STATE OF LOUISIANA DEPARTMENT OF HEALTH MEDICAID DENTAL BENEFIT PROGRAM MANAGEMENT

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

MCNA Dental

July 25, 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 MCNA Dental (MCNA) for Medicaid dental benefits and services provided to eligible children and adults in Louisiana. 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 95 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.

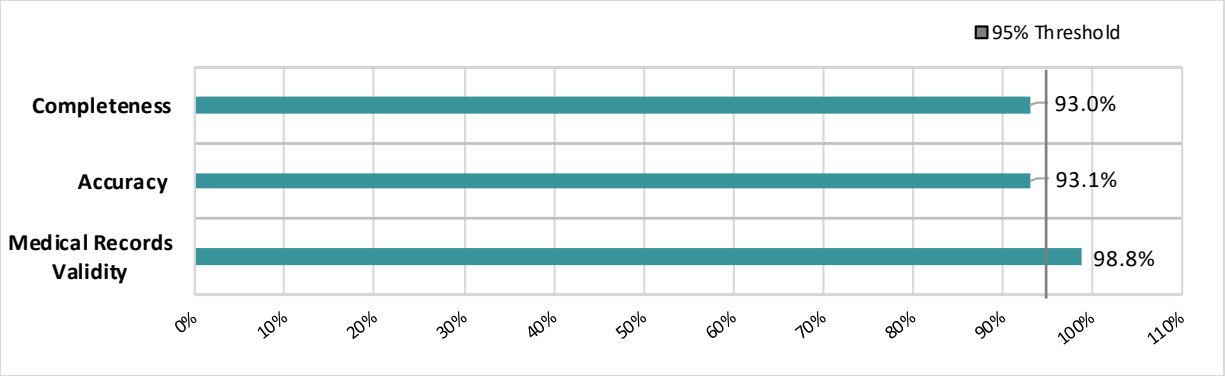
Findings

- **Completeness:** In all analyses the completion percentages for SFY 2021 fell below the 95 percent threshold. This includes the average completion percentage when compared to the CDJ paid amounts (93.6 percent) as well as the overall aggregate completion percentage (93.0 percent).

- **Accuracy:** The overall accuracy percentage was 93.1 percent for all key data elements reviewed.

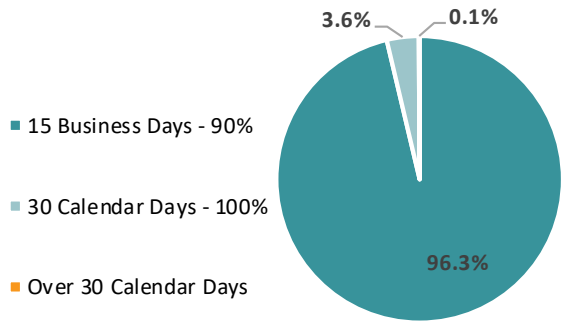
[1] In 2019, CMS updated the EQRO protocols and the encounter data validation is now referred to as Protocol 5.

- **Medical Record Validation Rates:** 147 of the medical records requested (98 percent) were submitted for review. Three (3) of the medical records requested could not be obtained by the health plan, as the facilities were permanently closed. The validation rate for the medical records tested met the 95 percent threshold (98.8 percent).

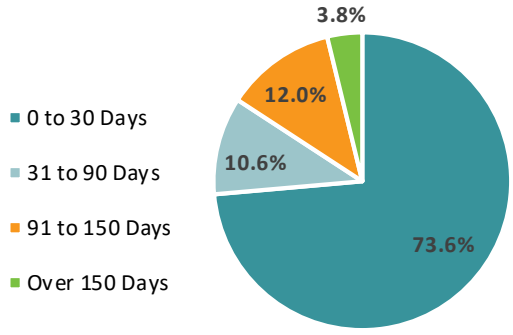


- **Timeliness:** The required levels of timeliness were met for the payment of claims. The health plan submitted 73.6 percent of encounters within 30 days of adjudication. On average, the health plan submitted encounters within 31 days.

Timely Payment of Claims



Timely Encounter Submissions



Introduction

Louisiana provides dental benefits to qualified children and adults enrolled in Medicaid and the Children's Health Insurance Plan (LaCHIP). Benefits are provided primarily to children and young adults under twenty-one (21) years of age. Services include exams and cleanings every six (6) months, fluoride treatments, x-rays, screenings and assessments, sealants, fillings, extractions, crowns, root canals, and emergency dental services. Dental benefits for adults, twenty-one (21) years of age and over, are limited to services related to dentures or removable prosthodontics[2]. The Louisiana Department of Health (LDH) contracts with dental health plans to administer its Medicaid dental benefit program with the objective of achieving the goals of improved coordination of care, better dental health outcomes, increased quality of dental care, improved access to essential specialty dental services, outreach and education to promote dental health, and increased enrollee responsibility and self-management.

In 2016, the Centers for Medicare & 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.

LDH engaged Myers and Stauffer LC (Myers and Stauffer) to perform Protocol 5 to evaluate the

[2] The branch of dentistry concerned with the design, manufacture, and fitting of artificial replacements for teeth and other parts of the mouth. https://www.dictionary.com/browse/prosthodontics
[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

completeness and accuracy of the encounter data submitted by MCNA for SFY 2021 beneficiaries enrolled in the State's Medicaid dental benefit 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, 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. Responses to the PHE changed throughout the measurement period to reflect the fluctuations in the PHE[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 State's requirements.	

Activity 2: Review Health Plan Capability

The health plan's information system and controls were evaluated to determine the health plan's ability to collect and submit complete and accurate encounter data. A survey was developed and documentation was requested to gain an understanding of the health plan's structure and processes. Interviews were also conducted with health plan personnel.

MCNA Health Care Holdings, LLC was formed in 2011 to be the parent company of Managed Care of North America, Inc. and MCNA Insurance Company, doing business as MCNA Dental[8]. During the interviews, Myers and Stauffer learned that the health plan was acquired by UnitedHealth Group. On November 19, 2020, MCNA Health Care Holdings LLC became a wholly-owned subsidiary of UnitedHealth Group. MCNA retained its name and brand and continued functioning as the dental health plan contracted by the State to administer dental services to Medicaid and LaCHIP[9]. MCNA maintains its corporate headquarters in Fort Lauderdale, Florida; however, interviews were conducted primarily with UnitedHealth Group personnel located in Austin, Texas.

The survey and personnel interviews included questions related to claims processing, data submissions, enrollment, data systems, controls and mechanisms[10]. 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**
2-A	The health plan accepts claims into its system that may be invalid. If the health plan is able to identify the provider, member or CDT, it accepts the claim into its system and denies the claim, as appropriate. If the data missing on the invalid claim causes the claim to not be fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) edits, the invalid claims are withheld and not submitted as an encounter to the FAC, as the FAC only accepts encounters that are fully HIPAA compliant. The health plan represented that the percentage of claims not submitted as encounters for calendar year 2021 was approximately 5 percent.	The health plan is contractually required to submit complete and accurate encounter data to the FAC. By accepting invalid claims that are not fully HIPAA compliant and cannot be accepted by the FAC, the encounter data submitted by the health plan is incomplete. The health plan indicated that invalid claims represent approximately 5 percent of total claims. This practice could potentially result in the completeness of the encounter data falling below the required 95 percent completeness threshold. As afforded in the contract with LDH (2.14.2.3.1) the health plan may reject claims because of missing or incomplete information. In addition (2.14.2.1.9), the health plan should require that providers comply with the American Dental Association (ADA) national coding standards and formats.

[8] https://ldh.la.gov/assets/HealthyLa/Act212/SFY19Appendices/VI.6_Audited_FS_MCNA.pdf and https://www.mcna.net/en/company-overview
[9] https://www.fwdds.org/news-details/2020/11/20/unitedhealth-group-acquires-mcna-dental
[10] 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

Findings and Recommendations		
Findings		Recommendations
		Rejecting incomplete or invalid claims back to the provider could ensure that all claims processed by the health plan are HIPAA compliant, accurate and capable of being submitted to the State as encounters.

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.

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 dental 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. 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 five (5) percent error threshold (i.e., at least 95 percent complete).[11]

Cash Disbursement Journals and Timely Encounter Submissions

Under a separate contract with LDH, Myers and Stauffer 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 Validation 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 95 percent when compared to the CDJ files that are submitted monthly to Myers and Stauffer by the health plan. 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 95 percent threshold was used for validation. Detailed results can be found in the May 2022 Encounter Data Validation Report, Appendix B.

[11] DBPM Contract Section 2.14.11.10, effective January 1, 2020 and extended through December 31, 2021.

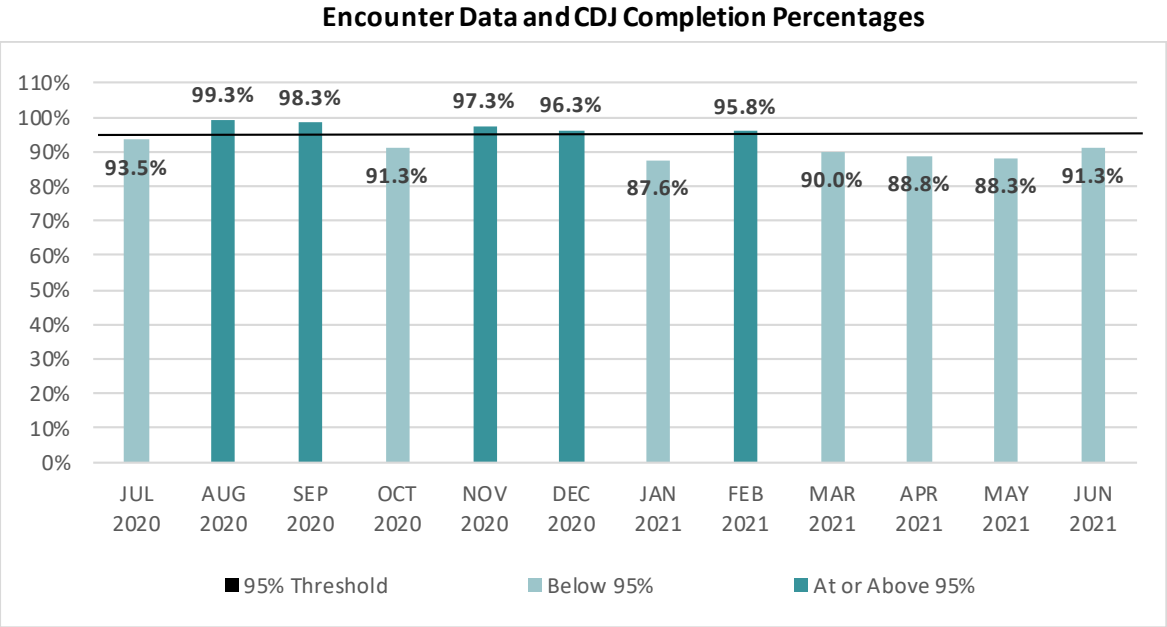


Figure 1: Encounter Data and CDJ Completion Percentages. The paid amount from the CDJs for SFY 2021 were used as the criteria for comparison. A 95 percent threshold was used for validation. The health plan's average completion percentage for SFY 2021 was 93.6 percent.

The health plan's monthly completion percentages were below the 95 percent threshold for seven (7) out of the twelve (12) month measurement period. The health plan's average completion percentage for SFY 2021 was below the 95 percent threshold.

Sample Claims

Sample Claims data submitted by the health plan for two sample months, October 2020 and April 2021, was also used to evaluate encounter data completeness. The comparison of the claim sample data to the encounter data sought to ensure that all claims were included in the sample claims and/or encounter data. The health plan-submitted claims sample data was traced to encounter data using data elements provided in the claims sample data. The encounters were evaluated against the claims sample 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 each sample month. A 95 percent threshold was used for validation. Encounter completion percentages, for both sample months, were below the 95 percent threshold when compared to sample claim counts and when compared to sample claim paid amounts. Detailed results can be found in Appendix C and detailed results of the overall completion percentage can be found in Appendix D.

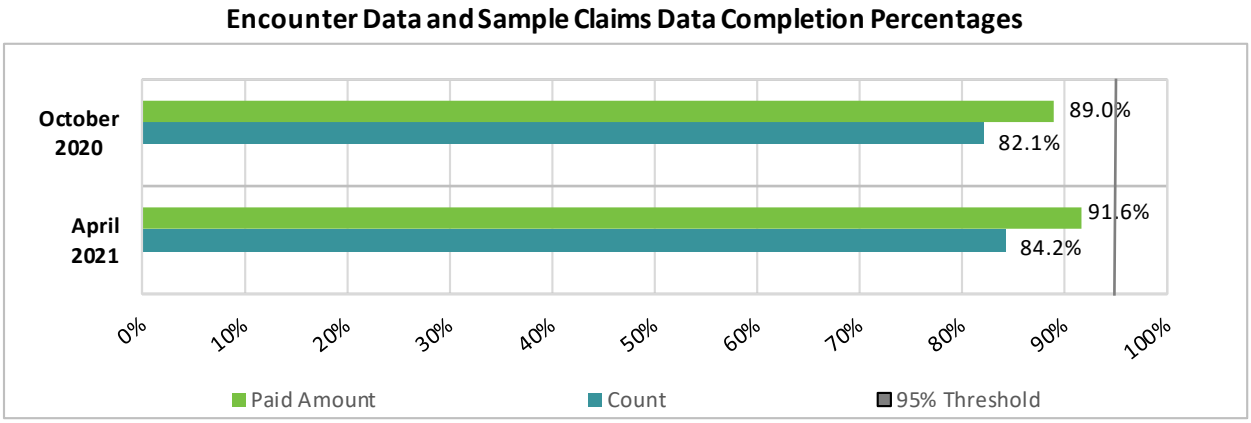


Figure 2: Encounter data and Sample Claims Data Completion Percentages. The count and paid amount from the sample claims data were used as the criteria for comparison. A 95 percent threshold was used for validation.

Completion percentages below 100 percent indicate records are missing from the encounter data. Missing encounters may be due to incomplete data, timing differences, or claims, voids, replacements, adjustments and/or other transactions 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 95 percent threshold was used as the accuracy goal for each of the key data elements. Encounter data accuracy issues were noted with MMIS ICN values provided in the health plan-submitted claims sample data. Accuracy percentages are presented in **Table 1**. The key data elements evaluated and specific testing results are presented in Appendix E.

Accuracy Percentages – Key Data Elements Analysis			
Sample Month	**Valid Values**	**Missing Values**	**Erroneous Values**
October 2020	93.4%	0.0%	6.6%
April 2021	92.5%	0.0%	7.5%
Total Average	***93.1%***	***0.0%***	***6.9%***

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 five percent per key data element. MMIS ICN values were not populated for about 10 percent of the records in the health plan-submitted claims sample data.

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**: The encounter paid amounts were below the 95 percent threshold for 7 of the 12 months in the measurement period. The health plan's completion percentage for SFY 2021 was below the 95 percent threshold (93.6 percent).	The health plan in conjunction with the FAC, should investigate and identify the causes of encounters missing from 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 should submit payment adjustments to ensure adjustments, voids and denied claims are accurately addressed in the encounter data.
3-B	**Completeness - Sample Claims Count:** Encounter counts were below the 95 percent threshold for both sample months (82.1 percent and 87.2 percent, respectively).	
3-C	**Completeness - Sample Claims Paid Amount:** Encounter paid amounts were below the 95 percent threshold for both sample months (89.0 percent and 91.6 percent, respectively).	
3-D	**Accuracy - MMIS ICN:** MMIS_ICN values submitted in the claims sample data reflect the ICN from the 835 response associated with the last detail line of an encounter. (i.e., the MMIS ICN assigned to the last detail line was applied to the entire encounter). For example, if three procedures were performed during a member's visit each procedure performed would receive a unique ICN from the FAC. The claims sample reflects the same MMIS ICN value for all 3 service lines associated with the indicated member/visit/date of service. Additionally, MMIS ICN values were missing from about 10 percent of the claims sample data.	LDH requires the health plans to submit dental encounters at the line/detail/service level. The health plan should ensure it is properly capturing and storing the ICN as assigned by the FAC and returned to the health plan on the 835 or proprietary response file(s) to ensure the appropriate audit trails are in place.

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 for SFY 2021 were compared to SFY 2020 values to evaluate changes 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., units) and total paid amounts were divided by the average number of members for the respective period to determine per member utilization. **Table 2** shows the resulting utilization and paid amounts per member.

Per Member Per Year Utilization and Paid Amounts by Service Type

Description	SFY 2020				SFY 2021			
Members								
Total Member Months	18,239,026				15,059,902			
Average Number of Members	1,519,919				1,254,992			
Category of Service	**Count**	**PMPY Count**	**Paid Amount**	**PMPY Amount**	**Count**	**PMPY Count**	**Paid Amount**	**PMPY Amount**
Diagnostic	1,088,994	0.7	$29,356,615	$19	888,198	0.7	$23,824,549	$19
Preventive	939,859	0.6	$28,081,521	$18	747,378	0.6	$22,729,889	$18
Restorative	374,840	0.3	$38,967,188	$26	305,214	0.2	$32,273,573	$26
Adjunctive General Services	136,109	0.1	$6,970,528	$5	110,575	0.1	$5,707,940	$5
Oral & Maxillofacial Surgery	90,649	0.1	$9,926,578	$7	76,591	0.0	$8,211,566	$6
Endodontics	38,846	0.0	$5,677,387	$4	32,442	0.0	$4,646,278	$4
Prosthodontics – Removable	12,834	0.0	$4,943,243	$3	10,983	0.0	$4,172,158	$3
Other Dental Services	1,226	0.0	$394,091	$0	949	0.0	$262,627	$0
Total Health Plan Services	***2,683,357***	***1.8***	***$124,317,151***	***$82***	***2,172,330***	***1.7***	***$101,828,579***	***$81***

Table 2: Per Member Utilization and Paid Amount Statistics. The average number of members equals total member months divided by twelve (12). Per member counts and paid amounts are based on counts and paid amount, divided by the average number of members. Differences are due to rounding.

Prior to SFY 2021 and through December 31, 2020, MCNA was the sole statewide dental managed care health plan. Effective January 1, 2021, LDH contracted with a second dental managed care health plan to deliver dental services to Medicaid-enrolled adults and children. As a result, the number of members enrolled with MCNA decreased (-17.4 percent) from SFY 2020 to SFY 2021. Although the number of members decrease, the per member utilization and per member paid amounts remained the same. The lack of change in per member services may be a result of the PHE. Federal and state responses to the PHE triggered social and economic disruptions, and periodically limited health care services to essential, emergent services.

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[12] claims within 15 business days of receipt, 100 percent within 30 calendar days and fully adjudicate (pay or deny all pended claims within 60 calendar days of the date of receipt[13]. **Table 3** shows the results of the payment of claims analysis.

Timely Payment of Claims			
Number of Days – Percentage Requirement	Count	Percentage	
		Absolute	Cumulative
15 Business Days – 90%	2,401,959	96.3%	96.3%
30 Calendar Days – 100%	89,743	3.6%	99.9%
60 Calendar Days – 100%	3,624	0.1%	100.0%
Over 60 Calendar Days – 100%	22	0.0%	100.0%
Total	***2,495,348***	***100.0%***	

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 required levels 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. 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.

[12] 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.
[13] DBMP Contract Section 2.14.2.1, effective January 1, 2020 and extended through January 1, 2021.

Timely Encounter Submissions			
		Percentage	
Number of Days	Count	Absolute	Cumulative
0 to 30 Days	1,826,051	73.6%	73.6%
31 to 60 Days	111,433	4.5%	78.0%
61 to 90 Days	151,924	6.1%	84.1%
91 to 120 Days	149,476	6.0%	90.1%
121 to 150 Days	150,185	6.0%	96.1%
Over 150 Days	96,279	3.9%	100.0%
Total	***2,495,348***	***100.0%***	

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 2.5 million encounters submitted with SFY 2021 dates of service, the health plan submitted 73.6 percent of encounters within 30 days of adjudication. On average, the health plan submitted encounters within 31 days.

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**
There were no findings related to our review of the health plan's timely payment of claims.		
3-E	The health plan submitted 73.6 percent of all encounters with SFY 2021 dates of service within 30 days of adjudication, which is below the 95 percent completeness threshold.	The health plan should regularly monitor its encounter submission processes to ensure encounters are submitted timely and issues with rejected encounters are resolved and resubmitted quickly.

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 (dental) 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[14], random sampling of records was selected from the encounter data for review. The encounter records selected for review were forwarded to the health plan for retrieval of the dental record from the provider.

The dental records review is dependent on the ability of the provider to locate and submit complete and accurate dental records. Dental records were to be submitted to Myers and Stauffer by March 11, 2022. Records submitted after the due date, records with incorrect dates of service, and incomplete dental records were excluded from the validation.

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

Dental Records Summary				
Description	**Requested**	**Missing**	**Replaced**	**Total Dental Records Received**
Dental Records	150	3	0	147
Percentage of Requested Records Received and Tested				***98.0%***

Table 5: Dental Records Summary. 147 of the 150 dental records requested were submitted and tested. The health plan indicated that it was unable to obtain the three missing records as the facilities were permanently closed.

Validation

The dental records were reviewed and compared to the encounter data to validate that the tested key data elements were supported by the dental record documentation. Each key data element was independently evaluated against the dental record and deemed supported or unsupported (i.e., the dental 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 dental records supported the key data element(s).
- Unsupported: Encounters for which the dental records included information that was different from the encounter key data element(s) and/or encounters for which the dental records did not include the information to support the encounter key data element(s).

[14] 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

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

Dental Records Validation Rates		
Description	**Supported Validation Rate**	**Unsupported Validation Rate**
Total	***98.8%***	***1.2%***

Table 6: Dental Record Validation Rates. 147 of the 150 dental records requested were tested. Supported and unsupported determinations were for each key data element tested and not a claim level determination.

Findings and Recommendations

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

Findings and Recommendations		
	Findings	**Recommendations**
4-A	147 of the 150 records requested (98 percent) were submitted for testing. The health plan was not able to obtain the three (3) missing records, as the facilities were permanently closed.	The health plan should review its provider contracts to ensure dental records remain available/obtainable should the provider become defunct.
There were no findings related to our review of the dental record and encounter key data elements.		

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		
2-A	The health plan accepts claims into its system that may be invalid. If the health plan is able to identify the provider, member or CDT, it accepts the claim into its system and denies the claim, as appropriate. If the data missing on the invalid claim causes the claim to not be fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) edits, the invalid claims are withheld and not submitted as an encounter to the FAC, as the FAC only accepts encounters that are fully HIPAA compliant. The health plan represented that the percentage of claims not submitted as encounters for calendar year 2021 was approximately 5 percent.	The health plan is contractually required to submit complete and accurate encounter data to the FAC. By accepting invalid claims that are not fully HIPAA compliant and cannot be accepted by the FAC, the encounter data submitted by the health plan is incomplete. The health plan indicated that invalid claims represent approximately 5 percent of total claims. This practice could potentially result in the completeness of the encounter data falling below the required 95 percent completeness threshold. As afforded in the contract with LDH (2.14.2.3.1) the health plan may reject claims because of missing or incomplete information. In addition (2.14.2.1.9), the health plan should require that providers comply with the American Dental Association (ADA) national coding standards and formats. Rejecting incomplete or invalid claims back to the provider could ensure that all claims processed by the health plan are HIPAA compliant, accurate and capable of being submitted to the State as encounters.
Activity 3 – Analyze Electronic Encounter Data		
3-A	**Completeness – CDJs**: The encounter paid amounts were below the 95 percent threshold for 7 of the 12 months in the measurement period. The health plan's completion percentage for SFY 2021 was below the 95 percent threshold (93.6 percent).	The health plan in conjunction with the FAC, should investigate and identify the causes of encounters missing from 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 should submit payment adjustments to ensure adjustments, voids and denied claims are accurately addressed in the encounter data.
3-B	**Completeness - Sample Claims Count:** Encounter counts were below the 95 percent threshold for both sample months (82.1 percent and 87.2 percent, respectively).	

Findings and Recommendations		
	Findings	**Recommendations**
3-C	**Completeness - Sample Claims Paid Amount:** Encounter paid amounts were below the 95 percent threshold for both sample months (89.0 percent and 91.6 percent, respectively).	The health plan in conjunction with the FAC, should investigate and identify the causes of encounters missing from 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 should submit payment adjustments to ensure adjustments, voids and denied claims are accurately addressed in the encounter data.
3-D	**Accuracy - MMIS ICN:** MMIS_ICN values submitted in the claims sample data reflect the ICN from the 835 response associated with the last detail line of an encounter. (i.e., the MMIS ICN assigned to the last detail line was applied to the entire encounter). For example, if three procedures were performed during a member's visit each procedure performed would receive a unique ICN from the FAC. The claims sample reflects the same MMIS ICN value for all 3 service lines associated with the indicated member/visit/date of service. Additionally, MMIS ICN values were missing from about 10 percent of the claims sample data.	LDH requires the health plans to submit dental encounters at the line/detail/service level. The health plan should ensure it is properly capturing and storing the ICN as assigned by the FAC and returned to the health plan on the 835 or proprietary response file(s) to ensure the appropriate audit trails are in place.
There were no findings related to our review of the health plan's timely payment of claims.		
3-E	The health plan submitted 73.6 percent of all encounters with SFY 2021 dates of service within 30 days of adjudication, which is below the 95 percent completeness threshold.	The health plan should regularly monitor its encounter submission processes to ensure encounters are submitted timely and issues with rejected encounters are resolved and resubmitted quickly.
Activity 4 – Review of Medical Records		
4-A	147 of the 150 records requested (98 percent) were submitted for testing. The health plan was not able to obtain the three (3) missing records, as the facilities were permanently closed.	The health plan should review its provider contracts to ensure dental records remain available/obtainable should the provider become defunct.
There were no findings related to our review of the dental records.		

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 Dental Association (ADA) – The recognized leading source of oral health-related information for dental service providers and its patients.

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.

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.

Claims – A request for payment submit by a health care provider to the managed care health plan for medical services rendered to the health plan's member(s).

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).

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).

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).

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.

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.

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%	95%	95%	95%	95%	95%
Submission Requirements for Subcontractor Encounters (for delegated vendors only)*	95%	95%	95%	95%	95%	95%	95%
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
DBPM Encounter MMIS Submission Cut-off Date (by 12 noon CST/CDT)1	6/24/20 Encounters: May 2020 7/22/2020 Encounters: June 2020	8/19/20 Encounters: July 2020 9/23/2020 Encounters: August 2020	10/21/20 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
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 DBPM Encounter Reconciliation Due to LDH	9/22/2020	11/17/2020	1/26/2021	3/23/2021	5/18/2021	7/20/2021	9/21/2021
LDH to Provide DBPM with Draft Encounter Reconciliation	9/23/2020	11/18/2020	1/27/2021	3/24/2021	5/19/2021	7/21/2021	9/22/2021
Myers and Stauffer to Post Raw Encounter Data Files and Supplemental Duplicates / Calculated Voids Files	9/23/2020	11/18/2020	1/27/2021	3/24/2021	5/19/2021	7/21/2021	9/22/2021
Due from DBPM to be Included in the Next Report: Feedback on (1) Duplicates / Voids File and (2) Encounter Reconciliation	9/30/2020	11/25/2020	2/03/2021	3/31/2021	5/26/2021	7/28/2021	9/29/2021

* 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 DBPM Encounter Reconciliation reports will be delayed by two days.

Appendix B

March 1, 2020 through February 28, 2022

Comparison of Louisiana Medicaid Dental Benefit Management Program Encounters to Cash Disbursements for MCNA Dental Plans

May 17, 2022

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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STUDY PURPOSE

The Louisiana Department of Health (LDH) engaged Myers and Stauffer LC to analyze Louisiana Dental Benefit Program Manager (DBPM) encounter data that has been submitted by the Dental Benefit Program Manager (DBPM) contractor, MCNA Dental Plans, to Louisiana's fiscal agent contractor (FAC), Gainwell Technologies, and complete a comparison of the encounters to cash disbursement journals (CDJ) provided by the DBPM contractor. For purposes of this analysis, "encounter data" are claims that have been paid by the DBPM contractor to health care providers that have rendered health care services to members enrolled with the DBPM contractor.

Myers and Stauffer LC receives encounter data on a monthly basis from the FAC in a standardized data extract. This data extract contains paid and denied DBPM encounters that were submitted by the DBPM to the FAC and were subsequently loaded into the Medicaid Management Information System (MMIS).

Myers and Stauffer LC analyzes the information of each paid encounter in the MMIS to capture the amount paid on each line of an entire claim. In certain instances, we identify potential duplicate and calculated void encounters and conclude that some of these potential duplicates appear to be partial payments, some are actual duplicate submissions and some are replacement encounters without a matching void when the encounter data is compared to the CDJ submissions.

Once the potential duplicate and calculated void encounters have been identified, we adjust the encounter totals to reflect the actual payment made (i.e. removing the duplicate payment amounts from our analysis). The net encounter total is then used for the reconciliation analysis and compared to the DBPM submitted CDJs based on common fields, such as DBPM identification number (ID) and DBPM paid date.

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 Louisiana Department of Health (LDH) and should not be used for any other purpose.

LDH requested that, for this study, we review the plan's paid encounters to determine if the paid encounters meet the state contract minimum completeness requirement of **95 percent** when compared to the CDJ files that are submitted by the DBPM. The encounters and CDJ file utilized in this study met the following criteria:

- Encounters were paid within the reporting period of March 1, 2020 and extending through February 28, 2022;
- CDJ transactions had payment dates within the reporting period of March 1, 2020 and extending 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 — MCNA Cumulative Completion Totals and Percentages

Description	Entire Plan	Value-Added Services
Encounter Total (FAC reported)	**$180,467,732**	**$0**
Total Encounter Adjustments ($)	*($4,615,552)*	$0
Total Encounter Adjustments (%)	*-2.55%*	
Net Encounter Total	**$175,852,180**	**0%**
CDJ Total	**$185,827,485**	**$1,428,444**
Variance	*($9,975,306)*	*($1,428,444)*
Completion (%)	**94.63%**	**0.00%**
Contract Minimum Completeness Requirement (%)	**95.00%**	
Non-Compliant (%)	**-0.37%**	**-95.00%**

For this study, Myers and Stauffer analyzes the encounter data that is submitted by the DBPM to the FAC and loaded into the FAC MMIS. Encounters submitted by the DBPM 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 MCNA Encounters

Description	Encounter Count	Paid Amount	Paid Amount (% of Total*)
Total Encounter Amount (FAC Reported)	**5,238,650**	**$180,467,732**	**100.00%**
Adjustment Type			
Denied	(327,612)	*($4,615,232)*	*-2.55%*
Calculated Void	*0*	*$0*	*0.00%*
Duplicate	*(5)*	*($320)*	*0.00%*
Total Adjustments Made	*(327,617)*	*($4,615,552)*	*-2.55%*
Net Encounter Amounts	**4,911,033**	**$175,852,180**	**97.45%**

** 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 5 on page 13 for further explanation.*

During this analysis, Myers and Stauffer identified potential data issues that may impact the completion percentages for MCNA Dental.

Please reference Table C on page 7 for MCNA Dental's reconciliation period table. This table contains detailed reconciliation totals, completion percentages, and encounter analysis adjustments.

Data issues that may cause the cumulative completion percentage to be below 95 percent:

1. We noted monthly completion percentages below 95 percent for the following months:

    - July 2020, January 2021, September 2021 and January 2022 appear to have missing CDJ void transactions when compared to the corresponding encounters.
    - April 2021 and October 2021 appear to have a combination of missing CDJ void transactions and CDJ transactions that are incremental rather than void/replacement transactions when compared to the encounter transactions.
    - July 2021, August 2021 and February 2022 appear to have encounters that were denied by the FAC when compared to CDJ transactions.

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

2. We noted monthly completion percentages above 100 percent for the following months:

    - November 2021 and December 2021 appear to have missing CDJ void and replacement transactions when compared to the corresponding encounter transactions.

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

3. For MCNA value-added services (VAS) given in Table D, we noted the following:

    - No encounters appear to be identified as VAS when compared to the corresponding VAS CDJ transactions.

Table C - MCNA							
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	$10,594,723	($38,868)	0%	$10,555,855	$10,648,449	($92,594)	99.13%
April 2020	$2,340,686	($21,680)	-1%	$2,319,006	$2,349,030	($30,024)	98.72%
May 2020	$8,241,750	($94,216)	-1%	$8,147,534	$8,238,857	($91,323)	98.89%
June 2020	$8,494,335	($33,166)	0%	$8,461,169	$8,506,262	($45,093)	99.46%
July 2020	$11,181,628	($41,923)	0%	$11,139,705	$11,919,476	($779,772)	93.45%
August 2020	$10,664,040	($54,675)	-1%	$10,609,365	$10,689,274	($79,909)	99.25%
September 2020	$10,195,769	($866,716)	-9%	$9,329,053	$9,493,996	($164,943)	98.26%
October 2020	$12,715,726	($35,986)	0%	$12,679,740	$13,889,262	($1,209,523)	91.29%
November 2020	$11,023,953	($41,948)	0%	$10,982,005	$11,286,577	($304,571)	97.30%
December 2020	$11,785,473	($43,564)	0%	$11,741,909	$12,193,452	($451,543)	96.29%
January 2021	$6,972,008	($24,028)	0%	$6,947,981	$7,932,292	($984,311)	87.59%
February 2021	$5,350,165	($31,908)	-1%	$5,318,257	$5,552,738	($234,481)	95.77%
March 2021	$7,505,134	($52,417)	-1%	$7,452,716	$8,279,838	($827,122)	90.01%
April 2021	$5,897,920	($48,567)	-1%	$5,849,353	$6,588,314	($738,961)	88.78%
May 2021	$5,419,833	($40,966)	-1%	$5,378,867	$6,094,627	($715,760)	88.25%
June 2021	$5,253,398	($45,005)	-1%	$5,208,393	$5,705,225	($496,832)	91.29%
July 2021	$6,700,437	($423,855)	-6%	$6,276,582	$7,197,806	($921,224)	87.20%
August 2021	$6,032,009	($962,002)	-16%	$5,070,008	$6,152,923	($1,082,915)	82.39%
September 2021	$4,283,578	($45,069)	-1%	$4,238,510	$4,508,289	($269,779)	94.01%
October 2021	$6,803,506	($258,103)	-4%	$6,545,403	$7,160,093	($614,691)	91.41%
November 2021	$5,877,858	($180,786)	-3%	$5,697,072	$5,674,184	$22,888	100.40%
December 2021	$6,660,093	($1,091,326)	-16%	$5,568,767	$5,057,283	$511,483	110.11%
January 2022	$5,234,620	($74,603)	-1%	$5,160,017	$5,390,673	($230,657)	95.72%
February 2022	$5,239,088	($64,174)	-1%	$5,174,914	$5,318,566	($143,652)	97.29%
Cumulative Totals	**$180,467,732**	**-$4,615,552**	**-3%**	**$175,852,180**	**$185,827,485**	**-$9,975,306**	**94.63%**
					State Contract Minimum Completeness Percentage Requirement		*95.00%*
						Non-Compliant	***-0.37%***

Table D — MCNA VAS							
Paid Month	VAS Monthly Encounter Total (FAC Reported)	VAS Monthly Encounter Total (Adjustments)	VAS Percentage of Encounters Adjusted	VAS Monthly Encounter Net Total	VAS CDJ Monthly Reported Total	VAS Monthly Variance	VAS 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	$0	$0	
August 2020	$0	$0		$0	$0	$0	
September 2020	$0	$0		$0	$0	$0	
October 2020	$0	$0		$0	$0	$0	
November 2020	$0	$0		$0	$0	$0	
December 2020	$0	$0		$0	$0	$0	
January 2021	$0	$0		$0	$847	($847)	0.00%
February 2021	$0	$0		$0	$3,295	($3,295)	0.00%
March 2021	$0	$0		$0	$8,619	($8,619)	0.00%
April 2021	$0	$0		$0	$7,752	($7,752)	0.00%
May 2021	$0	$0		$0	$8,075	($8,075)	0.00%
June 2021	$0	$0		$0	$11,554	($11,554)	0.00%
July 2021	$0	$0		$0	$14,349	($14,349)	0.00%
August 2021	$0	$0		$0	$6,390	($6,390)	0.00%
September 2021	$0	$0		$0	$6,775	($6,775)	0.00%
October 2021	$0	$0		$0	$11,996	($11,996)	0.00%
November 2021	$0	$0		$0	$8,445	($8,445)	0.00%
December 2021	$0	$0		$0	$6,787	($6,787)	0.00%
January 2022	$0	$0		$0	$639,210	($639,210)	0.00%
February 2022	$0	$0		$0	$694,349	($694,349)	0.00%
Cumulative Totals	**$0**	**$0**		**$0**	**$1,428,444**	**-$1,428,444**	**0%**
						State Contract Minimum Completeness Percentage Requirement	*95.00%*
						Non-Compliant	***-95.00%***

Chart 1. Monthly CDJ totals and encounter submission for MCNA Dental

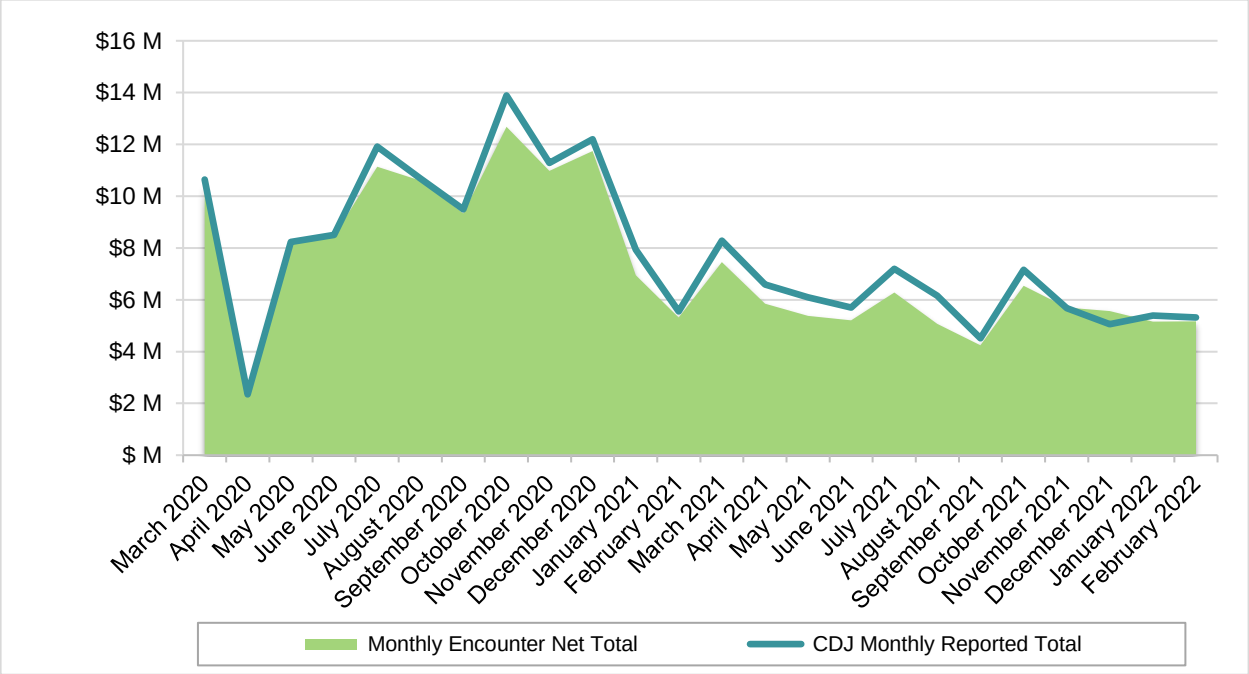
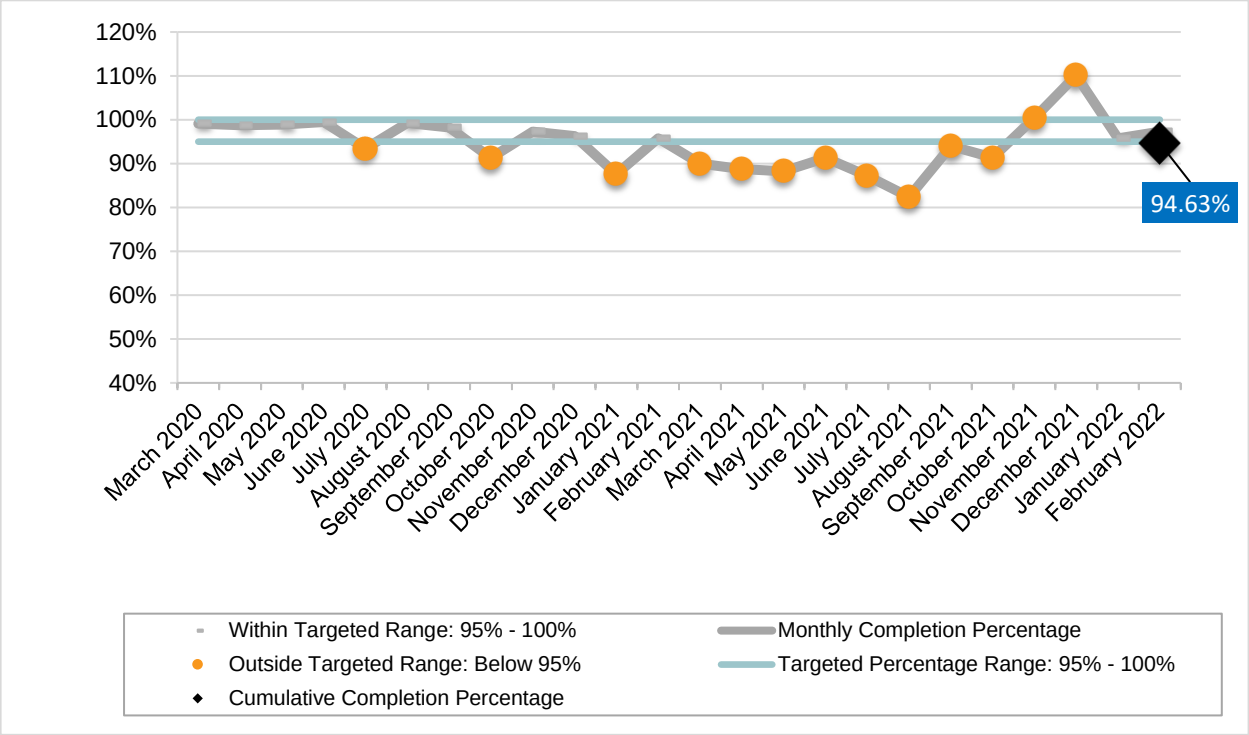


Chart 2. MCNA Dental's monthly encounter submissions expressed as a percentage of payments submitted to the FAC to reported DBPM monthly CDJ payment



The following terms are used throughout this document:

- **Cash Disbursement Journal (CDJ) Monthly Reported Total** – The sum of all payments from the dental benefit management program (DBPM) contractor to LDH.
- **Fiscal Agent Contractor (FAC)** – A contractor selected to design, develop and maintain the claims processing system (Medicaid Management Information System); Gainwell Technologies is the current FAC.
- **Gainwell Technologies (Gainwell)** – State fiscal agent contractor, known as DXC Technology prior to October 1, 2020
- **Dental Benefit Program Manager (DBPM)** – A program authorized under a 1915(b) Medicaid waiver to serve all Medicaid beneficiaries eligible for dental services including children, eligible SCHIP Medicaid expansion children and adults. It was implemented statewide in July 2014 as a Prepaid Ambulatory Health Plan (PAHP).
- **Louisiana Department of Health (LDH) -** The agency in charge of overseeing the health services for the citizens of the state of Louisiana.
- **Medicaid Management Information System (MMIS)** – The claims processing system used by the FAC to adjudicate Louisiana Medicaid and LaCHIP claims. DBPM -submitted encounters are loaded into this system and assigned a unique claim identifier.
- **Monthly Completion Percentage** – The percentage of the monthly encounter net total in relation to the CDJ monthly reported total.
- **Monthly Encounter Net Total** – The sum of the encounter submissions for a given month incorporating the Myers and Stauffer LC encounter data adjustments made to the encounter submissions stored in the FAC's encounter data warehouse.
- **Monthly Encounter Total (Adjustments)** – The sum of all Myers and Stauffer LC adjustments for a given month that were removed from the encounter submissions stored in the FAC's encounter data warehouse.
- **Monthly Encounter Total (FAC Reported)** – The sum of all encounter submissions for a given month stored in the FAC's encounter data warehouse.
- **Monthly Variance** – The difference between the monthly encounter net total and the CDJ monthly reported total.
- **Dental Benefit Program Manager (DBPM) Contractor** – A private organization contracted to manage the Louisiana Dental Benefit Program Manager. Managed Care of North America (MCNA) Dental Plans is one of the two current DBPM contractors.

Encounters from medical service types were combined on like data fields. We analyzed the reported information of each encounter to capture the amount paid on the entire claim. Encounter totals were calculated by summarizing the data by the DBPM paid date and DBPM identification number (ID). The DBPM's submitted cash disbursements were summarized by paid date to create a matching table. These matching tables were combined using common fields and were used to produce the results.

1. When the DBPM submits an adjustment encounter, the FAC's encounter processing system automatically creates a void for the original (replaced) encounter. These system-generated voids bear the same paid date as the original encounter. In order to more accurately reconcile to the cash payments, we have attempted to match these voids' paid dates to the adjustment dates. However, we were unable to reallocate void encounters for which there was not an associated adjustment encounter.

2. Instances were noted where a record's transaction type implied a specific sign valuation for the DBPM 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. Where possible, these CDJ and/or encounter payment amounts were adjusted to reflect the expected sign of the payment in accordance with the transaction type.

3. We instructed the DBPM 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.

4. Separately itemized interest expenses are excluded from the CDJ and encounter totals when the interest amounts are included in the DBPM paid amounts on the encounters and/or CDJ transaction amounts.

5. 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 and B).

6. Opportunities for improving the encounter reconciliation process have been identified during the analysis of the encounter data and cash disbursement journals, as well as frequent interactions with the DBPM, 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 prior reports or modify reconciliation processes in the future.

Appendix C: Claims Sample Completeness

Description	Dental					
	October 2020		April 2021		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Claims Sample Data						
Claims Sample Total	331,941	$13,877,073	151,950	$6,207,232	483,891	$20,084,305
Reconciling Adjustment	0	$0	0	$0	0	$0
Net Claims Sample Total	331,941	$13,877,073	151,950	$6,207,232	483,891	$20,084,305
Encounter Data						
Total Matched Encounters	276,898	$12,416,468	135,643	$5,797,913	412,541	$18,214,381
Less Surplus Encounters	(4,398)	($18,943)	(7,634)	($86,925)	(12,032)	($105,868)
Payment Adjustments	0	($43,303)	0	($28,065)	0	($71,368)
Net Matched Encounters	272,500	$12,354,222	128,009	$5,682,923	400,509	$18,037,145
Encounter Completeness Percentage	***82.1%***	***89.0%***	***84.2%***	***91.6%***	***82.8%***	***89.8%***

Appendix D: Overall Completeness

Description	CDJs	Claims Sample		Total		
		Dental		Total		
	Total Paid Amount	Total Count	Total Paid Amount	Total Count	Total Paid Amount	Overall Average[1]
Health Plan-Submitted Data						
Total Health Plan Data	$109,625,071	483,891	$20,084,305	483,891	$129,709,376	130,193,267
Encounter Data						
Total Matched Encounters	$103,965,047	412,541	$18,214,381	412,541	$122,179,428	122,591,969
Adjustments	($1,327,703)	(12,032)	($177,237)	(12,032)	($1,504,940)	(1,516,972)
Net Matched Encounters	***$102,637,344***	***400,509***	***$18,037,145***	***400,509***	***$120,674,489***	***121,074,998***
Encounter Completeness Percentage	***93.6%***	***82.8%***	***89.8%***	***82.8%***	***93.0%***	***93.0%***

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

Appendix E: Key Data Element Matching

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	271,796	98.2%	0	0.0%	5,102	1.8%	130,013	95.8%	0	0.0%	5,630	4.2%	401,809	97.4%	0	0.0%	10,732	2.6%
Billing Provider NPI/Number	276,898	100.0%	0	0.0%	0	0.0%	135,643	100.0%	0	0.0%	0	0.0%	412,541	100.0%	0	0.0%	0	0.0%
Date of Service	276,898	100.0%	0	0.0%	0	0.0%	135,643	100.0%	0	0.0%	0	0.0%	412,541	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	271,631	98.1%	N/A		5,267	1.9%	127,088	93.7%	N/A		8,555	6.3%	398,719	96.6%	N/A		13,822	3.4%
Health Plan Paid Amount	267,512	96.6%	0	0.0%	9,386	3.4%	126,498	93.3%	0	0.0%	9,145	6.7%	394,010	95.5%	0	0.0%	18,531	4.5%
Health Plan Paid Date	265,465	95.9%	0	0.0%	11,433	4.1%	127,978	94.3%	0	0.0%	7,665	5.7%	393,443	95.4%	0	0.0%	19,098	4.6%
MMIS ICN	67,332	24.3%	0	0.0%	209,566	75.7%	32,432	23.9%	0	0.0%	103,211	76.1%	99,764	24.2%	0	0.0%	312,777	75.8%
MMIS Member Number (Medicaid ID)	276,898	100.0%	0	0.0%	0	0.0%	135,643	100.0%	0	0.0%	0	0.0%	412,541	100.0%	0	0.0%	0	0.0%
Place of Service	276,663	99.9%	0	0.0%	235	0.1%	135,183	99.7%	0	0.0%	460	0.3%	411,846	99.8%	0	0.0%	695	0.2%
Procedure Code	276,898	100.0%	0	0.0%	0	0.0%	135,643	100.0%	0	0.0%	0	0.0%	412,541	100.0%	0	0.0%	0	0.0%
Service Provider NPI/Number	276,808	100.0%	0	0.0%	90	0.0%	135,599	100.0%	0	0.0%	44	0.0%	412,407	100.0%	0	0.0%	134	0.0%
Service Provider Specialty/Taxonomy	272,570	98.4%	0	0.0%	4,328	1.6%	133,081	98.1%	0	0.0%	2,562	1.9%	405,651	98.3%	0	0.0%	6,890	1.7%
Tooth Number	266,982	96.4%	N/A		9,916	3.6%	130,263	96.0%	N/A		5,380	4.0%	397,245	96.3%	N/A		15,296	3.7%
Tooth Surface	276,875	100.0%	N/A		23	0.0%	135,627	100.0%	N/A		16	0.0%	412,502	100.0%	N/A		39	0.0%
Total	***3,621,226***	***93.4%***	***0***	***0.0%***	***255,346***	***6.6%***	***1,756,334***	***92.5%***	***0***	***0.0%***	***142,668***	***7.5%***	***5,377,560***	***93.1%***	***0***	***0.0%***	***398,014***	***6.9%***
Total Records in the Encounter Dataset	276,898						135,643						412,541					
Number of Key Data Element Evaluated	14						14						14					
Maximum Count	3,876,572	100.0%					1,899,002	100.0%					5,775,574	100.0%				

Appendix F: Medi Appendix G: Medical Records Validity Rates

Dental					
Key Data Element	Total Elements Sampled	Supported Elements		Unsupported Elements	
		Count	Percent	Count	Percent
Member Name	147	147	100.0%	0	0.0%
Member DOB	147	144	98.0%	3	2.0%
Date of Service	147	147	100.0%	0	0.0%
Billing Provider	147	146	99.3%	1	0.7%
Place of Service	147	145	98.6%	2	1.4%
Procedure Code	147	144	98.0%	3	2.0%
Tooth Number	44	42	95.5%	2	4.5%
Tooth Surfaces	17	16	94.1%	1	5.9%
Servicing Provider	147	146	99.3%	1	0.7%
Total	***1,090***	***1,077***	***98.8%***	***13***	***1.2%***

Note: 147 of the 150 medical records requested were submitted and tested.

Health Plan Response:

The health plan stated that it had no comments on the report.