

DEPARTMENT OF COMMUNITY HEALTH

REPORT #10:

**GEORGIA FAMILIES PROGRAM
DENTAL SERVICE CLAIMS**

**INDEPENDENT ACCOUNTANT'S REPORT ON
APPLYING AGREED-UPON PROCEDURES**



Myers and Stauffer_{LC}

Certified Public Accountants

TABLE OF CONTENTS

Independent Accountant’s Report on Applying Agreed-Upon Procedures	3
Background	7
Methodology	8
Findings	11
Observations and Recommendations	17
Exhibits	20

EXHIBIT A: AGREED-UPON PROCEDURES

EXHIBIT B: STATISTICIAN SAMPLING REPORT

EXHIBIT C: STATISTICIAN REVIEW

INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

Georgia Department of Community Health:

The Department of Community Health (DCH or Department) engaged Myers and Stauffer LC to apply agreed-upon procedures for the purpose of testing the accuracy of payments for a sample of dental service claims adjudicated by the Georgia Families (GF) program contracted Care Management Organizations (CMO) or their dental subcontractor(s). Claim payments were analyzed to determine if the payment was made according to the CMO's (or the CMO's subcontractor's) coverage, payment policies and the contract between the CMO/dental subcontractor and the dental provider. The Department will determine the applicability and use of the results from applying these agreed-upon procedures. DCH's management is responsible for the Department's policies and procedures, as well as vendor management functions.

We have performed the agreed-upon procedures described in Exhibit A dated April 27, 2009, which were agreed to by the Department. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described in Exhibit A dated April 27, 2009 either for the purpose for which this report has been requested or for any other purpose.

The following terms may be used throughout this document:

- **Adjudicate** – A determination of the outcome of a healthcare claim. Claims may pay, deny, or in some cases have an alternative adjudication outcome.
- **Avesis** – The dental subcontractor to Peach State Health Plan (PSHP). Avesis was subcontracted with PSHP to administer the provision of dental care services to PSHP GF members through May 31, 2009.
- **Boost Sample** – An additional sample that is drawn and tested in order to reduce the margin of error on an estimate that results from testing of a sample.
- **Capitation Claim** – A per Medicaid and/or PeachCare for Kids™ member fixed payment amount made by the Department to a care management organization in return for the administration and provision of healthcare services rendered to the enrolled Medicaid and/or PeachCare for Kids™ member.

- **Care Management Organization (CMO)** – A private organization that has entered into a risk-based contractual arrangement with DCH to obtain and finance care for enrolled Medicaid recipients or PeachCare for Kids™ members. CMOs receive a per capita or capitation claim payment from DCH for each enrolled member. The three CMOs contracted by the Department to provide services for DCH members are AMERIGROUP Community Care (AMERIGROUP or AMGP), Peach State Health Plan (Peach State or PSHP), and WellCare of Georgia (WellCare).
- **Claim** – An electronic or paper record submitted by a healthcare provider to a payer detailing the healthcare services provided to a patient for which the provider is requesting payment. A claim may contain multiple healthcare services.
- **Claim Detail (Claim Line)** – A portion of a claim that documents a specific healthcare service.
- **Claims Processing System** – A computer system or set of systems that determine the reimbursement amount for services billed by the healthcare provider.
- **Confidence Interval** – An estimated range of values that is likely to include an unknown population parameter, the estimated range being computed from sample data with inferences made to the population.
- **Denied Claim** – A claim submitted by a healthcare provider for reimbursement that is deemed by the payor to be ineligible for payment under the terms of the contract between the healthcare provider and payor.
- **Doral** - The dental subcontractor to AMERIGROUP and WellCare of Georgia. Doral is subcontracted with AMERIGROUP and with WellCare to administer the provision of dental care services to AMERIGROUP and Wellcare GF members, respectively. Effective June 1, 2009, Doral became the dental subcontractor to PSHP.
- **Dr. David Bivin** – Associate Professor, Department of Economics, Indiana University – Purdue University Indianapolis, who specializes in econometrics. Dr. Bivin used statistical techniques to consider the statistical strategies and methods, and to perform quality assurance on the statistical findings.
- **Dr. Ye Zhang** – Assistant Professor, Department of Economics, Indiana University – Purdue University Indianapolis, who assisted in the performance of quality assurance measures on the statistical findings.

- **Extrapolation** – The application of the mean dollar amount in error from the sample of claims to a population of claims.
- **Fee-For-Service (FFS)** – A healthcare delivery system in which a healthcare provider receives a specific reimbursement amount from the payor for each healthcare service provided to a patient. In some cases, the service must be authorized in advance.
- **Fee-For-Service (FFS) Claim** – A payment made by a payor to a healthcare provider after a service has been provided to a patient covered by the payor. A FFS claim consists of one or more line items that detail specific healthcare service(s) provided.
- **Georgia Families (GF)** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids™ in which the Department contracts with Care Management Organizations to manage the care of eligible recipients.
- **In-Network Provider** – A provider that has entered into a Provider Contract with the CMO or its dental subcontractor to provide services.
- **Liability** – A claim payment amount that was not made in accordance with CMO (or the CMO's subcontractor) coverage, payment policies, and contractual obligations resulting in an underpayment to the entity receiving the claim payment.
- **Margin of Error** – The half width of the confidence interval and a measure of how close the estimate is to the true value.
- **Medicaid Management Information System (MMIS)** – Claims processing system used by the Department's fiscal agent claims processing vendor to process Georgia Medicaid and PeachCare for Kids™ FFS claims and capitation claims.
- **Mispayment** – A claim payment amount that was not made in accordance with CMO (or the CMO's subcontractor) coverage, payment policies, and contractual obligations resulting in either an overpayment (receivable) or underpayment (liability) to the entity receiving the claim payment.
- **Paid Claim** – A claim submitted by a healthcare provider for reimbursement that is deemed by the payor to be eligible for payment under the terms of the contract between the healthcare provider and payor.
- **PeachCare for Kids™ Program (PeachCare)** – The Georgia DCH's State Children's Health Insurance Program (SCHIP) funded by Title XXI of the Social Security Act, as amended.

- **Point Estimate of the Population Total** – The average error of the sample scaled by the number of observations (claims or lines) in the population.
- **Provider Manual** – A document created by a healthcare payor that describes the coverage and payment policies for healthcare providers that provide healthcare services to patients covered by the payor.
- **Receivable** – The portion of an actual claim payment amount in excess of the payment amount that would be in accordance with CMO (or the CMO's subcontractor) coverage, payment policies, and contractual obligations resulting in an overpayment to the entity receiving the claim payment.
- **Subcontractor** – Any third party who has a written contract with a CMO to perform a specified part of the CMO's obligations under their DCH contract.

BACKGROUND

Myers and Stauffer LC was engaged to assist the Department in its efforts to assess the policies and procedures of the Georgia Families program, including studying and reporting on certain issues presented by providers, selected claims paid or denied by CMOs, and selected GF policies and procedures. Initial phases of the engagement focused on hospital and physician provider subjects. Previously issued reports, are available online at <http://dch.georgia.gov>. These reports assessed payment and denial trends of hospital and physician claims, the payment accuracy of selected claims, and certain CMO policies and procedures.

In consultation with the Department, we analyzed the data and documentation received from the CMOs (or its subcontractor), and we did not independently validate or verify the information. Each CMO attested and warranted that the information they provided was “accurate, complete and truthful, and [was] consistent with the ethics statements and policies of DCH.”

METHODOLOGY

The objective of this engagement was to apply agreed-upon procedures to test the accuracy of payments for a sample of dental service claims adjudicated by the CMOs or their dental subcontractor(s) that administer the GF program. These claim payments were analyzed to determine if the payment was made according to the CMO's (or the CMO's subcontractor's) coverage, payment policies and the contract between the CMO/dental subcontractor and the dental provider. If the claim was paid incorrectly, we estimated the amount of the underpayment or overpayment (collectively referred to as "mispayments") for the claim in consultation with the CMO, the CMO's subcontractor, and/or the Department.

The claims universe from which the sample was drawn included CMO/subcontractor paid and denied claims of both Medicaid and PeachCare for Kids™ members for dental care provider claims. The claims requested from the CMOs included all dental claims with dates of service from June 1, 2006 through November 30, 2008. The Department considers the start-up and implementation period to be June 1, 2006 through June 30, 2007. Claims analyzed for this initiative included this period, as well as the post implementation periods through November 30, 2008.

It should be acknowledged that claims selected from this time period will likely include mispayments and issues that are unique to the Georgia Families start-up and implementation period. We understand that considerable efforts have been made by providers, the CMOs, the subcontractors and DCH to address these start-up related issues. Therefore, it is likely that mispayments and issues identified from a more recent period could be different and may reflect the improvement efforts by these parties.

The sampling methodology and statistical procedures used for this analysis were developed in consultation with Dr. David Bivin, a statistical consultant to Myers and Stauffer. Dr. Bivin has previously assisted in developing the sampling methodologies and statistical estimations for the GF hospital and physician claims.

The margin of error on the estimate of mispayments depends upon the variability of the data and when, as in this analysis, there is no prior knowledge of the variance, there is a potential of drawing too few observations to achieve the desired reliability. Therefore, the recommended approach was to determine a minimum sample size that would be used as a beta sample. The Department would determine the need for a boost sample after the analysis of the beta sample has been completed.

The sample for the beta test was equal to 2,000 claim detail lines per CMO. This sample implies a probability of approximately 90 percent for selecting a claim with a mispayment, under the assumption of a mispayment rate of at least five percent. Based on the results of the beta sample, additional sampling and testing could be used to expand upon or address specific issues or problems identified in the beta sample. The

variation of the mispayments identified in the beta test could be used to estimate a margin of error on a larger sample, if authorized by the Department.

The selection and analysis of 2,000 claims per CMO provided confidence intervals at the 95 percent level for the mean dollar amount of mispayment per claim detail line and the total dollars in mispayments per CMO. Because prior testing results of dental mispayments were not available, it was not possible to achieve a desired level of precision on the estimated margins of error. The final margins of error are based on the distribution and variability of the observed mispayments, which are a function of each CMO/subcontractor, their individual claims processing and adjudication and other unique factors. Table 1 below illustrates the universe counts and beta sample size by CMO.

Table 1: Claims Universe and Sample Sizes for CMO Dental Claims

Care Management Organizations	Universe Claim Count	Detail Line Count	Sample Size (Detail Lines)
AMGP / Doral	705,363	2,879,102	2,000
PSHP / Avesis	852,768	3,384,311	2,000
WellCare / Doral	1,407,977	5,653,830	2,000
TOTAL	2,966,108	11,917,243	6,000

A data request was prepared and sent to each CMO/subcontractor on December 16, 2008 that requested all paid and denied dental service claims for the specified period, as well as all contracts, rate files and reference data necessary to analyze claim payments and denials. The due date for each CMO to provide the requested data and information was January 30, 2009. Significant communication with the CMOs and their subcontractor(s) occurred to address questions, obtain additional information or clarifications, or resolve various issues involving the claims data submitted. Although substantial portions of the data were received during March and April 2009, follow up data that was either missing from earlier submissions or that was submitted to correct issues was submitted by the CMOs as late as July 6, 2009. Myers and Stauffer received approval from the Department to establish June 30, 2009 as the cut-off date for the CMO's to submit additional data, corrections and clarifications and to proceed at that time with the planned analysis despite certain unresolved issues with the data. As appropriate, the potential effect of these issues is disclosed in the findings of this report. See "Analytical Limitations" included at the end of this report. As required, the CMOs provided an attestation that the data they provided was "accurate, complete, and truthful, and [was] consistent with the ethics statements and policies of DCH".

A random sample of paid and denied claims was drawn from the universe of claims using a random selection function in SQL Server. Separate samples were drawn for each CMO.

Each sampled claim was selected and tested at the “detail” level, which refers to information that is contained on the claim filed by the provider. We analyzed the final payment amount (i.e., net of all known adjustments as of the date the CMOs submitted the claims data) made to the provider by the CMO/subcontractor. We analyzed each claim in the sample based on the contract between the CMO/subcontractor and the dental provider. Unlike other provider categories, we understand that the dental subcontractors utilize a common fee schedule for reimbursement of dental services. Nearly all providers within specified categories (e.g., pregnant women, specific counties or regions, etc) receive the same fees. Therefore, based on the fee schedules obtained from the CMOs, we completed our analysis using the following procedures:

- 1) We determined the payment status of the claim detail line.
- 2) If the claim detail line payment status was “denied”, we analyzed the reason and attempted to determine, with the information available, whether the denial was appropriate.
- 3) If the claim detail line payment status of “denied” appeared to be inappropriate, we computed the expected payment for the detail claim line based on the applicable fee schedule for the dental provider.
- 4) If the claim detail line payment status was ‘paid’, we computed the expected payment for the claim detail line based on the applicable fee schedule for the dental provider.
- 5) By comparing the expected payment amount to the actual payment amount, we computed the dollar value of the mispayment, as applicable, for the detail claim line.
- 6) The potential mispayments were sent to the CMO and/or subcontractor for comment. We requested that the CMO/subcontractor demonstrate the calculation of the actual payment amount for each potential mispayment and provide all supporting policies, procedures and other reference data, if not already provided, to support the payment.
- 7) If significant anomalies had occurred in the sample, or at the Department’s request, the sample size could be expanded to a larger set of detail claim lines as appropriate.

Upon completing the analysis for each sampled claim, the results were sent to Dr. Bivin and Dr. Zhang to complete the analyses of the mean per claim mispayment amounts, total mispayment amounts, and confidence intervals for each CMO, as well as perform quality assurance procedures to confirm the statistical calculations.

FINDINGS

The dental claims universe included all paid and denied dental service claims of both Medicaid and PeachCare for Kids™ members. The claims included dates of service from June 1, 2006 through November 30, 2008. Sampled dental claims were analyzed to determine if the payment was made according to the CMO's (or the CMO's subcontractor's) coverage, payment policies and the contract between the CMO/dental subcontractor and the dental provider or the fee schedule applicable to the provider.

For confirmed mispayments, we determined the estimated amount of the underpayment (liability to the CMO) or overpayment (receivable to the CMO) for the claim detail line. All potential errors were provided to the CMOs and the CMOs were asked to provide a detailed response indicating how the claim was adjudicated, including providing all applicable documentation. We discussed the sampled claims noted with potential mispayments with the Department, the CMOs and the subcontractors as necessary.

The CMOs were given an opportunity to provide comments or submit additional information. We noted in several instances that the comments and/or additional information submitted by the CMOs raised additional questions, or was insufficient to support their position. Several iterations of question and answer with the CMOs were completed. Once all outstanding questions to the CMOs were addressed, we finalized the list of claims with mispayments. In many cases, the CMOs could not provide supporting documentation and/or we came to a different conclusion on the claim from the CMO.

For reference, the following payment totals for each CMO/subcontractor were received and utilized in our analyses. These claims include dental service claims from general, pediatric, and other dental specialists with incurred dates of service from June 1, 2006 through November 30, 2008 billed on the ADA claim form.

Table 2: Dental Claim Payments by CMO

	AMGP / Doral	PSHP / Avesis	WellCare / Doral	Total
General / Pediatric Dental Providers	\$75,177,692	\$114,117,027	\$182,735,306	\$372,030,025
Dental Specialists	\$8,748,287	\$8,376,758	\$17,247,533	\$34,372,578
Total	\$83,925,979	\$122,493,785	\$199,982,839	\$406,402,603

The following tables display the findings by CMO as well as provide contextual reference for the volume of mispayments.

Table 3: Summary of Dental Claim Detail Lines Paid/Denied Correctly

	AMGP / Doral	PSHP / Avesis	WellCare / Doral
Sample Size	2,000	2,000	2,000
Claim Detail Lines Paid/Denied Correctly	1,923	1,971	1,985
Percent of Claim Detail Lines Paid/Denied Correctly	96.1%	98.5%	99.2%

Table 4A: Primary Issues Affecting Claims Payment Accuracy for AMGP/Doral

Issue	Number of Detail Line Errors	Percent of Total Claim Detail Lines	Percent of Total Mispayments
Incorrect application of "rural" fee when "urban" fee should be applied and vice versa.	52	0.0018%	67.5%
Application of fee from wrong rate period.	15	0.0005%	19.5%
Incorrect denial due to member eligibility when member was, in fact, eligible.	2	0.0001%	2.6%
Inadequate response or supporting documentation to demonstrate the claim paid or denied correctly.	2	0.0001%	2.6%
Incorrect application of coverage and benefit limitations.	5	0.0002%	6.5%
Incorrect application of lessor of logic.	1	0.0000%	1.3%
AMGP/Doral	77	0.0027%	100%

Table 4B: Primary Issues Affecting Claims Payment Accuracy for PSHP/Avesis

Issue	Number of Detail Line Errors	Percent of Total Claim Detail Lines	Percent of Total Mispayments
Incorrect application of coverage and benefit limitations.	18	0.0005%	62.1%
Incorrect rate applied from fee schedule.	4	0.0001%	13.8%
Incorrect denial due to member eligibility when member was, in fact, eligible.	5	0.0001%	17.2%
Inadequate response or supporting documentation to demonstrate the claim paid or denied correctly.	2	0.0001%	6.9%
PSHP/Avesis	29	0.0009%	100%

Table 4C: Primary Issues Affecting Claims Payment Accuracy for WellCare/Doral

Issue	Number of Detail Line Errors	Percent of Total Claim Detail Lines	Percent of Total Mispayments
Incorrect application of coverage and benefit limitations.	5	0.00009%	33.3%
Incorrect denial due to member eligibility when member was, in fact, eligible.	2	0.00004%	13.3%
Inadequate response or supporting documentation to demonstrate the claim paid or denied correctly.	4	0.00007%	26.7%
Incorrect denial due to provider termination.	1	0.00002%	6.7%
Application of wrong fee schedule amount.	3	0.00005%	20.0%
WellCare/Doral	15	0.00027%	100%

Figure 1 below illustrates the number of AMGP / Doral sample claims with mispayments by month. The spikes occurring in October, November and December 2007 and again in February, April, and October 2008 all appear to be related to the assignment of “urban” versus “rural” at the provider location level. For example, the provider was set up as “urban”, but was listed on the supporting documentation as “rural”.

Figure 1: AMGP/Doral Sample Claims Mispayments by Month

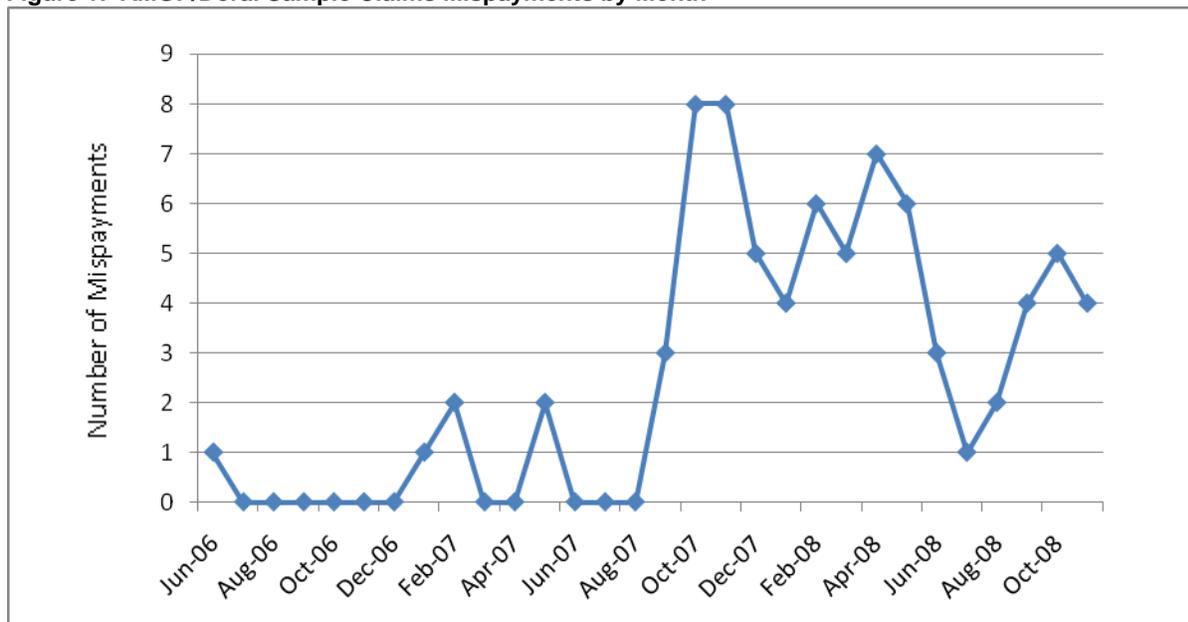


Figure 2 below illustrates the number of PSHP / Avesis sample claims with mispayments by month. In August 2006, mispayments were related to benefit age

limitations. For example, D1120 (Prophylaxis) should not have been billed based on the age of the patient. The mispayments in December 2006 were related to benefit limitations on age and member eligibility issues. The July and December 2007 spikes in mispayments were related to benefit limitations on radiographs.

Figure 2: PSHP/Avesis Sample Claims Mispayments by Month

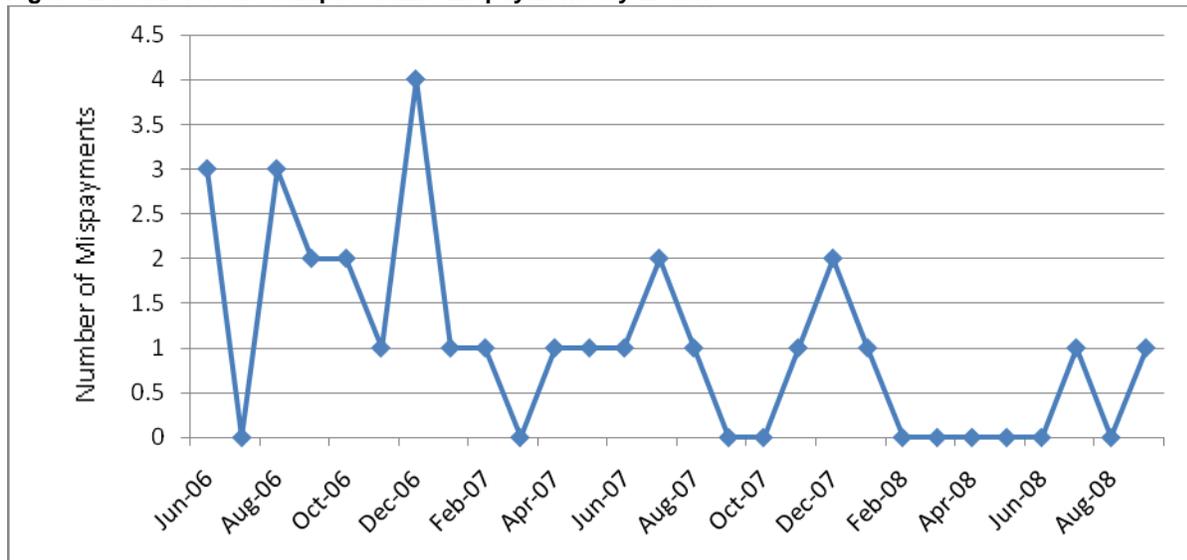
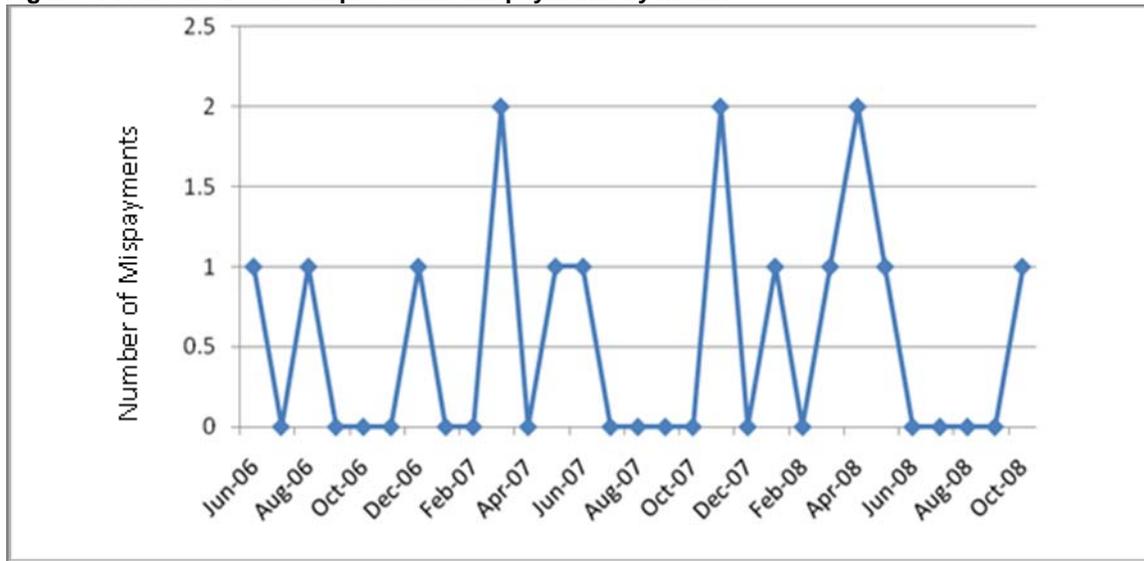


Figure 3 below illustrates the number of WellCare / Doral sample claims with mispayments by month. In March 2007, mispayments are related to incorrect application of benefit limitations on procedure codes D1203 and D0150. The mispayments in November 2007 also appear to be related to the incorrect application of benefit limitations, this time for procedure codes D1351 and D1120. The April 2008 spike in mispayments is related to the incorrect application of dental fees.

Figure 3: WellCare/Doral Sample Claims Mispayments by Month



The tables below provide the summary of mispayments and the statistical calculations related to the beta sample. Table 5A includes the total liabilities (underpayments) and receivables (overpayments) resulting from the analysis of the sample, as well as the mispayment rate for each CMO and dental subcontractor.

Table 5A: Beta Sample Findings

	AMGP / Doral	PSHP / Avesis	WellCare / Doral
Total Sample Liabilities	\$304.33	\$191.68	\$129.35
Total Sample Receivables	\$174.56	\$529.36	\$477.09
Claim Detail Lines in Sample	2,000	2,000	2,000
Claim Detail Lines with Mispayments	77	29	15
Percent Claim Detail Lines with Mispayments	3.9%	1.5%	.8%
Claim Detail Lines in Population	2,879,102	3,384,311	5,653,830

Table 5B below includes the population estimates computed based on the findings from the beta sample. The “point estimate” is the average liability or receivable from the beta sample extended to the population. However, the true value of the mispayments falls between the lower and upper boundaries of the confidence interval.

Table 5B: Population Estimates Based on Beta Sample Findings

	AMGP / Doral	PSHP / Avesis	WellCare / Doral
95% Lower Bound - Liabilities	\$693,850	\$591,903	\$666,095
95% Upper Bound - Liabilities	\$182,347	\$56,802	\$65,228
95% Point Estimate - Liabilities	\$438,099	\$324,352	\$365,661
Margin of Error - Liabilities	±\$255,752	±\$267,550	±\$300,434
<hr/>			
95% Lower Bound - Receivables	\$153,525	\$471,402	\$71,108
95% Upper Bound - Receivables	\$349,051	\$1,320,117	\$2,768,494
95% Point Estimate - Receivables	\$251,288	\$895,759	\$1,348,693
Margin of Error - Receivables	±\$97,763	±\$424,358	±\$1,419,801

Based on the findings for the beta sample, the Department determined that there was not a need to conduct a boost sample. Therefore, no additional testing will be completed on dental claims, at this time. However, the Department informed us that follow-up analysis will be completed at a later date.

OBSERVATIONS AND RECOMMENDATIONS

We make the following recommendations regarding dental claim pricing by the GF CMOs. As previously indicated, the sample of claims analyzed as part of the agreed upon procedures include services rendered during the start-up and implementation periods of the Georgia Families program. Claims selected for these periods are likely to have different mispayments and potential issues than claims selected from a subsequent period.

Recommendations Applicable to the CMOs and/or Subcontractors

- 1) Contracts between the subcontractors and the dental providers should clearly identify all of the parameters used to determine the pricing of the claims. We noted that although “lesser of” language was included in the Doral contracts, the criteria for exceptions to that logic were not included even though exceptions appear to be applicable through our analysis.
- 2) Steps should be taken to ensure that Explanation of Payment language included on the claim is accurate and sufficiently informative for the provider to clearly identify the reason why a claim was denied or was paid differently than anticipated.
- 3) The CMOs/subcontractors should take steps to ensure that the provider directories are kept accurate and up to date. We observed instances where the information in the directory was contradicted by information in the provider files.
- 4) The CMOs/subcontractors should ensure that the applicable coverage and benefit limitations are being properly applied.
- 5) When incorporating “rural” versus “urban” parameters within the reimbursement methodologies, specific policies should be used to describe the criteria used to identify the rural and urban status of providers. Care should be taken by the CMO/subcontractor to ensure that the parameters are being applied correctly to individual providers.

Recommendations Applicable to the Department

- 6) The Department may wish to consider including in the model contract between the CMO and the Department, a minimum payment accuracy rate required for dental service claims and other provider categories in the post implementation periods.

- 7) For confirmed mispayments, the Department may wish to consider a requirement that these claims be corrected, and that the CMOs complete an analysis to identify similar mispayments for claims not selected in the beta sample.

Analytical Limitations

- 1) Although we requested all paid and denied dental claims with dates of service from June 1, 2006 through November 30, 2008, it appears that PSHP/Avesis submitted only those claims that were *adjudicated* during that time period. The claims payment accuracy rates presented in our findings could vary if PSHP/Avesis had instead submitted all the claims that were specifically requested.
- 2) During our analysis, we noted that the claim payment status indicators included on some of the claim detail lines by PSHP/Avesis did not actually reflect the correct payment status of the claim. In some instances, claim detail lines that were noted on the claim as paid by Avesis were, in fact, denied.
- 3) In some cases, the CMOs/subcontractors may have adjusted, reprocessed, or corrected claims that we identified as potential mispayments. This information may not have been provided to us in all cases or may have occurred subsequent to our providing the list of claims to each CMO/subcontractor. Therefore, as of the date of this report, the mispayment dollar amounts included in our findings may not reflect the actual amount owed to dental providers by the CMOs/subcontractors or owed by these providers to the CMOs/subcontractors.
- 4) Each of the CMOs/subcontractors was provided with a list of claims and given the opportunity to provide additional clarification and documentation to resolve any potential errors. For a number of claims, there was limited information and documentation available to us, in which cases we were prevented from determining the appropriate reimbursement amount. Subsequent requests for clarification was provided to each CMO/subcontractor for those claims, and as of the date of this report, a number of those claims were not sufficiently supported by the CMOs and are included as mispayments in the calculations shown on Tables 3, 4A-C, 5A-B.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the accuracy of payments for dental service claims adjudicated by the CMOs or their dental subcontractor(s) that administer the GF program. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Georgia Department of Community Health and is not intended to be and should not be used by anyone other than this specified party.

Myers and Stauffer LC

Myers and Stauffer LC
Indianapolis, Indiana
September 30, 2009

EXHIBITS

SFY 2009: GEORGIA FAMILIES

**DENTAL SERVICE
CLAIMS TESTING
FOR THE GEORGIA
DEPARTMENT OF
COMMUNITY HEALTH**

EXHIBIT A: AGREED UPON PROCEDURES

APRIL 27, 2009

TABLE OF CONTENTS

Table of Contents	2
Introduction	3
Project Team	6
Objective	7
Claims Universe for Testing	8
Claim Selection Methodology and Analytical Procedures	9
<i>Sample Size</i>	9
Deliverables	11
Other Information	13
<i>M&S Workpapers</i>	13
<i>Data Sources</i>	13
<i>Timeline</i>	13

INTRODUCTION

This document provides a summary of the study methodology and agreed-upon procedures used for Georgia Families Program dental claims testing performed for the Department of Community Health (the “Department”), including a computation of a sample mispayment rate. After analysis of applying these agreed-upon procedures to a sample of claims, and in consultation with the Department, the Department may request that we also compute an estimate of the aggregate dollar value of mispayments for each Care Management Organization for claims adjudicated between June 1, 2006 and November 30, 2008 as addressed by these procedures. These procedures will be completed for the Department and no other specified parties. The Department will determine the applicability and use of the results from applying these agreed-upon procedures.

This agreed-upon procedures engagement will be conducted in accordance with the attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which the report has been requested or for any other purpose.

The following terms may be used throughout this document:

- **Adjudicate** – A determination of the outcome of a healthcare claim. Claims may pay, deny, or in some cases have an alternative adjudication outcome.
- **Boost Sample** – An additional sample that is drawn and tested in order to reduce the margin of error on an estimate that results from testing of a sample.
- **Capitation Claim** - A per Medicaid and/or PeachCare for Kids™ member fixed payment amount made by the Department to a care management organization in return for the administration and provision of healthcare services rendered to the enrolled Medicaid and/or PeachCare for Kids™ member.
- **Care Management Organization (CMO)** – A private organization that has entered into a risk-based contractual arrangement with DCH to obtain and finance care for enrolled Medicaid recipients or PeachCare for Kids™ members. CMOs receive a per capita or capitation claim payment from DCH for each enrolled member. The three CMOs contracted by the Department to provide services for DCH members are AMERIGROUP Community Care (AMERIGROUP or AMGP), Peach State Health Plan (Peach State or PSHP), and WellCare of Georgia (WellCare).

SFY 2009 Georgia Families – Dental Repricing Exhibit A

- **Claim** – An electronic or paper record submitted by a healthcare provider to a payer detailing the healthcare services provided to a patient for which the provider is requesting payment. A claim may contain multiple healthcare services.
- **Claim Detail (Claim Line)** – A portion of a claim that documents a specific healthcare service.
- **Denied Claim** – A claim submitted by a healthcare provider for reimbursement that is deemed by the payor to be ineligible for payment under the terms of the contract between the healthcare provider and payor.
- **Georgia Families (GF)** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids™ in which the Department contracts with Care Management Organizations to manage the care of eligible recipients.
- **Fee-For-Service (FFS)** – A healthcare delivery system in which a healthcare provider receives a specific reimbursement amount from the payor for each healthcare service provided to a patient.
- **Fee-for-service (FFS) claim** - A payment made by a payor to a healthcare provider after a service has been provided to a patient covered by the payor. In some cases, the service must be authorized in advance. A FFS claim consists of one or more line items that detail specific healthcare service(s) provided.
- **Liability** – A claim payment amount that was not made in accordance with CMO (or the CMO's subcontractor) coverage, payment policies, and contractual obligations resulting in an underpayment to the entity receiving the claim payment.
- **Medicaid Management Information System (MMIS)** – Claims processing system used by the Department's fiscal agent claims processing vendor to process Georgia Medicaid and PeachCare for Kids™ FFS claims and capitation claims.
- **Mispayment** – A claim payment amount that was not made in accordance with CMO (or the CMO's subcontractor) coverage, payment policies, and contractual obligations resulting in either an overpayment (receivable) or underpayment (liability) to the entity receiving the claim payment.
- **Paid Claim** – A claim submitted by a healthcare provider for reimbursement that is deemed by the payor to be eligible for payment under the terms of the contract between the healthcare provider and payor.
- **PeachCare for Kids™ program (PeachCare)** – The Georgia DCH's State Children's Health Insurance Program (SCHIP) funded by Title XXI of the Social Security Act, as amended.
- **Receivable** – The portion of an actual claim payment amount in excess of the payment amount that would be in accordance with CMO (or the CMO's

SFY 2009 Georgia Families – Dental Repricing Exhibit A

subcontractor) coverage, payment policies, and contractual obligations resulting in an overpayment to the entity receiving the claim payment.

- **Subcontractor** -- Any third party who has a written contract with a CMO to perform a specified part of the CMO's obligations under their DCH contract.
- **Suspended Claim** – A claim submitted by a healthcare provider for reimbursement that is queued by the payor for examination, or where additional information is necessary to adjudicate the claim.

**SFY 2009 Georgia Families – Dental Repricing
Exhibit A**

PROJECT TEAM

The following key personnel will be used for this engagement:

Jared Duzan – co project director
Keenan Buoy, CPA – co project director
Beverly Kelly, CPA, CFE – co project manager
Ryan Farrell – co project manager
Kevin Londeen, CPA – quality assurance
Ron Beier, CPA – quality assurance
David Bivin, PhD – statistician
Ye Zhang, PhD - statistician

We anticipate that staffing for this engagement may include resources in our Atlanta, Indianapolis, Topeka, and Kansas City offices. Other firm-wide resources and consultants may be utilized as necessary to accomplish project objectives.

**SFY 2009 Georgia Families – Dental Repricing
Exhibit A**

OBJECTIVE

The objective of this engagement is to apply agreed-upon procedures to test the accuracy of payments for a sample of dental care provider claims adjudicated by the CMOs, or their subcontractor(s), that administer the GF program. These claim payments will be analyzed to determine if the payment was made according to the CMO's (or the CMO's subcontractor) coverage, payment policies, and contract between the CMO or its subcontractor(s) and the provider. If the outcome of a claim is not in accordance with these provisions, a determination will be made of the amount of the mispayment for the claim in consultation with the CMO, the subcontractor(s), the Department, and/or the provider.

CLAIMS UNIVERSE FOR TESTING

The claims universe will include CMO/subcontractor paid and denied claims of both Medicaid and PeachCare members for dental care provider claims. The claims will have dates of service between June 1, 2006 and November 30, 2008. A sample of dental care provider claims will be selected from the claims submitted by the CMOs or their subcontractors.

CLAIM SELECTION METHODOLOGY AND ANALYTICAL PROCEDURES

The sample period will include paid or denied claims with dates of service between June 1, 2006 and November 30, 2008. All claims will be tested at the claim line level. Each claim line in the sample will be independently re-priced based on the contract between the CMO or its subcontractor(s) and the dental provider. The following steps will be used to test claims:

- 1) Determine the payment status of the claim line.
- 2) If claim line payment status is 'denied' or 'suspended', analyze the reason and attempt to determine, with the information available, whether the denial or suspension is appropriate.
- 3) If the claim line payment status of 'denied' or 'suspended' appears to be inappropriate, compute the expected payment for the detail claim line based on the contract between the dentist and the CMO or subcontractor.
- 4) If claim line payment status is 'paid', compute the expected payment for the claim line based on the contract between the dentist and the CMO or subcontractor.
- 5) Compute the dollar value mispayment, as applicable, for the claim line.
- 6) Identified mispayments will be sent to the CMO, subcontractor and/or dental provider for comment. Unless indicated otherwise, we will rely on the follow-up information received from the CMO or its subcontractor(s) in determining whether the potential mispayment is, in fact, a confirmed mispayment and the dollar value of the mispayment. We reserve the right to not accept this information from the CMO or its subcontractor(s) in the event that circumstances require special consideration or handling. CMOs have been required to attest to the accuracy and reliability of the information they have provided for this initiative. In the event of a dispute between Myers and Stauffer and the CMO regarding the correct adjudication or payment amount on a claim, the Department's decision regarding the adjudication determination will constitute the final decision.

Sample Size

The total claim line count from all CMOs for dental services is 11,917,243. The agreed upon sample size is 2,000 claim lines for each CMO. It should be noted that achieving any estimated margin of error might not be possible due to the variability of the observed mispayments, which are a function of each CMO, CMO/subcontractor claims processing and adjudication, and other unique factors specific to the CMOs, its subcontractor(s) and dental claims. The sample size was not prepared to achieve a desired margin of error and as such, may indicate findings that are significantly different from those that would be achieved by utilizing a larger sample size. Based on the initial results of the analysis, Myers and Stauffer in consultation with DCH may choose to increase the sample size for one or all of the CMOs in order to reduce the margin of error on the estimates.

**SFY 2009 Georgia Families – Dental Repricing
Exhibit A**

Sample Sizes for CMO Dental Claims			
Care Management Organizations	Universe Claim Count	Line Item Detail Count	Sample Size
AMERIGROUP	705,363	2,879,102	2,000
Peach State Health Plan	852,768	3,384,311	2,000
WellCare	1,407,977	5,653,830	2,000
TOTAL	2,966,108	11,917,243	6,000

The sampling methodology and statistical procedures used for this analysis were developed in consultation with Dr. David Bivin, a statistical consultant to Myers and Stauffer. Based on a preliminary analysis of the average dental payment made by the CMOs, and the number of claims in the universe, Dr. Bivin determined several sample size options by modeling potential mispayment rates between one and five percent.

Assuming a five percent mispayment rate, it is estimated that the margin of error will be within one percent of the true mispayment amount. It is estimated that the proposed sample size will provide confidence intervals at the 95 percent level for the mean dollar amount of mispayment per claim and the total dollars in mispayments per CMO. However, please note that because limited data was available to determine the sample size and estimated margin of error, it is not possible to guarantee a level of precision on the estimate. The final margins of error will be based on the distribution and variability of the mispayments in the sample of dental claims processed by the CMOs or their subcontractors, which are a function of each entity's claims processing and adjudication, and other unique factors specific to the CMOs, subcontractors and dental claims.

After applying these agreed-upon procedures to the selected sample for each CMO, Myers and Stauffer and Dr. Bivin will provide information to the Department regarding the sample, including whether the sample size was sufficient to achieve a minimal margin of error. At that time, the Department may authorize Myers and Stauffer to perform a boost sample, if necessary, to reduce the margin of error on the estimate to acceptable levels, as determined by the Department. In the event the Department does not authorize a boost sample, we will report only the claim accuracy rate from applying the agreed-upon procedures to the sample. This rate will be based on the number of line items without mispayments and the total number of line items selected for each CMO. No other statistics will be provided other than the accuracy rate of the sample, unless requested by the Department. We will work closely with the Department to determine the appropriate course of action based on the findings from the sample.

**SFY 2009 Georgia Families – Dental Repricing
Exhibit A**

DELIVERABLES

We will report the claim accuracy rate from applying the agreed-upon procedures to the sample. This rate will be based on the number of claim lines without mispayments, the total number of claim lines selected for each CMO, and will be reported as follows:

	AMGP	PSHP	WellCare
Sample Size			
Claim Detail Lines Paid/Denied Correctly			
Percent of Claim Detail Lines Paid/Denied Correctly			

In the event that the sample size is sufficient to achieve a minimal margin of error on the estimate, we will also provide the estimated dollar value of mispayments by CMO. This estimate may also be provided based on a boost sample, or at the request of the Department, as discussed in the previous section. The average dollar amount of mispayment per claim line, by CMO, will be used to compute an estimate of the mispayments applicable to the universe of claims for each CMO. A confidence interval, margin of error, point estimate, lower bound, and upper bound will be prepared for each CMO. This information will generally be presented as illustrated in the example tables below:

Statistics			
Claims Sample	AMGP	PSHP	WellCare
Sample Liabilities			
Sample Receivables			
Sample Net Mispayments			
Claims in Sample			
Claims with Mispayments			
Percent Claims with Mispayments			

**SFY 2009 Georgia Families – Dental Repricing
Exhibit A**

Statistics			
Confidence Interval Total Population Mispayments	AMGP	PSHP	WellCare
Mean Mispayment			
Claims in Population			
95% Lower Bound - Liabilities			
95% Upper Bound - Liabilities			
95% Point Estimate - Liabilities			
Margin of Error - Liabilities			
95% Lower Bound - Receivables			
95% Upper Bound - Receivables			
95% Point Estimate - Receivables			
Margin of Error - Receivables			

In addition to the statistics reported above, we will provide an overview of the reasons for the mispayments, other observations, as well as any applicable recommendations for corrective actions. Recommendations, if necessary, will be subdivided by those applicable to the CMOs, those applicable to providers, and those applicable to the Department.

OTHER INFORMATION

M&S Workpapers

To test the volume of claims within the available time, spreadsheet tools, formulas, databases, and computerized algorithms will be utilized as a means to re-price claims. These tools are proprietary and are for Myers and Stauffer LC internal use only. Workpapers are available to the Department upon request.

Data Sources

Each CMO will provide the data and reference file information needed for this engagement and attest to the accuracy of this information. Based on the CMO's signed attestation and direction from the Department, Myers and Stauffer LC will accept this information as accurate and reliable. The CMO, or their subcontractor(s), may provide additional information on the selected claims as necessary.

Timeline

Testing of dental claim payments will begin upon the Department's approval of these agreed upon procedures and continue through approximately May 2009. Approximately 4 weeks will be used to complete this analysis. However, additional time may be necessary, depending on the number of potential mispayments identified and the response time of the CMOs.

Exhibit B

Sampling Dental Claims

David Bivin

February 28th, 2009

The purpose of this project, as with previous projects conducted by Myers and Stauffer is to obtain a precise estimate of total liabilities and receivables resulting from errors in processing provider claims. Unfortunately there are tradeoffs between precision and cost that make it unfeasible to sample the entire population of claims. So the question is how many claims should be sampled?

With projects of this type, the typical goal is not only to obtain a point estimate of total liabilities and total receivables but to make a statement about the reliability of these estimates. When the observations are drawn from the same population the margin of error is

$$ME = 1.96N \sqrt{\frac{\sigma^2}{n} \frac{(N-n)}{(N-1)}}$$

where ME is the margin of error associated with the 95% confidence interval. N is the population size, n is the sample size, and σ^2 is the variance of the distribution. A common use of this formula is to begin with a desired margin of error and define the sample size required to achieve that margin of error. As may be apparent from the formula, the ideal sample size rises as the desired margin of error shrinks, the variance rises, or the population rises.

There are several reasons why this formula cannot be directly employed in the analyses that have been undertaken by Myers and Stauffer. The first is that the data are drawn from multiple populations (strata). These populations are allowed to have different variances and this must be taken into account. The formula above can easily be expanded to allow for this and thus the issue is not a concern.

The second and third issues bear directly on the problem of selecting the appropriate sample size and both argue in favor of drawing larger samples than would be required under the assumptions used to construct the formula above.

The first issue is that the variance is not known and must be estimated from the data. Without knowledge of the variance, the sample size required to achieve a given margin of error cannot be determined. There is a tendency, then, to over-sample in order to assure the desired margin of error target is achieved.

The second issue is that a large proportion of the claims were processed correctly and thus there are far more zero liabilities and receivables than one would expect in a totally random sample. The estimate of the variance is zero unless at least one liability and/or receivable is observed. The problem is exacerbated by the fact that error rates tend to be low so one might observe only one error in 100 observations. It is further exacerbated by the fact that the error rate is not known beforehand so we cannot make a reliable prediction as to how many observations must be drawn before the first error is observed.

One way to overcome this uncertainty is to rely on estimates of the variance and error rates from past data. Myers and Stauffer has employed this method in its ongoing estimates of liabilities and receivables in Georgia Medicare claims.

But this approach may not be feasible for dental claims because these claims have not been analyzed in the past and we cannot assume that they will exhibit the same behavior as the other claims. The alternative in this case is a beta test: draw a small sample in order to estimate the variance and the error rate and then use these estimates to determine the sample size required to achieve the desired margin of error. Beta tests are preferred when sampling costs and the penalty for unreliable estimates are both large.

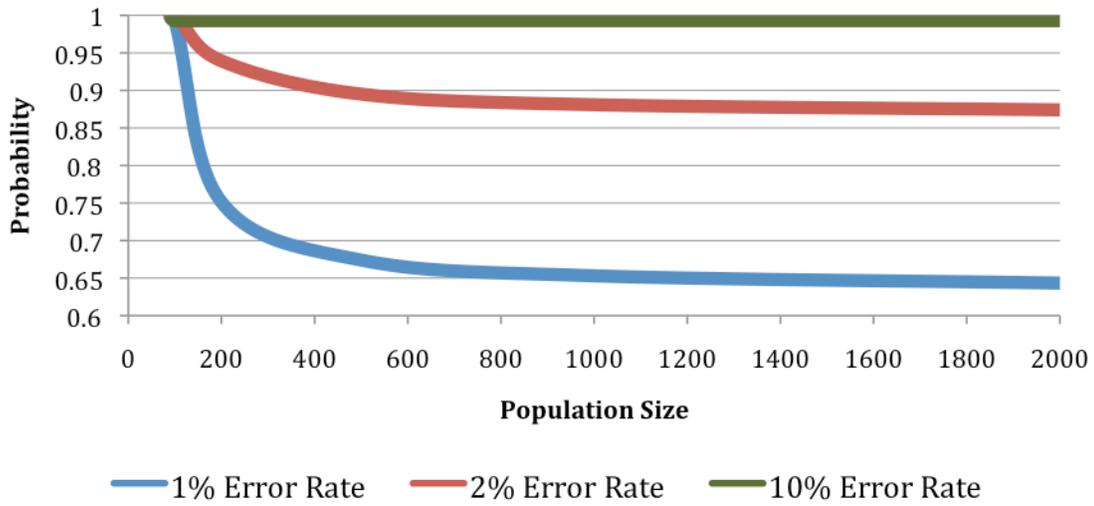
Still the sample size for the beta test must be determined and one encounters the same difficulties describe above: the probability of a liability or a receivable is unknown and very small samples run the risk of not uncovering any errors. So it is important that sufficient observation be drawn. Myers and Stauffer recommended 500 observations for the beta test. If the error rate is one percent, we would expect to observe five liabilities and or receivables. If the error rate is 10%, this number jumps to 50. Based upon my experience with similar data and the assumption that the error rate will be one percent or above, I believe that this will be adequate. An additional reassuring feature of the data is that the average dental claim is small. Thus we would expect most of the errors to be small as well. As a result, our estimate of the standard deviation should be more reliable.

Finally, it is worth emphasizing the two sources of uncertainty in the data: is the claim in error and, if so, how large is the error? If the only goal is to estimate the error rate, then the uncertainty associated with the magnitude of the error is ignored. This is a major source of uncertainty and so reliable estimates of the error rate can be obtained with smaller samples. This is especially true when error rates are small (as we expect to be the case) because the standard deviation of the estimated rate shrinks as the rate approaches zero. In this case, the major concern is that sufficient observations are drawn so that at least one error is observed.

The graph on the following page illustrates how the probability of drawing at least one claim with an error declines with the population size and the error rate. The

sample size in each case is 100. The probability declines very rapidly for small populations and eventually arrives at 65% for large populations when the error rate is 1% (87% when the error rate is 5%). This suggests that when the populations are large (as they tend to be with the Georgia data), that larger samples are necessary to insure that at least one error is observed when the error rate is thought to be small.

Probability of Drawing at Least One Claim with an Error when the Sample Size is 100



SHORT VERSION

Selecting the sample size required to achieve a given margin of error when one has no prior knowledge of the data is a difficult task. The margin of error depends upon the variability of the data and when there is no prior knowledge of the variance, there is a real possibility of drawing too few observations to achieve the desired reliability. A common approach in this situation is to draw a small sample of the data and analyze that prior to the full-scale analysis. That is the recommended approach here. The important concern is that sufficient observations be drawn to insure that some observations contain errors. With an error rate that might be as low as one percent, this will require far more observations than would be the case if the error rate was much larger. In this case, Myers and Stauffer recommended 500 observations for the beta test. If the error rate is one percent, we would expect to observe five liabilities and or receivables. If the error rate is 10%, this number jumps to 50. Based upon our experience with similar data and the assumption that the error rate will be one percent or above, we believe that this will be adequate. An additional reassuring feature of the data is that the average dental claim is small. Thus we would expect most of the errors to be small as well. As a result, our estimate of the standard deviation should be more reliable.

Exhibit C

Memorandum

Date: July 31, 2009

From: Ye Zhang, Indiana University-Purdue University Indianapolis

RE: Georgia Care Management Organization (CMO) Dental Claim Confidence Interval and Margin of Error Check

The attached document contains results produced by me from the three dental claims data file, namely, AmeriGroup, Peach State, and WellCare. Each column in the table corresponds to one of the three CMOs.

The 95% confidence interval estimates for total liabilities and total receivables are produced with program coded with statistical language S. There are differences between my results on the confidence intervals for total liabilities and receivables and the original results, which were provided in the original spreadsheet. The differences are due to (1) the different finite population correction method we use to calculate the standard errors of the total amount estimates; (2) the different treatments for three denial claims from CMO Peach State's raw data. I recommend adjusting the results according to my calculations.

As a result of those differences, the margins of error need to be adjusted accordingly.

Other part of the statistical analysis, my results are consistent with the original results, hence I confirm.