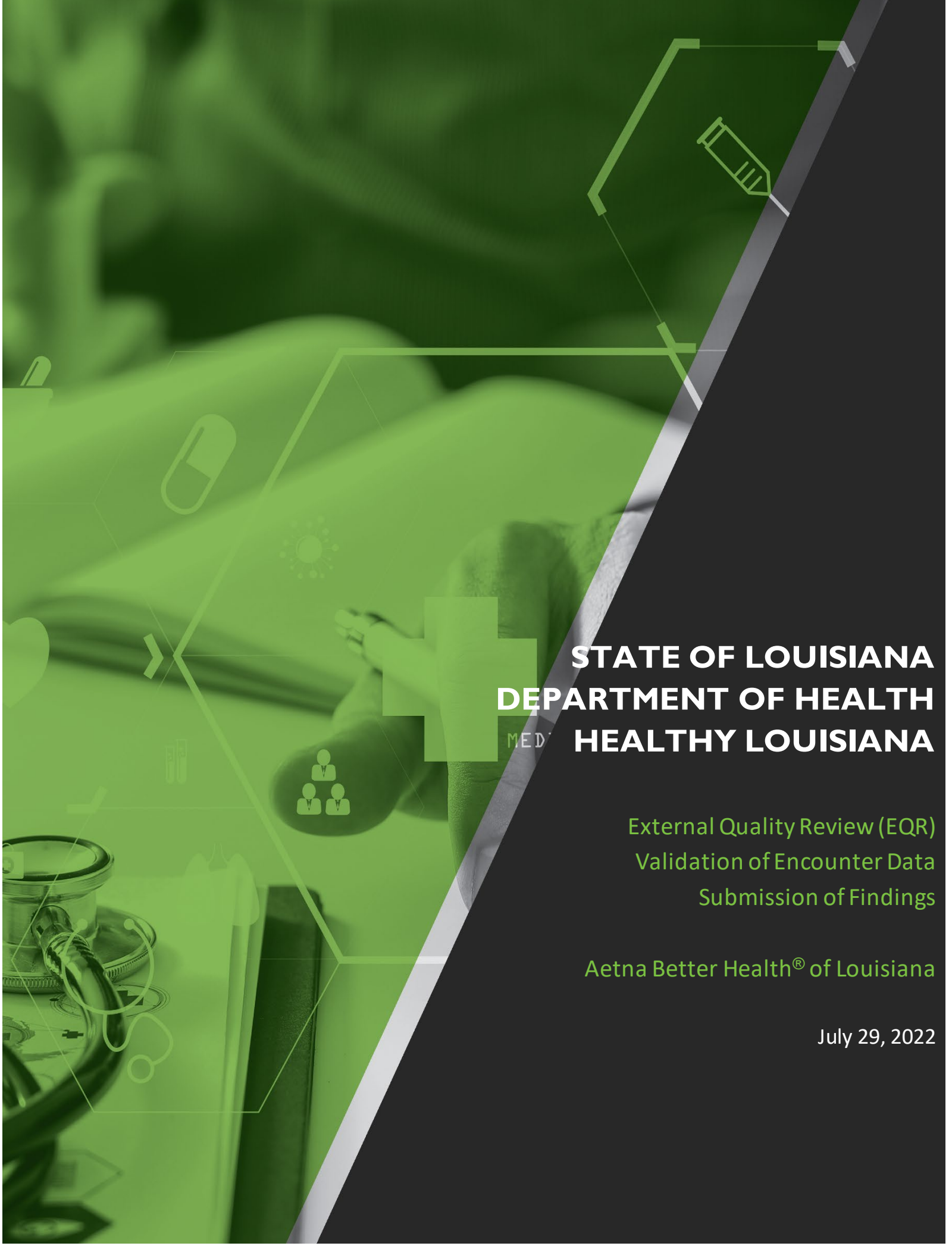

STATE OF LOUISIANA
DEPARTMENT OF HEALTH
HEALTHY LOUISIANA

External Quality Review (EQR)
Validation of Encounter Data
Submission of Findings

Aetna Better Health® of Louisiana

July 29, 2022

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Executive Summary

The Louisiana Department of Health (LDH) engaged Myers and Stauffer to perform External Quality Review (EQR) Protocol 5[1] to evaluate the completeness and accuracy of the encounter data submitted by Aetna Better Health® of Louisiana (ABH) for members enrolled in the State's Medicaid Managed Care program. The health plan's state fiscal year (SFY) 2021 (i.e., July 1, 2020 through June 30, 2021) encounters were reviewed to determine if the encounters met the State's contract requirements for completeness, accuracy, prompt payment and encounter submission timeliness. The health plan-submitted data and encounters evaluated included the following:

- Monthly cash disbursement journals (CDJ), which include payment dates and amounts paid by the health plan to providers (i.e., the bi-monthly Encounter Data Validation Report).
- Claims sample data which included transactions with payment/adjudication dates within two selected sample months, October 2020 and April 2021.
- Encounter data provided by the fiscal agent contractor (FAC), on a monthly basis, in a standardized data extract and included encounters received and processed by the FAC and transmitted to Myers and Stauffer through March 29, 2022.
- Medical records were randomly sampled from encounters with dates of service during the measurement period. A sample size of 150 medical records was approved by LDH for review.

A 97 percent completeness, accuracy, and validity threshold was used for comparing the encounters to the CDJs, claims sample data and medical records submitted by the health plan.

Our work was performed in accordance with the American Institute of Certified Public Accountants (AICPA) professional standards for consulting engagements. We were not engaged to, nor did we perform, an audit, examination, or review services. We express no opinion or conclusion related to the procedures performed or the information and documentation we reviewed. In addition, our engagement was not specifically designed for, and should not be relied on, to disclose errors, fraud, or other illegal acts that may exist.

Observations and findings are based on the information provided and known at the time of the review. The findings and issues noted may reside with the health plan and/or the FAC. The health plan should work with LDH and the FAC to resolve issues noted with the encounter data.

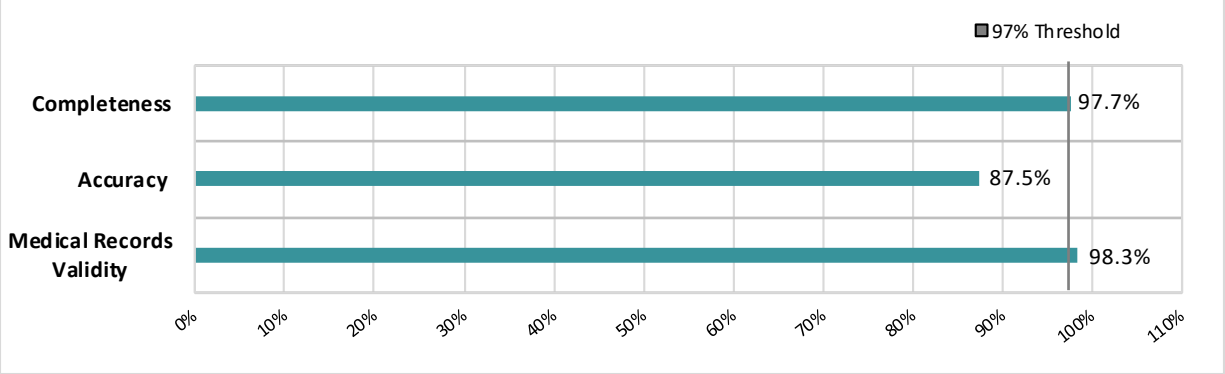
Findings

- **Completeness:** The average completion percentage for SFY 2021 was below the 97 percent threshold (96.4 percent) when compared to CDJ paid amounts. Encounter paid amounts were at or above 100 percent when compared to claims sample paid amounts. On the basis of claims sample counts, completion percentages were below the 97 percent threshold for medical, non-emergency medical transportation (NEMT), and pharmacy encounters and at 100 percent for dental and vision encounters. The average aggregate completion percentage met the 97 percent

[1] In 2019, CMS updated the EQRO protocols and the encounter data validation is now referred to as Protocol 5.

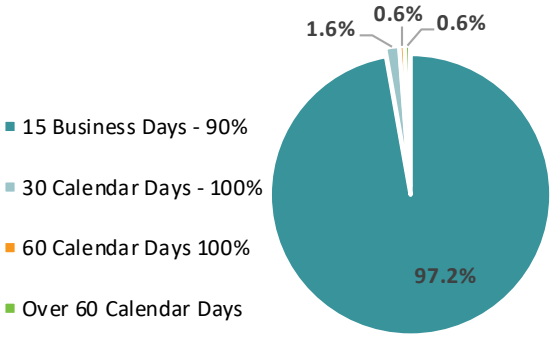
threshold (97.7 percent).

- **Accuracy:** The overall accuracy percentage was 87.5 percent for all encounter types and all key data elements reviewed.
- **Medical Record Validation Rates:** 135 of the medical records requested were submitted for review. Two (2) of the medical records submitted were for a different member or for a member that was not seen by the provider on the indicated date of service resulting in 133 records (88.7 percent) being tested. The validation rate for the medical records tested met the 97 percent threshold (98.3 percent).

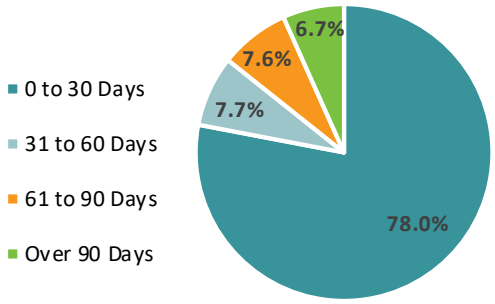


- **Timeliness:** The required level of timeliness was met for the 15 business days criteria for the payment of claims. The health plan submitted 78.0 percent of encounters within 30 days of adjudication. On average, the health plan submits encounters within 28 days. The delegated dental vendor, however, took an average of 238 days to submit encounters.

Timely Payment of Claims



Timely Encounter Submissions



Introduction

Louisiana's Medicaid managed care program, known as Healthy Louisiana, is the means by which most of Louisiana's Medicaid and Children's Health Insurance Program (LaCHIP) recipients receive health care services. Medicaid recipients enroll in a managed care plan for health care services. The plans differ from one another by offering diverse provider networks, referral policies, health management programs, and extra services and incentives. The overriding goal is to encourage enrollees to own their own health and the health of their families. [2]

In 2016, the Centers for Medicare and Medicaid Services (CMS) established requirements for states to improve the reliability of encounter data collected from managed care health plans. Under CMS' Medicaid managed care final rule, states are required to conduct an independent audit of encounter data reported by each managed care health plan. CMS indicated that states could fulfill this requirement by conducting an encounter data validation assessment based on EQR Protocol 5[3]. While Protocol 5 is a voluntary protocol, CMS strongly encourages states to contract with qualified entities to implement Protocol 5 to evaluate its Medicaid encounter data and meet the audit requirement of the final rule. Protocol 5 measures the completeness and accuracy of the encounter data that has been adjudicated (i.e., paid or denied) by the health plan and submitted to the State's Fiscal Agent Contractor (FAC). States may be at risk for loss of federal financial participation/reimbursement if the encounter data is incomplete and/or inaccurate.

Encounter data validation can assist states in reaching the goals of transparency and payment reform to support its efforts in quality measurement and improvement. The final Medicaid Managed Care Rule strengthens the requirements for state monitoring of managed care programs. Under the rule, each state Medicaid agency must have a monitoring system that addresses all aspects of the state's managed care program[4]. Additionally, states are required to provide accurate encounter data to the actuaries, as well as to CMS as part of the T-MSIS project. Protocol 5 enables states to meet these data validation and monitoring requirements. Protocol 5 evaluates state/department policies, as well as the policies, procedures, and systems of the health plan, assists states in gauging utilization, identifying potential gaps in services, evaluating program effectiveness, and identifying strengths and opportunities to enhance oversight.

The Louisiana Department of Health (LDH) engaged Myers and Stauffer LC (Myers and Stauffer) to perform Protocol 5 to evaluate the completeness and accuracy of the encounter data submitted by ABH for SFY 2021 members enrolled in the State's Medicaid Managed Care program. CMS guidelines were followed and implemented during the review.

During the measurement period a public health emergency was in effect. On March 11, 2020,

[2] https://ldh.la.gov/page/32
[3] 81 Fed. Reg. 27,498, 27,603 (May 6, 2016).
[4] Electronic Code of Federal Regulations: https://www.ecfr.gov/cgi-bin/text-idx?SID=888e7bb305afac68ec3793a21b77a4ba&mc=true&node=pt42.4.438&rgn=div5

Louisiana's Governor, John Bel Edwards, declared a public health emergency (PHE)[5]. Federal and state responses to the PHE[6] triggered social and economic disruptions, and periodically limited health care services to essential, emergency services. Although the PHE changed to reflect the fluctuations of the PHE, it remained in effect throughout the measurement period[7].

Our work was performed in accordance with American Institute of Certified Public Accountants (AICPA) professional standards for consulting engagements. We were not engaged to, nor did we perform, an audit, examination, or review services. We express no opinion or conclusion related to the procedures performed or the information and documentation we reviewed. In addition, our engagement was not specifically designed for, and should not be relied on, to disclose errors, fraud, or other illegal acts that may exist.

For each activity, a summary of results and observations are presented along with detailed analyses. Observations and findings are based on the information provided, interviews with subject matter experts, and known data limitations at the time of the review. The report is written specific to the health plan; however, the findings and issues noted may reside with the fiscal agent contractor (FAC). The recommendations and findings within this report provide an opportunity for the health plan to review its processes to ensure information and data submitted to the State and/or captured by the FAC is complete and accurate. The expectation is for the health plan to work with LDH and the FAC to resolve issues noted within the encounter data.

[5] https://content.govdelivery.com/accounts/WIGOV/bulletins/280ac92
[6] https://content.govdelivery.com/accounts/WIGOV/bulletins/281127d
[7] The public health emergency order was in effect for 24 months and expired on March 16, 2022. https://gov.louisiana.gov/index.cfm/newsroom/detail/3589#:~:text=expires%20this%20week.-,Gov.,remained%20in%20effect%20ever%20since.

Activity 1: Review State Requirements

The purpose of Activity 1 is to review information about the State's requirements for collecting and submitting encounter data. This review determines if additional or updated requirements are needed to ensure encounter data is complete and accurate. LDH provided Myers and Stauffer with the State-required items (as listed in Protocol 5), as well as acceptable error rates, and accuracy and completeness thresholds.

In addition to reviewing the State requirements, LDH's contract with the health plan was reviewed in detail. Myers and Stauffer also met with LDH and FAC representatives regularly. Monthly status meetings conducted with LDH and the FAC ensured that our understanding of policies, processes and systems were accurate.

Observations made from the reviews are summarized below along with recommendations for LDH and/or the FAC.

Findings and Recommendations	
Findings	**Recommendations**
There were no findings related to our review of the State's requirements.	

Activity 2: Review Health Plan Capability

The health plan's information system and controls were evaluated to determine its ability to collect and submit complete and accurate encounter data. A survey was developed, requested documentation was reviewed, and interviews were conducted with health plan personnel to gain an understanding of the health plan's structure and processes. The survey and personnel interviews included questions related to claims processing, data submissions, enrollment, data systems, controls and mechanisms[8]. The requested documentation supported work flows, policies and procedures, and organizational structures.

Observations and findings related to the review and interviews are summarized below along with recommendations for LDH and the health plan.

Findings and Recommendations	
Findings	**Recommendations**
There were no findings related to our review of the health plan's capability.	

[8] Questions found in Appendix V, Attachment B of the Validation of Encounter Data protocol were included in the survey. https://www.medicaid.gov/medicaid/quality-of-care/downloads/app5-attachb-isreview.pdf

Activity 3: Analyze Electronic Encounter Data

Activity 3 determines the validity of the encounter data submitted to the State and requires verifying its completeness and accuracy. Health plan-submitted CDJs and claims sample data were compared to the encounter data submitted to the FAC to determine the encounter data's integrity (i.e., completeness and accuracy). Statistics and distributions were also generated on the data for validation.

The health plan contracted with third party vendors to administer its vision, dental, NEMT, and pharmacy benefits. CDJs and claims sample data were also submitted by the third party vendors. These files were separately compared to the encounter data to determine the completeness and accuracy of the data submitted to LDH, via the health plan's delegated vendors.

Completeness

Complete encounter data is dependent upon the timely submission of encounters. Encounters are a record of claims that have been adjudicated by the health plan to providers that have rendered health care services to members enrolled with the health plan. These encounters are submitted by the Medicaid managed care health plans to LDH via the FAC, Gainwell Technologies.

According to the health plan's contract with LDH, the health plan must submit complete and accurate encounter data at least monthly for all dates of service during the contract period. This includes all claims paid, denied, adjusted, and voided by the health plan and its delegated vendors. Encounters are due in accordance with the encounter reconciliation schedule published by LDH or its contracted review organization (Appendix A). Encounter data completeness is measured by comparing the encounters to cash disbursements within a three (3) percent error threshold (i.e., at least 97 percent and not more than 100 percent of cash disbursements).[9]

Cash Disbursement Journals

Under the contract with LDH, Myers and Stauffer also performs a bi-monthly reconciliation of the health plan-submitted CDJs to the FAC encounter data to measure the encounter data completeness (i.e., Encounter Data Reconciliation Report). On a monthly basis, Myers and Stauffer receives encounter data from the FAC in a standardized data extract, which includes both paid and denied encounters. The health plan's paid encounters are reviewed to determine if the paid encounters meet the State's contract minimum completeness requirement of 97 percent when compared to the CDJ files, which are submitted monthly to Myers and Stauffer by the health plan and its delegated vendors. For this validation, the encounter extract included encounters received and accepted by the FAC and transmitted to Myers and Stauffer through March 29, 2022.

Figure 1, below, shows the monthly completion percentages obtained after the comparison of the CDJ paid amounts to the encounter paid amounts for SFY 2021. A 97 percent threshold was used for validation. Detailed results can be found in the May 2022 Encounter Data Validation Report, Appendix B.

[9] Contract Amendment #2, Attachment B2, Section 17.9.3.2, effective July 1, 2020.

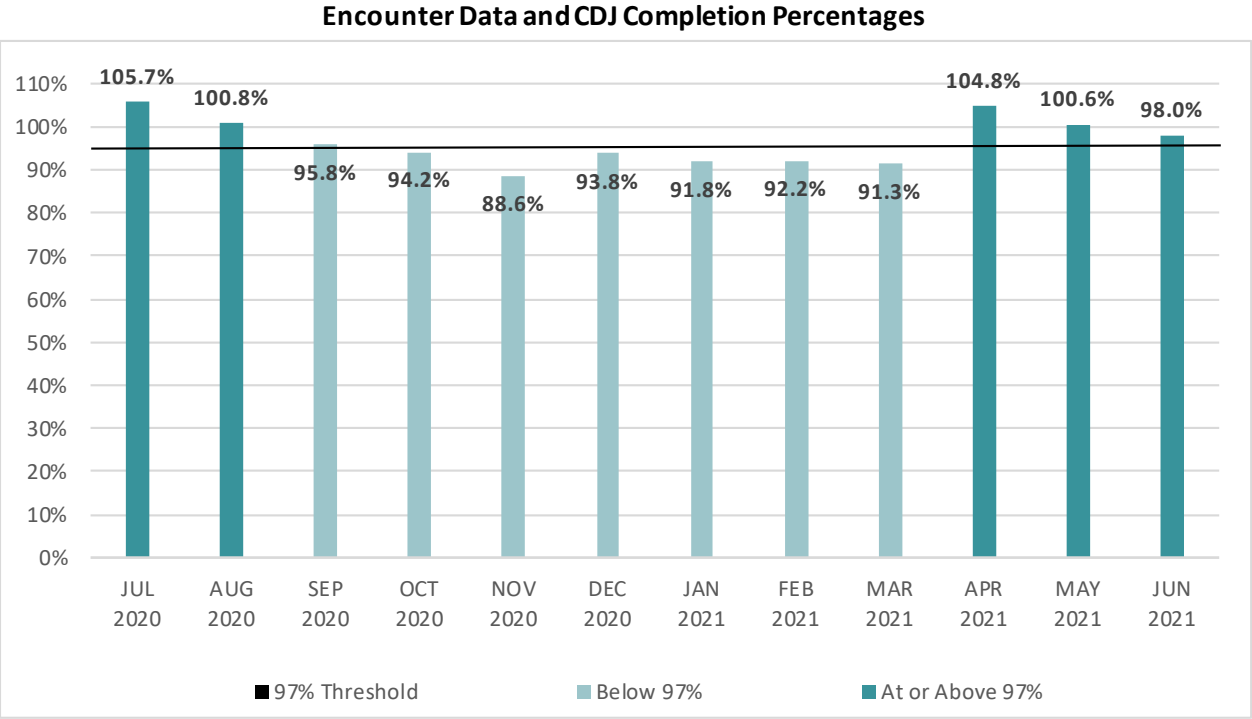


Figure 1: Encounter Data and CDJ Completion Percentages. The paid amount from the CDJs for SFY 2021 were used as the criteria for comparison. A 97 percent threshold was used for validation. For SFY 2021, the health plan's average completion percentage, including delegated vendors, was 96.4 percent.

The health plan's monthly completion percentages were below the 97 percent threshold for seven (7) out of the twelve (12) month measurement period, and completion percentages for four (4) of the twelve (12) months exceeded 100 percent. The health plan's average completion percentage for SFY 2021 was below the 97 percent threshold.

Sample Claims

The comparison of the sample claims data to the encounter data sought to ensure that all claims are included in the sample claims and/or encounter data. The health plan-submitted sample claims data was traced to encounter data using data elements provided in the claims sample data. The encounters were evaluated against the sample claims data based on the following criteria:

- Sample Claim Count: The number of sample claims that were identified in the encounters.
- Sample Claim Paid Amount: Sample claim paid amounts compared to encounter paid amounts.

Figure 2 shows the completion percentages obtained after the identification of sample claims in the encounters and the comparison of the sample claim paid amounts to encounter paid amounts for the two sample months combined. A 97 percent threshold was used for validation. Encounter completion percentages, based on claims sample counts, were at 100 percent for dental and vision encounters and below the threshold for medical and pharmacy encounters. The completion percentages of encounters, on a paid amount basis, were at or above 100 percent when compared with sample claim paid amounts

for all encounter types with the exception of NEMT encounters. NEMT encounters were below the 97 percent threshold when compared to both sample claim counts and paid amounts. Detailed results can be found in Appendix B and detailed results of the overall completion percentage can be found in Appendix C.

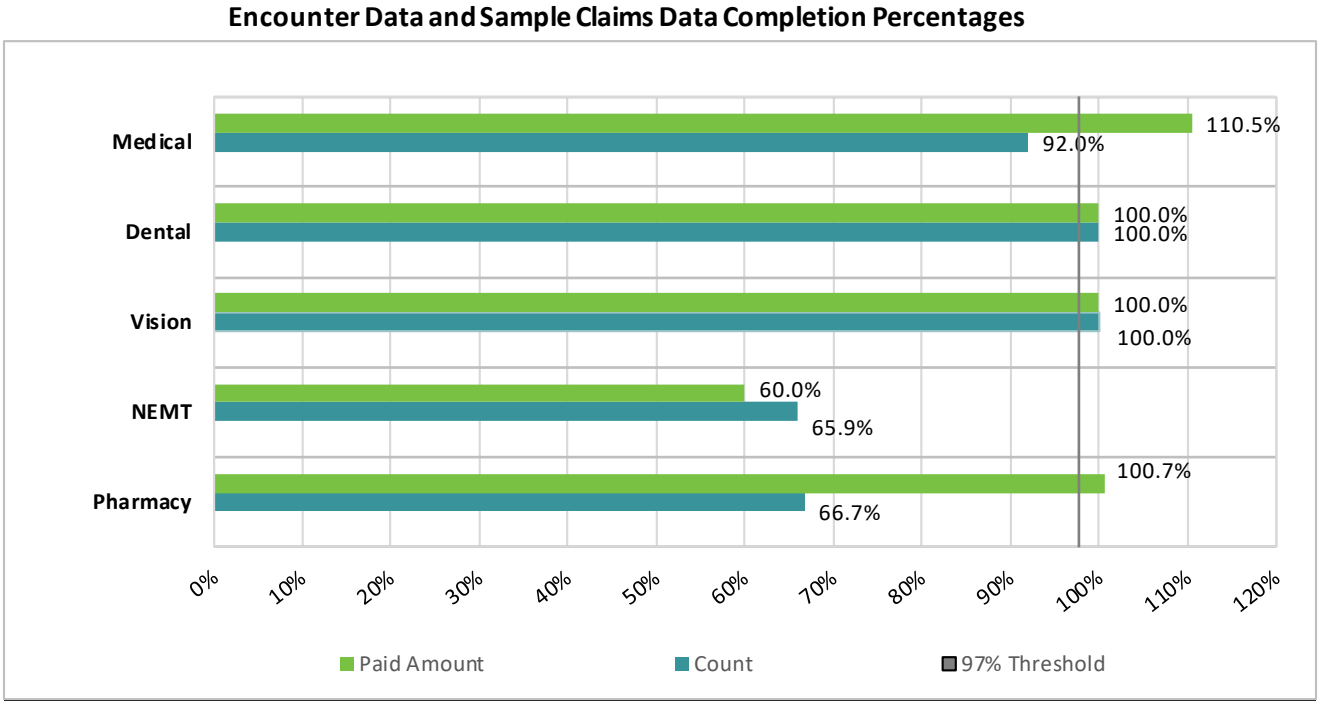


Figure 2: Encounter data and Sample Claims Data Completion Percentages. The count and paid amounts from the sample claims data were used as the criteria for comparison. A 97 percent threshold was used for validation. Values reflect the two sample months combined.

Completion percentages above 100 percent are indicative of surplus encounters. Surplus encounters represent records for services that potentially were not provided or were duplicative of other service records. Completion percentages below 100 percent indicate there are records missing from the encounter data. Missing and surplus encounters may be due to incomplete data, timing differences, potential duplicates, or claims, voids, replacements, adjustments and/or other transactions present or absent from the encounter data.

Accuracy

For the purpose of validating encounter data accuracy, certain key data elements were selected for testing. The key data elements of the encounters traced to the sample claims data were compared to the corresponding key data elements on the sample claim. Consistency checks on blank or null data element values were also applied. The key data elements were evaluated based on the following criteria:

- Valid Values: The encounter key data element value matched the sample claim key data element value. If the encounter key data element was blank (or NULL) and the data element in the sample claim was also blank (or NULL), it was considered valid.

- Missing Values: The encounter key data element was blank (or NULL) and the data element in the sample was populated (i.e., had a value).
- Erroneous Values: The encounter key data element had a value (i.e., was populated) and the sample claim key data element value was populated, and the values were not the same.

A 97 percent threshold was used as the accuracy goal for each of the key data elements. Encounter data accuracy issues were noted for billed charges, health plan paid date, MMIS ICN, tooth number/surface (dental) and basis of reimbursement (pharmacy). Accuracy percentages by encounter type are presented in **Table 1**. The key data elements evaluated and specific testing results are presented in Appendix D.

Accuracy Percentages – Key Data Elements Analysis			
Encounter Type	**Valid Values**	**Missing Values**	**Erroneous Values**
Inpatient	97.4%	0.1%	2.5%
Outpatient	94.6%	0.0%	5.4%
Professional	88.2%	0.0%	11.8%
Dental	85.8%	0.0%	14.2%
Vision	86.3%	0.1%	13.6%
NEMT	74.4%	0.1%	25.5%
Pharmacy	80.3%	3.1%	16.6%
Total Average	***87.5%***	***0.8%***	***11.7%***

Table 1: Encounter Accuracy Percentages – Key Data Elements Analysis. Individual key data element validity and accuracy rates were calculated based on the total number of records in the encounter dataset. The encounter data's targeted error rate was expected to be below three percent per key data element.

Findings and Recommendations

The findings from the completeness and accuracy analyses of the encounter data are summarized below, including recommendations for LDH, the FAC and/or the health plan.

Findings and Recommendations		
	Findings	**Recommendations**
3-A	**Completeness – CDJs**: Encounter paid amounts were below the 97 percent threshold for seven of the twelve months in the measurement period, and exceeded 100 percent for four of the twelve months. The health plan's completion percentage for SFY 2021 was below the 97 percent threshold (96.4 percent).	The health plan/delegated vendor, in conjunction with the FAC, should investigate and identify the causes of surplus and/or missing encounters present or absent in the encounter data. Any issues noted during the investigation requiring encounter data revisions should be accurately addressed and incorporated into the FAC encounter data. Additionally, the health plan/delegated vendor should submit payment adjustments to ensure duplicates, voids and denied claims are accurately addressed in the encounter data.
3-B	**Completeness - Sample Claims Count:** Medical, NEMT and pharmacy encounter counts were below the 97 percent threshold (92.0 percent, 65.9 percent and 66.7 percent,	

Findings and Recommendations		
	Findings	**Recommendations**
	respectively) and were at 100 percent for dental and vision encounters.	
3-C	**Completeness - Sample Claims Paid Amount:** Encounter paid amounts were at or above 100 percent for all encounter types.	
3-D	**Accuracy:** • **Admission Date** – Inpatient • **Billed Charges** – Inpatient, Outpatient, Professional, NEMT and Pharmacy • **Billing Provider NPI** – Professional and Dental • **Date of Service** – Professional • **Member Medicaid ID** – Professional • **Place of Service** – Professional • **Procedure Code** – Professional • **Service Provider NPI** – Professional • **Service Provider Specialty/Taxonomy** – Professional and Dental • **Amount Health Plan Paid Pharmacy Benefits Manager** – Pharmacy • **Basis of Reimbursement** – Pharmacy • **Health Plan Paid Date** - Pharmacy Both the encounter data and the claims sample data reflected valid values and the values did not agree.	The health plan/delegated vendor should ensure it is properly capturing and maintaining encounter data elements within the claims system and data warehouse and be able to submit this information in the encounter submissions and on future claim sample submissions and/or ad hoc reporting. Additionally, the FAC, the health plan and its delegated vendor should work together to ensure key data elements are properly submitted and captured in the encounter data.
3-E	**Accuracy:** • **Tooth Number and Tooth Surface** - Dental • **Accuracy – Prescribing Provider NPI** – Pharmacy Encounter values were not populated for the non-matching values.	
3-F	**Accuracy – Service Provider Specialty / Taxonomy:** NEMT – Claims sample values were not populated.	
3-G	**Accuracy – Former/Original Claim ICN:** Inpatient, Outpatient, Professional and NEMT – The encounter value is populated and the sample claim is not or vice versa.	The health plan should ensure that appropriate audit trails are in place for all adjusted, replaced and void claims. The original ICN should be linked to the replacement, adjustment and/or void claim and the original ICN information is available to trace the replacement/adjustment back to the original claim.
3-H	**Accuracy – Health Plan Paid Amount:** Outpatient, Professional and NEMT - The encounter value is a negative value and the claims sample is a positive value or vice versa, and/or both the encounter and the claim	The health plan/delegated vendor should submit payment adjustments to ensure duplicates, voids and denied claims are accurately addressed in the encounter data.

Findings and Recommendations		
	Findings	**Recommendations**
	reflected positive amounts and the amounts did not agree.	
3-I	**Accuracy – Health Plan Paid Date:** Inpatient, Outpatient and Professional - The claim appears to be an adjustment and/or replacement and reflects the latest health plan paid date and the encounter appears to reflect the paid date of the original encounter.	This is a known limitation of the encounter data extract as the FAC overwrites the paid date of the adjustment with the paid date of the original encounter. The health plan/delegated vendor, however, should review its encounter submission procedures to ensure health plan/delegated vendor paid dates are submitted in accordance with encounter submission requirements. Additionally, the health plan/delegated vendor should review its claims system and data warehouse processes to ensure accurate adjudication dates (i.e., the date a determination was made to pay or deny a claim) are being reported on all encounter submissions. The FAC should also review its processes to ensure it is capturing the health plan/delegated vendor's adjudication date(s), as submitted by the health plan/delegated vendor, on all submitted encounters. The health plan, delegated vendor and the FAC should work together to resolve these issues.
3-J	**Accuracy – MMIS ICN:** Inpatient, Outpatient, Professional, Dental, Vision, NEMT and Pharmacy – The claims sample appears to reflect an original MMIS assigned ICN and the encounter data reflects an adjustment and/or replacement MMIS ICN, (potentially) indicating that only one and/or only the final claim sequence/iteration is being submitted as an encounter.	The health plan's contract with LDH (17.9.5) requires the health plan to submit all claims paid, denied or adjusted/void as encounters. The health plan should review its claims/data warehouse/encounter data submission processes to ensure all claim sequences/iterations are captured and stored appropriately and are included in the encounter submissions. Collapsing claim sequences/iterations into a single record line, may result in incomplete encounter data, and/or completion percentages below the contract specified threshold (97 percent). Additionally, the health plan/delegated vendor should ensure it is properly storing the MMIS ICN as assigned by the FAC and returned to the health plan on the 835 or proprietary response file(s).

Statistics and Distributions

To further support the encounter data validation process, encounters with SFY 2021 dates of service were analyzed for consistency among attributes such as member utilization and paid amounts, timeliness of payments, and encounter submissions timeliness. Health plan statistics were compared to Healthy Louisiana program data to evaluate variances and detect any missing categories of encounter data.

Members, Utilization and Paid Amounts

Enrollment data was used to evaluate utilization data on a per member basis. The total number of

utilized services (i.e., procedures) and total paid amounts for SFY 2021 were divided by the average number of members for the measurement period to determine per member utilization. **Table 2** shows the resulting utilization and paid amounts per member. Detailed results can be found in Appendix E.

The health plan's membership represented 7.7 percent of Healthy Louisiana's total member population. Per member counts and paid amounts were greater than Healthy Louisiana's, as a whole, per member counts and paid amounts.

Per Member Per Year Utilization and Paid Amounts by Service Type						
	Healthy Louisiana		ABH		Percentage of Healthy Louisiana	
Members						
Total Member Months	18,647,517		1,445,006		7.7%	
Average Number of Members	1,553,960		120,417			
Service Type	PMPY Count	PMPY Paid Amount	PMPY Count	PMPY Paid Amount	Percentage Variance	
					Count	Paid Amount
Ancillary	4.8	$238	5.3	$212	10.4%	-10.9%
Dental	0.4	$20	0.7	$29	75.0%	45.0%
Inpatient	1.6	$1,013	2.0	$1,143	25.0%	12.8%
NEMT	0.6	$28	1.2	$45	100.0%	60.7%
Outpatient	12.0	$747	14.4	$913	20.0%	22.2%
Pharmacy	17.0	$1,302	19.1	$1,620	12.4%	24.4%
Primary Care	9.9	$343	9.3	$334	-6.1%	-2.6%
Specialty Care	7.9	$591	8.7	$613	10.1%	3.7%
Vision	1.0	$35	0.7	$31	-30.0%	-11.4%
Total Health Plan Services	***55.2***	***$4,317***	***61.4***	***$4,940***	***11.2%***	***14.4%***

Table 2: Per Member Utilization and Paid Amount Statistics. Positive percentage variances indicate that the health plan's PMPY counts and/or paid amounts are greater than counts and/or paid amounts of Healthy Louisiana's as a whole. Differences are due to rounding.

Timeliness

Timely Payment of Claims

This analysis measures the compliance of the health plan in paying or denying claims submitted by providers for payment. The contract between LDH and the health plan requires that the health plan perform an initial screening of the claim within five (5) business days of receipt of the claim, and either reject the claim or assign a unique control number and enter it into its system for processing and adjudication. The health plan must process and pay or deny at least 90 percent of all clean[10] claims

[10] A clean claim is one that can be processed without obtaining additional information from the healthcare provider or a third party. For purposes of this analysis, all claims were considered clean.

within 15 business days of receipt, 99 percent within 30 calendar days and fully adjudicate (pay or deny all pended claims within 60 calendar days of the date of receipt[11]. On December 1, 2020, the 30 calendar days percentage requirement increased to 100 percent[12]. **Table 3** shows the results of the analysis. Detailed results can be found in Appendix F.

Timely Payment of Claims				
Encounter Type	**15 Business Days 90%**	**30 Calendar Days 100%**	**60 Calendar Days 100%**	**Average Days**
Inpatient	92.4%	96.1%	98.3%	11
Outpatient	95.9%	98.1%	98.9%	9
Professional	97.2%	98.9%	99.5%	6
Dental	92.1%	98.0%	99.0%	7
Vision	98.6%	98.9%	99.2%	4
NEMT	98.2%	98.9%	99.7%	3
Pharmacy	99.4%	99.5%	99.7%	8
Overall Average	***97.2%***	***98.8%***	***99.4%***	***7***

Table 3: Timely Payment of Claims measures the percentage of claims paid (adjudicated) by the health plan within the designated number of days. Percentages reflect encounters with SFY 2021 dates of service.

The health plan received dates and health plan paid (adjudicated) dates from encounters with SFY 2021 dates of service were used for the analysis. The number of days between these dates were used to determine the percentage of claims paid (adjudicated) by the health plan within the designated timeframes. The health plan met the 15 business days required level of timeliness for the payment of claims.

Timely Encounter Submissions

This analysis measures the percentage of encounters submitted by the health plan to the FAC after adjudicating (i.e., paying or denying) the claim within certain timeframes. The health plan's contract with LDH requires the health plan to submit encounters monthly. As a result, encounters with SFY 2021 dates of service were evaluated based on 30-day increments. The number of days between the health plan paid date and the Julian date (i.e., date the encounter was submitted to the FAC; digits one through four of the FAC assigned ICN number) from the encounters were used to determine the percentage of encounters submitted within the indicated number of days. **Table 4** shows the results of the encounter submission analysis. Detailed results can be found in Appendix H.

[11] Contract Attachment B, Statement of Work, Section 17.2, Claims Processing, contract effective January 1, 2020.
[12] Contract Amendment #3, Attachment B3, Section 17.2.1.3, effective December 1, 2020.

Timely Encounter Submissions					
Encounter Type	**30 Days**	**60 Days**	**90 Days**	**120 Days**	**Average Days**
Inpatient	70.0%	81.5%	87.7%	89.0%	52
Outpatient	83.8%	94.6%	96.7%	97.4%	18
Professional	81.8%	89.9%	92.4%	94.2%	25
Dental	21.0%	21.5%	22.2%	26.6%	238
Vision	93.0%	95.5%	96.7%	97.3%	12
NEMT	63.6%	75.5%	84.8%	88.4%	43
Pharmacy	71.2%	74.7%	99.7%	99.7%	23
Overall Average	***78.0%***	***85.7%***	***93.4%***	***94.5%***	***28***

Table 4: Timely Encounter Submissions measures the percentage of encounters submitted by the health plan to the FAC within the indicated number of days after adjudicating the claim. Percentages reflect encounters with SFY 2021 dates of service.

Of the approximately 11.5 million encounters submitted with SFY 2021 dates of service the health plan submitted 78.0 percent of encounters within 30 days of adjudication. On average, the health plan submitted encounters within 28 days. The health plan's dental vendor, however, took an average of 238 days to submit encounters.

Findings and Recommendations

The findings from the timeliness analysis are presented below, including recommendations for LDH, the FAC and/or the health plan.

Findings and Recommendations		
	Findings	**Recommendations**
3-K	**Timely Payment of Claims**: The health plan met the 15 business days level of timeliness for the payment of claims to providers. The health plan did not meet the 30 and 60 calendar days requirements.	The health plan should continue to regularly monitor its claims processing system and delegated vendors to ensure claims are processed promptly and within contractual timeframes.
3-L	**Timely Encounter Submissions**: The health plan submitted 78.0 percent of encounters with SFY 2021 dates of service within 30 days. On average, the health plan submitted encounters within 28 days. The delegated dental vendor, however, took an average of 238 days to submit encounters.	The health plan should regularly monitor its delegated vendors' encounter submission processes to ensure encounters are submitted timely. Additionally, processes should be reviewed to ensure encounters rejected by the FAC are quickly resolved and resubmitted.

Activity 4: Review of Medical Records

Activity 4 attempts to confirm or provide supporting information for the findings detailed in the Activity 3 analysis of encounter data. This is done by tracing certain key data elements from the encounters to the provider medical record. Encounter data with dates of service during the measurement period was used as the population for the selection of records for review. A sample size of 150 records was approved by LDH for testing. A non-statistical[13], random sampling of records was selected from the encounter data for review.

The encounter records selected for review were forwarded to the health plan on January 28, 2022 for retrieval of the medical records. The notification to the health plan stated that medical records were due to Myers and Stauffer by March 11, 2022. On March 15, 2022, Myers and Stauffer sent an inventory of outstanding medical records to the health plan and extended the due date for submitting the outstanding records to March 31, 2022. The health plan was also informed that due to timelines and deliverables required by the contract with LDH for this engagement, we were unable to further extend the deadline for submitting the requested medical records and that medical records submitted after the extended due date would not be included in the validation.

Table 5 below summarizes the number of records requested, received, replaced or missing, and the net number of medical records tested.

Medical Records Summary					
Description	**Inpatient**	**Outpatient**	**Professional** (includes Dental, Vision and/or NEMT)	**Pharmacy**	**Total**
Requested	1	40	64	45	150
Missing	0	6	9	0	15
Incorrect Record Submitted	0	0	2	0	2
Replaced	0	0	0	0	0
Medical Records Received and Tested	1	34	53	45	133
Percentage of Requested Records Tested	***100.0%***	***85.0%***	***82.8%***	***100.0%***	***88.7%***

Table 5: Medical Records Summary. 135 of the 150 medical records requested were submitted. One of the medical records submitted was for a different member and one stated that the member was not seen on the indicated date of service. These two (2) records were not included in the validation. The health plan indicated that multiple attempts were made to obtain all of the requested records. The on-going PHE, staffing shortages and an overburdened healthcare community may have prevented the health plan from procuring medical records from providers within the expected timeframe.

Validation

The medical records were reviewed and compared to the encounter data to validate that the tested key data elements were supported by the medical record documentation. Each key data element was

[13] Non-statistical sampling is the selection of a test group, such as sample size, that is based on the examiner's judgement, rather than a formal statistical method.
https://www.accountingtools.com/articles/non-statistical-sampling.html

independently evaluated against the medical record and deemed supported or unsupported (i.e., the medical record supported or did not support the encounter key data element value). The validation was segregated in the following manner:

- Supported: Encounters for which the medical records supported the key data element(s).
- Unsupported: Encounters for which the medical records included information that was different from the encounter key data element(s) and/or encounters for which the medical records did not include the information to support the encounter key data element(s).

Table 6, below, reflects the validation rates from the medical record key data element review. The detail analysis is included in Appendix I.

Medical Records Validation Rates		
Encounter Types	**Supported Validation Rate**	**Unsupported Validation Rate**
Inpatient	90.9%	9.1%
Outpatient	96.1%	3.9%
Professional (includes Dental, Vision and/or NEMT)	98.9%	1.1%
Pharmacy	100.0%	0.0%
Total	***98.3%***	***1.7%***

Table 6: Medical Record Validation Rates. 133 of the 150 medical records requested were tested. Supported and unsupported determinations were for each key data element tested and not a claim level determination. One inpatient record was selected for review, as a result, supported or unsupported values will have a significant impact on the validation rates.

Findings and Recommendations

The findings from the encounter data testing against medical records are presented below, including recommendations for LDH, the FAC and/or the health plan.

Findings and Recommendations		
	Findings	**Recommendations**
4-A	135 of the 150 records requested were submitted. Two (2) of the records submitted were for a different member or for a member that was not seen by the provider on the indicated date of service. These records were excluded from the validation resulting in 133 of the 150 medical records requested (88.7 percent) being tested.	The health plan should work with the providers to ensure it receives medical records for the requested members and/or dates of service.
4-B	Validation rates for the 133 medical records tested met the 97 percent threshold (98.3 percent).	

Activity 5: Submission of Findings

Activity 5 summarizes the findings and recommendations identified in Activity 1 through Activity 4. The table below contains finding numbers corresponding to the activity and sequential finding within each section of the report.

Findings and Recommendations		
	Findings	**Recommendations**
Activity 1 – Review State Requirements		
There were no findings related to our review of the State's requirements.		
Activity 2 – Review Health Plan Capability		
There were no findings related to our review of the health plan's capability.		
Activity 3 – Analyze Electronic Encounter Data		
3-A	**Completeness – CDJs**: Encounter paid amounts were below the 97 percent threshold for seven of the twelve months in the measurement period, and exceeded 100 percent for four of the twelve months. The health plan's completion percentage for SFY 2021 was below the 97 percent threshold (96.4 percent).	The health plan/delegated vendor, in conjunction with the FAC, should investigate and identify the causes of surplus and/or missing encounters present or absent in the encounter data. Any issues noted during the investigation requiring encounter data revisions should be accurately addressed and incorporated into the FAC encounter data. Additionally, the health plan/delegated vendor should submit payment adjustments to ensure duplicates, voids and denied claims are accurately addressed in the encounter data.
3-B	**Completeness - Sample Claims Count:** Medical, NEMT and pharmacy encounter counts were below the 97 percent threshold (92.0 percent, 65.9 percent and 66.7 percent, respectively) and were at 100 percent for dental and vision encounters.	
3-C	**Completeness - Sample Claims Paid Amount:** Encounter paid amounts were at or above 100 percent for all encounter types.	
3-D	**Accuracy:** • **Admission Date** – Inpatient • **Billed Charges** – Inpatient, Outpatient, Professional, NEMT and Pharmacy • **Billing Provider NPI** – Professional and Dental • **Date of Service** – Professional • **Member Medicaid ID** – Professional • **Place of Service** – Professional • **Procedure Code** – Professional • **Service Provider NPI** – Professional • **Service Provider Specialty/Taxonomy** – Professional and Dental • **Amount Health Plan Paid Pharmacy Benefits Manager** – Pharmacy • **Basis of Reimbursement** – Pharmacy	The health plan/delegated vendor should ensure it is properly capturing and maintaining encounter data elements within the claims system and data warehouse and be able to submit this information in the encounter submissions and on future claim sample submissions and/or ad hoc reporting. Additionally, the FAC, the health plan and its delegated vendor should work together to ensure key data elements are properly submitted and captured in the encounter data.

Findings and Recommendations		
	Findings	**Recommendations**
	• **Health Plan Paid Date** - Pharmacy Both the encounter data and the claims sample data reflected valid values and the values did not agree.	
3-E	**Accuracy:** • **Tooth Number and Tooth Surface** - Dental • **Accuracy – Prescribing Provider NPI –** Pharmacy Encounter values were not populated for the non-matching values.	The health plan/delegated vendor should ensure it is properly capturing and maintaining encounter data elements within the claims system and data warehouse and be able to submit this information in the encounter submissions and on future claim sample submissions and/or ad hoc reporting. Additionally, the FAC, the health plan and its delegated vendor should work together to ensure key data elements are properly submitted and captured in the encounter data.
3-F	**Accuracy – Service Provider Specialty / Taxonomy:** NEMT – Claims sample values were not populated.	
3-G	**Accuracy – Former/Original Claim ICN:** Inpatient, Outpatient, Professional and NEMT – The encounter value is populated and the sample claim is not or vice versa.	The health plan should ensure that appropriate audit trails are in place for all adjusted, replaced and void claims. The original ICN should be linked to the replacement, adjustment and/or void claim and the original ICN information is available to trace the replacement/adjustment back to the original claim.
3-H	**Accuracy – Health Plan Paid Amount:** Outpatient, Professional and NEMT - The encounter value is a negative value and the claims sample is a positive value or vice versa, and/or both the encounter and the claim reflected positive amounts and the amounts did not agree.	The health plan/delegated vendor should submit payment adjustments to ensure duplicates, voids and denied claims are accurately addressed in the encounter data.
3-I	**Accuracy – Health Plan Paid Date:** Inpatient, Outpatient and Professional - The claim appears to be an adjustment and/or replacement and reflects the latest health plan paid date and the encounter appears to reflect the paid date of the original encounter.	This is a known limitation of the encounter data extract as the FAC overwrites the paid date of the adjustment with the paid date of the original encounter. The health plan/delegated vendor, however, should review its encounter submission procedures to ensure health plan/delegated vendor paid dates are submitted in accordance with encounter submission requirements. Additionally, the health plan/delegated vendor should review its claims system and data warehouse processes to ensure accurate adjudication dates (i.e., the date a determination was made to pay or deny a claim) are being reported on all encounter submissions. The FAC should also review its processes to ensure it is capturing the health plan/delegated vendor's adjudication date(s), as submitted by the health plan/delegated vendor, on all submitted encounters. The health plan, delegated vendor and the FAC should work together to resolve these issues.

Findings and Recommendations		
	Findings	**Recommendations**
3-J	**Accuracy – MMIS ICN:** Inpatient, Outpatient, Professional, Dental, Vision, NEMT and Pharmacy – The claims sample appears to reflect an original MMIS assigned ICN and the encounter data reflects an adjustment and/or replacement MMIS ICN, (potentially) indicating that only one and/or only the final claim sequence/iteration is being submitted as an encounter.	The health plan's contract with LDH (17.9.5) requires the health plan to submit all claims paid, denied or adjusted/void as encounters. The health plan should review its claims/data warehouse/encounter data submission processes to ensure all claim sequences/iterations are captured and stored appropriately and are included in the encounter submissions. Collapsing claim sequences/iterations into a single record line, may result in incomplete encounter data, and/or completion percentages below the contract specified threshold (97 percent). Additionally, the health plan/delegated vendor should ensure it is properly storing the MMIS ICN as assigned by the FAC and returned to the health plan on the 835 or proprietary response file(s).
3-K	**Timely Payment of Claims**: The health plan met the 15 business days level of timeliness for the payment of claims to providers. The health plan did not meet the 30 and 60 calendar days requirements.	The health plan should continue to regularly monitor its claims processing system and delegated vendors to ensure claims are processed promptly and within contractual timeframes.
3-L	**Timely Encounter Submissions**: The health plan submitted 78.0 percent of encounters with SFY 2021 dates of service within 30 days. On average, the health plan submitted encounters within 28 days. The delegated dental vendor, however, took an average of 238 days to submit encounters.	The health plan should regularly monitor its delegated vendors' encounter submission processes to ensure encounters are submitted timely. Additionally, processes should be reviewed to ensure encounters rejected by the FAC are quickly resolved and resubmitted.
Activity 4 – Review of Medical Records		
4-A	135 of the 150 records requested were submitted. Two (2) of the records submitted were for a different member or for a member that was not seen by the provider on the indicated date of service. These records were excluded from the validation resulting in 133 of the 150 medical records requested (88.7 percent) being tested.	The health plan should work with the providers to ensure it receives medical records for the requested members and/or dates of service
4-B	Validation rates for the 133 medical records tested met the 97 percent threshold (98.3 percent).	

Glossary

834 file – HIPAA-compliant benefit enrollment and maintenance documentation.

835 file – HIPAA-compliant health care claim payment/advice documentation.

837 file – The standard format used by institutional providers and health care professionals and suppliers to transmit health care claims electronically.

Adjudication – The process of determining whether a claim should be paid or denied.

American Institute of Certified Public Accountants (AICPA) – The national professional organization of Certified Public Accountants.

Capitation – A payment arrangement for health care services that pays a set amount for each enrolled member assigned to a provider and/or health plan.

Ancillary Services – Supplies and equipment, laboratory and diagnostic tests, therapies (i.e., physical, occupational and speech) and home health services requested by a health care provider as a supplement to fundamental services.

Cash Disbursement Journal (CDJ) – A journal used to record and track cash payments by the health plan or other entity.

Centers for Medicare & Medicaid Services (CMS) – The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

Centers for Medicare & Medicaid Services (CMS) Medicaid and the Children's Health Insurance Program (CHIP) Managed Care Final Rule – On April 25, 2016 CMS published the Medicaid and CHIP Managed Care Final Rule which modernizes the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The final rule aligns many of the rules governing Medicaid managed care with those of other major sources of coverage; implements statutory provisions; strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It also ensures appropriate beneficiary protections and enhances policies related to program integrity.

Certified Public Accountant (CPA) – A designation given by the AICPA to individuals that pass the uniform CPA examination and meet the education and experience requirements. The CPA designation helps enforce professional standards in the accounting industry.

CFR – Code of Federal Regulations.

Data Warehouse (DW) – A central repository for storing, retrieving, and managing large amounts of current and historical electronic data. Data stored in the warehouse is uploaded from the operational systems and may pass through additional processing functions before it is stored in the warehouse. Also known as an enterprise data warehouse (EDW).

Delegated Vendor– A vendor to whom the health plan has contractually assigned responsibility for the provision and oversight of approval, payment, and administration of medical services to the Medicaid health plan's members. Also known as a subcontractor.

Dental Services - Dentistry is the evaluation, diagnosis, prevention, and/or treatment (i.e., non-surgical, surgical, or related procedures) of diseases, disorders, injuries, and malformations of the teeth, gums, jaws, and mouth. Dental services include the removal, correction, and replacement of decayed, damaged, or lost parts, including the filling and crowning of teeth, the straightening of teeth, and the construction of artificial dentures.

Encounter – A health care service rendered to a member, by a unique provider, on a single date of service, whether paid or denied by a coordinated care organization. One patient encounter may result in multiple encounter records.

Encounter Data – Claims that have been adjudicated by the health plan or subcontracted vendor(s), if applicable, for providers that have rendered health care services to members enrolled with the health plan. These claims are submitted to LDH via the FAC for use in rate setting, federal reporting, program oversight and management, tracking, accountability, and other ad-hoc analyses.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review or other EQR-related activities as set forth in 42 CFR §438.358, or both.

External Quality Review (EQR) – The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that health plans, or its contractors, furnish to Medicaid recipients.

Fiscal Agent Contractor (FAC) – A contractor selected to design, develop, and maintain the claims processing Medicaid Management Information System (MMIS). Gainwell Technologies is the current FAC for Louisiana. Also known as a fiscal intermediary (FI).

Health Plan – A private organization that has entered into a contractual arrangement with LDH to obtain and finance care for enrolled Medicaid members. Health plans receive a capitation or per member per month (PMPM) payment from LDH for each enrolled member. Also referred to as Managed Care Organization (MCO), Managed Care Plan (MCP) or Managed Care Entity (MCE).

Health Insurance Portability and Accountability Act (HIPAA) – A set of federal regulations designed to protect the privacy and maintain security of protected health information (PHI).

Information Systems Capabilities Assessment (ISCA) – A tool for collecting facts about a health plan's information system to ensure that the health plan maintains an information system that can accurately and completely collect, analyze, integrate and report data on member and provider attributes, and services furnished to members. An ISCA is a required part of multiple mandatory External Quality Review protocols.

Internal Control Number (ICN) - A numerical mechanism used to track health care claims and encounters. Also referred to as Transaction Control Number (TCN) or a Document Control Number (DCN).

Inpatient Services - Care or treatment provided to members who are extremely ill, have severe trauma, unable to care for themselves or have physical illnesses whose condition requires admission for at least

one overnight stay. Lengths of stay are generally short and patients are provided 24-hour care in a safe and secure facility.

Julian Date – A continuous count of days in a calendar year. For example, February 1 is 032.

Key Data Element – A fundamental unit of information that has a unique meaning and distinct units or values (i.e., numbers, characters, figures, symbols, a specific set of values, or range of values) defined for use in performing computerized processes.

Louisiana Children's Health Insurance Program (LaCHIP) – The Insurance program that provides low-cost health coverage to Louisiana children in families that earn too much money to qualify for Medicaid but not enough to buy private insurance.

Louisiana Department of Health (LDH) – The department within the state of Louisiana that oversees and administers Medicaid.

Medicaid Management Information System (MMIS) – The claims processing system used by the FAC to adjudicate Louisiana Medicaid claims. Health plan-submitted encounters are loaded into this system and assigned a unique claim identifier.

Outpatient Services - Care or treatment that can be provided in a few hours at a facility without an overnight stay. Patients continue working or attend school, interacting and living their lives while receiving treatment. Outpatient services include rehabilitation services such as counseling and/or substance abuse.

Per Member Per Month (PMPM) – The amount paid to a health plan each month for each person for whom the health plan is responsible for providing health care services under a capitation agreement.

Potential Duplicate (PDUP) – An encounter that Myers and Stauffer LC has identified as being a potential duplicate of another encounter in the FAC's data warehouse.

Primary Care Services - Medical providers in family and general practice, obstetrics and gynecology (for preventive and maternity care), pediatrics (without other sub specialties), and internal medicine (without other sub specialties) are generally considered primary care providers. Federally qualified health clinics and rural health clinics are included, as these clinics provide comprehensive primary and preventative care to underserved areas or populations. Primary care services provide a range of preventive and restorative care over a period of time and primary care providers, generally, coordinate all of the care that a member receives.

Specialty Care Services - Specialists are medical providers who devote attention to a particular branch of medicine (i.e., any type of medical provider who is not considered a primary care provider) in which they have extensive training and education. Specialty care includes services such as cardiology, diabetes, endocrinology, and behavioral health.

Sub-Capitated Provider – A health care provider that is paid on a capitated or per member per month (PMPM) basis that has contracted with a health plan paid under a capitated system and shares a portion of the health plan's capitated premium.

Validation – The review of information, data, and procedures to determine the extent to which encounter data is accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

Appendix A: Encounter Reconciliation Schedule

	September 2020 Reconciliation	November 2020 Reconciliation	January 2021 Reconciliation	March 2021 Reconciliation	May 2021 Reconciliation	July 2021 Reconciliation	September 2021 Reconciliation
Overall Encounter Submission Goal (cumulative)*	95%	95%	97% - 100%	97% - 100%	97% - 100%	97% - 100%	97% - 100%
Submission Requirements for Subcontractor Encounters (for delegated vendors only)*	95%	95%	97% - 100%	97% - 100%	97% - 100%	97% - 100%	97% - 100%
Reconciliation Time Period	7/1/2018 - 06/30/2020	9/1/2018 - 08/31/2020	11/1/2018 - 10/31/2020	1/1/2019 - 12/31/2020	3/1/2019 - 2/28/2021	5/1/2019 - 04/30/2021	7/1/2019 - 06/30/2021
MCO Pharmacy Encounter MMIS Submission Cut-off Date (by 12 noon CST/CDT)[1]	6/24/2020 Encounters: May 2020 7/22/2020 Encounters: June 2020	8/19/2020 Encounters: July 2020 9/23/2020 Encounters: August 2020	10/21/2020 Encounters: September 2020 11/18/2020 Encounters: October 2020	12/23/2020 Encounters: November 2020 1/20/2021 Encounters: December 2020	2/17/2021 Encounters: January 2021 3/24/2021 Encounters: February 2021	4/21/2021 Encounters: March 2021 5/19/2021 Encounters: April 2021	6/23/2021 Encounters: May 2021 7/21/2021 Encounters: June 2021
MCO Non-Pharmacy Encounter MMIS Submission Cut-off Date (by 12 noon CST/CDT)[1]	6/25/2020 Encounters: May 2020 7/23/2020 Encounters: June 2020	8/20/2020 Encounters: July 2020 9/24/2020 Encounters: August 2020	10/22/2020 Encounters: September 2020 11/19/2020 Encounters: October 2020	12/24/2020 Encounters: November 2020 1/21/2021 Encounters: December 2020	2/18/2021 Encounters: January 2021 3/25/2021 Encounters: February 2021	4/22/2021 Encounters: March 2021 5/20/2021 Encounters: April 2021	6/24/2021 Encounters: May 2021 7/22/2021 Encounters: June 2021
Cash Disbursement Journal Files due to Myers and Stauffer	*expected: 6/15/2020, 7/15/2020*	*expected: 8/17/2020, 9/15/2020*	*expected: 10/15/2020, 11/16/2020*	*expected: 12/15/2020, 1/15/2021*	*expected: 2/15/2021, 3/15/2021*	*expected: 4/15/2021, 5/17/2021*	*expected: 6/15/2021, 7/15/2021*
Draft MCO Encounter Reconciliations Due to LDH	9/10/2020	11/5/2020	1/12/2021	3/11/2021	5/6/2021	7/8/2021	9/9/2021
LDH to Provide MCOs with Draft Encounter Reconciliations	9/11/2020	11/6/2020	1/13/2021	3/12/2021	5/7/2021	7/9/2021	9/10/2021
Myers and Stauffer to Post Raw Encounter Data Files and Supplemental Duplicates / Calculated Voids Files	9/11/2020	11/6/2020	1/13/2021	3/12/2021	5/7/2021	7/9/2021	9/10/2021
Due from MCOs to be Included in the Next Report: Feedback on (1) Duplicates / Voids File and (2) Encounter Reconciliation	9/18/2020	11/13/2020	1/20/2021	3/19/2021	5/14/2021	7/16/2021	9/17/2021

* LDH and Myers and Stauffer will not round encounter submission results

[1] The MMIS submission cut-off-date is set by the FAC and is subject to change per changes to the data extract frequency or data processes.

[2] For every day the encounter data from the FAC is delayed, the MCO Encounter Reconciliation report will be delayed by two days.

Appendix B

Louisiana Department of Health

Comparison of Louisiana Managed Care Organization Encounter Data to Cash Disbursements for Aetna Better Health of Louisiana March 1, 2020 through February 28, 2022

May 5, 2022

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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Study Purpose

Louisiana Department of Health (LDH) engaged Myers and Stauffer LC to analyze Healthy Louisiana encounter data that has been submitted by the managed care organizations (MCO) to Louisiana's fiscal agent contractor (FAC), Gainwell, and complete a comparison of the encounters to cash disbursement journals provided by each MCO. For purposes of this analysis, "encounter data" are claims that have been paid by MCOs or delegated vendors (e.g., vision and pharmacy) to health care providers that have provided health care services to members enrolled with the MCO. Encounter data is submitted to LDH via the FAC for LDH's use in rate setting, federal reporting, program management and oversight, tracking, accounting, ad hoc analyses, and other activities.

LDH requested that, for this study, we estimate the percentage of each MCO delegated vendor paid encounters that appear to be included in the FAC's database. This analysis includes these percentages for the entire plan, as well as separate vision, non-emergency transportation (NET), dental value-added service (VAS), and pharmacy delegated vendor encounters paid during the period March 1, 2020 through February 28, 2022. We have also included the percentages for total non-vendor MCO paid encounters.

Our work was performed in accordance with American Institute of Certified Public Accountants (AICPA) professional standards for consulting engagements. We were not engaged to, nor did we perform, an audit, examination, or review services; accordingly, we express no opinion or conclusion related to the procedures performed or the information and documentation we reviewed. In addition, our engagement was not specifically designed for, and should not be relied on, to disclose errors, fraud, or other illegal acts that may exist.

The results of our engagement and this report are intended only for the internal use of the LDH and should not be used for any other purpose.

Summary

LDH requested that, for this study, we review the plan's paid encounters to determine if the paid encounters meet the state contract completeness range of **97 percent to 100 percent** when compared to the cash disbursements journal (CDJ) files that are submitted by the MCO. The encounters and CDJ files utilized in this study met the following criteria:

- Encounters were paid within the reporting period of March 1, 2020 through February 28, 2022;
- CDJ transactions had payment dates within the reporting period of March 1, 2020 through February 28, 2022;
- Encounters were received and accepted by the FAC and transmitted to Myers and Stauffer LC through March 29, 2022.

Table A — Aetna Cumulative Completion Totals and Percentages

			Delegated Vendor				
Description	**Entire Plan**	**Non-Vendor**	**ModivCare (NET)**	**OneCall (NET)**	**Superior Vision (Vision)**	**DentaQuest (Dental)**	**CVS Health (Pharmacy Benefits)**
Encounter Total (FAC reported)	$1,510,802,759	$1,064,711,729	$1,598,109	$14,764,693	$4,346,394	$16,702,531	$408,679,303
Total Encounter Adjustments ($)	($309,010,016)	($274,687,034)	($149,287)	($4,130,572)	($422,557)	($11,273,200)	($18,347,367)
Total Encounter Adjustments (%)	*-20.45%*	*-25.79%*	*-9.34%*	*-27.97%*	*-9.72%*	*-67.49%*	*-4.48%*
Net Encounter Total	**$1,201,792,743**	**$790,024,695**	**$1,448,822**	**$10,634,122**	**$3,923,836**	**$5,429,332**	**$390,331,936**
CDJ Total	**$1,225,496,449**	**$813,124,505**	**$1,485,147**	**$10,871,994**	**$4,005,496**	**$4,696,241**	**$391,313,066**
Variance	*($23,703,706)*	*($23,099,810)*	*($36,325)*	*($237,872)*	*($81,660)*	*$733,090*	*($981,129)*
Completion (%)	**98.06%**	**97.15%**	**97.55%**	**97.81%**	**97.96%**	**115.61%**	**99.74%**
100% Limited^ Completion (%)	***98.00%***					***100.00%***	
Contract Minimum Completeness Requirement (%)	**97.00%**						
Non-Compliant (%)						**15.61%**	

^ - To avoid overstating the Entire Plan results in situations where an individual vendor's cumulative completion percentage exceeds 100 percent, we have decreased the Entire Plan encounter totals by the total variance in comparison to the CDJ. Please see data analysis assumption number 9 on page 27 for further explanation.

Encounter Data Analysis

For this study, Myers and Stauffer analyzes the encounter data that is submitted by the MCO to the FAC and loaded into the FAC Medicaid Management Information System (MMIS). Encounters submitted by the MCO that were rejected by the FAC for errors in submission or other reasons are not transmitted to Myers and Stauffer.

Furthermore, Myers and Stauffer analyzes the encounter data from the FAC MMIS and makes the following adjustments. Table B below outlines the impact of applying these encounter analysis adjustments to the encounter paid amounts, when compared to the raw data received.

1. The payment amounts associated with denied encounters are identified as zero dollars in the encounter reconciliation analysis since they bear no impact on cash disbursements.

2. We identified potential duplicate encounters using our encounter review logic. Based on a comparison to the CDJ files, we noted some of these potential duplicates appear to be partial payments, some are actual duplicate submissions, and some are replacement encounters without a matching void. At the direction of LDH, we have attempted to adjust our totals to reflect the actual payment made and have removed duplicate payment amounts from our analysis.

Table B — Myers and Stauffer LC's Adjustments to Aetna Encounters

Description	Encounter Count	Paid Amount	Paid Amount (% of Total*)
Total Encounter Amount (FAC Reported)	**23,539,173**	**$1,510,802,759**	**100.00%**
Adjustment Type			
Denied	(7,081,283)	*($302,130,744)*	*-19.99%*
Calculated Void	*(30,096)*	*($1,419,168)*	*-0.09%*
Duplicate	*(105,624)*	*($5,460,104)*	*-0.36%*
Total Adjustments Made	*(7,217,003)*	*($309,010,016)*	*-20.45%*
Net Encounter Amounts	**16,322,170**	**$1,201,792,743**	**79.55%**

** Percentage ratios are rounded down for each adjustment type and may not add up to the total percentage of adjustments made for this reporting period. Please see data analysis assumption number 7 on page 27 for further explanation.*

Data Issues and Recommendations

During this analysis, Myers and Stauffer identified potential data issues that may impact the completion percentages for specific delegated vendors and/or non-vendor. **Section A** details issues related to non-compliant cumulative completion percentages, while **Section B** notes outstanding data issues that Aetna may need to work to identify and resolve.

Please reference Tables 1 through 7 starting on page 9 for Aetna's entire plan, delegated vendor, and non-vendor reconciliation period tables for detailed reconciliation totals, completion percentages, and encounter analysis adjustments.

Please reference Table A on page 4 for Aetna's reconciliation period table. This table contains detailed reconciliation totals, completion percentages, and encounter analysis adjustments.

SECTION A – Data issues that may cause cumulative completion percentages outside the targeted range (below 97 percent or above 100 percent):

1. **DentaQuest (Table 5):** DentaQuest's cumulative completion percentage is significantly above the 100 percent threshold at 115.61 percent for the reporting period.

    - DentaQuest recently submitted replacement CDJs for all months through October 2021 of the reporting period. While these resubmissions eliminated some of the monthly completion percentage fluctuations, most monthly completion percentages are now in the middle 120 percentage range. These high monthly completion percentages appear to be due to missing CDJ transactions and/or mismatched paid amounts when compared to the encounters.

    - The monthly completion percentages for July 2021, August 2021, November 2021 and February 2022 are low at 86.16, 85.68, 82.68 and 86.46 percent, respectively. These low percentages appear to be due to missing encounters, encounters that were system-denied by the FAC and/or mismatched paid amounts or dates.

We recommend Aetna work with LDH, DentaQuest and Gainwell to identify and correct any CDJ file and/or encounter data submission issues.

SECTION B – Data issues and notes that currently may not impact cumulative compliance:

2. **OneCall NET (Table 2):** OneCall's monthly completion percentages are high for one month and low for seven months of the reporting period.

    - The low percentages appear to be due to mismatched paid amounts and/or encounters that were system-denied by the FAC.

    - The monthly completion percentage for October 2021 is very high at 315.11 percent which appears to be due to CDJ void transactions not found in the encounters for transactions that occurred in prior paid months.

We recommend Aetna work with LDH, OneCall and Gainwell to identify and correct any CDJ file and/or encounter data submission issues.

3. **ModivCare (Table 3):** ModivCare's monthly completion percentage is 91.93 percent for July 2020.

    - This low percentage appears to be due to missing encounters and/or encounters system-denied by the FAC when compared to the CDJ transactions.

We recommend Aetna work with LDH, ModivCare and Gainwell to identify and correct any CDJ file and/or encounter data submission issues.

4. **Superior Vision (Table 4):** Superior Vision's monthly completion percentages are high for three months and low for eight months of the reporting period.

    - The high monthly completion percentages appear to be due to missing CDJ transactions and/or mismatched paid amounts.

    - The low monthly completion percentages appear to be due to missing encounters, encounters system-denied by the FAC and/or mismatched paid amounts.

    - The monthly completion percentages for May 2020 and October 2021 are high at 118.74 percent and 110.04 percent, respectively. These high completion percentages appear to be due to missing CDJ transactions when compared to encounters.

We recommend Aetna work with LDH, Superior Vision and Gainwell to identify and correct any CDJ file and/or encounter data submission issues.

5. **CVS Health (Table 6):** CVS Health has monthly completion percentages exceeding 100 percent for eight months of the reporting period.

    - These high completion percentages may be explained by instances of encounters that have been voided and resubmitted that do not have matching transactions in the CDJ files (void encounters include the same paid date as the original claim).

We recommend Aetna work with LDH, CVS Health and Gainwell to identify and correct any CDJ file and/or encounter data submission issues.

6. **Non-Vendor (Table 7):** Aetna's Non-Vendor monthly completion percentages are low for eleven months and high for nine months of the reporting period.

    - The low completion percentages appear to be due to mismatched paid amounts or dates and/or missing encounters or encounters that were system-denied by the FAC.

    - The high completion percentages appear to be due to mismatched paid amounts such as negative CDJ adjustment transactions not found in the encounters.

We recommend Aetna work with LDH and Gainwell to identify and correct any CDJ file and/or encounter data submission issues.

Value Added Services (VAS) Summary

Value-added services are included in the MCO's non-emergency medical transportation, vision, dental, and non-vendor CDJ and encounter totals. VAS CDJ data is identified based on the VAS amount field of the CDJ files received from the MCO and VAS encounter data is identified based on the first character of the Plan ICN field.

Below is a summary of the cumulative completion percentages for all delegated vendor and non-vendor paid VAS encounters submitted to Gainwell, for the reporting period of March 1, 2020 through February 28, 2022. The VAS CDJ and encounter totals in the table below are included in the entire plan, non-vendor and delegated vendor completion percentage tables as well.

Table C — Aetna VAS Cumulative Completion Totals and Percentages

Description	Entire Plan VAS	Non-Vendor VAS	Delegated Vendor			
			ModivCare VAS (NET)	OneCall VAS (NET)	Superior Vision VAS (Vision)	DentaQuest VAS (Dental)[1]
Encounter Total (FAC reported)	$20,415,197	$429,152	$0	$278,130	$3,005,384	$16,702,531
Total Encounter Adjustments ($)	($11,760,200)	($119,677)	$0	($71,803)	($295,520)	($11,273,200)
Total Encounter Adjustments (%)	*-57.60%*	*-27.88%*	*0.00%*	*-25.81%*	*-9.83%*	*-67.49%*
Net Encounter Total	**$8,654,997**	**$309,475**	**$0**	**$206,327**	**$2,709,863**	**$5,429,332**
CDJ Total	**$7,917,052**	**$295,798**	**$5,309**	**$209,991**	**$2,709,712**	**$4,696,241**
Variance	*$737,945*	*$13,676*	*($5,309)*	*($3,664)*	*$152*	*$733,090*
Completion (%)	**109.32%**	**104.62%**	**0.00%**	***98.25%***	***100.00%***	**115.61%**
100% Limited^ Completion (%)	***99.88%***	***100.00%***				***100.00%***
Contract Minimum Completeness Requirement (%)	**97.00%**					
Non-Compliant (%)	**9.32%**	**4.62%**	**-97.00%**			**15.61%**

^ – To avoid overstating the VAS Entire Plan results in situations when the MCO or an individual vendor's cumulative completion percentage exceeds 100 percent, we reduced such encounter totals by the period's variance in comparison with the CDJs. Please see data analysis assumption number 9 on page 27 for further explanation.

Potential issues that may cause a significant impact on the VAS completion percentages are listed below:

1. ModivCare has submitted CDJ transactions with VAS amounts for several months of the reporting period. There have been no VAS encounters submitted.
2. OneCall's VAS monthly completion percentages are low for twelve months of the reporting period. The low percentage months appear to be due to missing encounters, encounters that were system-denied by the FAC and/or mismatched paid amounts between the encounters and CDJ transactions. The total VAS CDJ transactions for October 2021 are negative due to void transactions for prior paid months.
3. Superior Vision's VAS monthly completion percentages are low for ten months and high for five months of the reporting period. The low monthly percentages appear to be due to missing encounters and/or encounters that were system-denied by the FAC. The high monthly completion percentages appear to be due to missing CDJ transactions and/or CDJ transactions not identified as VAS when compared to encounters.
4. Aetna's Non-Vendor VAS cumulative completion percentage is above the compliance threshold range at 104.62 percent due to several high monthly completion percentages. The monthly completion percentages are either high or low for nineteen of the twenty-four months of the reporting period. The low monthly completion percentages appear to be due to mismatched paid amounts, missing encounters and/or encounters that were system-denied by the FAC when compared to the CDJ transactions while the high percentage months appear to be caused by mismatched paid amounts and/or dates.

1 – Since all dental services are VAS, the VAS dental totals indicated on this page are identical to the totals shown in Table 5 – Aetna DentaQuest (Dental) on page 13. The potential data issues for DentaQuest are addressed in item 1 on page 6.

Aetna Better Health of Louisiana Entire Plan Monthly Table

Table 1 — Aetna (Entire Plan)							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
March 2020	$60,760,842	($14,986,565)	-25%	$45,774,277	$44,676,810	$1,097,467	102.45%
April 2020	$51,410,708	($8,132,280)	-16%	$43,278,427	$43,623,435	($345,008)	99.20%
May 2020	$47,791,366	($8,858,011)	-19%	$38,933,355	$39,850,608	($917,253)	97.69%
June 2020	$56,966,038	($11,784,302)	-21%	$45,181,736	$46,035,383	($853,647)	98.14%
July 2020	$67,114,690	($15,318,305)	-23%	$51,796,385	$49,003,628	$2,792,757	105.69%
August 2020	$63,750,392	($14,274,455)	-22%	$49,475,937	$49,080,666	$395,270	100.80%
September 2020	$58,903,856	($10,043,280)	-17%	$48,860,577	$50,987,724	($2,127,147)	95.82%
October 2020	$60,718,393	($13,486,876)	-22%	$47,231,516	$50,154,169	($2,922,653)	94.17%
November 2020	$52,661,720	($10,280,699)	-20%	$42,381,021	$47,832,283	($5,451,263)	88.60%
December 2020	$62,317,377	($11,590,263)	-19%	$50,727,114	$54,054,015	($3,326,901)	93.84%
January 2021	$53,546,368	($8,420,848)	-16%	$45,125,519	$49,149,893	($4,024,373)	91.81%
February 2021	$51,512,834	($10,057,020)	-20%	$41,455,815	$44,982,149	($3,526,335)	92.16%
March 2021	$73,453,117	($17,520,199)	-24%	$55,932,918	$61,234,971	($5,302,053)	91.34%
April 2021	$72,528,112	($21,567,947)	-30%	$50,960,164	$48,637,389	$2,322,776	104.77%
May 2021	$67,154,641	($12,224,501)	-18%	$54,930,140	$54,586,032	$344,107	100.63%
June 2021	$71,255,586	($14,023,142)	-20%	$57,232,444	$58,378,147	($1,145,703)	98.03%
July 2021	$69,955,551	($17,708,432)	-25%	$52,247,119	$50,892,274	$1,354,846	102.66%
August 2021	$71,290,112	($16,648,103)	-23%	$54,642,009	$55,553,695	($911,686)	98.35%
September 2021	$62,246,593	($9,911,756)	-16%	$52,334,837	$52,420,595	($85,758)	99.83%
October 2021	$75,012,258	($14,094,570)	-19%	$60,917,688	$57,428,699	$3,488,988	106.07%
November 2021	$67,292,665	($14,189,480)	-21%	$53,103,185	$51,655,182	$1,448,004	102.80%
December 2021	$67,565,967	($11,673,557)	-17%	$55,892,410	$56,527,992	($635,582)	98.87%
January 2022	$60,871,328	($9,640,222)	-16%	$51,231,107	$53,687,949	($2,456,842)	95.42%
February 2022	$64,722,245	($12,575,203)	-19%	$52,147,043	$55,062,762	($2,915,719)	94.70%
Cumulative Totals	**$1,510,802,759**	**($309,010,016)**	**-20%**	**$1,201,792,743**	**$1,225,496,449**	**($23,703,706)**	**98.06%**
100% Limited^ Cumulative Total				$1,201,059,653	$1,225,496,449	($24,436,796)	98.00%
					State Contract Minimum Completeness Percentage Requirement		*97.00%*

^ - Since the DentaQuest cumulative completion percentage exceeds 100 percent, we have decreased the Entire Plan encounter totals by the total variance in comparison to the CDJ to avoid overstating the Entire Plan results. Please see data analysis assumption number 9 on page 27 for further explanation.

Aetna Better Health of Louisiana OneCall Monthly Table

Table 2 — Aetna OneCall (Non-Emergency Transportation)							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
March 2020	$0	$0		$0	$0	$0	
April 2020	$0	$0		$0	$0	$0	
May 2020	$0	$0		$0	$0	$0	
June 2020	$0	$0		$0	$0	$0	
July 2020	$438,970	($245,071)	-56%	$193,899	$196,010	($2,111)	98.92%
August 2020	$753,359	($407,456)	-54%	$345,903	$352,027	($6,124)	98.26%
September 2020	$737,639	($351,703)	-48%	$385,936	$441,521	($55,585)	87.41%
October 2020	$508,421	($59,345)	-12%	$449,077	$549,118	($100,041)	81.78%
November 2020	$559,947	($90,103)	-16%	$469,844	$586,785	($116,941)	80.07%
December 2020	$618,777	($163,296)	-26%	$455,481	$605,796	($150,315)	75.18%
January 2021	$570,153	($132,760)	-23%	$437,393	$489,824	($52,431)	89.29%
February 2021	$746,130	($264,502)	-35%	$481,628	$540,822	($59,194)	89.05%
March 2021	$701,505	($186,087)	-27%	$515,418	$527,679	($12,261)	97.67%
April 2021	$480,688	($120,725)	-25%	$359,963	$368,100	($8,136)	97.78%
May 2021	$1,069,774	($584,649)	-55%	$485,126	$498,175	($13,049)	97.38%
June 2021	$856,459	($259,292)	-30%	$597,166	$599,337	($2,171)	99.63%
July 2021	$783,866	($165,199)	-21%	$618,666	$622,769	($4,103)	99.34%
August 2021	$724,046	($91,972)	-13%	$632,074	$637,009	($4,935)	99.22%
September 2021	$1,017,028	($279,758)	-28%	$737,270	$753,084	($15,813)	97.90%
October 2021	$825,840	($165,492)	-20%	$660,348	$209,557	$450,791	315.11%
November 2021	$754,403	($125,489)	-17%	$628,914	$642,842	($13,929)	97.83%
December 2021	$836,118	($137,213)	-16%	$698,905	$716,018	($17,113)	97.60%
January 2022	$933,935	($158,890)	-17%	$775,044	$794,944	($19,899)	97.49%
February 2022	$847,634	($141,569)	-17%	$706,066	$740,578	($34,512)	95.33%
Cumulative Totals	**$14,764,693**	**($4,130,572)**	**-28%**	**$10,634,122**	**$10,871,994**	**($237,872)**	**97.81%**
100% Limited Cumulative Total							
						State Contract Minimum Completeness Percentage Requirement	*97.00%*

Aetna Better Health of Louisiana ModivCare Monthly Table

Table 3 — Aetna ModivCare (Non-Emergency Transportation)							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
March 2020	$471,695	($59,446)	-13%	$412,249	$413,357	($1,108)	99.73%
April 2020	$266,427	($33,288)	-12%	$233,139	$234,096	($957)	99.59%
May 2020	$345,601	($44,461)	-13%	$301,140	$309,081	($7,941)	97.43%
June 2020	$251,086	($4,778)	-2%	$246,308	$246,696	($388)	99.84%
July 2020	$229,177	($6,619)	-3%	$222,558	$242,069	($19,511)	91.93%
August 2020	$11,958	($478)	-4%	$11,480	$11,525	($45)	99.61%
September 2020	$7,819	$0	0%	$7,819	$7,856	($37)	99.52%
October 2020	$5,021	$0	0%	$5,021	$5,046	($25)	99.49%
November 2020	$1,578	$0	0%	$1,578	$1,578	$0	100.00%
December 2020	$277	$0	0%	$277	$6,561	($6,284)	4.22%
January 2021	$647	$0	0%	$647	$647	$0	100.00%
February 2021	$0	$0		$0	$0	$0	
March 2021	$2,072	$0	0%	$2,072	$2,072	$0	100.00%
April 2021	$0	$0		$0	$29	($29)	0.00%
May 2021	$0	$0		$0	$0	$0	
June 2021	$592	$0	0%	$592	$592	$0	100.00%
July 2021	$666	($218)	-33%	$448	$448	$0	100.00%
August 2021	$0	$0		$0	$0	$0	
September 2021	$3,431	$0	0%	$3,431	$3,431	$0	100.00%
October 2021	$0	$0		$0	$0	$0	
November 2021	$0	$0		$0	$0	$0	
December 2021	$62	$0	0%	$62	$62	$0	100.00%
January 2022	$0	$0		$0	$0	$0	
February 2022	$0	$0		$0	$0	$0	
Cumulative Totals	**$1,598,109**	**($149,287)**	**-9%**	**$1,448,822**	**$1,485,147**	**($36,325)**	**97.55%**
100% Limited Cumulative Total							
						State Contract Minimum Completeness Percentage Requirement	*97.00%*

Aetna Better Health of Louisiana Superior Vision Monthly Table

Table 4 — Aetna Superior Vision (Vision)							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
March 2020	$355,999	($162,746)	-46%	$193,253	$197,785	($4,532)	97.70%
April 2020	$76,975	($42,599)	-55%	$34,376	$38,289	($3,912)	89.78%
May 2020	$154,199	($78,802)	-51%	$75,397	$63,496	$11,901	118.74%
June 2020	$165,560	($7,385)	-4%	$158,175	$161,906	($3,731)	97.69%
July 2020	$171,506	($8,067)	-5%	$163,440	$168,013	($4,573)	97.27%
August 2020	$175,323	($10,362)	-6%	$164,960	$172,708	($7,747)	95.51%
September 2020	$174,367	($17,616)	-10%	$156,750	$163,727	($6,977)	95.73%
October 2020	$194,282	($10,297)	-5%	$183,985	$190,576	($6,591)	96.54%
November 2020	$188,947	($4,711)	-2%	$184,236	$189,014	($4,779)	97.47%
December 2020	$164,947	($4,171)	-3%	$160,776	$165,368	($4,591)	97.22%
January 2021	$203,528	($7,962)	-4%	$195,566	$203,744	($8,177)	95.98%
February 2021	$184,681	($7,103)	-4%	$177,578	$184,871	($7,293)	96.05%
March 2021	$227,756	($7,296)	-3%	$220,460	$227,839	($7,379)	96.76%
April 2021	$161,939	($3,936)	-2%	$158,003	$162,236	($4,233)	97.39%
May 2021	$196,647	($5,657)	-3%	$190,990	$196,858	($5,867)	97.01%
June 2021	$174,108	($4,569)	-3%	$169,538	$174,108	($4,569)	97.37%
July 2021	$153,552	($3,971)	-3%	$149,582	$153,207	($3,626)	97.63%
August 2021	$194,640	($4,409)	-2%	$190,231	$193,804	($3,573)	98.15%
September 2021	$132,892	($4,065)	-3%	$128,828	$127,558	$1,270	100.99%
October 2021	$173,579	($4,141)	-2%	$169,438	$153,965	$15,473	110.04%
November 2021	$172,326	($4,821)	-3%	$167,504	$171,112	($3,608)	97.89%
December 2021	$162,006	($6,227)	-4%	$155,779	$160,095	($4,316)	97.30%
January 2022	$187,478	($5,117)	-3%	$182,360	$186,575	($4,215)	97.74%
February 2022	$199,159	($6,529)	-3%	$192,630	$198,643	($6,013)	96.97%
Cumulative Totals	**$4,346,394**	**($422,557)**	**-10%**	**$3,923,836**	**$4,005,496**	**($81,660)**	**97.96%**
100% Limited Cumulative Total							
						State Contract Minimum Completeness Percentage Requirement	*97.00%*

Aetna Better Health of Louisiana DentaQuest Monthly Table

Table 5— Aetna DentaQuest (Dental)							
Paid Month	Monthly Encounter Total (FAC Reported)	Monthly Encounter Total (Adjustments)	Percentage of Encounters Adjusted	Monthly Encounter Net Total	CDJ Monthly Reported Total	Monthly Variance	Monthly Completion Percentage
March 2020	$895,803	($665,223)	-74%	$230,580	$183,260	$47,319	125.82%
April 2020	$266,282	($188,410)	-71%	$77,872	$57,220	$20,652	136.09%
May 2020	$519,769	($359,213)	-69%	$160,556	$116,167	$44,389	138.21%
June 2020	$832,845	($589,432)	-71%	$243,413	$175,276	$68,137	138.87%
July 2020	$995,376	($705,465)	-71%	$289,911	$232,636	$57,275	124.62%
August 2020	$986,904	($704,623)	-71%	$282,281	$235,461	$46,820	119.88%
September 2020	$825,107	($591,183)	-72%	$233,924	$188,578	$45,347	124.04%
October 2020	$1,240,936	($888,295)	-72%	$352,641	$280,848	$71,793	125.56%
November 2020	$978,816	($708,602)	-72%	$270,214	$215,526	$54,688	125.37%
December 2020	$1,234,027	($919,189)	-74%	$314,838	$251,383	$63,455	125.24%
January 2021	$982,049	($699,332)	-71%	$282,718	$222,359	$60,359	127.14%
February 2021	$864,193	($627,505)	-73%	$236,688	$191,065	$45,623	123.87%
March 2021	$795,933	($573,256)	-72%	$222,677	$177,590	$45,087	125.38%
April 2021	$1,364,835	($984,600)	-72%	$380,235	$320,395	$59,840	118.67%
May 2021	$988,255	($693,396)	-70%	$294,859	$237,983	$56,876	123.89%
June 2021	$999,314	($754,015)	-75%	$245,299	$205,638	$39,661	119.28%
July 2021	$510,648	($330,328)	-65%	$180,321	$209,265	($28,945)	86.16%
August 2021	$194,430	($43,217)	-22%	$151,213	$176,468	($25,255)	85.68%
September 2021	$287,389	($106,457)	-37%	$180,932	$155,941	$24,991	116.02%
October 2021	$185,765	($27,951)	-15%	$157,814	$162,647	($4,832)	97.02%
November 2021	$175,107	($23,811)	-14%	$151,296	$182,971	($31,674)	82.68%
December 2021	$183,140	($18,278)	-10%	$164,862	$164,236	$626	100.38%
January 2022	$158,636	($15,818)	-10%	$142,818	$143,563	($745)	99.48%
February 2022	$236,972	($55,601)	-23%	$181,371	$209,765	($28,395)	86.46%
Cumulative Totals	**$16,702,531**	**($11,273,200)**	**-67%**	**$5,429,332**	**$4,696,241**	**$733,090**	**115.61%**
100% Limited^ Cumulative Total				$4,696,241	$4,696,241	$0	100.00%
						State Contract Minimum Completeness Percentage Requirement	*97.00%*
						Non-Compliant	***15.61%***

^ - Since the DentaQuest cumulative completion percentage exceeds 100 percent, we have decreased the encounter totals by the total variance in comparison to the CDJ to avoid overstating the Entire Plan results. Please see data analysis assumption number 9 on page 27 for further explanation.

Aetna Better Health of Louisiana CVS Health Monthly Table

Table 6 — Aetna CVS Health (Pharmacy Benefits)							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
March 2020	$16,279,987	($2,993,679)	-18%	$13,286,307	$13,316,806	($30,498)	99.77%
April 2020	$16,181,618	($129,701)	-1%	$16,051,917	$16,025,717	$26,200	100.16%
May 2020	$12,799,932	($30,939)	0%	$12,768,993	$12,853,298	($84,305)	99.34%
June 2020	$13,585,400	($547,832)	-4%	$13,037,568	$13,129,966	($92,398)	99.29%
July 2020	$18,117,659	($661,900)	-4%	$17,455,759	$17,431,002	$24,757	100.14%
August 2020	$14,531,634	($547,684)	-4%	$13,983,950	$14,162,631	($178,681)	98.73%
September 2020	$17,452,520	($491,680)	-3%	$16,960,840	$17,046,812	($85,972)	99.49%
October 2020	$14,892,677	($431,241)	-3%	$14,461,437	$14,507,071	($45,634)	99.68%
November 2020	$14,787,377	($335,476)	-2%	$14,451,900	$14,530,105	($78,205)	99.46%
December 2020	$18,783,557	($81,246)	0%	$18,702,311	$18,754,392	($52,081)	99.72%
January 2021	$13,892,408	($41,882)	0%	$13,850,526	$14,131,377	($280,851)	98.01%
February 2021	$14,571,465	($51,767)	0%	$14,519,698	$14,615,898	($96,200)	99.34%
March 2021	$19,683,098	($113,670)	-1%	$19,569,428	$19,393,875	$175,553	100.90%
April 2021	$16,236,071	($51,198)	0%	$16,184,873	$16,220,447	($35,574)	99.78%
May 2021	$16,249,182	($19,084)	0%	$16,230,098	$16,190,266	$39,832	100.24%
June 2021	$20,236,215	($30,115)	0%	$20,206,100	$20,171,320	$34,781	100.17%
July 2021	$16,443,996	($29,699)	0%	$16,414,297	$16,493,749	($79,452)	99.51%
August 2021	$20,974,635	($4,208,166)	-20%	$16,766,469	$16,752,005	$14,464	100.08%
September 2021	$18,415,481	($42,663)	0%	$18,372,818	$18,490,729	($117,911)	99.36%
October 2021	$16,519,164	($59,562)	0%	$16,459,601	$16,320,410	$139,191	100.85%
November 2021	$16,666,870	($33,584)	0%	$16,633,286	$16,636,043	($2,757)	99.98%
December 2021	$28,026,852	($7,257,000)	-26%	$20,769,852	$20,805,429	($35,577)	99.82%
January 2022	$15,818,909	($55,471)	0%	$15,763,438	$16,025,309	($261,872)	98.36%
February 2022	$17,532,597	($102,128)	-1%	$17,430,470	$17,308,409	$122,060	100.70%
Cumulative Totals	**$408,679,303**	**($18,347,367)**	**-4%**	**$390,331,936**	**$391,313,066**	**($981,129)**	**99.74%**
100% Limited Cumulative Total							
						State Contract Minimum Completeness Percentage Requirement	*97.00%*

Aetna Better Health of Louisiana Non-Vendor Monthly Table

Table 7 — Aetna Non-Vendor							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
March 2020	$42,757,358	($11,105,470)	-26%	$31,651,888	$30,565,602	$1,086,287	103.55%
April 2020	$34,619,406	($7,738,283)	-22%	$26,881,123	$27,268,113	($386,990)	98.58%
May 2020	$33,971,865	($8,344,597)	-25%	$25,627,269	$26,508,567	($881,298)	96.67%
June 2020	$42,131,148	($10,634,875)	-25%	$31,496,272	$32,321,538	($825,266)	97.44%
July 2020	$47,162,002	($13,691,183)	-29%	$33,470,819	$30,733,899	$2,736,920	108.90%
August 2020	$47,291,214	($12,603,852)	-27%	$34,687,362	$34,146,315	$541,048	101.58%
September 2020	$39,706,404	($8,591,098)	-22%	$31,115,306	$33,139,229	($2,023,922)	93.89%
October 2020	$43,877,055	($12,097,699)	-28%	$31,779,356	$34,621,510	($2,842,154)	91.79%
November 2020	$36,145,056	($9,141,807)	-25%	$27,003,249	$32,309,275	($5,306,027)	83.57%
December 2020	$41,515,791	($10,422,361)	-25%	$31,093,430	$34,270,515	($3,177,086)	90.72%
January 2021	$37,897,582	($7,538,912)	-20%	$30,358,670	$34,101,942	($3,743,272)	89.02%
February 2021	$35,146,365	($9,106,143)	-26%	$26,040,223	$29,449,493	($3,409,271)	88.42%
March 2021	$52,042,752	($16,639,889)	-32%	$35,402,863	$40,905,915	($5,503,052)	86.54%
April 2021	$54,284,578	($20,407,488)	-38%	$33,877,090	$31,566,182	$2,310,908	107.32%
May 2021	$48,650,783	($10,921,716)	-22%	$37,729,066	$37,462,750	$266,316	100.71%
June 2021	$48,988,899	($12,975,150)	-26%	$36,013,749	$37,227,153	($1,213,405)	96.74%
July 2021	$52,062,823	($17,179,018)	-33%	$34,883,806	$33,412,835	$1,470,971	104.40%
August 2021	$49,202,361	($12,300,338)	-25%	$36,902,023	$37,794,410	($892,387)	97.63%
September 2021	$42,390,372	($9,478,814)	-22%	$32,911,558	$32,889,852	$21,706	100.06%
October 2021	$57,307,911	($13,837,424)	-24%	$43,470,486	$40,582,121	$2,888,365	107.11%
November 2021	$49,523,960	($14,001,774)	-28%	$35,522,185	$34,022,214	$1,499,972	104.40%
December 2021	$38,357,790	($4,254,840)	-11%	$34,102,951	$34,682,151	($579,201)	98.32%
January 2022	$43,772,371	($9,404,925)	-21%	$34,367,447	$36,537,558	($2,170,111)	94.06%
February 2022	$45,905,883	($12,269,376)	-27%	$33,636,506	$36,605,366	($2,968,860)	91.88%
Cumulative Totals	**$1,064,711,729**	**($274,687,034)**	**-26%**	**$790,024,695**	**$813,124,505**	**($23,099,810)**	**97.15%**
100% Limited Cumulative Total							
						State Contract Minimum Completeness Percentage Requirement	*97.00%*

Aetna Summary Reporting Charts

Chart 1. Monthly CDJ totals and encounter submission for Aetna Better Health of Louisiana

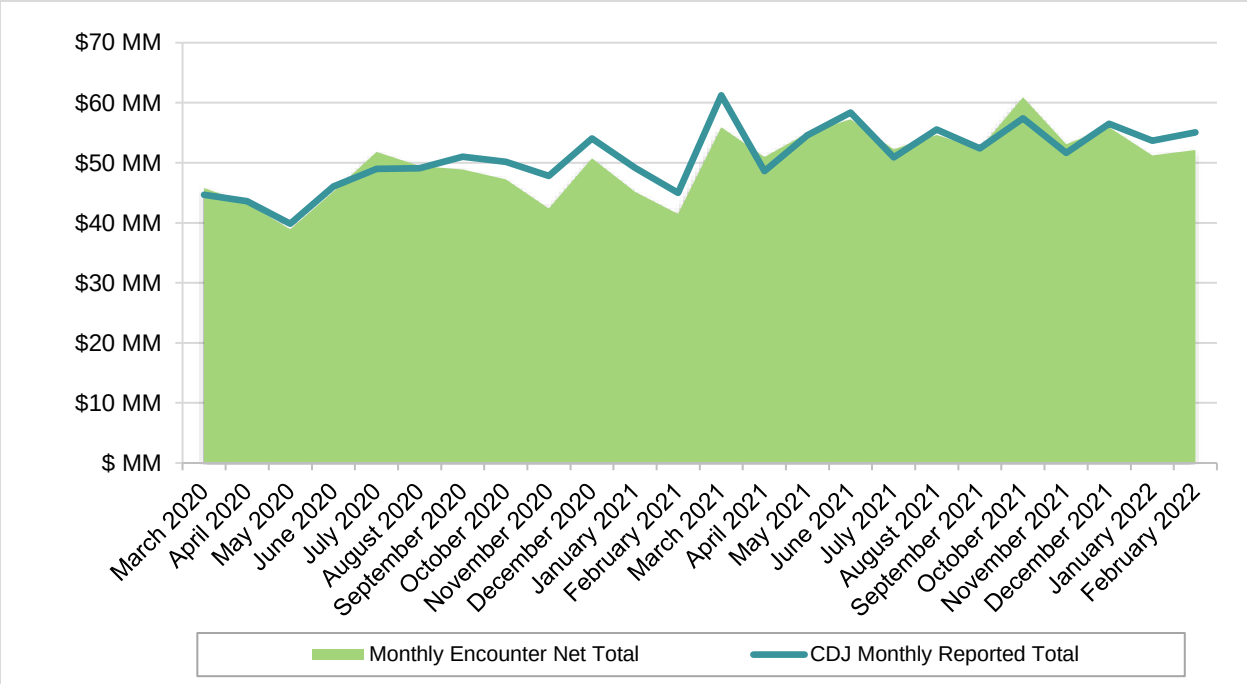
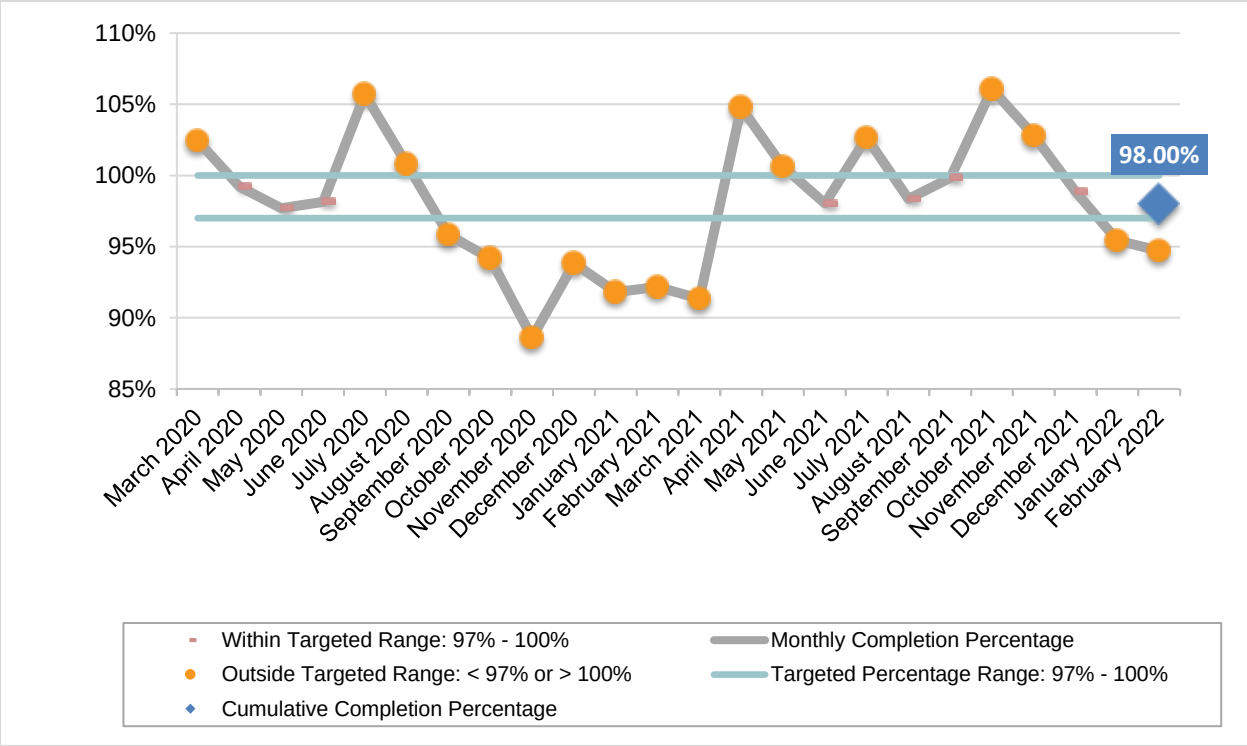


Chart 2. Aetna Better Health of Louisiana's monthly encounter submissions expressed as a percentage of payments submitted to the FAC to reported MCO monthly CDJ payment



Appendix A – Value Added Services (VAS) Monthly Tables

Table 1V — Aetna VAS (Entire Plan)							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
March 2020	$1,161,828	($787,762)	-68%	$374,066	$331,263	$42,803	112.92%
April 2020	$335,784	($223,558)	-67%	$112,226	$91,071	$21,155	123.22%
May 2020	$638,785	($417,924)	-65%	$220,862	$169,686	$51,175	130.15%
June 2020	$967,367	($600,825)	-62%	$366,542	$301,336	$65,206	121.63%
July 2020	$1,209,715	($770,711)	-64%	$439,004	$373,146	$65,858	117.64%
August 2020	$1,168,238	($745,537)	-64%	$422,702	$378,471	$44,230	111.68%
September 2020	$1,004,976	($626,440)	-62%	$378,537	$340,763	$37,774	111.08%
October 2020	$1,419,315	($901,388)	-64%	$517,926	$455,803	$62,123	113.62%
November 2020	$1,135,757	($713,399)	-63%	$422,358	$372,794	$49,564	113.29%
December 2020	$1,375,567	($928,478)	-67%	$447,090	$391,390	$55,700	114.23%
January 2021	$1,145,383	($707,378)	-62%	$438,005	$384,471	$53,535	113.92%
February 2021	$1,022,387	($637,106)	-62%	$385,281	$347,763	$37,518	110.78%
March 2021	$981,042	($584,091)	-60%	$396,951	$361,940	$35,011	109.67%
April 2021	$1,495,897	($990,184)	-66%	$505,713	$451,320	$54,394	112.05%
May 2021	$1,146,031	($698,935)	-61%	$447,096	$394,751	$52,345	113.26%
June 2021	$1,138,449	($758,903)	-67%	$379,546	$345,003	$34,543	110.01%
July 2021	$632,954	($334,447)	-53%	$298,507	$330,535	($32,028)	90.31%
August 2021	$337,103	($46,806)	-14%	$290,297	$317,927	($27,630)	91.30%
September 2021	$400,622	($113,456)	-28%	$287,166	$262,028	$25,139	109.59%
October 2021	$325,859	($31,987)	-10%	$293,872	$275,046	$18,826	106.84%
November 2021	$325,525	($33,882)	-10%	$291,643	$303,796	($12,153)	95.99%
December 2021	$324,966	($24,469)	-8%	$300,498	$304,358	($3,860)	98.73%
January 2022	$316,480	($21,130)	-7%	$295,349	$278,293	$17,056	106.12%
February 2022	$405,167	($61,408)	-15%	$343,760	$354,098	($10,339)	97.08%
Cumulative Totals	**$20,415,197**	**($11,760,200)**	**-58%**	**$8,654,997**	**$7,917,052**	**$737,945**	**109.32%**
100% Limited^ Cumulative Total				$7,908,078	$7,917,052	($8,973)	99.88%
						State Contract Minimum Completeness Percentage Requirement	*97.00%*
						Non-Compliant	***9.32%***

^ - Since the Non-Vendor and DentaQuest cumulative completion percentages exceed 100 percent, we have decreased the Entire Plan encounter totals by the total variance in comparison to the CDJ to avoid overstating the Entire Plan results. Please see data analysis assumption number 9 on page 27 for further explanation.

Appendix A – Value Added Services (VAS) Monthly Tables

Table 2V — Aetna OneCall VAS (Non-Emergency Transportation)							
Paid Month	Monthly Encounter Total (FAC Reported)	Monthly Encounter Total (Adjustments)	Percentage of Encounters Adjusted	Monthly Encounter Net Total	CDJ Monthly Reported Total	Monthly Variance	Monthly Completion Percentage
March 2020	$0	$0		$0	$0	$0	
April 2020	$0	$0		$0	$0	$0	
May 2020	$0	$0		$0	$0	$0	
June 2020	$0	$0		$0	$0	$0	
July 2020	$16,815	($9,623)	-57%	$7,192	$7,371	($178)	97.57%
August 2020	$29,539	($16,075)	-54%	$13,464	$13,932	($468)	96.64%
September 2020	$43,435	($19,466)	-45%	$23,968	$26,364	($2,395)	90.91%
October 2020	$37,079	($3,388)	-9%	$33,691	$37,332	($3,641)	90.24%
November 2020	$15,306	($2,070)	-14%	$13,235	$15,495	($2,260)	85.41%
December 2020	$9,636	($3,698)	-38%	$5,938	$8,931	($2,992)	66.49%
January 2021	$7,410	($1,629)	-22%	$5,781	$5,806	($25)	99.57%
February 2021	$9,905	($3,133)	-32%	$6,772	$7,740	($968)	87.49%
March 2021	$9,893	($3,322)	-34%	$6,570	$7,393	($822)	88.87%
April 2021	$7,470	($2,448)	-33%	$5,021	$5,130	($108)	97.89%
May 2021	$4,781	($540)	-11%	$4,241	$4,521	($280)	93.80%
June 2021	$6,407	($1,153)	-18%	$5,255	$5,255	$0	100.00%
July 2021	$7,518	($16)	0%	$7,503	$7,503	$0	100.00%
August 2021	$7,659	($292)	-4%	$7,367	$7,466	($98)	98.68%
September 2021	$7,036	($662)	-9%	$6,373	$6,758	($385)	94.30%
October 2021	$8,088	($750)	-9%	$7,337	($5,630)	$12,967	-130.32%
November 2021	$11,612	($1,550)	-13%	$10,062	$10,842	($780)	92.80%
December 2021	$11,278	($485)	-4%	$10,794	$10,991	($197)	98.20%
January 2022	$14,159	($549)	-4%	$13,610	$14,162	($552)	96.10%
February 2022	$13,104	($954)	-7%	$12,150	$12,631	($481)	96.19%
Cumulative Totals	**$278,130**	**($71,803)**	**-26%**	**$206,327**	**$209,991**	**($3,664)**	**98.25%**
100% Limited Cumulative Total							
						State Contract Minimum Completeness Percentage Requirement	*97.00%*

Appendix A – Value Added Services (VAS) Monthly Tables

Table 3V — Aetna ModivCare VAS (Non-Emergency Transportation)							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
March 2020	$0	$0		$0	$0	$0	
April 2020	$0	$0		$0	$0	$0	
May 2020	$0	$0		$0	$0	$0	
June 2020	$0	$0		$0	$0	$0	
July 2020	$0	$0		$0	$3,515	($3,515)	0.00%
August 2020	$0	$0		$0	$129	($129)	0.00%
September 2020	$0	$0		$0	$222	($222)	0.00%
October 2020	$0	$0		$0	$0	$0	
November 2020	$0	$0		$0	$0	$0	
December 2020	$0	$0		$0	$318	($318)	0.00%
January 2021	$0	$0		$0	$0	$0	
February 2021	$0	$0		$0	$0	$0	
March 2021	$0	$0		$0	$35	($35)	0.00%
April 2021	$0	$0		$0	$0	$0	
May 2021	$0	$0		$0	$0	$0	
June 2021	$0	$0		$0	$0	$0	
July 2021	$0	$0		$0	$30	($30)	0.00%
August 2021	$0	$0		$0	$0	$0	
September 2021	$0	$0		$0	$1,060	($1,060)	0.00%
October 2021	$0	$0		$0	$0	$0	
November 2021	$0	$0		$0	$0	$0	
December 2021	$0	$0		$0	$0	$0	
January 2022	$0	$0		$0	$0	$0	
February 2022	$0	$0		$0	$0	$0	
Cumulative Totals	**$0**	**$0**		**$0**	**$5,309**	**($5,309)**	**0.00%**
100% Limited Cumulative Total							
						State Contract Minimum Completeness Percentage Requirement	*97.00%*
						Non-Compliant	***-97.00%***

Appendix A – Value Added Services (VAS) Monthly Tables

Table 4V — Aetna Superior Vision VAS (Vision)							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
March 2020	$245,640	($112,460)	-46%	$133,180	$136,086	($2,907)	97.86%
April 2020	$49,591	($26,939)	-54%	$22,652	$24,465	($1,813)	92.58%
May 2020	$104,266	($53,078)	-51%	$51,188	$43,675	$7,514	117.20%
June 2020	$116,275	($5,802)	-5%	$110,473	$113,271	($2,797)	97.53%
July 2020	$121,644	($6,411)	-5%	$115,232	$118,891	($3,659)	96.92%
August 2020	$120,654	($6,029)	-5%	$114,626	$118,213	($3,587)	96.96%
September 2020	$120,585	($14,969)	-12%	$105,616	$111,313	($5,697)	94.88%
October 2020	$128,694	($8,351)	-6%	$120,343	$125,754	($5,411)	95.69%
November 2020	$129,039	($2,444)	-2%	$126,595	$129,039	($2,444)	98.10%
December 2020	$115,392	($3,334)	-3%	$112,058	$115,813	($3,755)	96.75%
January 2021	$143,775	($5,933)	-4%	$137,841	$143,945	($6,104)	95.75%
February 2021	$135,024	($5,562)	-4%	$129,462	$135,214	($5,752)	95.74%
March 2021	$163,252	($5,941)	-4%	$157,311	$163,252	($5,941)	96.36%
April 2021	$114,520	($2,839)	-2%	$111,682	$114,732	($3,050)	97.34%
May 2021	$141,853	($4,231)	-3%	$137,623	$142,049	($4,427)	96.88%
June 2021	$122,653	($3,421)	-3%	$119,232	$122,653	($3,421)	97.21%
July 2021	$101,447	($3,032)	-3%	$98,414	$101,270	($2,856)	97.18%
August 2021	$120,262	($2,731)	-2%	$117,530	$119,807	($2,277)	98.09%
September 2021	$87,248	($1,984)	-2%	$85,265	$86,670	($1,405)	98.37%
October 2021	$118,945	($3,171)	-3%	$115,775	$104,831	$10,944	110.43%
November 2021	$117,881	($3,680)	-3%	$114,201	$99,482	$14,719	114.79%
December 2021	$115,338	($3,976)	-3%	$111,362	$114,568	($3,206)	97.20%
January 2022	$129,960	($4,350)	-3%	$125,610	$106,802	$18,808	117.61%
February 2022	$141,445	($4,853)	-3%	$136,592	$117,918	$18,675	115.83%
Cumulative Totals	**$3,005,384**	**($295,520)**	**-10%**	**$2,709,863**	**$2,709,712**	**$152**	**100.00%**
100% Limited Cumulative Total							
						State Contract Minimum Completeness Percentage Requirement	*97.00%*

Appendix A – Value Added Services (VAS) Monthly Tables

Table 5V — Aetna DentaQuest VAS (Dental)							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
March 2020	$895,803	($665,223)	-74%	$230,580	$183,260	$47,319	125.82%
April 2020	$266,282	($188,410)	-71%	$77,872	$57,220	$20,652	136.09%
May 2020	$519,769	($359,213)	-69%	$160,556	$116,167	$44,389	138.21%
June 2020	$832,845	($589,432)	-71%	$243,413	$175,276	$68,137	138.87%
July 2020	$995,376	($705,465)	-71%	$289,911	$232,636	$57,275	124.62%
August 2020	$986,904	($704,623)	-71%	$282,281	$235,461	$46,820	119.88%
September 2020	$825,107	($591,183)	-72%	$233,924	$188,578	$45,347	124.04%
October 2020	$1,240,936	($888,295)	-72%	$352,641	$280,848	$71,793	125.56%
November 2020	$978,816	($708,602)	-72%	$270,214	$215,526	$54,688	125.37%
December 2020	$1,234,027	($919,189)	-74%	$314,838	$251,383	$63,455	125.24%
January 2021	$982,049	($699,332)	-71%	$282,718	$222,359	$60,359	127.14%
February 2021	$864,193	($627,505)	-73%	$236,688	$191,065	$45,623	123.87%
March 2021	$795,933	($573,256)	-72%	$222,677	$177,590	$45,087	125.38%
April 2021	$1,364,835	($984,600)	-72%	$380,235	$320,395	$59,840	118.67%
May 2021	$988,255	($693,396)	-70%	$294,859	$237,983	$56,876	123.89%
June 2021	$999,314	($754,015)	-75%	$245,299	$205,638	$39,661	119.28%
July 2021	$510,648	($330,328)	-65%	$180,321	$209,265	($28,945)	86.16%
August 2021	$194,430	($43,217)	-22%	$151,213	$176,468	($25,255)	85.68%
September 2021	$287,389	($106,457)	-37%	$180,932	$155,941	$24,991	116.02%
October 2021	$185,765	($27,951)	-15%	$157,814	$162,647	($4,832)	97.02%
November 2021	$175,107	($23,811)	-14%	$151,296	$182,971	($31,674)	82.68%
December 2021	$183,140	($18,278)	-10%	$164,862	$164,236	$626	100.38%
January 2022	$158,636	($15,818)	-10%	$142,818	$143,563	($745)	99.48%
February 2022	$236,972	($55,601)	-23%	$181,371	$209,765	($28,395)	86.46%
Cumulative Totals	**$16,702,531**	**($11,273,200)**	**-67%**	**$5,429,332**	**$4,696,241**	**$733,090**	**115.61%**
100% Limited^ Cumulative Total				$4,696,241	$4,696,241	$0	100.00%
						State Contract Minimum Completeness Percentage Requirement	*97.00%*
						Non-Compliant	***15.61%***

^ - Since the DentaQuest VAS cumulative completion percentage exceeds 100 percent, we have decreased the encounter totals by the total variance in comparison to the CDJ to avoid overstating the Entire Plan results. Please see data analysis assumption number 9 on page 27 for further explanation.

Appendix A – Value Added Services (VAS) Monthly Tables

Table 6V — Aetna VAS Non-Vendor							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
March 2020	$20,386	($10,079)	-49%	$10,307	$11,917	($1,610)	86.49%
April 2020	$19,911	($8,209)	-41%	$11,702	$9,386	$2,315	124.66%
May 2020	$14,750	($5,633)	-38%	$9,117	$9,845	($728)	92.61%
June 2020	$18,247	($5,591)	-31%	$12,656	$12,789	($133)	98.95%
July 2020	$75,881	($49,211)	-65%	$26,669	$10,735	$15,934	248.43%
August 2020	$31,141	($18,810)	-60%	$12,331	$10,737	$1,594	114.85%
September 2020	$15,849	($821)	-5%	$15,028	$14,286	$742	105.19%
October 2020	$12,606	($1,355)	-11%	$11,251	$11,869	($618)	94.79%
November 2020	$12,596	($283)	-2%	$12,314	$12,734	($420)	96.69%
December 2020	$16,511	($2,257)	-14%	$14,255	$14,945	($690)	95.38%
January 2021	$12,149	($484)	-4%	$11,665	$12,361	($695)	94.37%
February 2021	$13,264	($906)	-7%	$12,358	$13,744	($1,385)	89.91%
March 2021	$11,964	($1,571)	-13%	$10,393	$13,670	($3,277)	76.03%
April 2021	$9,072	($297)	-3%	$8,776	$11,063	($2,288)	79.32%
May 2021	$11,141	($769)	-7%	$10,373	$10,197	$176	101.72%
June 2021	$10,074	($314)	-3%	$9,761	$11,457	($1,697)	85.19%
July 2021	$13,340	($1,071)	-8%	$12,269	$12,467	($197)	98.41%
August 2021	$14,752	($565)	-4%	$14,186	$14,186	$0	100.00%
September 2021	$18,948	($4,352)	-23%	$14,596	$11,598	$2,998	125.84%
October 2021	$13,061	($115)	-1%	$12,946	$13,199	($253)	98.08%
November 2021	$20,926	($4,842)	-23%	$16,084	$10,501	$5,583	153.16%
December 2021	$15,210	($1,731)	-11%	$13,480	$14,563	($1,083)	92.56%
January 2022	$13,725	($413)	-3%	$13,312	$13,766	($455)	96.69%
February 2022	$13,646	$0	0%	$13,646	$13,784	($138)	99.00%
Cumulative Totals	**$429,152**	**($119,677)**	**-28%**	**$309,475**	**$295,798**	**$13,676**	**104.62%**
100% Limited^ Cumulative Total				$295,798	$295,798	$0	100.00%
						State Contract Minimum Completeness Percentage Requirement	*97.00%*
						Non-Compliant	***4.62%***

^ - Since the Non-Vendor VAS cumulative completion percentage exceeds 100 percent, we have decreased the encounter totals by the total variance in comparison to the CDJ to avoid overstating the Entire Plan results. Please see data analysis assumption number 9 on page 27 for further explanation.

Appendix B – Definitions and Acronyms

The following terms are used throughout this document:

- **Bayou Health** – The state of Louisiana's Medicaid managed care program name from inception through April 2016. Starting in February 2012, many members of the traditional Medicaid "delivery system" were transitioned from fee-for-service to Bayou Health. Prior to February 1, 2015, Bayou Health's executed contracts included three risk-based prepaid health plans and two non-risk based shared savings plans (**Bayou Health 1.0**). Beginning February 1, 2015, the prepaid risk bearing managed care organization (MCO) model became the only delivery system for the Bayou Health program (**Bayou Health 2.0**). Effective May 2016, the Louisiana Medicaid managed care program was rebranded and became **Healthy Louisiana**.

- **Cash Disbursement Journal (CDJ) Monthly Reported Total** – The sum of all payments from an MCO or delegated vendor to service providers for a given month as reported by the MCO to the Louisiana Department of Health (LDH).

- **CDJ Cumulative Reported Total** – The sum of all payments from an MCO or delegated vendor to service providers for the reconciliation period as reported by the MCO to the LDH. This amount is inclusive of all amounts within the reporting period.

- **Cumulative Encounter Total** – The sum of all paid amounts on the encounters submitted to and stored in the fiscal agent contractor's (FAC) system. This amount is inclusive of all amounts within the reporting period.

- **Cumulative Variance** – The difference between the cumulative encounter total and the CDJ cumulative reported total.

- **DXC Technology (DXC)** – State fiscal agent contractor prior to October 1, 2020. Now known as Gainwell.

- **Fiscal Agent Contractor (FAC)** – A contractor selected to design, develop and maintain the claims processing system (Medicaid Management Information System); Gainwell is the current FAC.

- **Gainwell Technologies (Gainwell)** – State fiscal agent contractor, known as DXC Technology prior to October 1, 2020.

- Healthy Louisiana – The state of Louisiana's Medicaid managed care program name as of May 2016, formerly Bayou Health.

- **Louisiana Department of Health (LDH)** – The agency in charge of overseeing the health services for the citizens of the state of Louisiana.

- **Managed Care Organization (MCO)** – A private organization that has entered into a risk-based contractual arrangement with LDH to obtain and finance care for enrolled Medicaid or Louisiana Children's Health Insurance Program (LaCHIP) members. MCOs receive a capitation or per member, per month (PMPM) payment from LDH for each enrolled member. During the reporting period, five MCOs were operating in Louisiana. They are Healthy Blue – formerly Amerigroup Louisiana, Inc., AmeriHealth Caritas Louisiana (ACLA), Louisiana Healthcare Connections (LHCC), Aetna Better Health of Louisiana (Aetna), and United Healthcare Community Plan (UHC)

- **Medicaid Management Information System (MMIS)** – The claims processing system used by the FAC to adjudicate Louisiana Medicaid and LaCHIP claims. MCO submitted encounters are loaded into this system and assigned a unique claim identifier.

- **Molina Medicaid Solutions (MMS)** – State fiscal agent contractor prior to October 1, 2018. Now known as Gainwell.

- **Monthly Encounter Total** – The sum of all paid amounts for a given month on the encounters submitted to and stored in the FAC's system.
- **Monthly Variance** – The difference between the monthly encounter total and the CDJ monthly reported total.
- **Value-Added Services (VAS)** – A covered service provided by the MCO to its members that is currently a non-covered service in the state's fee-for-service plan, for which the MCO received no additional capitated payment. Also known as Expanded Services.

Appendix C – Analysis

Encounters from institutional, medical, and pharmacy claim types were combined on like data fields. We analyzed the line reported information of each encounter to capture the amount paid on the entire claim. Encounter totals were calculated by summarizing the data by the MCO paid date, MCO identification number (ID), and specific delegated vendor criteria. MCO submitted cash disbursements were summarized by paid date, MCO ID, and specific delegated vendor criteria to create a matching table. These matching tables were combined using common fields between the tables and were used to produce the results.

Based on criteria provided by the MCO, we identified the Aetna Better Health of Louisiana's encounters as follows:

- ***OneCall - Non-Emergency Transportation (NET)***
  - Plan ICN field prefix contains 'OC' in the third and fourth positions.
- ***ModivCare (formerly known as LogistiCare) - Non-Emergency Transportation (NET)***[1]
  - Plan ICN field prefix contains 'TR' in the third and fourth positions.
- ***Superior Vision - Vision Services***
  - Plan ICN field prefix contains 'VI' in the third and fourth positions.
- ***DentaQuest - Dental Services***
  - Plan ICN field prefix contains 'DE' in the third and fourth positions.
- ***CVS Health - Pharmacy Benefits***
  - Claim type code of '12'.
- ***Aetna - Non-Vendor***
  - All other plan submitted encounters that do not meet the listed criteria.

1 – Replaced by OneCall – Effective July 1, 2020

Appendix D – Data Analysis Assumptions

1. This analysis is performed on encounter data that was submitted by the MCOs to the FAC and loaded into the FAC MMIS. Encounters submitted by any MCO that were rejected by the FAC for errors in submission or other reasons are not being transmitted to Myers and Stauffer LC.

2. For the purposes of this study, the payment amounts associated with denied encounters are identified as zero dollars in the encounter reconciliation analysis since they bear no impact on cash disbursements.

3. A voiding encounter has the same paid date as the original/voided encounter, which may differ from when the void or adjustment occurred. Therefore, the voiding encounters were coded to match the adjustment claim's paid date to allow for the proper matching of cash disbursements that occurred due to these void transactions. However, we were unable to reallocate the void encounters in which there was not an associated adjustment claim.

4. Instances were noted where a record's transaction type implied a specific sign valuation for the MCO paid amount (e.g., a void implied that the amount should be negative). However, the data submitted for these records did not accurately reflect the correct sign valuation. In addition, the paid amounts of certain void and back out encounters did not accurately reflect the paid amount of the corresponding encounter being adjusted. Where possible, these CDJ and/or encounter payment amounts were adjusted to reflect the expected sign and amount of the payment in accordance with the transaction type.

5. We instructed the MCOs to exclude referral fees, management fees and other non-encounter related fees from the CDJ data that is submitted to Myers and Stauffer LC. We reviewed the CDJs for these payments and removed them from the analysis when they were identified.

6. Separately itemized interest expenses are excluded from the CDJ and encounter totals when the interest amounts are included in the MCO paid amounts on the encounters and/or CDJ transactions.

7. Percentage ratios noted in this report are rounded down. The sum of the percentages may not add up to the percentage sum total (Tables A, B and C).

8. The short run-out period for encounter submissions may not allow sufficient time for the MCOs to resolve encounter submission issues noted in previous encounter reconciliation reports. This may result in lower completion percentages when reconciling the encounter to CDJ totals.

9. Cumulative completion percentages exceeding 100 percent were noted for DentaQuest and Non-Vendor value-added services (VAS). So that the impacted amounts do not overstate the Entire Plan results, we have decreased the applicable encounters' monthly reported totals by the variance between the encounter data and cash disbursement journals. Therefore, the cumulative completion percentages were decreased to a maximum of 100 percent (Tables A, C, 5, 5V and 6V on pages 4, 8, 13, 22 and 23, respectively).

10. Opportunities for improving the encounter reconciliation process have been identified during analysis of the encounter data and cash disbursement journals, as well as frequent interactions with the MCOs, their delegated vendors, LDH and the FAC. While we have attempted to account for these situations, other potential issues within the data may exist that have not yet been identified which may require us to restate a report or modify reconciliation processes in the future.

Appendix C: Claims Sample Completeness

Description	Inpatient						Outpatient					
	October 2020		April 2021		Total		October 2020		April 2021		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Claims Sample Data												
Claims Sample Total	20,455	$12,105,544	38,263	$10,464,683	58,718	$22,570,227	196,714	$8,531,295	342,557	$2,562,269	539,271	$11,093,564
Reconciling Adjustment	(18,758)	($1,791,050)	(35,138)	($1,689,972)	(53,896)	($3,481,022)	(13,224)	($667,619)	(109,340)	$5,355,221	(122,564)	$4,687,602
Net Claims Sample Total	1,697	$10,314,494	3,125	$8,774,711	4,822	$19,089,205	183,490	$7,863,676	233,217	$7,917,490	416,707	$15,781,166
Encounter Data												
Total Matched Encounters	1,673	$10,582,396	3,150	$10,836,654	4,823	$21,419,050	166,625	$9,885,435	238,578	$12,745,111	405,203	$22,630,545
Less Surplus Encounters	(31)	$0	(136)	($902,824)	(167)	($902,824)	(73)	($1,329)	(23,888)	($2,694,543)	(23,961)	($2,695,872)
Payment Adjustments	0	($124,115)	0	($564,529)	0	($688,644)	0	($839,634)	0	($504,818)	0	($1,344,452)
Net Matched Encounters	1,642	$10,458,282	3,014	$9,369,301	4,656	$19,827,583	166,552	$9,044,471	214,690	$9,545,750	381,242	$18,590,221
Encounter Completeness Percentage	***96.8%***	***101.4%***	***96.4%***	***106.8%***	***96.6%***	***103.9%***	***90.8%***	***115.0%***	***92.1%***	***120.6%***	***91.5%***	***117.8%***

Description	Professional						Total Medical					
	October 2020		April 2021		Total		October 2020		April 2021		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Claims Sample Data												
Claims Sample Total	376,335	$13,361,910	386,382	$13,405,777	762,717	$26,767,687	593,504	$33,998,749	767,202	$26,432,728	1,360,706	$60,431,477
Reconciling Adjustment	(28,603)	($1,294,896)	(68,865)	($2,420,360)	(97,468)	($3,715,256)	(60,585)	($3,753,565)	(213,343)	$1,244,889	(273,928)	($2,508,676)
Net Claims Sample Total	347,732	$12,067,014	317,517	$10,985,417	665,249	$23,052,431	532,919	$30,245,184	553,859	$27,677,617	1,086,778	$57,922,802
Encounter Data												
Total Matched Encounters	359,167	$19,725,886	334,251	$14,433,204	693,418	$34,159,089	527,465	$40,193,716	575,979	$38,014,969	1,103,444	$78,208,685
Less Surplus Encounters	(33,923)	($2,186,644)	(46,089)	($2,519,567)	(80,012)	($4,706,211)	(34,027)	($2,187,973)	(70,113)	($6,116,933)	(104,140)	($8,304,906)
Payment Adjustments	0	($3,435,520)	0	($403,306)	0	($3,838,826)	0	($4,399,269)	0	($1,472,653)	0	($5,871,922)
Net Matched Encounters	325,244	$14,103,721	288,162	$11,510,331	613,406	$25,614,052	493,438	$33,606,474	505,866	$30,425,382	999,304	$64,031,857
Encounter Completeness Percentage	***93.5%***	***116.9%***	***90.8%***	***104.8%***	***92.2%***	***111.1%***	***92.6%***	***111.1%***	***91.3%***	***109.9%***	***92.0%***	***110.5%***

Description	Dental						Vision					
	October 2020		April 2021		Total		October 2020		April 2021		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Claims Sample Data												
Claims Sample Total	5,902	$265,606	6,221	$290,324	12,123	$555,930	5,882	$186,397	5,130	$160,910	11,012	$347,307
Reconciling Adjustment	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
Net Claims Sample Total	5,902	$265,606	6,221	$290,324	12,123	$555,930	5,882	$186,397	5,130	$160,910	11,012	$347,307
Encounter Data												
Total Matched Encounters[1]	5,953	$267,313	6,262	$291,022	12,215	$558,335	5,983	$190,561	5,165	$162,828	11,148	$353,389
Less Surplus Encounters	(51)	($2,458)	(41)	($1,367)	(92)	($3,825)	(101)	($3,592)	(40)	($1,714)	(141)	($5,306)
Payment Adjustments	0	$751	0	$669	0	$1,419	0	($572)	0	($290)	0	($862)
Net Matched Encounters	5,902	$265,606	6,221	$290,324	12,123	$555,930	5,882	$186,397	5,125	$160,825	11,007	$347,221
Encounter Completeness Percentage	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***99.9%***	***99.9%***	***100.0%***	***100.0%***

Description	NEMT						Pharmacy					
	October 2020		April 2021		Total		October 2020		April 2021		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Claims Sample Data												
Claims Sample Total	40,404	$1,140,987	28,165	$858,696	68,569	$1,999,682	308,919	$15,333,455	325,947	$17,523,642	634,866	$32,857,097
Reconciling Adjustment	(51)	($469)	(37)	($2,599)	(88)	($3,067)	0	$0	0	$0	0	$0
Net Claims Sample Total	40,353	$1,140,518	28,128	$856,097	68,481	$1,996,615	308,919	$15,333,455	325,947	$17,523,642	634,866	$32,857,097
Encounter Data												
Total Matched Encounters[1]	21,231	$391,760	23,920	$375,310	45,151	$767,071	206,775	$15,706,228	218,487	$17,769,677	425,262	$33,475,905
Less Surplus Encounters	0	$0	(2)	($1)	(2)	($1)	(713)	($61,280)	(923)	($101,717)	(1,636)	($162,996)
Payment Adjustments	0	$80,930	0	$349,121	0	$430,050	0	($138,532)	0	($90,016)	0	($228,547)
Net Matched Encounters	21,231	$472,690	23,918	$724,430	45,149	$1,197,120	206,062	$15,506,417	217,564	$17,577,945	423,626	$33,084,362
Encounter Completeness Percentage	***52.6%***	***41.4%***	***85.0%***	***84.6%***	***65.9%***	***60.0%***	***66.7%***	***101.1%***	***66.7%***	***100.3%***	***66.7%***	***100.7%***

Appendix D: Overall Completeness

Description	CDJs	Claims Sample										Total		
		Medical		Dental		Vision		NEMT		Pharmacy		Total		
	Total Paid Amount	Total Count	Total Paid Amount	Total Count	Total Paid Amount	Total Count	Total Paid Amount	Total Count	Total Paid Amount	Total Count	Total Paid Amount	Total Count	Total Paid Amount	Overall Average[1]
Health Plan-Submitted Data														
Total Health Plan Data	$618,081,066	1,360,706	$60,431,477	12,123	$555,930	11,012	$347,307	68,569	$1,999,682	634,866	$32,857,097	2,087,276	$714,272,559	$716,359,835
Reconciling Adjustment	$0	(273,928)	($2,508,676)	0	$0	0	$0	(88)	($3,067)	0	$0	(274,016)	($2,511,743)	($2,785,759)
Net Health Plan Data	***$618,081,066***	***1,086,778***	***$57,922,802***	***12,123***	***$555,930***	***11,012***	***$347,307***	***68,481***	***$1,996,615***	***634,866***	***$32,857,097***	***1,813,260***	***$711,760,816***	***$713,574,076***
Encounter Data														
Total Matched Encounters	$754,917,086	1,103,444	$78,208,685	12,215	$558,335	11,148	$353,389	45,151	$767,071	425,262	$33,475,905	1,597,220	$868,280,471	$869,877,691
Surplus/Duplicative Adjustments	($158,807,535)	(104,140)	($8,304,906)	(92)	($3,825)	(141)	($5,306)	(2)	($1)	(1,636)	($162,996)	(106,011)	($167,284,569)	($167,390,580)
Payment Adjustments	$0	0	($5,871,922)	0	$1,419	0	($862)	0	$430,050	0	($228,547)	0	($5,669,861)	($5,669,861)
Net Matched Encounters	***$596,109,551***	***999,304***	***$64,031,857***	***12,123***	***$555,930***	***11,007***	***$347,221***	***45,149***	***$1,197,120***	***423,626***	***$33,084,362***	***1,491,209***	***$695,326,041***	***$696,817,250***
Encounter Completeness Percentage	***96.4%***	***92.0%***	***110.5%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***65.9%***	***60.0%***	***66.7%***	***100.7%***	***82.2%***	***97.7%***	***97.7%***

[1] Overall Average equals Total Count plus Total Paid Amount

Appendix E: Key Data Element Matching

Inpatient																		
Key Data Element	October 2020						April 2021						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
Header Level	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Admission Date	1,516	90.6%	38	2.3%	119	7.1%	2,823	89.6%	131	4.2%	196	6.2%	4,339	90.0%	169	3.5%	315	6.5%
Bill Type (digits 1 and 2)	1,673	100.0%	0	0.0%	0	0.0%	3,110	98.7%	0	0.0%	40	1.3%	4,783	99.2%	0	0.0%	40	0.8%
Billed Charges	1,580	94.4%	0	0.0%	93	5.6%	2,959	93.9%	0	0.0%	191	6.1%	4,539	94.1%	0	0.0%	284	5.9%
Billing Provider NPI/Number	1,673	100.0%	0	0.0%	0	0.0%	3,141	99.7%	0	0.0%	9	0.3%	4,814	99.8%	0	0.0%	9	0.2%
Diagnosis Codes	1,673	100.0%	0	0.0%	0	0.0%	3,150	100.0%	0	0.0%	0	0.0%	4,823	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	1,660	99.2%	N/A		13	0.8%	2,599	82.5%	N/A		551	17.5%	4,259	88.3%	N/A		564	11.7%
Header First Date of Service	1,673	100.0%	0	0.0%	0	0.0%	3,150	100.0%	0	0.0%	0	0.0%	4,823	100.0%	0	0.0%	0	0.0%
Header Last Date of Service	1,673	100.0%	0	0.0%	0	0.0%	3,150	100.0%	0	0.0%	0	0.0%	4,823	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	1,659	99.2%	0	0.0%	14	0.8%	3,051	96.9%	0	0.0%	99	3.1%	4,710	97.7%	0	0.0%	113	2.3%
Health Plan Paid Date	1,652	98.7%	0	0.0%	21	1.3%	2,556	81.1%	0	0.0%	594	18.9%	4,208	87.2%	0	0.0%	615	12.8%
MMIS ICN	1,527	91.3%	0	0.0%	146	8.7%	2,323	73.7%	0	0.0%	827	26.3%	3,850	79.8%	0	0.0%	973	20.2%
MMIS Member Number (Medicaid ID)	1,670	99.8%	0	0.0%	3	0.2%	3,144	99.8%	0	0.0%	6	0.2%	4,814	99.8%	0	0.0%	9	0.2%
Service Provider NPI/Number	1,673	100.0%	0	0.0%	0	0.0%	3,149	100.0%	0	0.0%	1	0.0%	4,822	100.0%	0	0.0%	1	0.0%
Service Provider Specialty/Taxonomy	1,667	99.6%	0	0.0%	6	0.4%	3,148	99.9%	0	0.0%	2	0.1%	4,815	99.8%	0	0.0%	8	0.2%
Surgical Procedure Codes	1,673	100.0%	N/A		0	0.0%	3,150	100.0%	N/A		0	0.0%	4,823	100.0%	N/A		0	0.0%
Sub-Total	***24,642***	***98.2%***	***38***	***0.2%***	***415***	***1.7%***	***44,603***	***94.4%***	***131***	***0.3%***	***2,516***	***5.3%***	***69,245***	***95.7%***	***169***	***0.2%***	***2,931***	***4.1%***
Total Records in the Encounter Dataset	1,673						3,150						4,823					
Number of Key Data Element Evaluated	15						15						15					
Maximum Header Count	25,095	100.0%					47,250	100.0%					72,345	100.0%				
Detail Level	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Revenue Code	17,006	99.4%	0	0.0%	109	0.6%	32,166	100.0%	0	0.0%	14	0.0%	49,172	99.8%	0	0.0%	123	0.2%
Maximum Detail Count	17,115	100.0%					32,180	100.0%					49,295	100.0%				
Total Header and Detail Level	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Total	***41,648***	***98.7%***	***38***	***0.1%***	***524***	***1.2%***	***76,769***	***96.6%***	***131***	***0.2%***	***2,530***	***3.2%***	***118,417***	***97.4%***	***169***	***0.1%***	***3,054***	***2.5%***
Maximum Total Count	42,210	100.0%					79,430	100.0%					121,640	100.0%				

Outpatient																		
Key Data Element	October 2020						April 2021						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Bill Type (digits 1 and 2)	166,625	100.0%	0	0.0%	0	0.0%	238,578	100.0%	0	0.0%	0	0.0%	405,203	100.0%	0	0.0%	0	0.0%
Billed Charges	117,773	70.7%	0	0.0%	48,852	29.3%	166,876	69.9%	0	0.0%	71,702	30.1%	284,649	70.2%	0	0.0%	120,554	29.8%
Billing Provider NPI/Number	162,445	97.5%	0	0.0%	4,180	2.5%	233,626	97.9%	0	0.0%	4,952	2.1%	396,071	97.7%	0	0.0%	9,132	2.3%
Diagnosis Codes	166,625	100.0%	0	0.0%	0	0.0%	238,578	100.0%	0	0.0%	0	0.0%	405,203	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	157,090	94.3%	N/A		9,535	5.7%	194,192	81.4%	N/A		44,386	18.6%	351,282	86.7%	N/A		53,921	13.3%
Health Plan Paid Amount	165,027	99.0%	0	0.0%	1,598	1.0%	223,130	93.5%	0	0.0%	15,448	6.5%	388,157	95.8%	0	0.0%	17,046	4.2%
Health Plan Paid Date	161,854	97.1%	0	0.0%	4,771	2.9%	200,113	83.9%	0	0.0%	38,465	16.1%	361,967	89.3%	0	0.0%	43,236	10.7%
Line First Date of Service	166,625	100.0%	0	0.0%	0	0.0%	238,550	100.0%	28	0.0%	0	0.0%	405,175	100.0%	28	0.0%	0	0.0%
Line Last Date of Service	166,604	100.0%	0	0.0%	21	0.0%	238,540	100.0%	28	0.0%	10	0.0%	405,144	100.0%	28	0.0%	31	0.0%
MMIS ICN	136,688	82.0%	0	0.0%	29,937	18.0%	163,492	68.5%	0	0.0%	75,086	31.5%	300,180	74.1%	0	0.0%	105,023	25.9%
MMIS Member Number (Medicaid ID)	166,482	99.9%	0	0.0%	143	0.1%	238,365	99.9%	0	0.0%	213	0.1%	404,847	99.9%	0	0.0%	356	0.1%
Procedure Code	166,625	100.0%	N/A		0	0.0%	238,578	100.0%	N/A		0	0.0%	405,203	100.0%	N/A		0	0.0%
Procedure Code Modifiers	166,625	100.0%	N/A		0	0.0%	238,578	100.0%	N/A		0	0.0%	405,203	100.0%	N/A		0	0.0%
Revenue Code	165,824	99.5%	0	0.0%	801	0.5%	237,634	99.6%	0	0.0%	944	0.4%	403,458	99.6%	0	0.0%	1,745	0.4%
Service Provider NPI/Number	166,492	99.9%	0	0.0%	133	0.1%	238,395	99.9%	0	0.0%	183	0.1%	404,887	99.9%	0	0.0%	316	0.1%
Service Provider Specialty/Taxonomy	166,342	99.8%	0	0.0%	283	0.2%	238,449	99.9%	15	0.0%	114	0.0%	404,791	99.9%	15	0.0%	397	0.1%
Total	***2,565,746***	***96.2%***	***0***	***0.0%***	***100,254***	***3.8%***	***3,565,674***	***93.4%***	***71***	***0.0%***	***251,503***	***6.6%***	***6,131,420***	***94.6%***	***71***	***0.0%***	***351,757***	***5.4%***
Total Records in the Encounter Dataset	166,625						238,578						405,203					
Number of Key Data Element Evaluated	16						16						16					
Maximum Count	2,666,000	100.0%					3,817,248	100.0%					6,483,248	100.0%				

Professional																		
Key Data Element	October 2020						April 2021						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
	Count	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	Count	Percent	Count	Percent	Count	Percent
Billed Charges	252,114	70.2%	0	0.0%	107,053	29.8%	231,373	69.2%	0	0.0%	102,878	30.8%	483,487	69.7%	0	0.0%	209,931	30.3%
Billing Provider NPI/Number	338,812	94.3%	0	0.0%	20,355	5.7%	308,838	92.4%	0	0.0%	25,413	7.6%	647,650	93.4%	0	0.0%	45,768	6.6%
Diagnosis Codes	359,167	100.0%	0	0.0%	0	0.0%	334,251	100.0%	0	0.0%	0	0.0%	693,418	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	338,598	94.3%	N/A		20,569	5.7%	307,466	92.0%	N/A		26,785	8.0%	646,064	93.2%	N/A		47,354	6.8%
Health Plan Paid Amount	324,804	90.4%	0	0.0%	34,363	9.6%	291,656	87.3%	0	0.0%	42,595	12.7%	616,460	88.9%	0	0.0%	76,958	11.1%
Health Plan Paid Date	295,827	82.4%	0	0.0%	63,340	17.6%	263,625	78.9%	0	0.0%	70,626	21.1%	559,452	80.7%	0	0.0%	133,966	19.3%
Line First Date of Service	324,554	90.4%	0	0.0%	34,613	9.6%	292,254	87.4%	0	0.0%	41,997	12.6%	616,808	89.0%	0	0.0%	76,610	11.0%
Line Last Date of Service	324,629	90.4%	0	0.0%	34,538	9.6%	292,232	87.4%	0	0.0%	42,019	12.6%	616,861	89.0%	0	0.0%	76,557	11.0%
MMIS ICN	241,883	67.3%	0	0.0%	117,284	32.7%	223,761	66.9%	0	0.0%	110,490	33.1%	465,644	67.2%	0	0.0%	227,774	32.8%
MMIS Member Number (Medicaid ID)	318,604	88.7%	0	0.0%	40,563	11.3%	281,137	84.1%	0	0.0%	53,114	15.9%	599,741	86.5%	0	0.0%	93,677	13.5%
Place of Service	340,895	94.9%	1,222	0.3%	17,050	4.7%	311,268	93.1%	696	0.2%	22,287	6.7%	652,163	94.1%	1,918	0.3%	39,337	5.7%
Procedure Code	328,400	91.4%	174	0.0%	30,593	8.5%	293,935	87.9%	90	0.0%	40,226	12.0%	622,335	89.7%	264	0.0%	70,819	10.2%
Procedure Code Modifiers	358,880	99.9%	N/A		287	0.1%	333,320	99.7%	N/A		931	0.3%	692,200	99.8%	N/A		1,218	0.2%
Service Provider NPI/Number	329,594	91.8%	0	0.0%	29,573	8.2%	296,024	88.6%	0	0.0%	38,227	11.4%	625,618	90.2%	0	0.0%	67,800	9.8%
Service Provider Specialty/Taxonomy	331,237	92.2%	101	0.0%	27,829	7.7%	300,034	89.8%	323	0.1%	33,894	10.1%	631,271	91.0%	424	0.1%	61,723	8.9%
Total	***4,807,998***	***89.2%***	***1,497***	***0.0%***	***578,010***	***10.7%***	***4,361,174***	***87.0%***	***1,109***	***0.0%***	***651,482***	***13.0%***	***9,169,172***	***88.2%***	***2,606***	***0.0%***	***1,229,492***	***11.8%***
Total Records in the Encounter Dataset	359,167						334,251						693,418					
Number of Key Data Element Evaluated	15						15						15					
Maximum Count	5,387,505	100.0%					5,013,765	100.0%					10,401,270	100.0%				

Total Medical							
Key Data Elements	Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
		Count	Percent	Count	Percent	Count	Percent
Admission Date	4,823	4,339	90.0%	169	3.5%	315	6.5%
Bill Type (digits 1 and 2)	410,026	409,986	100.0%	0	0.0%	40	0.0%
Billed Charges	1,103,444	772,675	70.0%	0	0.0%	330,769	30.0%
Billing Provider NPI/Number	1,103,444	1,048,535	95.0%	0	0.0%	54,909	5.0%
Diagnosis Codes	1,103,444	1,103,444	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	1,103,444	1,001,605	90.8%	N/A		101,839	9.2%
First Date of Service	1,103,444	1,026,806	93.1%	28	0.0%	76,610	6.9%
Last Date of Service	1,103,444	1,026,828	93.1%	28	0.0%	76,588	6.9%
Health Plan Paid Amount	1,103,444	1,009,327	91.5%	0	0.0%	94,117	8.5%
Health Plan Paid Date	1,103,444	925,627	83.9%	0	0.0%	177,817	16.1%
MMIS ICN	1,103,444	769,674	69.8%	0	0.0%	333,770	30.2%
MMIS Member Number (Medicaid ID)	1,103,444	1,009,402	91.5%	0	0.0%	94,042	8.5%
Place of Service	693,418	652,163	94.1%	1,918	0.3%	39,337	5.7%
Procedure Code	1,098,621	1,027,538	93.5%	264	0.0%	70,819	6.4%
Procedure Code Modifiers	1,098,621	1,097,403	99.9%	N/A		1,218	0.1%
Revenue Code	454,498	452,630	99.6%	N/A		1,868	0.4%
Service Provider NPI/Number	1,103,444	1,035,327	93.8%	0	0.0%	68,117	6.2%
Service Provider Specialty/Taxonomy	1,103,444	1,040,877	94.3%	439	0.0%	62,128	5.6%
Surgical Procedure Codes	4,823	4,823	100.0%	N/A		0	0.0%
Total	***17,006,158***	***15,419,009***	***90.7%***	***2,846***	***0.0%***	***1,584,303***	***9.3%***

Dental																		
Key Data Element	October 2020						April 2021						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
	Count	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	Count	Percent	Count	Percent	Count	Percent
Billed Charges	5,953	100.0%	0	0.0%	0	0.0%	6,262	100.0%	0	0.0%	0	0.0%	12,215	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	4,243	71.3%	0	0.0%	1,710	28.7%	4,561	72.8%	0	0.0%	1,701	27.2%	8,804	72.1%	0	0.0%	3,411	27.9%
Date of Service	5,953	100.0%	0	0.0%	0	0.0%	6,262	100.0%	0	0.0%	0	0.0%	12,215	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	5,953	100.0%	N/A		0	0.0%	6,262	100.0%	N/A		0	0.0%	12,215	100.0%	N/A		0	0.0%
Health Plan Paid Amount	5,927	99.6%	0	0.0%	26	0.4%	6,228	99.5%	0	0.0%	34	0.5%	12,155	99.5%	0	0.0%	60	0.5%
Health Plan Paid Date	5,924	99.5%	0	0.0%	29	0.5%	6,234	99.6%	0	0.0%	28	0.4%	12,158	99.5%	0	0.0%	57	0.5%
MMIS ICN	95	1.6%	0	0.0%	5,858	98.4%	41	0.7%	0	0.0%	6,221	99.3%	136	1.1%	0	0.0%	12,079	98.9%
MMIS Member Number (Medicaid ID)	5,953	100.0%	0	0.0%	0	0.0%	6,262	100.0%	0	0.0%	0	0.0%	12,215	100.0%	0	0.0%	0	0.0%
Place of Service	5,950	99.9%	0	0.0%	3	0.1%	6,243	99.7%	0	0.0%	19	0.3%	12,193	99.8%	0	0.0%	22	0.2%
Procedure Code	5,750	96.6%	0	0.0%	203	3.4%	6,090	97.3%	0	0.0%	172	2.7%	11,840	96.9%	0	0.0%	375	3.1%
Service Provider NPI/Number	5,953	100.0%	0	0.0%	0	0.0%	6,262	100.0%	0	0.0%	0	0.0%	12,215	100.0%	0	0.0%	0	0.0%
Service Provider Specialty/Taxonomy	4,472	75.1%	0	0.0%	1,481	24.9%	4,817	76.9%	0	0.0%	1,445	23.1%	9,289	76.0%	0	0.0%	2,926	24.0%
Tooth Number	4,024	67.6%	N/A		1,929	32.4%	4,128	65.9%	N/A		2,134	34.1%	8,152	66.7%	N/A		4,063	33.3%
Tooth Surface	5,341	89.7%	N/A		612	10.3%	5,615	89.7%	N/A		647	10.3%	10,956	89.7%	N/A		1,259	10.3%
Total	***71,491***	***85.8%***	***0***	***0.0%***	***11,851***	***14.2%***	***75,267***	***85.9%***	***0***	***0.0%***	***12,401***	***14.1%***	***146,758***	***85.8%***	***0***	***0.0%***	***24,252***	***14.2%***
Total Records in the Encounter Dataset	5,953						6,262						12,215					
Number of Key Data Element Evaluated	14						14						14					
Maximum Count	83,342	100.0%					87,668	100.0%					171,010	100.0%				

Vision

Key Data Element	October 2020						April 2021						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
	Count	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	Count	Percent	Count	Percent	Count	Percent
Billed Charges	5,892	98.5%	0	0.0%	91	1.5%	5,137	99.5%	0	0.0%	28	0.5%	11,029	98.9%	0	0.0%	119	1.1%
Billing Provider NPI/Number	0	0.0%	0	0.0%	5,983	100.0%	0	0.0%	0	0.0%	5,165	100.0%	0	0.0%	0	0.0%	11,148	100.0%
Diagnosis Codes	5,973	99.8%	0	0.0%	10	0.2%	5,150	99.7%	0	0.0%	15	0.3%	11,123	99.8%	0	0.0%	25	0.2%
Former/Original Claim ICN	5,897	98.6%	N/A		86	1.4%	5,139	99.5%	N/A		26	0.5%	11,036	99.0%	N/A		112	1.0%
Health Plan Paid Amount	5,911	98.8%	0	0.0%	72	1.2%	5,144	99.6%	0	0.0%	21	0.4%	11,055	99.2%	0	0.0%	93	0.8%
Health Plan Paid Date	5,978	99.9%	0	0.0%	5	0.1%	5,139	99.5%	0	0.0%	26	0.5%	11,117	99.7%	0	0.0%	31	0.3%
First Date of Service	5,983	100.0%	0	0.0%	0	0.0%	5,165	100.0%	0	0.0%	0	0.0%	11,148	100.0%	0	0.0%	0	0.0%
Last Date of Service	5,983	100.0%	0	0.0%	0	0.0%	5,165	100.0%	0	0.0%	0	0.0%	11,148	100.0%	0	0.0%	0	0.0%
MMIS ICN	0	0.0%	0	0.0%	5,983	100.0%	0	0.0%	0	0.0%	5,165	100.0%	0	0.0%	0	0.0%	11,148	100.0%
MMIS Member Number (Medicaid ID)	5,983	100.0%	0	0.0%	0	0.0%	5,165	100.0%	0	0.0%	0	0.0%	11,148	100.0%	0	0.0%	0	0.0%
Place of Service	5,983	100.0%	0	0.0%	0	0.0%	5,161	99.9%	0	0.0%	4	0.1%	11,144	100.0%	0	0.0%	4	0.0%
Procedure Code	5,888	98.4%	0	0.0%	95	1.6%	5,137	99.5%	0	0.0%	28	0.5%	11,025	98.9%	0	0.0%	123	1.1%
Procedure Code Modifiers	5,983	100.0%	N/A		0	0.0%	5,165	100.0%	N/A		0	0.0%	11,148	100.0%	N/A		0	0.0%
Service Provider NPI/Number	5,983	100.0%	0	0.0%	0	0.0%	5,165	100.0%	0	0.0%	0	0.0%	11,148	100.0%	0	0.0%	0	0.0%
Service Provider Specialty/Taxonomy	5,983	100.0%	0	0.0%	0	0.0%	5,165	100.0%	0	0.0%	0	0.0%	11,148	100.0%	0	0.0%	0	0.0%
Total	***77,420***	***86.3%***	***0***	***0.0%***	***12,325***	***13.7%***	***66,997***	***86.5%***	***0***	***0.0%***	***10,478***	***13.5%***	***144,417***	***86.3%***	***0***	***0.1%***	***22,803***	***13.6%***
Total Records in the Encounter Dataset	5,983						5,165						11,148					
Number of Key Data Element Evaluated	15						15						15					
Maximum Count	89,745	100.0%					77,475	100.0%					167,220	100.0%				

NEMT																		
Key Data Element	October 2020						April 2021						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
	Count	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	Count	Percent	Count	Percent	Count	Percent
Billed Charges	18,929	89.2%	0	0.0%	2,302	10.8%	16,745	70.0%	0	0.0%	7,175	30.0%	35,674	79.0%	0	0.0%	9,477	21.0%
Billing Provider NPI/Number	0	0.0%	0	0.0%	21,231	100.0%	0	0.0%	0	0.0%	23,920	100.0%	0	0.0%	0	0.0%	45,151	100.0%
Former/Original Claim ICN	19,269	90.8%	N/A		1,962	9.2%	18,331	76.6%	N/A		5,589	23.4%	37,600	83.3%	N/A		7,551	16.7%
Health Plan Paid Amount	18,867	88.9%	0	0.0%	2,364	11.1%	16,702	69.8%	0	0.0%	7,218	30.2%	35,569	78.8%	0	0.0%	9,582	21.2%
Health Plan Paid Date	21,163	99.7%	0	0.0%	68	0.3%	23,855	99.7%	0	0.0%	65	0.3%	45,018	99.7%	0	0.0%	133	0.3%
Date of Service	21,231	100.0%	0	0.0%	0	0.0%	23,920	100.0%	0	0.0%	0	0.0%	45,151	100.0%	0	0.0%	0	0.0%
MMIS ICN	15,105	71.1%	0	0.0%	6,126	28.9%	8,897	37.2%	0	0.0%	15,023	62.8%	24,002	53.2%	0	0.0%	21,149	46.8%
MMIS Member Number (Medicaid ID)	21,231	100.0%	0	0.0%	0	0.0%	23,920	100.0%	0	0.0%	0	0.0%	45,151	100.0%	0	0.0%	0	0.0%
Procedure Code	21,231	100.0%	0	0.0%	0	0.0%	23,920	100.0%	0	0.0%	0	0.0%	45,151	100.0%	0	0.0%	0	0.0%
Procedure Code Modifiers	21,231	100.0%	N/A		0	0.0%	23,920	100.0%	N/A		0	0.0%	45,151	100.0%	N/A		0	0.0%
Service Provider NPI/Number	21,216	99.9%	0	0.0%	15	0.1%	23,881	99.8%	0	0.0%	39	0.2%	45,097	99.9%	0	0.0%	54	0.1%
Service Provider Specialty/Taxonomy	0	0.0%	0	0.0%	21,231	100.0%	0	0.0%	0	0.0%	23,920	100.0%	0	0.0%	0	0.0%	45,151	100.0%
Total	***199,473***	***78.3%***	***0***	***0.0%***	***55,299***	***21.7%***	***204,091***	***71.1%***	***0***	***0.0%***	***82,949***	***28.9%***	***403,564***	***74.4%***	***0***	***0.1%***	***138,248***	***25.5%***
Total Records in the Encounter Dataset	21,231						23,920						45,151					
Number of Key Data Element Evaluated	12						12						12					
Maximum Count	254,772	100.0%					287,040	100.0%					541,812	100.0%				

Pharmacy																		
Key Data Element	October 2020						April 2021						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
	Count	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	Count	Percent	Count	Percent	Count	Percent
Amount MCO Paid Pharmacy Benefits Manager	196,216	94.9%	0	0.0%	10,559	5.1%	203,904	93.3%	0	0.0%	14,583	6.7%	400,120	94.1%	0	0.0%	25,142	5.9%
Basis of Reimbursement	62,257	30.1%	23,055	11.1%	121,463	58.7%	68,801	31.5%	29,283	13.4%	120,403	55.1%	131,058	30.8%	52,338	12.3%	241,866	56.9%
Billed Charges	47,989	23.2%	0	0.0%	158,786	76.8%	30,088	13.8%	0	0.0%	188,399	86.2%	78,077	18.4%	0	0.0%	347,185	81.6%
Date Filled	206,775	100.0%	0	0.0%	0	0.0%	218,487	100.0%	0	0.0%	0	0.0%	425,262	100.0%	0	0.0%	0	0.0%
Days Supply	205,588	99.4%	0	0.0%	1,187	0.6%	217,155	99.4%	0	0.0%	1,332	0.6%	422,743	99.4%	0	0.0%	2,519	0.6%
Former MMIS Claim ICN	205,196	99.2%	N/A		1,579	0.8%	216,508	99.1%	N/A		1,979	0.9%	421,704	99.2%	N/A		3,558	0.8%
Health Plan Paid Amount	205,553	99.4%	0	0.0%	1,222	0.6%	217,078	99.4%	0	0.0%	1,409	0.6%	422,631	99.4%	0	0.0%	2,631	0.6%
Health Plan Paid Date	53,995	26.1%	0	0.0%	152,780	73.9%	59,672	27.3%	0	0.0%	158,815	72.7%	113,667	26.7%	0	0.0%	311,595	73.3%
MMIS ICN	143,446	69.4%	0	0.0%	63,329	30.6%	155,255	71.1%	0	0.0%	63,232	28.9%	298,701	70.2%	0	0.0%	126,561	29.8%
MMIS Member Number (Medicaid ID)	206,753	100.0%	0	0.0%	22	0.0%	218,449	100.0%	0	0.0%	38	0.0%	425,202	100.0%	0	0.0%	60	0.0%
National Drug Code (NDC)	206,461	99.8%	227	0.1%	87	0.0%	218,103	99.8%	282	0.1%	102	0.0%	424,564	99.8%	509	0.1%	189	0.0%
Prescribing Provider NPI	141,210	68.3%	65,520	31.7%	45	0.0%	143,287	65.6%	75,158	34.4%	42	0.0%	284,497	66.9%	140,678	33.1%	87	0.0%
Prescription Number	206,775	100.0%	0	0.0%	0	0.0%	218,487	100.0%	0	0.0%	0	0.0%	425,262	100.0%	0	0.0%	0	0.0%
Quantity Dispensed	205,612	99.4%	0	0.0%	1,163	0.6%	217,180	99.4%	0	0.0%	1,307	0.6%	422,792	99.4%	0	0.0%	2,470	0.6%
Refill Number	206,652	99.9%	123	0.1%	0	0.0%	218,411	100.0%	76	0.0%	0	0.0%	425,063	100.0%	199	0.0%	0	0.0%
Total	***2,500,478***	***80.6%***	***88,925***	***2.9%***	***512,222***	***16.5%***	***2,620,865***	***80.0%***	***104,799***	***3.2%***	***551,641***	***16.8%***	***5,121,343***	***80.3%***	***193,724***	***3.1%***	***1,063,863***	***16.6%***
Total Records in the Encounter Dataset	206,775						218,487						425,262					
Number of Key Data Element Evaluated	15						15						15					
Maximum Count	3,101,625	100.0%					3,277,305	100.0%					6,378,930	100.0%				

Key Data Elements	Number of Encounters Evaluated	Total					
		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
		Count	Percent	Count	Percent	Count	Percent
Admission Date	4,823	4,339	90.0%	169	3.5%	315	6.5%
Bill Type (digits 1 and 2)	410,026	409,986	100.0%	0	0.0%	40	0.0%
Billed Charges	1,597,220	909,670	57.0%	0	0.0%	687,550	43.0%
Billing Provider NPI/Number	1,171,958	1,057,339	90.2%	0	0.0%	114,619	9.8%
Diagnosis Codes	1,114,592	1,114,567	100.0%	0	0.0%	25	0.0%
Former/Original Claim ICN	1,597,220	1,484,160	92.9%	0	0.0%	113,060	7.1%
First Date of Service	1,597,220	1,520,582	95.2%	28	0.0%	76,610	4.8%
Last Date of Service	1,114,592	1,037,976	93.1%	28	0.0%	76,588	6.9%
Health Plan Paid Amount	1,597,220	1,490,737	93.3%	0	0.0%	106,483	6.7%
Health Plan Paid Date	1,597,220	1,107,587	69.3%	0	0.0%	489,633	30.7%
MMIS ICN	1,597,220	1,092,513	68.4%	0	0.0%	504,707	31.6%
MMIS Member Number (Medicaid ID)	1,597,220	1,503,118	94.1%	0	0.0%	94,102	5.9%
Place of Service	716,781	675,500	94.2%	1,918	0.3%	39,363	5.5%
Procedure Code	1,167,135	1,095,554	93.9%	264	0.0%	71,317	6.1%
Procedure Code Modifiers	1,154,920	1,153,702	99.9%	0	0.0%	1,218	0.1%
Revenue Code	454,498	452,630	99.6%	0	0.0%	1,868	0.4%
Service Provider NPI/Number	1,171,958	1,103,787	94.2%	0	0.0%	68,171	5.8%
Service Provider Specialty/Taxonomy	1,171,958	1,061,314	90.6%	439	0.0%	110,205	9.4%
Surgical Procedure Codes	4,823	4,823	100.0%	0	0.0%	0	0.0%
Tooth Number	12,215	8,152	66.7%	0	0.0%	4,063	33.3%
Tooth Surface	12,215	10,956	89.7%	0	0.0%	1,259	10.3%
Amount MCO Paid Pharmacy Benefits Manager	425,262	400,120	94.1%	0	0.0%	25,142	5.9%
Basis of Reimbursement	425,262	131,058	30.8%	52,338	12.3%	241,866	56.9%
Days Supply	425,262	422,743	99.4%	0	0.0%	2,519	0.6%
National Drug Code (NDC)	425,262	424,564	99.8%	509	0.1%	189	0.0%
Prescribing Provider NPI	425,262	284,497	66.9%	140,678	33.1%	87	0.0%
Prescription Number	425,262	425,262	100.0%	0	0.0%	0	0.0%
Quantity Dispensed	425,262	422,792	99.4%	0	0.0%	2,470	0.6%
Refill Number	425,262	425,063	100.0%	199	0.0%	0	0.0%
Total	***24,265,130***	***21,235,091***	***87.5%***	***196,570***	***0.8%***	***2,833,469***	***11.7%***

Appendix F: Per Member Utilization and Paid Amounts

Description	Healthy Louisiana				ABH				Percentage of Healthy Louisiana	
Members										
Total member Months	18,647,517				1,445,006				7.7%	
Average Number of Members[1]	1,553,960				120,417					
									Percentage Variance	
Service Type	***Count***	***PMPY[2] Count***	***Paid Amount***	***PMPY[2] Amount***	***Count***	***PMPY[2] Count***	***Paid Amount***	***PMPY[2] Amount***	***Count***	***Amount***
Ancillary	7,536,454	4.8	$369,328,879	$238	643,241	5.3	$25,557,151	$212	10.4%	-10.9%
Dental	675,232	0.4	$30,378,419	$20	82,651	0.7	$3,459,193	$29	75.0%	45.0%
Inpatient	2,486,478	1.6	$1,574,479,956	$1,013	235,058	2.0	$137,635,914	$1,143	25.0%	12.8%
NEMT	964,598	0.6	$42,755,814	$28	150,182	1.2	$5,478,242	$45	100.0%	60.7%
Outpatient	18,571,405	12.0	$1,160,044,808	$747	1,733,169	14.4	$109,913,301	$913	20.0%	22.2%
Pharmacy	26,389,256	17.0	$2,023,521,112	$1,302	2,298,838	19.1	$195,114,123	$1,620	12.4%	24.4%
Primary Care	15,329,225	9.9	$533,349,382	$343	1,117,346	9.3	$40,231,559	$334	-6.1%	-2.6%
Specialty	12,347,345	7.9	$918,889,789	$591	1,048,326	8.7	$73,818,072	$613	10.1%	3.7%
Vision	1,539,985	1.0	$54,406,638	$35	87,832	0.7	$3,696,035	$31	-30.0%	-11.4%
Total Services[3]	***85,839,978***	***55.2***	***$6,707,154,798***	***$4,317***	***7,396,643***	***61.4***	***$594,903,590***	***$4,940***	***11.2%***	***14.4%***

[1] Total member months divided by the number of months in the measurement period.
[2] Per member per year counts and/or paid amount divided by the average number of members.
[3] Differences are due to rounding.

Appendix G: Timely Payment of Claims

Encounter Type	15 Business Days - 90%		30 Calendar Days - 99%			60 Calendar Days - 100%			Over 60 Days - 100%			Total		Average Days
		Percentage		Percentage			Percentage			Percentage			Percentage of Total Count	
	Count	Absolute	Count	Absolute	Cumulative	Count	Absolute	Cumulative	Count	Absolute	Cumulative	Count		
Inpatient	40,481	92.4%	1,642	3.7%	96.1%	969	2.2%	98.3%	728	1.7%	100.0%	43,820	0.4%	11
Outpatient	3,026,249	95.9%	69,534	2.2%	98.1%	23,801	0.8%	98.9%	34,913	1.1%	100.0%	3,154,497	27.5%	9
Professional	4,845,890	97.2%	84,350	1.7%	98.9%	31,174	0.6%	99.5%	26,165	0.5%	100.0%	4,987,579	43.5%	6
Dental	240,405	92.1%	15,276	5.9%	98.0%	2,740	1.0%	99.0%	2,535	1.0%	100.0%	260,956	2.3%	7
Vision	74,654	98.6%	231	0.3%	98.9%	266	0.4%	99.2%	570	0.8%	100.0%	75,721	0.7%	4
NEMT	396,364	98.2%	2,701	0.7%	98.9%	3,204	0.8%	99.7%	1,409	0.3%	100.0%	403,678	3.5%	3
Pharmacy	2,526,536	99.4%	3,446	0.1%	99.5%	5,807	0.2%	99.7%	7,051	0.3%	100.0%	2,542,840	22.2%	8
Total	***11,150,579***	***97.2%***	***177,180***	***1.6%***	***98.8%***	***67,961***	***0.6%***	***99.4%***	***73,371***	***0.6%***	***100.0%***	***11,469,091***	***100.0%***	***7***

Appendix H: Timely Encounter Submissions

Encounter Type	30 Days		60 Days			90 Days			120 Days			Over 120 Days			Total		Average Days
		Percentage		Percentage			Percentage			Percentage			Percentage			Percentage of Total Count	
	Count	Absolute	Count	Absolute	Cumulative	Count	Absolute	Cumulative	Count	Absolute	Cumulative	Count	Absolute	Cumulative	Count		
Inpatient	30,679	70.0%	5,039	11.5%	81.5%	2,695	6.2%	87.7%	594	1.4%	89.0%	4,813	11.0%	100.0%	43,820	0.4%	52
Outpatient	2,643,985	83.8%	339,250	10.8%	94.6%	67,475	2.1%	96.7%	21,607	0.7%	97.4%	82,180	2.6%	100.0%	3,154,497	27.5%	18
Professional	4,079,246	81.8%	402,477	8.1%	89.9%	128,802	2.6%	92.4%	86,795	1.7%	94.2%	290,259	5.8%	100.0%	4,987,579	43.5%	25
Dental	54,898	21.0%	1,177	0.5%	21.5%	1,962	0.8%	22.2%	11,389	4.4%	26.6%	191,530	73.4%	100.0%	260,956	2.3%	238
Vision	70,423	93.0%	1,888	2.5%	95.5%	910	1.2%	96.7%	466	0.6%	97.3%	2,034	2.7%	100.0%	75,721	0.7%	12
NEMT	256,971	63.6%	47,887	11.9%	75.5%	37,582	9.3%	84.8%	14,683	3.6%	88.4%	46,644	11.6%	100.0%	403,767	3.5%	43
Pharmacy	1,811,491	71.2%	88,726	3.5%	74.7%	634,200	24.9%	99.7%	1,141	0.0%	99.7%	7,705	0.3%	100.0%	2,543,263	22.2%	23
Total	***8,947,693***	***78.0%***	***886,444***	***7.7%***	***85.7%***	***873,626***	***7.6%***	***93.4%***	***136,675***	***1.2%***	***94.5%***	***625,165***	***5.5%***	***100.0%***	***11,469,603***	***100.0%***	***28***

Appendix I: Medical Records Validity Rate

	Inpatient					Outpatient					Professional (Includes Dental, Vision and NEMT)				
	Total Elements Sampled	Supported Elements		Unsupported Elements		Total Elements Sampled	Supported Elements		Unsupported Elements		Total Elements Sampled	Supported Elements		Unsupported Elements	
Key Data Element		Count	Percent	Count	Percent		Count	Percent	Count	Percent		Count	Percent	Count	Percent
Member Name	1	1	100.0%	0	0.0%	34	34	100.0%	0	0.0%	53	53	100.0%	0	0.0%
Member Date of Birth	1	1	100.0%	0	0.0%	34	34	100.0%	0	0.0%	53	53	100.0%	0	0.0%
Admit Date	1	1	100.0%	0	0.0%	N/A					N/A				
First Date of Service	1	1	100.0%	0	0.0%	34	33	97.1%	1	2.9%	53	52	98.1%	1	1.9%
Last Date of Service	1	1	100.0%	0	0.0%	N/A					N/A				
Billing Provider	1	1	100.0%	0	0.0%	34	33	97.1%	1	2.9%	53	53	100.0%	0	0.0%
Type of Bill Code	1	1	100.0%	0	0.0%	34	33	97.1%	1	2.9%	N/A				
Revenue Code	9	9	100.0%	0	0.0%	34	33	97.1%	1	2.9%	N/A				
Place of Service	N/A					N/A					53	53	100.0%	0	0.0%
Procedure Code	N/A					31	30	96.8%	1	3.2%	53	53	100.0%	0	0.0%
Procedure Modifiers	N/A					5	4	80.0%	1	20.0%	38	38	100.0%	0	0.0%
Diagnosis Codes	4	3	75.0%	1	25.0%	112	104	92.9%	8	7.1%	127	123	96.9%	4	3.1%
Surgical Procedure Codes	1	0	100.0%	1	0.0%	N/A					N/A				
Servicing Provider	1	1	100.0%	0	0.0%	34	33	97.1%	1	2.9%	52	51	98.1%	1	1.9%
Prescription Number	N/A					N/A					N/A				
National Drug Code (NDC)	N/A					N/A					N/A				
Quantity Dispensed	N/A					N/A					N/A				
Days Supply	N/A					N/A					N/A				
Prescribing Provider	N/A					N/A					N/A				
Total	***22***	***20***	***90.9%***	***2***	***9.1%***	***386***	***371***	***96.1%***	***15***	***3.9%***	***535***	***529***	***98.9%***	***6***	***1.1%***

Note: 135 medical records were submitted. Two (2) of the medical records submitted were for a different member or a member that was not seen on the indicated date of service.
A total of 150 medical records were requested.

	Pharmacy					Total				
	Total Elements Sampled	Supported Elements		Unsupported Elements		Total Elements Sampled	Supported Elements		Unsupported Elements	
Key Data Element		Count	Percent	Count	Percent		Count	Percent	Count	Percent
Member Name	45	45	100.0%	0	0.0%	133	133	100.0%	0	0.0%
Member DOB	45	45	100.0%	0	0.0%	133	133	100.0%	0	0.0%
Admit Date	N/A					1	1	100.0%	0	0.0%
First DOS	45	45	100.0%	0	0.0%	133	131	98.5%	2	1.5%
Billing Provider	45	45	100.0%	0	0.0%	46	46	100.0%	0	0.0%
Last DOS	N/A					88	87	98.9%	1	1.1%
Type of Bill Code	N/A					35	34	97.1%	1	2.9%
Revenue Code	N/A					43	42	97.7%	1	2.3%
Place of Service	N/A					53	53	100.0%	0	0.0%
Procedure Code	N/A					84	83	98.8%	1	1.2%
Procedure Modifiers	N/A					43	42	97.7%	1	2.3%
Diagnosis Codes	N/A					243	230	94.7%	13	5.3%
Surgical Procedure Codes	N/A					1	0	0.0%	1	100.0%
Servicing Provider	N/A					87	85	97.7%	2	2.3%
Prescription Number	45	45	100.0%	0	0.0%	45	45	100.0%	0	0.0%
National Drug Code (NDC)	45	45	100.0%	0	0.0%	45	45	100.0%	0	0.0%
Quantity Dispensed	45	45	100.0%	0	0.0%	45	45	100.0%	0	0.0%
Days Supply	45	45	100.0%	0	0.0%	45	45	100.0%	0	0.0%
Prescribing Provider	41	41	100.0%	0	0.0%	41	41	100.0%	0	0.0%
Total	***401***	***401***	***100.0%***	***0***	***0.0%***	***1,344***	***1,321***	***98.3%***	***23***	***1.7%***

Note: 135 medical records were submitted. Two (2) of the medical records submitted were for a different member or a member that was not seen on the indicated date of service. A total of 150 medical records were requested.

Health Plan Response

Findings and Recommendations			ABHLA Response
	Findings	**Recommendations**	
3-A	**Completeness – CDJs:** Encounter paid amounts were below the 97 percent threshold for seven of the twelve months in the measurement period, and exceeded 100 percent for four of the twelve months. The health plan's completion percentage for SFY 2021 was below the 97 percent threshold(96.4 percent).	The health plan/delegated vendor, in conjunction with the FAC, should investigate and identify the causes of surplus and/or missing encounters present or absent in the encounter data. Any issues noted during the investigation requiring encounter data revisions should be accurately addressed and incorporated into the FAC encounter data. Additionally, the health plan/delegated vendor should submit payment adjustments to ensure duplicates, voids and denied claims are accurately addressed in the encounter data.	ABHLA acknowledges month over month variances where results are below or above expected limits. In 2021, we conducted a system audit (claims and encounters) and implemented enhancements in support of ongoing compliance. There is a process difference between ABH and M&S methodology where if a new iteration of an encounter is received before a previously iteration is submitted, only the most recent is submitted. This process may result in monthly completion discrepancies, however, net dollars for CDJ completeness are accurate. As part of our governance, we continue to evaluate results. Variances are reviewed on an ongoing basis to address and resolve. Findings are discussed during bi-monthly Aetna Encounter Data meetings.
3-B	**Completeness - Sample Claims Count:** Medical, NEMT and pharmacy encounter counts were below the 97 percent threshold (92.0 percent, 65.9 percent and 66.7 percent, respectively) and were at 100 percent for dental and vision encounters.		Vendors continue to evaluate month over month variances in results below or above limits. There have been instances where changes in process (i.e. transportation rate increase and multiple line requirement) have resulted in configuration updates along with the need to void and resubmit encounters which impacts these results. ABHLA meets with vendors weekly to review results as well as monitor progress on gap remediation.
3-C	**Completeness - Sample Claims Paid Amount:** Encounter paid amounts were at or above 100 percent for all encounter types.		ABHLA acknowledges month over month variances where results are below or above expected limits. In 2021, we conducted a system audit (claims and encounters) and implemented enhancements in support of ongoing compliance. There is a process difference between ABH and M&S methodology where if a new iteration of an encounter is received before a previously iteration is submitted, only the most recent is submitted. This process may result in monthly completion discrepancies, however, net dollars for CDJ completeness are accurate. As part of our governance, we continue to evaluate results. Variances are reviewed on an ongoing basis to address and resolve. Findings are discussed during bi-monthly Aetna Encounter Data meetings.

Findings and Recommendations			ABHLA Response
	Findings	**Recommendations**	
3-E	**Accuracy:** · **Tooth Number and Tooth Surface** - Dental · **Prescribing Provider NPI –** Pharmacy Encounter values were not populated for the non-matching values.	The health plan/delegated vendor should ensure it is properly capturing and maintaining encounter data elements within the claims system and data warehouse and be able to submit this information in the encounter submissions and on future claim sample submissions and/or ad hoc reporting. Additionally, the FAC, the health plan and its delegated vendor should work together to ensure key data elements are properly submitted and captured in the encounter data.	Per state requirements, dental encounters were submitted on 837P during 2021. Due to differences in file type requirements, this information could not be passed accurately in the encounter. This was changed to 837D on August 1, 2021. A project to void and resubmit historical encounters was completed. Vendor is currently reconciling results. ABHLA respectfully requests additional detail of the pharmacy findings for review.
3-F	**Accuracy – Service Provider Specialty / Taxonomy:** NEMT – Claims sample values were not populated.		The NEMT vendor is submitting the provider type, NPI and Taxonomy as directed by LDH in compliance with the provider type updates for NEMT providers.
3-G	**Accuracy – Former/Original Claim ICN:** Inpatient, Outpatient, Professional and NEMT – The encounter value is populated and the sample claim is not or vice versa.	The health plan should ensure that appropriate audit trails are in place for all adjusted, replaced and void claims. The original ICN should be linked to the replacement, adjustment and/or void claim and the original ICN information is available to trace the replacement/adjustment back to the original claim.	ABHLA acknowledges this finding. In 2021, we conducted system audit (claims and encounters) and implemented enhancements to ensure compliance.
3-H	**Accuracy – Health Plan Paid Amount:** Outpatient, Professional and NEMT - The encounter value is a negative value and the claims sample is a positive value or vice versa, and/or both the encounter and the claim reflected positive amounts and the amounts did not agree.	The health plan/delegated vendor should submit payment adjustments to ensure duplicates, voids and denied claims are accurately addressed in the encounter data.	On claims, positive and negative amounts are present due to reversal of previously paid claims. Encounters are always submitted as positive values. The frequency code determines if the encounter is a new day, adjustment or void.
3-I	**Accuracy – Health Plan Paid Date**: Inpatient, Outpatient and Professional- The claim appears to be an adjustment and/or replacement and reflects the latest health plan paid date and the encounter appears to reflect the paid date of the original encounter.	This is a known limitation of the encounter data extract as the FAC overwrites the paid date of the adjustment with the paid date of the original encounter. The health plan/delegated vendor, however, should review its encounter submission procedures to ensure health plan/delegated vendor paid dates are submitted in accordance with encounter submission requirements. Additionally, the health plan/delegated vendor should review its claims system and data warehouse processes to ensure accurate adjudication dates (i.e., the date a determination was made to pay or deny a claim) are being reported on all encounter submissions. The FAC should also review its processes to ensure it is capturing the health plan/delegated vendor's adjudication date(s), as submitted by the health plan/delegated vendor, on all submitted encounters. The health plan, delegated vendor and the FAC should work together to resolve these issues.	ABHLA has reviewed and confirmed that paid dates are submitted in accordance with encounter submission requirements. ABHLA regularly meets with vendors to address any data quality issues.

Findings and Recommendations			ABHLA Response
	Findings	**Recommendations**	
3-J	**Accuracy – MMIS ICN**: Inpatient, Outpatient, Professional, Dental, Vision, NEMT and Pharmacy– The claims sample appears to reflect an original MMIS assigned ICN and the encounter data reflects an adjustment and/or replacement MMIS ICN, (potentially) indicating that only one and/or only the final claim sequence/iterations being submitted as an encounter.	The health plan's contract with LDH (17.9.5) requires the health plan to submit all claims paid, denied or adjusted/voids encounters. The health plan should review its claims/data warehouse/encounter data submission processes to ensure all claim sequences/iterations are captured and stored appropriately and are included in the encounter submissions. Collapsing claim sequences/iterations into a single record line, may result in incomplete encounter data, and/or completion percentages below the contract specified threshold (97 percent). Additionally, the health plan/delegated vendor should ensure it is properly storing the MMIS ICN as assigned by the FAC and returned to the health plan on the 835 or proprietary response file(s).	ABLA acknowledges there is a process difference between ABH and M&S methodology. Our encounter management system business rules follow the following logic: if a newer iteration is received before a previous iteration is submitted, then only the newest iteration is submitted. While this may cause a month over month variation, the net encounter dollars compared to CDJ is accurate.
3-K	**Timely Payment of Claims**: The health plan met the 15 business days level of timeliness for the payment of claims to providers. The health plan did not meet the 30 and 60 calendar days requirements.	The health plan should continue to regularly monitor its claims processing system and delegated vendors to ensure claims are processed promptly and within contractual timeframes.	We acknowledge the assessment. We will continue to work with delegated vendors and continue monitoring timely claims processing to meet contractual timeframe.
3-L	**Timely Encounter Submissions**: The health plan submitted 78.0 percent of encounters with SFY 2021 dates of service within 30 days. On average, the health plan submitted encounters within 28 days. The delegated dental vendor, however, took an average of 238 days to submit encounters.	The health plan should regularly monitor its delegated vendors' encounter submission processes to ensure encounters are submitted timely. Additionally, processes should be reviewed to ensure encounters rejected by the FAC are quickly resolved and resubmitted.	ABHLA respectfully disagrees with the finding. Dental encounters significantly impacted overall plan results. As noted in finding 3-E, the state transitioned to 837D file type for encounters in August 2021. Rather than maintain 2 separate processes (837P vs. 837D), the dental vendor chose second state option to void and resubmit 2 years of historical encounters. Since the calculation is being made from the original adjudication date, the records appear untimely.
Activity 4 – Review of Medical Records			
4-A	135 of the 150 records requested were submitted. Two (2) of the records submitted were for a different member or for a member that was not seen by the provider on the indicated date of service. These records were excluded from the validation resulting in 133 of the 150 medical records requested (88.7 percent) being tested.	The health plan should work with the providers to ensure it receives medical records for the requested members and/or dates of service.	ABH will continue to work with providers to ensure acquisition of requested medical records. ABH has strengthened its processes for non-compliant providers in order to increase the response rate.
4-B	Validation rates for the 133 medical records tested met the 97 percent threshold (98.3 percent).		