their encounter claims, PSHP had submitted approximately 98 percent of their encounter claims, and WellCare had submitted approximately 96 percent of their encounter claims. Because the analysis was performed on a less than 100 percent complete set of encounter claims, there is a potential for certain claims that were inconsistent with the provisions of the Act may not have been identified.
- It is important to note that in certain instances, claims are rejected by the CMOs prior to entering the claims adjudication process and are not included in the encounter data submitted to the FAC by the CMOs. Because of the absence of this data in the encounters, we are unable to analyze impact of these "front-end" denials as they relate to the proper treatment of newborn claims in accordance with the provisions of the Act.
- Medicaid or PeachCare for KidsTM eligibility was determined using eligibility data provided by the FAC, current as of December 2009. Medicaid and PeachCare for KidsTM encounter claims data was based on data submissions supplied to the FAC by the CMOs, current as of December 31, 2009. Traditional Medicaid and

PeachCare for Kids™ claims data was based on claims data supplied by the FAC, current as of December 31, 2009.

- If we were unable to determine the identity of the newborn's mother but the newborn was enrolled with a CMO on the date of birth, that CMO was determined to be responsible for payment of charges for the newborn.
- There were 3,528 newborns identified that were excluded from the analysis: 1,835 of the 3,528 newborns were born to mothers who were not enrolled in the Georgia Medicaid or PeachCare for Kids™ programs; and 1,693 of the 3,528 newborns were born to mothers who enrolled in Georgia Medicaid or PeachCare for Kids™ at a date occurring subsequent to the newborn's birth and discharge from the hospital.
- As the eligibility data provided contains only an effective date and not spans of eligibility, we are unable to verify retroactive eligibility changes so the payor assignment of the mother and/or newborn may have been retroactively changed from one CMO to another or from Traditional Medicaid or PeachCare for Kids™ to a CMO. These changes may result in a responsible payor determination in the analysis that is not consistent with the payor that was responsible on the date of the service.

FINDINGS

The analysis of the Georgia Medicaid and PeachCare for Kids™ eligibility data identified 99,447 newborns with dates of birth between January 1, 2009 and December 31, 2009.

Newborns for Whom a Mother Could Not be Identified in the Data

We were unable to identify a mother for 1,213 of the 99,447 (1.2 percent) newborns based on the following:

- The mother of the newborn was not recorded in the newborn's member eligibility record;
- The Head of Household recorded on the newborn's member eligibility record was not the mother of the newborn and the record did not include the mother of the newborn in the household;
- The mother of the newborn was not enrolled in the Georgia Medicaid or PeachCare for Kids™ programs; and/or,
- The newborn was recorded as the Head of Household.

Although we were unable to identify a mother for these 1,213 newborns, they were included in the analysis since the newborn was enrolled with a CMO.

Newborns for Whom a Mother Was Identified in the Data

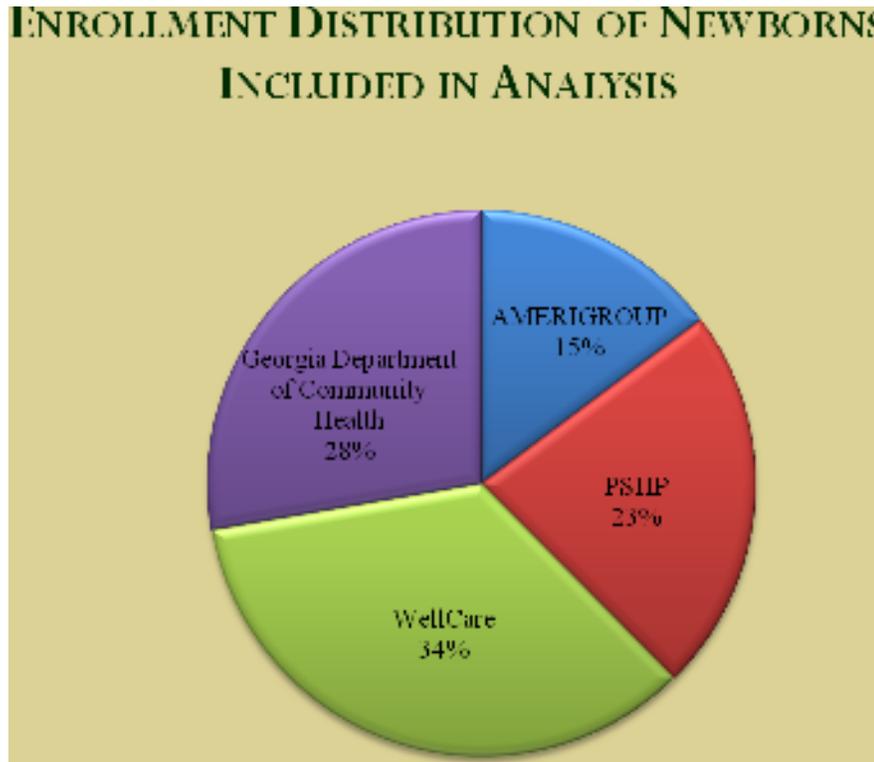
We identified 1,835 newborns (of the 99,447 or 1.8 percent) for whom we were able to identify a mother in the member eligibility file. However, it appears that these mothers were not enrolled in the Georgia Medicaid or PeachCare for Kids™ programs at the time that the newborn was delivered and discharged from the hospital.

We were also able to identify an additional 1,693 of the 99,447 (1.7 percent) newborns for whom a mother exists in the member eligibility file. However, these newborns were born to mothers who enrolled in Georgia Medicaid or PeachCare for Kids™ with an effective date subsequent to the newborns' birth and discharge from the hospital.

We adjusted the newborns in the analysis to account for both of the above situations. These 3,528 newborns identified (i.e., 1,835 plus 1,693) were excluded from further analysis since the provisions of the Act do not appear to apply in these instances. The hospital claims for the remaining 95,919 newborns were further analyzed as described below.

The enrollment distribution of either the mothers of the 95,919 newborns, or in cases where the mother was not eligible for Medicaid or PeachCare for Kids™ but the newborn was enrolled with a health plan is as follows:

Figure 1. Enrollment Distribution of Newborns Included in Analysis



**The Payor reflects the CMO assigned to the mother (or, if no mother was identified, the newborn) on the newborn's date of birth or the enrollment in Traditional Medicaid or PeachCare for Kids™ (i.e. the financial responsibility of the Georgia Department of Community Health). Mothers with multiple birth deliveries were reflected once for each newborn.*

Newborns for Whom No Claims Were Available

As of December 31, 2009, there appeared to be no inpatient hospital claims paid by the responsible payor for 24,174 newborns, or 25.2 percent of the total newborns included in the analysis. However, we identified 38 inpatient hospital claims paid by a payor other than the one we determined responsible (See Table 7, Newborn Claims Paid by Payor Other Than That Assigned to Mother or Newborn). From claims paid between January 1, 2010 and May 31, 2010, we identified another 6,239 inpatient hospital claims for these newborns, or 6.5 percent of the total. All available inpatient hospital claims for the 95,919 newborns paid through May 31, 2010 were included in the analysis.

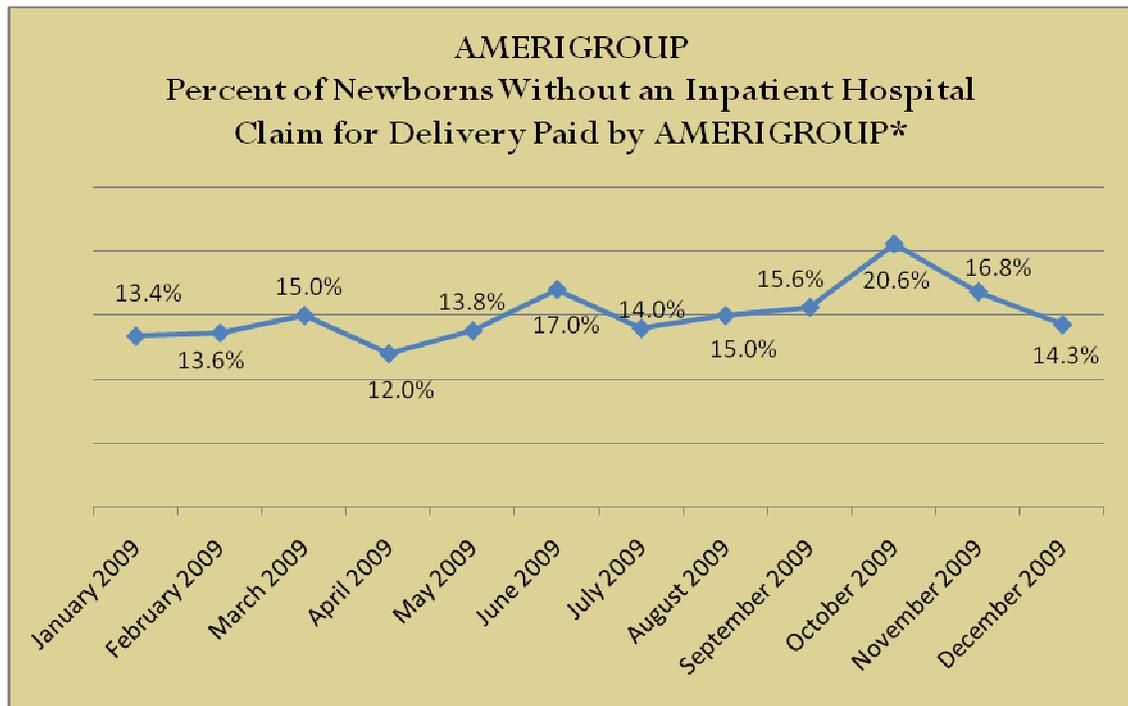
We were also able to identify 285 instances, or .3 percent of the total newborns, where nursery charges for the newborn were billed and paid on the mother's claim. Since these claims were not included on an inpatient hospital claim for the newborn, those claims were excluded from the analysis.

Possible reasons for the remaining 17,612 newborns with no claims available in the encounter or fee-for-service data include:

- A lag between the date of service and the date the provider submits the claim. Although we checked for any subsequent claims through May 31, 2010, claims for these 17,612 newborns did not appear in that data.
- Deliveries occurring in a non-inpatient setting and thus an inpatient hospital claim was not available;
- Deliveries that were the responsibility of a third party payor and a coordination of benefit claim was not submitted to the CMOs or the FAC;
- A completion rate of less than 100 percent for encounter claims data;
- The application of retroactive eligibility contributing to the appearance that a newborn inpatient hospital claim should have been paid even though the newborn did not appear to be eligible (i.e., per the eligibility file from the FAC) when the payor reviewed the member's eligibility on or within 72 hours of the date of birth; and finally
- Duplicate member files giving the appearance that a significant number of newborns were eligible for services on the date of birth yet no claim was available in the encounter data.

Additional detail regarding the monthly distribution of newborns without an inpatient hospital delivery claims by payor is included in Figures 2, 3, 4 and 5 below.

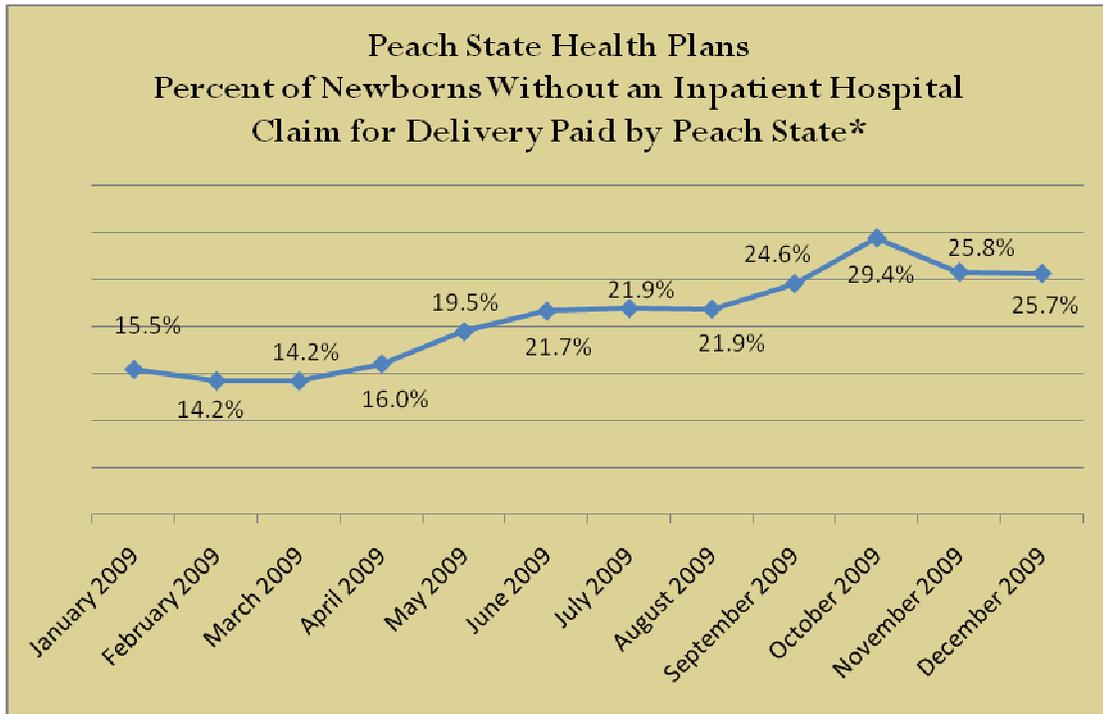
Figure 2. AMERIGROUP: Percent of Newborns without an Inpatient Hospital Claim for Delivery Paid by AMERIGROUP



**Reasons for the absence of a paid or denied claim in the data include a lag between the date of service and the date the provider submits the claim, deliveries occurring in a non-inpatient setting, deliveries that were the responsibility of a third party payor or a completion rate of less than 100 percent for encounter claims data. In addition, the application of retroactive eligibility may also contribute to the appearance that a newborn inpatient claim should have been paid even though the newborn did not appear to be eligible when the payor reviewed the eligibility on or within 72 hours of the date of birth. Finally, the presence of duplicate member eligibility files may also be contributing to the appearance of missing claims.*

Note that no inpatient hospital claim paid by AMERIGROUP was available for 2,161 (15.3 percent) AMERIGROUP newborns with a date of birth during calendar year 2009. As illustrated in Figure 2 above, this percent ranged from a low of 12.0 percent to a high of 20.6 percent on a monthly basis. We noted a spike in the percentage of newborns without an inpatient hospital claim for October 2009 but the rate decreased to approximately 14 percent by December 2009.

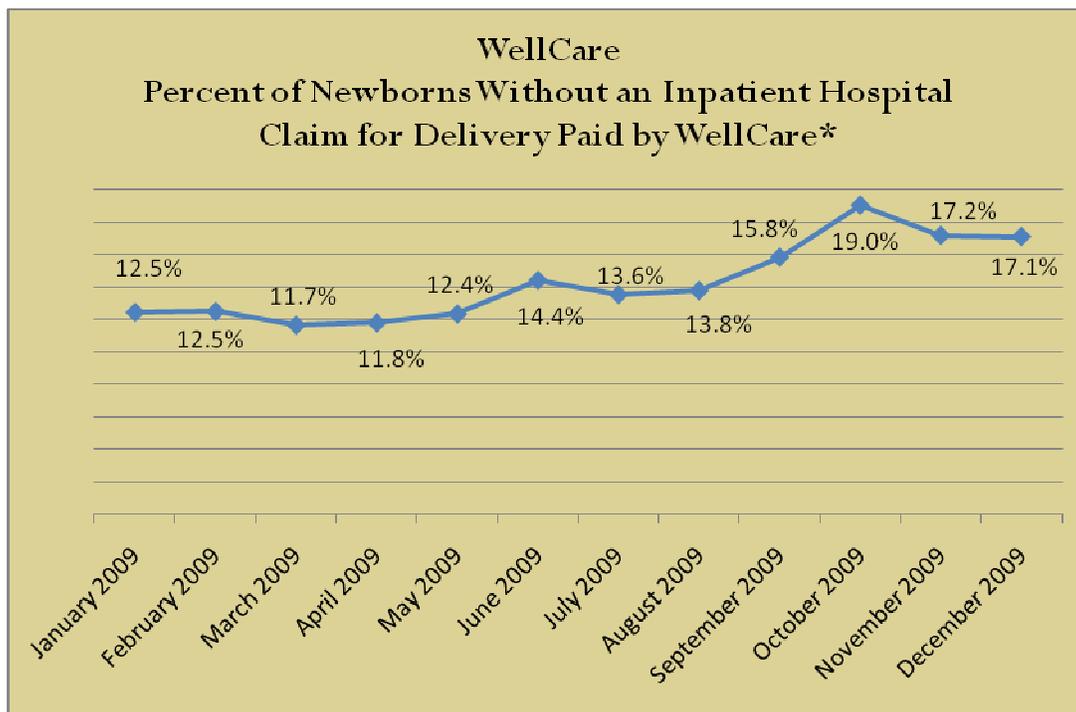
Figure 3. Peach State Health Plan: Percent of Newborns without an Inpatient Hospital Claim for Delivery Paid by Peach State



**Reasons for the absence of a paid or denied claim in the data include a lag between the date of service and the date the provider submits the claim, deliveries occurring in a non-inpatient setting, deliveries that were the responsibility of a third party payor or a completion rate of less than 100 percent for encounter claims data. In addition, the application of retroactive eligibility may also contribute to the appearance that a newborn inpatient claim should have been paid even though the newborn did not appear to be eligible when the payor reviewed the eligibility on or within 72 hours of the date of birth. Finally, the presence of duplicate member eligibility files may also be contributing to the appearance of missing claims.*

Note that no inpatient hospital claim paid by PSHP was available for 4,641 (21.2 percent) PSHP newborns with dates of birth during calendar year 2009. As illustrated in Figure 3 above, this percent ranged from a low of 14.2 percent to a high of 29.4 percent on a monthly basis. Similar to AMERIGROUP, we noted a spike in percentage of newborns without an inpatient hospital claim for October 2009 and that rate remained at approximately 25.7 percent through December 2009.

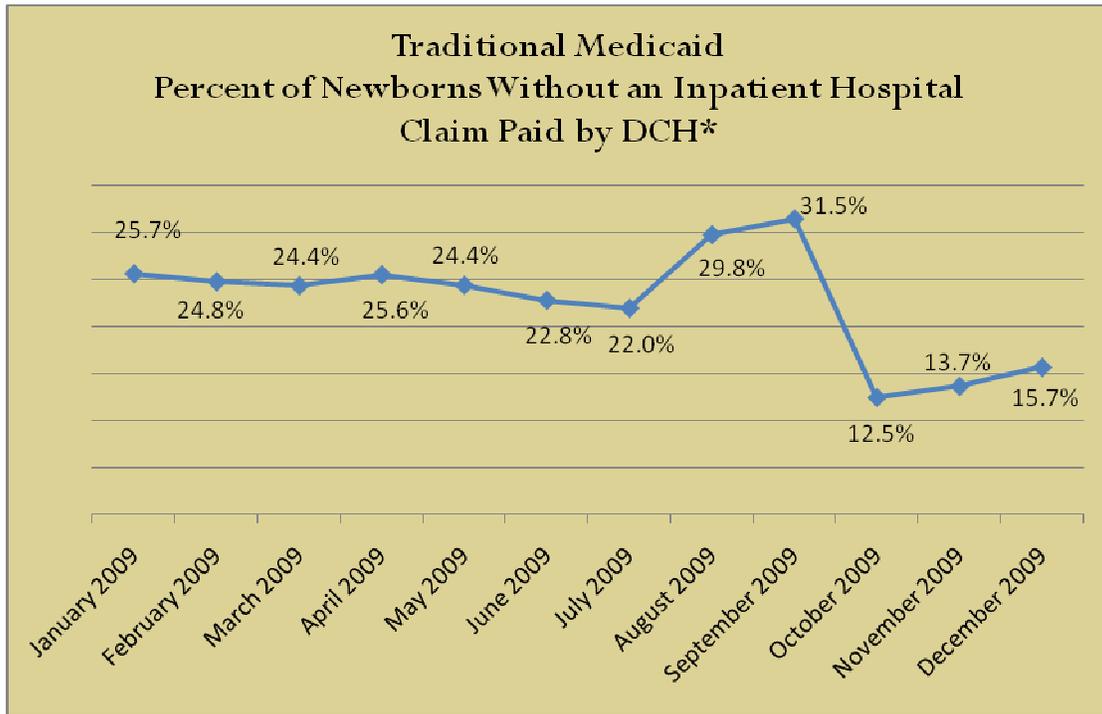
Figure 4. WellCare: Percent of Newborns without an Inpatient Hospital Claim for Delivery Paid by WellCare



**Reasons for the absence of a paid or denied claim in the data include a lag between the date of service and the date the provider submits the claim, deliveries occurring in a non-inpatient setting, deliveries that were the responsibility of a third party payor or a completion rate of less than 100 percent for encounter claims data. In addition, the application of retroactive eligibility may also contribute to the appearance that a newborn inpatient claim should have been paid even though the newborn did not appear to be eligible when the payor reviewed the eligibility on or within 72 hours of the date of birth. Finally, the presence of duplicate member eligibility files may also be contributing to the appearance of missing claims.*

No inpatient hospital claims paid by WellCare were available for 4,758 (14.3 percent) WellCare newborns with a date of birth during calendar year 2009. As illustrated in Figure 4 above, this percent ranged from a low of 11.8 percent to a high of 19 percent on a monthly basis. Similar to the other CMOs, we noted a spike in percentage of newborns without an inpatient hospital claim for October 2009 and that rate remained at approximately 17.1 percent through December 2009.

Figure 5. Traditional Medicaid and PeachCare for Kids™ Percent of Newborns without an Inpatient Hospital Claim for Delivery Paid by DCH



*Reasons for the absence of a paid or denied claim in the data include a lag between the date of service and the date the provider submits the claim, deliveries occurring in a non-inpatient setting, deliveries that were the responsibility of a third party payor or a completion rate of less than 100 percent for encounter claims data. In addition, the application of retroactive eligibility may also contribute to the appearance that a newborn inpatient claim should have been paid even though the newborn did not appear to be eligible when the payor reviewed the eligibility on or within 72 hours of the date of birth. Finally, the presence of duplicate member eligibility files may also be contributing to the appearance of missing claims.

As with each of the CMOs, inpatient hospital claims paid by DCH were not available for 6,375 (24 percent) Traditional Medicaid and PeachCare for Kids™ newborns with a date of birth during calendar year 2009. As illustrated in Figure 5 above, this percent ranged from a low of 12.5 percent to a high of 31.5 percent on a monthly basis. We noted a spike in percentage of newborns without an inpatient hospital claim for September 2009 and that rate declined to approximately 15.7 percent in December 2009.

Paid and Denied Claims for Newborns

The inpatient hospital claims identified for the newborns' birth were summarized by Payor. The Number of Newborn Claims Denied column in Table 1, below, reflects claims denied by the Payor that we determined to be financially responsible for the newborn. The percentages listed in Table 1 below include only those situations for which a paid or denied inpatient hospital claim was available in the data current as of May 31, 2010.

Table 1. Paid and Denied Inpatient Hospital Claims for Newborns

A	B	C	D = B - C	E	F	G = E / D	H = F / D
Payor	Newborns	Number of Newborns for Whom NO Inpatient Hospital Claim Paid by Responsible Payor Was Identified*	Number of Newborns Included in Analysis	Number of Inpatient Hospital Claims PAID for Newborns	Number of Inpatient Hospital Claims DENIED for Newborns	Percent of Inpatient Hospital Claims PAID for Newborns	Percent of Inpatient Hospital Claims DENIED for Newborns
AMERIGROUP	14,167	2,161	12,006	11,905	101	99.2%	0.8%
PSHP	21,858	4,641	17,217	16,804	413	97.6%	2.4%
WellCare	33,295	4,758	28,537	28,270	267	99.1%	0.9%
DCH	26,599	6,375	20,224	20,215	9	100.0%	0.0%
TOTAL	95,919	17,935	77,984	77,194	790	99.0%	1.0%

*Total includes the 285 newborns whose inpatient services were billed on the mother's claim.

AMERIGROUP Community Care (AMERIGROUP)

AMERIGROUP's encounter data reflects a claim payment rate of 99.2 percent of all claims submitted for newborns who were either delivered by mothers who were AMERIGROUP members or for newborns directly enrolled with AMERIGROUP. The AMERIGROUP encounter data reflects an average denial rate of 0.80 percent for newborn claim submissions. The table below categorizes the various reasons for the denied claims. During the course of the analysis, we did not identify inpatient hospital claims for newborns that appeared to have been denied inappropriately according to the provisions of Section 33-21A-6 of the Medicaid Care Management Organizations Act.¹

Table 2. AMERIGROUP Newborn Denials

AMERIGROUP Newborn Denials by Denial Reason	Claim Count	Percent
Submitted After Provider's Filing Limit	28	27.7%
Other Insurance Carrier Paid More than AMERIGROUP Allowable	18	17.8%
Coordination of Benefits	16	15.8%
Included in mothers per diem/case rate	11	10.9%
Level of Care Not Authorized.	6	5.9%
Member Not Eligible For Product Category	6	5.9%
Preauthorization Not Obtained	4	4.0%
Dates of Service Outside Authorization Period	3	3.0%

¹ The Act contains several provisions related to coverage and payment of claims. For purposes of this report, we only analyzed claims for compliance with the responsible party provisions. We did not determine compliance with any other provisions of the Act.

AMERIGROUP Newborn Denials by Denial Reason	Claim Count	Percent
Prior to Subscriber Effective Date	3	3.0%
Illegal please resubmit	1	1.0%
Incorrect Subscriber	1	1.0%
Newborn not enrolled - Bill DMAS	1	1.0%
Overpayment-Cost Containment OHI Overpay (Denial: 003 Reduced Allowable)	1	1.0%
Services Disallowed by UM	1	1.0%
Submit mother's claims - newborn charges included	1	1.0%
Total	101	100%

Peach State Health Plan (PSHP)

PSHP encounter data reflects a claim payment rate of for 97.6 percent of all claims submitted for newborns who were either delivered by mothers who were PSHP members or for newborns directly enrolled with PSHP. The PSHP encounter data reflects an average denial rate of 2.4 percent during 2009. We provided PSHP with a list of denied claims and requested the denial reasons which are noted in Table 3 below. We did not identify inpatient hospital claims for newborns that appeared to have been denied inappropriately according to the provisions of Section 33-21A-6 of the Medicaid Care Management Organizations Act. However, PSHP indicated the 271 claims with no denial reason were actually paid claims with a zero payment. We requested the reason that these claims were paid at zero. However, as of the date of this report, a response has not yet been received.

Table 3. PSHP Newborn Denials

PSHP Newborn Denials by Denial Reason	Claim Count	Percent
No Reason Provided*	271	65.6%
The time limit for filing has expired.	83	20.1%
Payment adjusted for absence of precertification/authorization/notification.	34	8.2%
Payment for charges adjusted.	9	2.2%
Services not documented in patients' medical records.	7	1.7%
Original payment decision is being maintained.	6	1.5%
Payment denied - Prior processing information appears incorrect.	2	0.5%
Duplicate claim/service.	1	0.2%
Total	413	100%

*PSHP indicated that these 271 claims were actually paid with a zero payment, rather than denied claims.

WellCare of Georgia (WellCare)

WellCare's encounter data reflects claim payments for 99.1 percent of all claims submitted for newborns who were either delivered by mothers who were WellCare

members or for newborns directly enrolled with WellCare. The WellCare encounter data reflects an average denial rate of 0.9 percent for newborn claim submissions during 2009. Table 4 below provides the reasons for the denials. As with each of the other CMOs, we did not identify inpatient hospital claims for newborns that appeared to have been denied inappropriately according to the provisions of Section 33-21A-6 of the Medicaid Care Management Organizations Act.

Table 4. WellCare Newborn Denials

WellCare Newborn Denials by Denial Reason	Claim Count	Percent
Timely Filing Limit	132	49.4%
No Denial Reason Provided. Claim has been reprocessed for Payment	64	24.0%
Authorization Denied	17	6.4%
No Prior Authorization Obtained	16	6.0%
Coordination of Benefits	15	5.6%
Duplicate of another claim or service	9	3.3%
Member not eligible on date of service	8	3.0%
No State Medicaid ID on File	4	1.5%
No contractual fee allowance	1	0.4%
Services Not Consistent with Authorization	1	0.4%
Total	267	100%

As noted in Table 4, approximately 24 percent of the denied claims did not have a denial reason. We requested from WellCare the reason that these claims were denied. Although WellCare did not provide the reason why these claims were denied, they informed us that the claims had been reprocessed for payment. As of the date of this report, the encounter data does not reflect the reprocessing of these claims nor has WellCare provided any additional information regarding the initial denials.

Georgia Department of Community Health

Claims data from Traditional Medicaid and PeachCare for Kids™ reflects claim payments for nearly 100 percent of claims submitted for newborns delivered by mothers who were enrolled in Traditional Medicaid or PeachCare for Kids™ at the time of the birth. The Traditional Medicaid and PeachCare for Kids™ data reflects an average denial rate of less than 0.1 percent for newborn claim submissions during calendar year 2009. Denial reason codes indicate that provider claim submission issues caused the majority of claim denials and do not appear to be in conflict with the provisions of the Act.

Payor Assignment

Based on the member eligibility file received from the FAC, the CMO assignment for each newborn member was not always assigned to the mother's Payor. We identified 2,638 out of 95,919, or 2.8 percent, of newborns with a Payor that differed from the mother's Payor on the newborn's date of birth. In Table 5 below, we identified the actual Payor assigned to those 2,638 newborns in Column C. The actual payor is based on the payor that either the newborn is assigned to or if the newborn is not assigned to a specific payor, then the payor to which the mother is assigned. Although approximately 2.8 percent of newborns are assigned to a different payor than their mother, this does not appear to be inconsistent with the provisions of the Act.

Table 5. Newborn Payor Assignments

A	B	C
Payor	Number of Newborns Based on Mother's CMO Assignment	Number of Newborns Based on Actual Payor Assignment*
AMERIGROUP	14,167	14,253
PSHP	21,858	22,046
WellCare	33,295	33,604
DCH	26,599	26,016
TOTAL	95,919	95,919

* Actual payor assignment is based on the payor that either 1) the newborn is enrolled with or 2) if the newborn is not enrolled with a payor, then the payor with which the mother is enrolled.

At the time of birth, the mother may be able to enroll the newborn with a payor that differs from her own. Therefore, the differences in enrollment are not necessarily an indication that inpatient hospital claims for newborns were paid inconsistent with the provisions of the Act. However, the difference in enrollment by payor provides DCH with information regarding enrollment trends of newborns. During the period being analyzed, it appears that each CMO tended to have a greater number of newborns that they were actually responsible for than they otherwise would be required to have based solely on the mother's enrollment. DCH, on the other hand, was responsible for fewer newborns than if responsibility for those newborns had been based solely on the mother's enrollment.

In addition, as noted earlier, since the eligibility data utilized in this analysis contains only an effective date and not spans of eligibility, we are unable to verify retroactive eligibility changes so the payor assignment of the mother and/or baby may have been retroactively changed from one CMO to another or from Traditional Medicaid or PeachCare for Kids™ to a CMO. These changes may result in a responsible payor

determination in the analysis that is not consistent with the payor that was responsible on the date of the service.

As a result of the assignment of newborns to a different payor, as illustrated in Table 6 below, 1,751 newborn claims appear to have been paid by the newborn's payor rather than the mother's payor. Table 6 provides additional details about these newborn claims, including the payor assignments, the number of claims for each payor, and the associated payment amounts. Again, this is not necessarily an indication of claims paid inconsistent with the provisions of the Act.

Table 6. Newborn Claim Count and Amount Paid

Mother's Payor	Newborn's Payor	Count of Newborn Claims	Amount Paid for Newborn Claims
AMERIGROUP	PSHP	20	\$245,023
	WellCare	38	\$59,141
	DCH	67	\$184,162
PSHP	AMERIGROUP	12	\$15,637
	WellCare	49	\$243,410
	DCH	84	\$316,195
WellCare	AMERIGROUP	31	\$244,497
	PSHP	43	\$558,581
	DCH	131	\$322,594
DCH	AMERIGROUP	270	\$871,926
	PSHP	389	\$2,626,265
	WellCare	617	\$2,401,843
TOTAL		1,751	\$8,089,273

There were an additional 38 newborn claims, as seen in Table 7 below, paid by a payor that does not appear to be associated with the mother or newborn. These 38 claims may be a function of retroactive eligibility changes.

Table 7 below reflects the payor assigned to the mother, the payor assigned to the newborn and the payor who ultimately made payment on the claim. It is important to note that the mother's payor assignment shown in the eligibility data may not be reflective of the mother's actual assignment on the newborn's date of birth due to the application of retroactive eligibility.

Table 7. Newborn Claims Paid by Payor Other Than That Assigned to Mother or Newborn

Mother's Payor	Newborn's Payor	Payor Who Issued Payment	Count of Newborn Claims	Amount Paid for Newborn Claims
AMERIGROUP	No Enrollment	DCH	3	\$4,220
	AMERIGROUP	DCH	1	\$4,243
	DCH	WellCare	1	\$1,048
PSHP	No Enrollment	WellCare	1	\$975
	No Enrollment	DCH	1	\$100,480
	PSHP	WellCare	3	\$3,608
	PSHP	DCH	1	\$1,104
WellCare	No Enrollment	DCH	2	\$13,438
	WellCare	PSHP	1	\$1,786
	WellCare	DCH	2	\$2,152
DCH	No Enrollment	AMERIGROUP	2	\$12,988
	No Enrollment	PSHP	2	\$1,947
	No Enrollment	WellCare	1	\$1,614
	DCH	AMERIGROUP	5	\$18,149
	DCH	PSHP	4	\$30,427
	DCH	WellCare	8	\$50,590
TOTAL			38	\$248,769

CONCLUSIONS AND RECOMMENDATIONS

- During the course of the analysis, we did not identify inpatient hospital claims for newborns that appeared to have been denied inappropriately according to the applicable provisions of Section 33-21A-6 of the Medicaid Care Management Organizations Act. For purposes of this report, the analysis was limited to the provisions of the Act related to the financially responsible party for newborn claims.
- We noted that a potentially significant large portion (18.4 percent) of the total newborns identified as eligible did not appear to have an inpatient claim or inpatient encounter for the date of birth at the time this analysis was performed. Possible reasons for a lack of claims include a lag between the date of service and the date the provider submits the claim, deliveries occurring in a non-inpatient setting, deliveries that were the responsibility of a third party payor, a completion rate of less than 100 percent for encounter claims data or front end denials. In addition, the application of retroactive eligibility may contribute to the appearance that a newborn inpatient claim should have been paid even though the newborn did not appear to be eligible when the payor reviewed the eligibility on or within 72 hours of the date of birth. Finally, the presence of duplicate member eligibility files may also be contributing to the appearance of missing claims. DCH may wish for each of the CMOs to identify the specific reasons why each of the newborns does not have a claim available.
- We identified 285 instances, or .3 percent of the total newborns, where nursery charges for the newborn were billed and paid on the mother's claim. According to the Georgia Department of Community Health Policies and Procedures for Hospital Services, Section 903.7, effective with dates of admission July 1, 1998 and greater, charges for the mother and baby must be billed separately. The total instances included 151 for PSHP, 72 for AMERIGROUP and 62 for WellCare. DCH may wish to communicate with each of the CMOs regarding the appropriateness of the payments.
- As of the date of this report, certain requests for clarification and/or additional data remain outstanding. This includes the reasons why the 271 claims for Peach State Health Plan were paid at zero and for WellCare of Georgia, the reasons why the 64 claims were denied which WellCare stated had been reprocessed for payment. DCH may wish to require the CMOs to respond to these outstanding items as well as require WellCare to demonstrate that the claims were indeed reprocessed.