

Board of Community Health
Audit Committee Meeting
September 13, 2007

The Board of Community Health Audit Committee met September 13, 2007, Twin Towers West, Floyd Room, 200 Piedmont Avenue, Atlanta, Georgia.

Committee members present were Mark Oshnock, Chairman, Ross Mason (via phone) and Richard Robinson.

DCH Staff available were: Carie Summers, Chief Financial Officer; John Hankins, Director, Internal Audit and Program Evaluation; Sonny Munter, Chief Information Officer; Julie Biel, Brian Dowd, Megan Wyatt and Jody McHoul of Capgemini.

Mr. Oshnock called the meeting to order at 9:08 a.m. The June 14 and August 9 Minutes were UNANIMOUSLY APPROVED.

Financial and Single Audit Work Status

Carie Summers, CFO, introduced the independent auditors Miller Edwards, Dave Decker, Matt Hill and Donarene Steele of BKR Metcalf Davis Mauldin and Jenkins, referred to as the Joint Venture. Mr. Decker reported that the Joint Venture has completed about 90% of the Single Audit portion. They have done a considerable amount of field work and are about 50% complete on the Financial Statement and expect to have the Financial Statements next week.

Mr. Hill said at this point they have found in their testing the following: 3 of 60 files reviewed for Medicaid eligibility have some problem with documentation of citizenship; 2 of 40 provider files tested could not find licensure documentation; 2 duplicate payments; and 1 PeachCare member who was over program age limit. Otherwise, the work is going fairly smoothly.

Resolution – FY 2008 OPEB

Ms. Summers said the Resolution Establishment of State Employer Contributions for Future OPEB Liabilities will be presented to the full Board today. The Resolution allows the Department to 1. take the proceeds from state agencies that the Department receives monthly and move it to the OPEB Trust Fund, and 2. authorize its transfer to the Employee Retirement System Division of Investment Services for long-term investment. Ms. Summers said at some later point the Department will bring the Committee and Board another Resolution that will deal with Pay as You Go distribution between active and retired employees for OPEB deposits. Also, in the future the Department will begin discussion on how to break up the Beginning Fund Balance for FY 2008.

Medicaid/PCK Benefits Testing Report for FY 2007 Audit

Ms. Summers introduced Jared Duzan, Shelley Llamas and Ryan Farrell of Myers and Stauffer. The Department has contracted with Myers and Stauffer since the FY 2004 audit for benefits testing. Ms. Llamas said testing for Medicaid and PeachCare for Kids claims for FY 2007 was performed in a general approach consistent with years past. This year's testing was separated into five groups of claims. Analytical procedures were developed and tested. Myers and Stauffer tested for duplicate payments and identification of payments that were paid to ineligible members or providers. When potential mispayments were identified, Myers and Stauffer worked closely with the Department to make sure that the Department was also in agreement that it was a liability or receivable. A liability for purposes of this report is an underpayment to the provider and a receivable would be an overpayment to the provider. These mispayments were then tabulated so the Department could determine whether an adjustment to the Financial Statements was necessary.

Group 1 consisted of a stratified random sample of 30,313 Fee-for-Service (FFS) claims, both Medicaid and PeachCare. The stratification was based on the category of service of the claim. The universe (from which the sample was pulled) included claims paid between July 1, 2006 and December 31, 2006. This universe included only paid claims (and did not include denied claims) and Medicare crossover claims except prescribed drugs. The claims universe excluded administrative fees, capitation payments that were included in Group 2, case management fees included in Group 4, health insurance premiums, Medicare buy-in premiums, cost settlement payments, and all non-claim specific payments. The sample results found were then used to compute the annual estimate using the 95% confidence interval to extrapolate to the 12 months. The point estimate for the total liabilities for Group 1 was \$285,760; total receivables were \$9,721, 538; and the net mispayments were \$9, 435,780. Some of the causes of mispayments were: incorrect application of maximum unit limits on procedure codes; incorrect application and/or exemption of co-payments; incorrect posting of claim exception codes; and lack of adjustments for retroactive system changes, including rate updates and Medicare member eligibility.

Group 2 consisted of all Georgia Families capitation claims paid July 1, 2006 to March 31, 2007. Myers and Stauffer annualized those findings from that period by obtaining the whole nine months of claims, reviewing 100% of those claims and computed a confidence interval around the estimates of overpayments for the remaining three months of the year. There were no liabilities found. Total Receivables for Georgia Families for that review were \$31,182,758. The majority of the estimated receivables were related to duplicate capitation payments.

Group 3 included a review to determine if there were any FFS claims inappropriately paid for Georgia Families members. (Care Management Organizations, or "CMOs," should be responsible for processing provider claims for these members' health care.) The claims universe for Group 3 included all FFS claims, including pharmacy, that were paid from July 1, 2006 to March 31, 2007. The annualized estimate for total

receivables attributed to Group 3 was \$11,565,020 and no liabilities. Through the review of Group 3, an error was identified in which the pharmacy benefits manager did not receive a correct member eligibility file for October 2006. As a result, an abnormal amount of prescription drug (pharmacy provider) claims was paid for capitated members in that month. The Department addressed this issue by requesting that Myers and Stauffer review the affected claims.

Group 4 included other capitation claims all paid between July 1, 2006 and December 31, 2006 for the programs Non-Emergency Transportation, Disease State Management, Georgia Better Health Care and Pre-Admission Screening Resident Review (PASRR). The annualized estimate of the liabilities was \$5,748; \$513, 481 total receivables and net mispayments \$507,734. The majority of those receivables were attributable to duplicate payments. The liabilities are related to PASRR resulting from an incorrect rate.

Group 5 is a result of the Department's identification of the October 2006 eligibility file problem through the review of Group 3 findings. The Department directed Myers and Stauffer to review this separate group of claims which was then termed Group 5. Group 5 included a review of pharmacy claims for services incurred and paid in October for which the member was ineligible for Medicaid or PeachCare services based on program eligibility information for October 2006. As a result of that review, the Department determined that some member eligibility files were not updated to include the member's date of death. The annualized estimate for receivables attributed to this group is \$74,700, no liabilities, and \$74,700 net mispayments.

After the delivery of the report, the Department notified Myers and Stauffer that measurement considering recoveries for payments after date of death is considered an actuarial service. When the actuaries estimated liabilities for claims filed after June 30, the actuary incorporated the historic pattern of these recoveries.

Department's Response to Report

Ms. Summers introduced Brian Dowd, Director of (Medicaid) Eligibility and Member Services, and Julie Biel of the Division of Financial Management. Ms. Summers asked Mr. Dowd and Ms. Biel to address duplicate payment errors.

Mr. Dowd said he recently hired three staff members to review daily action files from the MMIS that identifies suspended claims and possible duplicate member records. These staff members work the list daily to try stopping new duplicate member records from coming on the system. From July 30 through September 7 the staff members were able to capture 2,295 duplicate records. In addition, the CMOs have submitted some reports of what they think are potential duplicates; Mr. Dowd's staff has worked on claims that have been identified from the Myers and Stauffer reporting; and the Department was also able to get ACS to run a report on duplicate members with exact name, date of birth, and/or social security matches. As a result of this work, the Department has

completed two rounds of recoupments; the first round yielded \$6,084,196.24; the second round of recoupments is estimated at about \$6 million.

Mr. Dowd gave his perspective on why duplicates occur. He said what he is seeing is that many duplications are coming from information entered for newborns. Duplications could occur depending on how a provider enters a newborn's name in the system and how DFACS enters the child's name. A discussion ensued about other possible reasons for duplications and ways to prevent these duplications which could include edits to the current system or purchasing software developed for MMIS duplication analysis. Mr. Dowd said his goal is to stop the duplications and clean up the backlog. Ms. Summers said Mercer, the actuaries who are responsible for calculating the IBNR, make adjustments to the IBNR to reflect the fact that the base claims they are using to project IBNR were overstated.

The other corrective action for Group 1 (FFS claims) is comparable to the response to reports that Myers and Stauffer has done in the past. Ms. Summers said Myers and Stauffer has provided information that allows the Department to make sure that every error identified is either a system defect or input driven issue. The Department continues to make sure that there is a MMIS ticket to correct every error found that is a system defect. Mr. Munter said the Department is using a change control process to prioritize the tickets, understanding that the fiscal agent has some limited resources to work on the tickets. As these issues are addressed, claims are reprocessed and payments are made to pay the difference if the claim was underpaid or recovered if overpaid.

New Business

Mr. Oshnock asked that at a future meeting the Department give an update on its efforts to mitigate duplications and the status of a systems solution. Mr. Robinson asked for a report on the cost and benefits of performing benefits analysis on an ongoing basis instead of a year-end analysis and report. Ms. Summers suggested that the Committee discuss at the next meeting OPEB fund balance division and Pay As You Go contributions separation.

There being no further business, the meeting was adjourned at 10:17 a.m.

Audit Committee