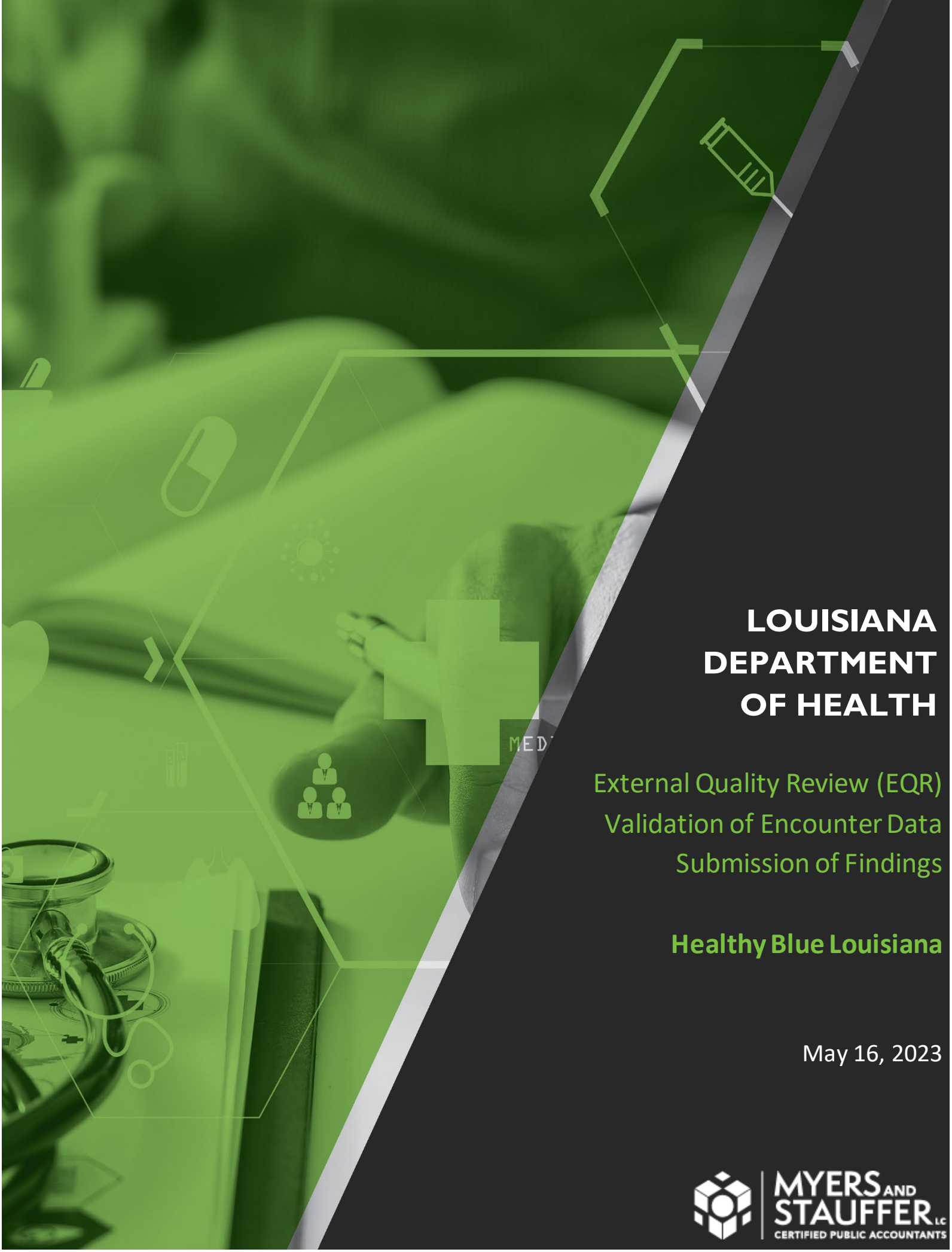


LOUISIANA DEPARTMENT OF HEALTH

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

Healthy Blue Louisiana

May 16, 2023

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

Executive Summary

The Louisiana Department of Health (LDH) engaged Myers and Stauffer to perform External Quality Review (EQR) Protocol 5 to evaluate the completeness and accuracy of the encounter data submitted by Healthy Blue Louisiana (HB) 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 included 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 March 2021.
- Encounter data provided by the fiscal agent contractor (FAC) in a standardized monthly data extract, which included encounters received and processed by the FAC and transmitted to Myers and Stauffer through July 26, 2022.
- Medical records which 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 within the encounter data.

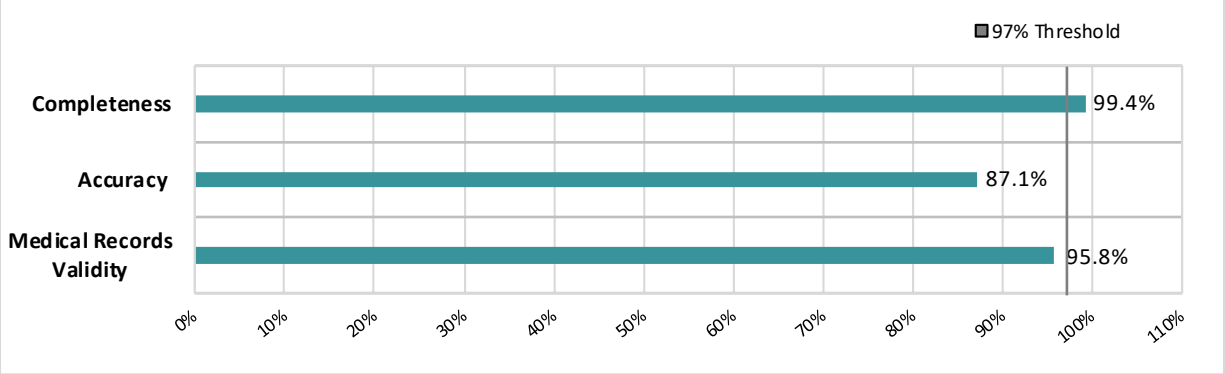
Findings

- **Completeness:** The average completion percentage for SFY 2021 was above the 97 percent threshold (99.5 percent) when compared to CDJ paid amounts. Medical, dental and pharmacy encounters were below the 97 percent threshold when compared to sample claims counts. When compared to sample claims paid amounts, encounter completion percentages were at or above the 97 percent threshold for all encounter types except dental (95.8 percent). The aggregate overall completion percentage (i.e., the total based on CDJ paid amounts, sample

claims counts and sample claims paid amounts) exceeded the 97 percent threshold (99.4 percent).

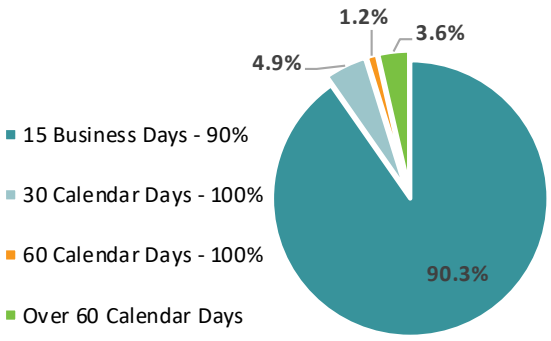
- **Accuracy:** The overall accuracy percentage was below the 97 percent threshold (87.1 percent). Encounter data accuracy issues were noted primarily with the delegated vendor data, most notably non-emergency medical transportation (NEMT) and pharmacy data; and medical encounter paid dates and internal control numbers (ICNs).

- **Medical Record Validation Rates:** 131 of the 150 (87.3 percent) medical records requested were submitted and tested. The validation rate for the medical records tested was below the 97 percent threshold (95.8 percent). Validity issues were primarily related to data supporting the encounter key data elements missing from the medical records.

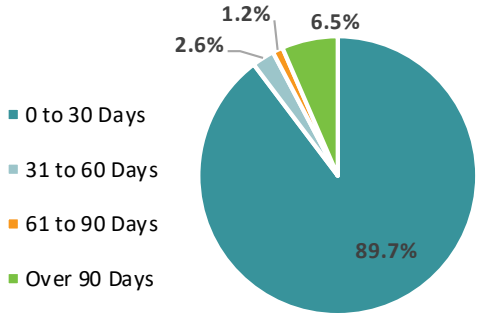


- **Timeliness:** The health plan met the 15 business day requirement for the payment of claims and did not meet the 30 and 60 calendar day requirement. The health plan submitted 92.4 percent of its encounter data within 60 days.

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. [1]

The Centers for Medicare & Medicaid Services (CMS) established requirements for states to improve the reliability of encounter data collected from managed care health plans. In 2016, the Medicaid managed care final rule, required states to conduct an independent audit of encounter data reported by each managed care health plan. Revisions to the Medicaid managed care regulations enhanced quality oversight criteria. Under the 2020 final rule, encounter data must include allowed and paid amounts and states must annually post on its website health plans that are exempt from external quality review [2].

CMS indicated that states could meet the independent audit requirement by conducting an encounter data validation study based on EQR Protocol 5 [3]. Protocol 5 assesses 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). Although Protocol 5 is a voluntary protocol, CMS strongly encourages states to contract with qualified entities to implement Protocol 5 to meet the audit requirement of the final rule. 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 Transformed Medicaid Statistical Information System (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 to perform Protocol 5 to evaluate the completeness and accuracy of the encounter data submitted by HB for members enrolled in the State's Medicaid Managed Care

[1] https://ldh.la.gov/page/32
[2] https://www.cms.gov/newsroom/fact-sheets/medicaid-childrens-health-insurance-program-chip-managed-care-final-rule-cms-2408-f
[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

program. EQR Protocol 5 validation analyses were performed on the health plan's SFY 2021 encounter data. CMS guidelines were followed and applied during the review.

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. Although the public health guidelines 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 capabilities.	

[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. Encounter data for the period July 1, 2020 through June 30, 2021 was used for the analyses. CDJs and claims sample data submitted by the health plan 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 operating in Louisiana 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 performs a bi-monthly reconciliation of the health plan-submitted CDJs to the FAC encounter data to measure 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. The CDJ files 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 July 26, 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

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

validation. The health plan's monthly completion percentages were at or above the 97 percent threshold for seven (7) out of the twelve (12) month measurement period.

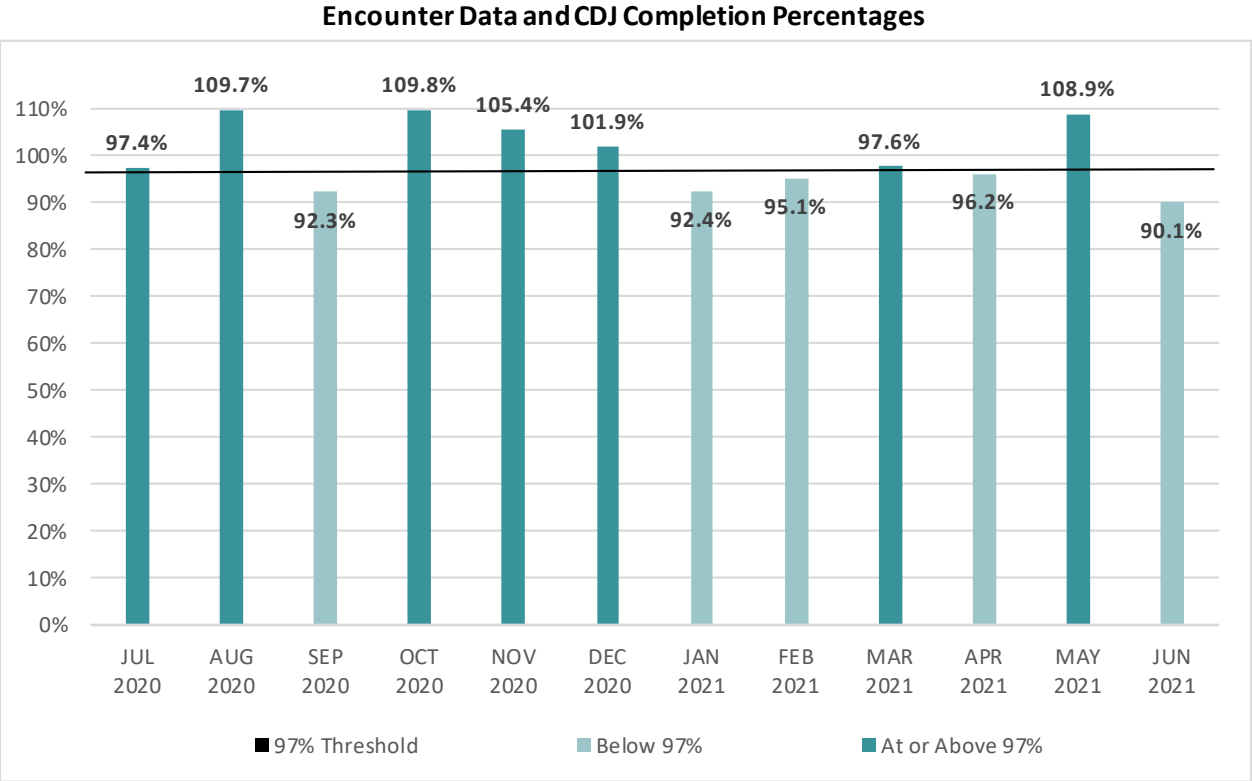


Figure 1 - Encounter Data and CDJ Completion Percentages: The health plan's average completion percentage for SFY 2021, including delegated vendors, was 99.5 percent. Detailed results can be found in the September 2022 Encounter Data Validation Report, Appendix B.

Completion percentages greater than 100 percent or below the threshold 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.

Sample Claims

The comparison of the sample claims 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 sample claims data was traced to encounter data using data elements provided in the sample claims data. The encounters were evaluated against the sample claims data based on the following criteria:

- Sample Claim Count: The number of claims from the sample that were identified in the encounters.
- Sample Claim Paid Amount: Sample claims 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 claims counts and paid amounts to encounter counts and paid amounts. A 97 percent threshold was used for validation.

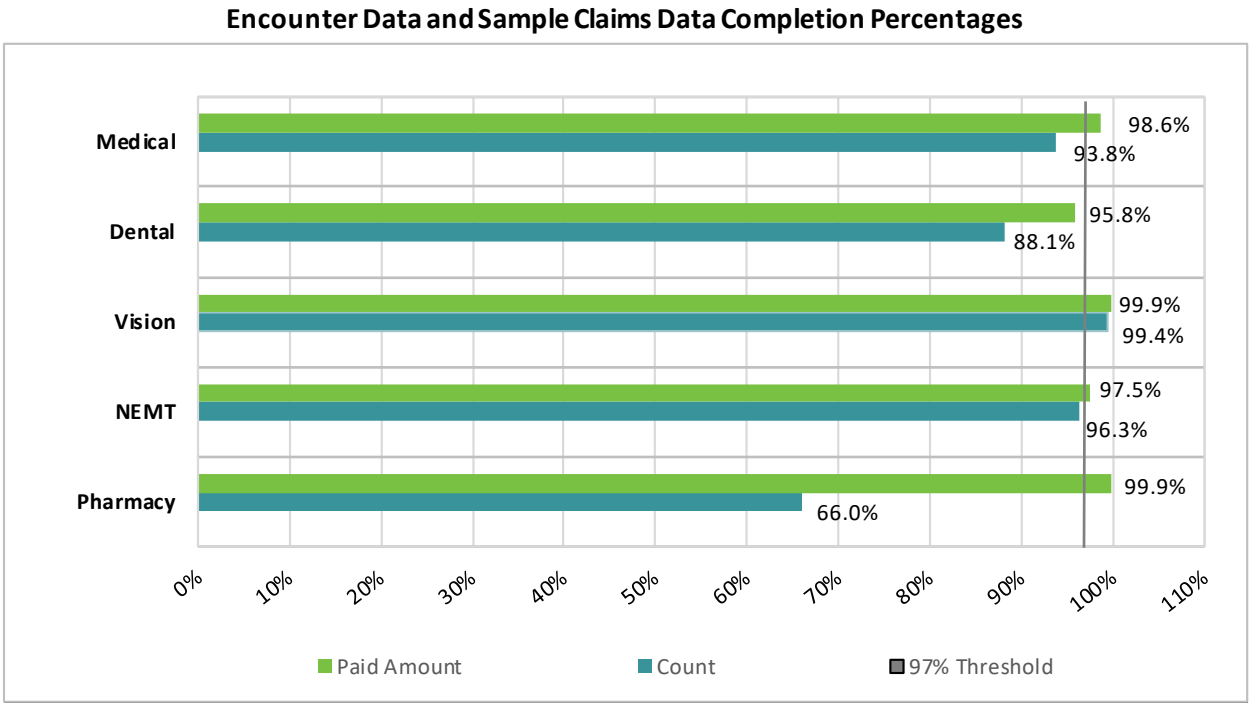


Figure 2 - Encounter data and Sample Claims Data Completion Percentages: Values reflect the two sample months combined. Detailed results can be found in Appendix C and overall completion percentages can be found in Appendix D.

Encounter completion percentages, based on sample claim counts, were below the 95 percent threshold for medical, dental and pharmacy encounters. On a paid amount basis, when compared to sample claim paid amounts, encounter paid amounts were at or above the 97 percent threshold for all encounter types except dental, which was 95.8 percent complete.

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.

Individual key data element validity and accuracy rates were calculated based on the total number of records in the encounter dataset. The targeted error rate was expected to be below three percent per key data element (i.e., a 97 percent accuracy threshold). Accuracy percentages are presented in **Table 1**, below. Accuracy issues were noted for health plan paid amounts and dates and billing/service provider NPIS and taxonomy/specialty.

Accuracy Percentages – Key Data Elements Analysis			
Encounter Type	**Valid Values**	**Missing Values**	**Erroneous Values**
Medical	90.6%	0.0%	9.4%
Dental	94.1%	0.0%	5.9%
Vision	92.7%	0.0%	7.3%
NEMT	74.9%	0.0%	25.1%
Pharmacy	78.4%	4.7%	16.9%
Total Average	***87.1%***	***1.2%***	***11.7%***

Table 1 - Encounter Accuracy Percentages – Key Data Elements Analysis: Values reflect the two sample months combined. The key data elements evaluated and specific testing results are presented in Appendix E.

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 health plan's monthly completion percentages were at or above the 97 percent threshold for seven (7) out of the twelve (12) month measurement period. For SFY 2021, the health plan's completion percentage was above the 97 percent threshold (99.5 percent).	The health plan, 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 should submit payment adjustments to ensure duplicates, voids and denied claims are accurately addressed in the encounter data.
3-B	**Completeness – Sample Claims Count:** The vision encounter completion percentage, based on sample claims counts, was above the 97 percent threshold. Medical, dental, NEMT and pharmacy encounter counts were below the threshold.	
3-C	**Completeness – Sample Claims Paid Amount:** Encounter completion percentages, based on sample claims amounts, were at or above the 97 percent threshold for medical, vision, NEMT and pharmacy encounters. Dental encounters were below the threshold.	

Findings and Recommendations		
	Findings	**Recommendations**
3-D	**Accuracy -** **Billed Charges:** Dental, NEMT and Pharmacy **Health Plan Paid Amount**: NEMT **Procedure Code:** NEMT Both the sample claims data and the encounter data reflect valid values and the values do 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/or its delegated vendor should work together to ensure key data elements are properly submitted and captured in the encounter data.
3-E	**Accuracy –** **Date of Service: NEMT** **Health Plan Paid Date:** Medical and Pharmacy The encounter date is before and/or after the sample claim date.	
3-F	**Accuracy - Prescribing Provider NPI, Amount Paid Pharmacy Benefits Manager** and **Basis of Reimbursement:** Pharmacy - The sample claim reflects a value and the encounter value is not populated or both the sample claims data and the encounter data reflect valid values and the values do not agree.	
3-G	**Accuracy - Former/Original Claim ICN:** Medical – The sample claim reflects a value and the encounter value is not populated, or both the sample claims data and the encounter data reflect valid values and the values do not agree.	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 – Member (Medicaid) ID:** Dental and Vision – The sample claims is not populated or the sample claims data appears to reflect the health plan's member ID.	The member ID is a proprietary number assigned by the health plan to identify members enrolled with the health plan. The Medicaid identification number verifies the member's Medicaid eligibility. The health plan/delegated vendor should ensure there is a crosswalk in place to link the health plan/delegated vendor's assigned member ID to the recipient's Medicaid ID and be able to provide either or both upon request.
3-I	**Accuracy – MMIS_ICN:** Medical, Dental, NEMT and Pharmacy– The sample claim value is not populated or the sample claims data appears to reflect an original claim MMIS ICN and the encounter ICN reflects an adjustment or replacement encounter ICN or vice versa. For example, the claim reflects a MMIS ICN of 1070123****** and the encounter reflects an ICN with a Julian date of 0309117******.	The health plan/delegated vendor should ensure that appropriate audit trails are in place and it is properly capturing and storing all ICN(s) assigned by the FAC and returned to the health plan/delegated vendor on the 835 or proprietary response file(s).

Findings and Recommendations		
	Findings	**Recommendations**
3-J	**Accuracy – Service/Attending/Rendering Provider Taxonomy:** Dental and NEMT – The sample claim value is not populated or both the sample claims data and the encounter data reflect valid values and the values do not agree.	The health plan should ensure it is properly maintaining provider data within the claims system and data warehouse and be able to submit this information in the encounter submissions. Additionally, the FAC and the health plan should work together to ensure the provider regulated values are properly submitted and captured in the encounter data.

Statistics and Distributions

To further support the encounter data validation process, encounters with dates of service during the measurement period were analyzed for consistency among attributes such as member utilization and paid amounts, timeliness of payments, and encounter submissions timeliness. SFY 2021 encounters were used for comparison to Healthy Louisiana program data to further evaluate the 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 the SFY 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.

Per Member Per Year[10] Utilization and Paid Amounts by Service Type						
Service Type	**Healthy Louisiana**		**HB**		**Percentage of Healthy Louisiana**	
	Count	**Paid Amount**	**Count**	**Paid Amount**	**Count**	**Paid Amount**
Ancillary	4.9	$240	4.9	$219	0.0%	-8.8%
Dental	0.4	$20	0.5	$20	25.0%	0.0%
Inpatient	1.6	$1,024	1.8	$1,084	12.5%	5.9%
NEMT	0.6	$27	0.6	$32	0.0%	18.5%
Outpatient	12.0	$748	12.6	$782	5.0%	4.5%
Pharmacy	17.0	$1,302	16.5	$1,492	-2.9%	14.6%
Primary Care	10.0	$345	9.7	$334	-3.0%	-3.2%
Specialty Care	8.0	$593	8.3	$616	3.8%	3.9%
Vision	1.0	$35	0.9	$33	-10.0%	-5.7%
Total Health Plan Services	***55.5***	***$4,334***	***55.8***	***$4,612***	***0.5%***	***6.4%***

Table 2 - Per Member Utilization and Paid Amount Statistics: Positive percentage variances indicate that the health plan's per member per year (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. Detailed results can be found in Appendix F.

[10] Counts and/or paid amount divided by the average number of members.

Variances 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, emergency services.

Timeliness

This analysis determines compliance with the timeliness requirements of the health plan's payment of provider claims and its submission of encounters to the FAC after adjudication (i.e., payment or denial).

Timely Payment of Claims

This analysis measures the compliance of the health plan in paying or denying (adjudicating) claims submitted by providers for payment. The contract between LDH and the health plan requires the health plan to process and pay or deny at least 90 percent of all clean[11] claims 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[12]. On December 1, 2020, the 30 calendar day percentage requirement increased to 100 percent[13].

The received dates and paid (adjudication) dates from the encounter data extract were used for the analysis. The number of days between these dates were used to determine the percentage of claims adjudicated (paid or denied) by the health plan within the designated timeframes. **Table 3** shows the results of the timely payment of claims analysis. The health plan met the 15 business day requirement for the payment of claims and did not meet the 30 and 60 calendar day requirement.

Timely Payment of Claims				
Encounter Type	**15 Business Days 90%**	**30 Calendar Days 100%**	**60 Calendar Days 100%**	**Average Calendar Days**
Medical	86.7%	93.5%	95.2%	17
Dental	91.5%	95.8%	96.4%	11
Vision	100.0%	100.0%	100.0%	0
NEMT	99.3%	99.7%	99.8%	15
Pharmacy	98.3%	98.9%	99.2%	9
Overall Average	***90.3%***	***95.2%***	***96.4%***	***14***

Table 3 - Timely Payment of Claims: Percentages reflect encounters with SFY 2021 dates of service. Detailed results can be found in Appendix G.

Timely Encounter Submissions

According to the health plan's contract with LDH, the health plan must submit encounter data at least monthly. Encounters are due in accordance with the encounter reconciliation schedule published by LDH or its contracted review organization (Appendix A). This allows encounter data submissions to be made in sufficient time to be extracted from the MMIS for review, analysis and inclusion in the encounter reconciliation reports prepared by Myers and Stauffer (Appendix B).

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

The paid dates and Julian dates (i.e., date the encounter was submitted to the FAC; digits one through four of the FAC assigned ICN number) from the encounter data extract were used for the analysis. **Table 4** shows the results of the encounter submission timeliness analysis. The health plan submitted 92.4 percent of its encounter data within 60 days.

Timely Encounter Submissions				
Encounter Type	**30 Days**	**60 Days**	**90 Days**	**Average Days**
Medical	89.2%	92.0%	93.0%	28
Dental	61.6%	64.7%	71.4%	90
Vision	93.4%	97.2%	97.7%	20
NEMT	21.0%	42.4%	55.9%	117
Pharmacy	99.0%	99.2%	99.4%	7
Overall Average	***89.7%***	***92.4%***	***93.5%***	***26***

Table 4 - Timely Encounter Submissions: Percentages reflect encounters with SFY 2021 dates of service. Detailed results can be found in Appendix H.

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 day level of timeliness for the payment of claims and did not meet the 30 and 60 calendar day 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 92.4 percent of encounters (both paid and denied) with SFY 2021 dates of service within 60 days. Dental and NEMT encounters diluted values with 64.7 percent and 42.4 percent, respectively, submitted within 60 days. Dental encounters were submitted, on average, within 90 days and NEMT encounters were submitted, on average, within 117 days.	The health plan should review its encounter submission process to ensure encounters rejected by the FAC are quickly resolved and resubmitted. Additionally, the health plan should regularly monitor its delegated vendors' encounter submission processes to ensure encounters are submitted timely.

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[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 on September 22, 2022 for retrieval of the medical records from the rendering provider. The notification to the health plan stated that medical records were due to Myers and Stauffer by November 7, 2022. Medical records submitted after the due date, records with incorrect dates of service, and incomplete medical records were excluded from the validation.

Under certain circumstances, EQR Protocol 5 allows for the substitution of medical records selected for review. The health plan notified Myers and Stauffer that the pharmacy records selected for review included encounters that were rejected by the pharmacy vendor. The records were rejected for a variety of reasons such as prior authorization, refill too soon, etc., and it was unlikely that claims were submitted for these records that could have paid. A review of the encounter data found that there were no paid encounters submitted for the rejected records, and replacement records were sent to the health plan.

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	**Medical**	**Dental**	**Vision**	**Pharmacy**	**Total**
Requested	96	1	3	50	150
Replaced	0	0	0	12	12
Missing	18	0	0	1	19
Medical Records Received and Tested	78	1	3	49	131
Percentage of Requested Records Tested	***81.3%***	***100.0%***	***100.0%***	***98.0%***	***87.3%***

Table 5 - Medical Records Summary: 131 of the 150 medical records requested (87.3 percent) were submitted and tested.

The health plan stated that numerous attempts were made to obtain the missing records and, despite their best efforts, the providers were non-responsive to the requests. There were also a small number of

[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

providers who indicated they had not ever seen the member(s) in question. For these providers, the health plan will be engaging their Special Investigation Unit to review for potential fraud.

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 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 reflected 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 reflects the validation rates from the medical record key data element review. A 97 percent threshold was used for validation. Validity issues were primarily related to data supporting the encounter key data elements missing from the medical records.

Medical Records Validation Rates		
Encounter Types	**Supported Validation Rate**	**Unsupported Validation Rate**
Medical	93.7%	6.3%
Dental	100.0%	0.0%
Vision	100.0%	0.0%
Pharmacy	99.3%	0.7%
Total Average	***95.8%***	***4.2%***

Table 6 - Medical Record Validation Rates: Supported validation rates were below the 97 percent threshold. The detailed analysis is included in Appendix I.

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	131 of the 150 (87.3 percent) medical records requested were submitted by the health plan. For the missing records, the providers were unresponsive to the health plan's requests and a small number of providers indicated that they had no record of the member and/or date of service requested.	The health plan should work with its providers to ensure medical records are available and that providers are contractually obligated to submit medical records upon request and within the specified time frame(s).

Findings and Recommendations		
	Findings	**Recommendations**
4-B	The validation rate for the 131 medical records tested was below the 97 percent threshold (95.8 percent).	The health plan should work with its providers to ensure appropriate data element values are submitted and captured in the claims and encounter submissions, and that the data elements submitted are supported by the medical record(s).

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 capabilities.		
Activity 3 – Analyze Electronic Encounter Data		
3-A	**Completeness – CDJs:** The health plan's monthly completion percentages were at or above the 97 percent threshold for seven (7) out of the twelve (12) month measurement period. For SFY 2021, the health plan's completion percentage was above the 97 percent threshold (99.5 percent).	The health plan, 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 should submit payment adjustments to ensure duplicates, voids and denied claims are accurately addressed in the encounter data.
3-B	**Completeness – Sample Claims Count:** The vision encounter completion percentage, based on sample claims counts, was above the 97 percent threshold. Medical, dental, NEMT and pharmacy encounter counts were below the threshold.	
3-C	**Completeness – Sample Claims Paid Amount:** Encounter completion percentages, based on sample claims amounts, were at or above the 97 percent threshold for medical, vision, NEMT and pharmacy encounters. Dental encounters were below the threshold.	
3-D	**Accuracy -** **Billed Charges:** Dental, NEMT and Pharmacy **Health Plan Paid Amount**: NEMT **Procedure Code:** NEMT Both the sample claims data and the encounter data reflect valid values and the values do 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/or its delegated vendor should work together to ensure key data elements are properly submitted and captured in the encounter data.
3-E	**Accuracy –** **Date of Service: NEMT** **Health Plan Paid Date:** Medical and Pharmacy The encounter date is before and/or after the sample claim date.	

Findings and Recommendations		
	Findings	**Recommendations**
3-F	**Accuracy - Prescribing Provider NPI, Amount Paid Pharmacy Benefits Manager** and **Basis of Reimbursement:** Pharmacy - The sample claim reflects a value and the encounter value is not populated or both the sample claims data and the encounter data reflect valid values and the values do not agree.	
3-G	**Accuracy - Former/Original Claim ICN:** Medical The sample claim reflects a value and the encounter value is not populated, or both the sample claims data and the encounter data reflect valid values and the values do not agree.	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 – Member (Medicaid) ID:** Dental and Vision – The sample claims is not populated or the sample claims data appears to reflect the health plan's member ID.	The member ID is a proprietary number assigned by the health plan to identify members enrolled with the health plan. The Medicaid identification number verifies the member's Medicaid eligibility. The health plan/delegated vendor should ensure there is a crosswalk in place to link the health plan/delegated vendor's assigned member ID to the recipient's Medicaid ID and be able to provide either or both upon request.
3-I	**Accuracy – MMIS_ICN:** Medical, Dental, NEMT and Pharmacy– The sample claim value is not populated or the sample claims data appears to reflect an original claim MMIS ICN and the encounter ICN reflects an adjustment or replacement encounter ICN or vice versa. For example, the claim reflects a MMIS ICN of 1070123****** and the encounter reflects an ICN with a Julian date of 0309117******.	The health plan/delegated vendor should ensure that appropriate audit trails are in place and it is properly capturing and storing all ICN(s) assigned by the FAC and returned to the health plan/delegated vendor on the 835 or proprietary response file(s).
3-J	**Accuracy – Service/Attending/Rendering Provider Taxonomy:** Dental and NEMT – The sample claim value is not populated or both the sample claims data and the encounter data reflect valid values and the values do not agree.	The health plan should ensure it is properly maintaining provider data within the claims system and data warehouse and be able to submit this information in the encounter submissions. Additionally, the FAC and the health plan should work together to ensure the provider regulated values are properly submitted and captured in the encounter data.
3-K	**Timely Payment of Claims:** The health plan met the 15 business day level of timeliness for the payment of claims and did not meet the 30 and 60 calendar day 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 92.4 percent of encounters (both paid and denied) with SFY 2021 dates of service within 60 days. Dental and NEMT encounters	The health plan should review its encounter submission process to ensure encounters rejected by the FAC are quickly resolved and resubmitted. Additionally, the health plan should regularly monitor

Findings and Recommendations		
	Findings	**Recommendations**
	diluted values with 64.7 percent and 42.4 percent, respectively, submitted within 60 days. Dental encounters were submitted, on average, within 90 days and NEMT encounters were submitted, on average, within 117 days.	its delegated vendors' encounter submission processes to ensure encounters are submitted timely.
Activity 4 – Review of Medical Records		
4-A	131 of the 150 (87.3 percent) medical records requested were submitted by the health plan. For the missing records, the providers were unresponsive to the health plan's requests and a small number of providers indicated that they had no record of the member and/or date of service requested.	The health plan should work with its providers to ensure medical records are available and that providers are contractually obligated to submit medical records upon request and within the specified time frame(s).
4-B	The validation rate for the 131 medical records tested was below the 97 percent threshold (95.8 percent).	The health plan should work with its providers to ensure appropriate data element values are submitted and captured in the claims and encounter submissions, and that the data elements submitted are supported by the medical record(s).

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

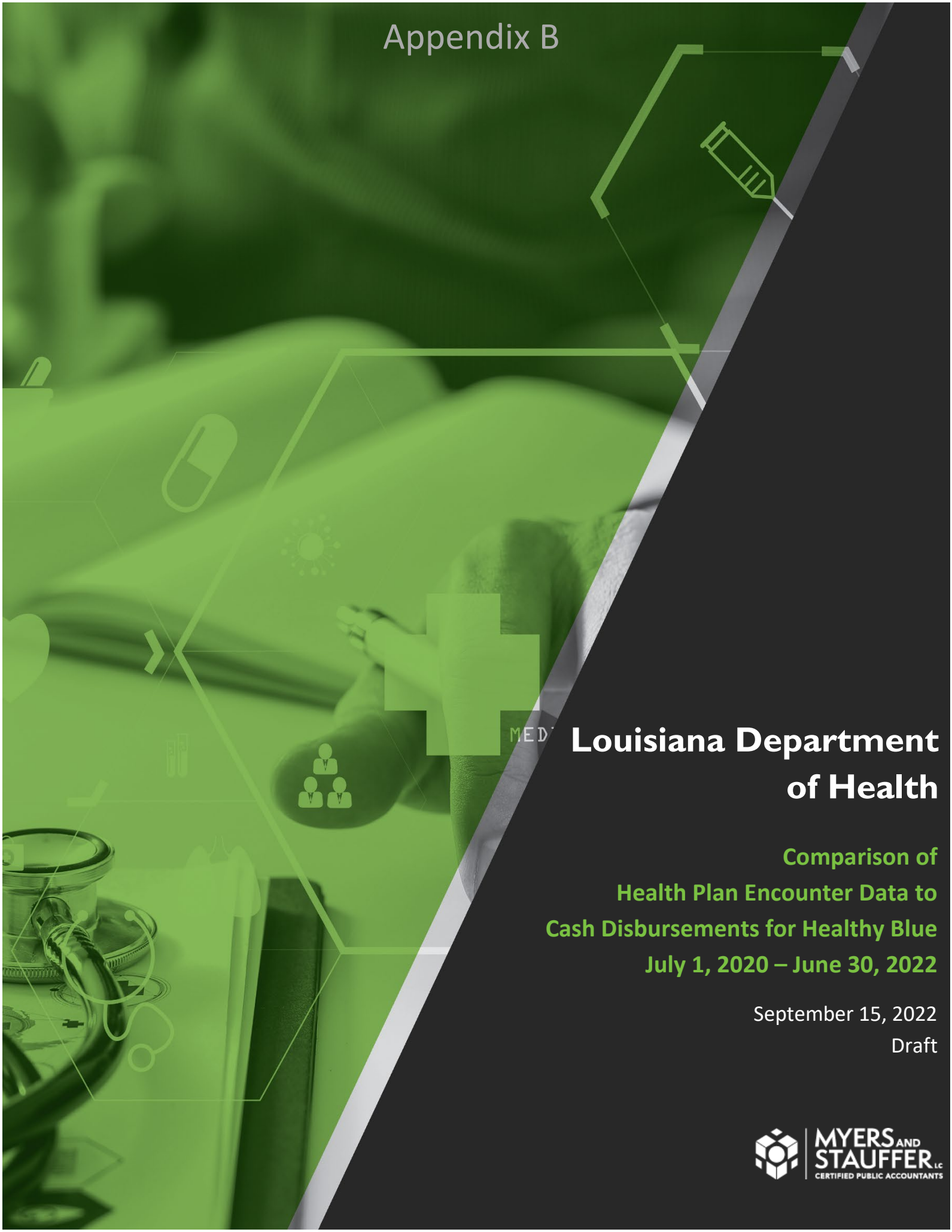
Description	September 2020 Reconciliation	November 2020 Reconciliation	January 2021 Reconciliation	March 2021 Reconciliation	May 2021 Reconciliation	July 2021 Reconciliation	September 2021 Reconciliation
Overall Encounter Submission Goal (cumulative)*	95%	95%	97% - 100%	97% - 100%	97% - 100%	97% - 100%	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 Health Plan Encounter Data to Cash Disbursements for Healthy Blue July 1, 2020 – June 30, 2022

September 15, 2022

Draft

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

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 Healthy Blue 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 medical transportation (NEMT), dental value-added service (VAS), and pharmacy delegated vendor encounters paid during the reporting period. 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

Entire Plan

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 disbursement journal (CDJ) files that are submitted by the MCO. The encounters and CDJ files utilized in this study met the following criteria:

- Encounter and CDJ transactions were paid within the reporting period of **July 1, 2020 through June 30, 2022**
- Encounters were received and accepted by the FAC and transmitted to Myers and Stauffer LC through **July 26, 2022**

Table A — Healthy Blue Cumulative Completion Totals and Percentages

			Delegated Vendor				
Description	**Entire Plan**	**Non-Vendor**	**Superior Vision**	**ModivCare (NEMT)**	**MediTrans (NEMT)**	**DentaQuest (Dental)**	**CVS Health (Pharmacy)**
Encounter Total (FAC reported)	$3,287,450,268	$2,224,085,716	$11,426,204	$67,084	$39,987,664	$15,170,226	$996,713,374
Total Encounter Adjustments ($)	($329,297,558)	($290,090,355)	($774,996)	($22,717)	($14,960,949)	($3,000,731)	($20,447,810)
Total Encounter Adjustments (%)	-10.01%	-13.04%	-6.78%	-33.86%	-37.41%	-19.78%	-2.05%
Net Encounter Total	**$2,958,152,710**	**$1,933,995,362**	**$10,651,208**	**$44,366**	**$25,026,715**	**$12,169,495**	**$976,265,565**
CDJ Total	**$2,981,437,950**	**$1,951,169,929**	**$10,721,546**	**$78,753**	**$28,684,686**	**$12,571,115**	**$978,211,920**
Variance	($23,285,239)	($17,174,567)	($70,338)	($34,387)	($3,657,971)	($401,620)	($1,946,356)
Completion (%)	**99.21%**	**99.11%**	**99.34%**	**56.33%**	**87.24%**	**96.80%**	**99.80%**
100% Limited Completion* (%)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Minimum Completeness (%)	**97.00%**						
Non-Compliant (%)	**N/A**	**N/A**	**N/A**	**-40.67%**	**-9.76%**	**-0.20%**	**N/A**

* To avoid overstating the Entire Plan results in situations where an individual vendor's cumulative completion percentage exceeds 100 percent, we decrease the Entire Plan encounter totals by the total variance in comparison to the CDJ. Please see Appendix B for more information on the limited completion percentage.

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 Healthy Blue Encounters

Description	Encounter Count	Paid Amount	Paid Amount (% of Total*)
Total Encounter Amount (FAC Reported)	**45,716,949**	**$3,287,450,268**	**100.00%**
Adjustment Type			
State System Denied	(2,012,850)	($325,514,327)	-9.90%
Health Plan Denied	(8,434,973)	($1,908,560)	-0.05%
Calculated Void	(7,103)	($788,002)	-0.02%
Duplicate	(14,834)	($1,086,669)	-0.03%
Total Adjustments Made	(10,469,760)	($329,297,558)	-10.01%
Net Encounter Amounts	**35,247,189**	**$2,958,152,710**	**89.99%**

* Due to rounding, the sum of the displayed percentages in this report may not add up to the total.

Summary Charts

Chart 1. Entire Plan CDJ and Encounter Totals by Paid Month

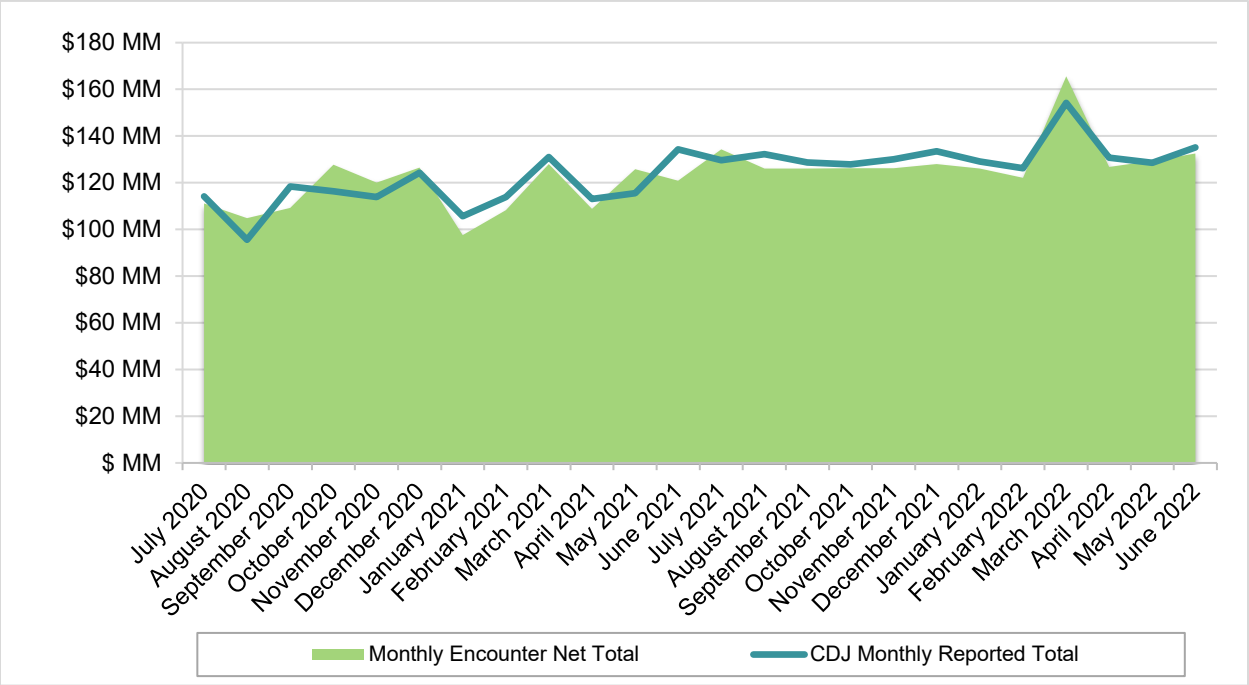
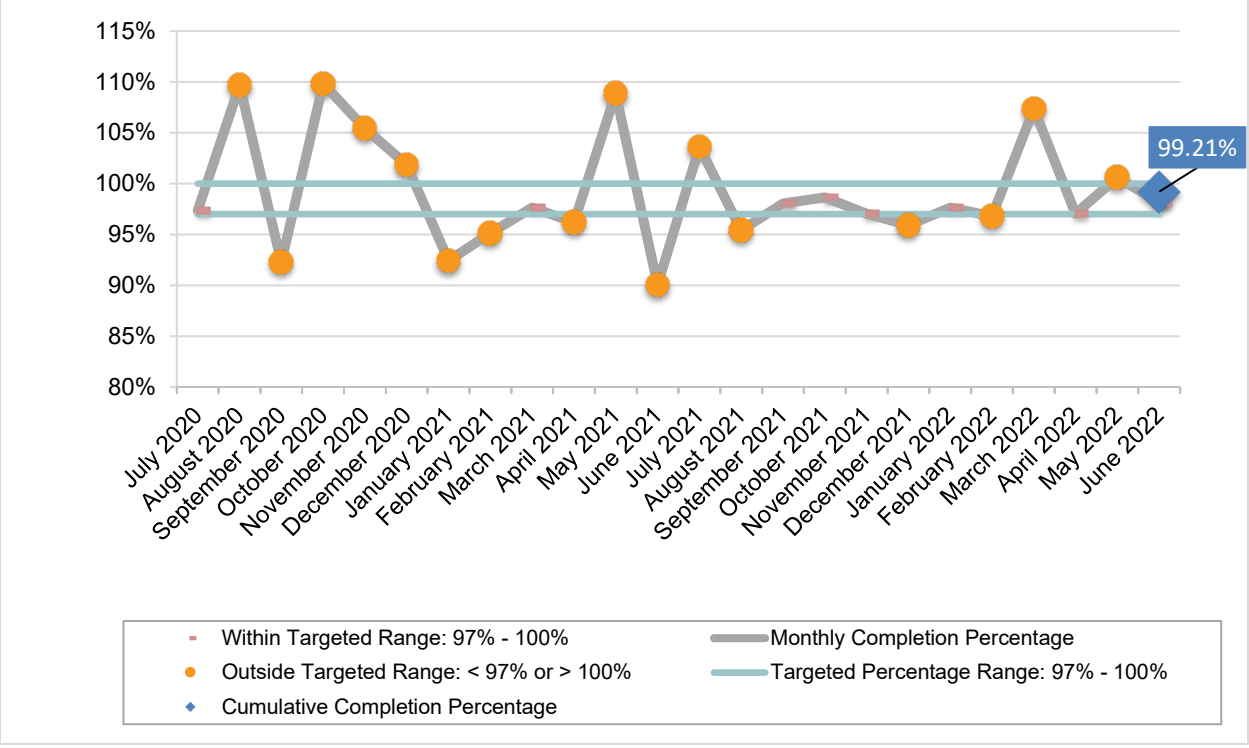


Chart 2. Entire Plan Completion Percentage by Paid Month



Data Issues and Recommendations

During this analysis, Myers and Stauffer identified potential data issues that may impact the completion percentages for Healthy Blue. Section A details issues related to non-compliant cumulative completion percentages, while Section B notes outstanding data issues that Healthy Blue may need to work to identify and resolve.

Please reference Tables 1 through 7 for Healthy Blue reconciliation period tables. These tables contain detailed reconciliation totals, completion percentages, and encounter analysis adjustments.

Section A: Data issues potentially impacting compliance:

1. **MediTrans (NEMT)** (Table 2): MediTrans' monthly completion percentages are low for fourteen months of the reporting period.
    - The low monthly completion percentages appear to be due to missing encounters, state system denied encounters and/or mismatched paid amounts when compared to the CDJ transactions.
    - The low monthly completion percentages for April 2022 through June 2022 appear to be due to missing encounters, state system denied encounters and/or encounter voids not found in the CDJ transactions. LDH recently directed the MCOs to hold transportation encounters until they could submit them with A0170 for temporary mileage increase per LDH Informational Bulletin 22-10. These percentages may be further explained by LDH recently directing MediTrans to void transportation encounters due to a permit audit.

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

2. **ModivCare (NEMT)** (Table 3): ModivCare's cumulative completion percentage is below the 97 percent compliance threshold at 56.33 percent for the reporting period. This appears to be due to many low monthly completion percentages. ModivCare is in the runout period as they were replaced by MediTrans on January 22, 2020.
    - The low monthly completion percentages appear to be due to missing encounters and/or encounters that were state system denied when compared to the CDJ transactions.

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

3. **DentaQuest** (Table 5): The monthly completion percentages are high or low for all but four months of the reporting period.
    - We have noted instances of void encounters that are potentially allocated to the month of original payment and not the date the void occurred as seen in the CDJ transactions.
    - We have identified instances of missing CDJ transactions when compared to encounters and missing encounters and/or encounters that were system-denied by the FAC when compared to the CDJ transactions.
    - The low monthly completion percentages for July 2021 appears to be due to a known Gainwell issue that is causing erroneous system denials. After the known issue is corrected, the encounters can be resubmitted.
    - The monthly completion percentage for August 2021 is high at 178.54 percent. This high monthly percentage appears to be due to missing CDJ transactions and/or mismatched paid amounts or dates.
    - There are approximately $72,501 of encounters for the June 2021 paid month that were submitted without the appropriate character in the Plan ICN to indicate VAS.

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

Section B: Data issues not currently impacting compliance:

4. **Superior Vision** (Table 4): Superior Vision's monthly completion percentages are high for eight months and low for two months of the reporting period.
    - The low percentages months appear to be due to mismatched paid amounts and/or missing encounters or state system denied encounters.
    - The high percentages months appear to be caused by missing CDJ transactions and/or mismatched paid amounts.

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

5. **CVS Health** (Table 6): There are nine monthly completion percentages that are above 100 percent.
    - These high percentages appear to be due to mismatched paid dates and amounts between the paid months. These mismatches may be due to CDJ and encounter void transactions not matching for the same paid month.

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

6. **Non-Vendor** (Table 7): The monthly completion percentages are high or low for twenty one months of the reporting period.
    - The high percentages appear to be due to missing CDJ transactions and/or mismatched paid dates and amounts between the paid months. These mismatches may be due to CDJ or encounter voids not matching for the same paid month.
    - The low percentages appear to be due to instances of missing encounters, state system denied encounters and/or mismatched paid amounts or dates.

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

Value-Added Services (VAS)

Value-added services are included in the MCO's vision, dental, non-emergency medical transportation 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. 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 — Healthy Blue VAS Cumulative Completion Totals and Percentages

Description	Entire Plan VAS	Non-Vendor VAS	Delegated Vendor		
			Superior Vision VAS	DentaQuest VAS (Dental)	MediTrans VAS (NEMT)
Encounter Total (FAC reported)	$23,479,691	$3,424,087	$4,491,048	$15,060,183	$504,373
Total Encounter Adjustments ($)	($4,073,750)	($600,537)	($31,035)	($2,963,190)	($478,987)
Total Encounter Adjustments (%)	-17.35%	-17.53%	-0.69%	-19.67%	-94.96%
Net Encounter Total	**$19,405,941**	**$2,823,550**	**$4,460,013**	**$12,096,993**	**$25,386**
CDJ Total	**$25,031,186**	**$6,583,580**	**$5,832,364**	**$12,570,490**	**$44,752**
Variance	($5,625,245)	($3,760,030)	($1,372,351)	($473,496)	($19,367)
Completion (%)	**77.52%**	**42.88%**	**76.47%**	**96.23%**	**56.72%**
100% Limited Completion* (%)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Minimum Completeness (%)	**97.00%**				
Non-Compliant (%)	**-19.48%**	**-54.12%**	**-20.53%**	**-0.77%**	**-40.28%**

* To avoid overstating the Entire Plan results in situations where an individual vendor's cumulative completion percentage exceeds 100 percent, we decrease the Entire Plan encounter totals by the total variance in comparison to the CDJ. Please see Appendix B for more information on the limited completion percentage.

Potential VAS data issues:

1. **MediTrans VAS** (Table 2V): The MediTrans VAS cumulative completion percentage is low for the reporting period. This appears to be due to missing VAS encounters and/or VAS encounter voids not found in the CDJ transactions.

2. **Superior Vision VAS** (Table 3V): Superior Vision's VAS completion percentage is below the compliance threshold at 76.47 percent. Three of the monthly completion percentages are high while thirteen are low. The high and low monthly completion percentages appear to be due to missing CDJ transactions or encounters and/or mismatched paid amounts. Low monthly completion percentages for August 2021 through June 2022 appear to be due to missing or state system denied encounters and/or encounters not identified as VAS.

3. **Non-Vendor VAS** (Table 5V): Non-Vendor VAS has four monthly completion percentages that are above 100 percent and twenty months that are below the 97 percent threshold. These high and low completion percentages appear to be due to missing encounters or CDJ transactions and/or mismatched paid amounts. The monthly completion percentages for August 2021 through May 2022 are low, which appears to be due to missing encounters, encounters not identified as VAS, VAS encounter voids not found in the CDJ transactions and/or state system denied encounters.

Monthly Tables

Entire Plan

Table 1 — Healthy Blue (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
July 2020	$121,589,930	($10,498,067)	-9%	$111,091,863	$114,086,675	($2,994,812)	97.37%
August 2020	$115,031,045	($10,194,194)	-9%	$104,836,851	$95,573,384	$9,263,467	109.69%
September 2020	$118,782,040	($9,562,615)	-8%	$109,219,425	$118,374,862	($9,155,437)	92.26%
October 2020	$140,900,791	($13,176,302)	-9%	$127,724,489	$116,287,672	$11,436,817	109.83%
November 2020	$132,234,852	($12,199,218)	-9%	$120,035,634	$113,842,337	$6,193,297	105.44%
December 2020	$140,443,064	($13,907,604)	-10%	$126,535,460	$124,232,260	$2,303,200	101.85%
January 2021	$107,756,259	($10,141,766)	-9%	$97,614,493	$105,640,781	($8,026,287)	92.40%
February 2021	$119,484,955	($11,193,510)	-9%	$108,291,445	$113,844,719	($5,553,274)	95.12%
March 2021	$133,809,496	($5,829,675)	-4%	$127,979,821	$131,060,228	($3,080,407)	97.64%
April 2021	$113,033,003	($4,256,058)	-4%	$108,776,945	$113,092,735	($4,315,789)	96.18%
May 2021	$129,993,583	($4,239,309)	-3%	$125,754,275	$115,497,896	$10,256,379	108.88%
June 2021	$127,221,831	($6,319,736)	-5%	$120,902,096	$134,250,256	($13,348,161)	90.05%
July 2021	$142,649,201	($8,294,858)	-6%	$134,354,342	$129,671,983	$4,682,359	103.61%
August 2021	$148,591,721	($22,485,871)	-15%	$126,105,850	$132,188,020	($6,082,170)	95.39%
September 2021	$158,060,294	($31,922,346)	-20%	$126,137,948	$128,643,099	($2,505,151)	98.05%
October 2021	$158,814,271	($32,652,499)	-21%	$126,161,772	$127,878,806	($1,717,035)	98.65%
November 2021	$154,179,879	($27,948,075)	-18%	$126,231,804	$130,093,941	($3,862,137)	97.03%
December 2021	$155,475,816	($27,499,873)	-18%	$127,975,943	$133,442,109	($5,466,166)	95.90%
January 2022	$141,474,612	($15,441,014)	-11%	$126,033,599	$129,054,183	($3,020,584)	97.65%
February 2022	$137,844,376	($15,698,326)	-11%	$122,146,051	$126,175,379	($4,029,328)	96.80%
March 2022	$172,282,311	($6,708,410)	-4%	$165,573,901	$154,202,028	$11,371,873	107.37%
April 2022	$143,505,400	($16,690,077)	-12%	$126,815,323	$130,689,602	($3,874,279)	97.03%
May 2022	$135,886,303	($6,573,266)	-5%	$129,313,037	$128,494,903	$818,133	100.63%
June 2022	$138,405,233	($5,864,888)	-4%	$132,540,344	$135,120,091	($2,579,747)	98.09%
Cumulative Totals	**$3,287,450,268**	**($329,297,558)**	**-10%**	**$2,958,152,710**	**$2,981,437,950**	**($23,285,239)**	**99.21%**
100% Limited Cumulative Total							**N/A**
						Minimum Completeness (%)	**97.00%**
						Non-Compliant	**N/A**

MediTrans (NEMT)

Table 2 — Healthy Blue MediTrans (NEMT)							
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
July 2020	$2,733,464	($1,229,928)	-45%	$1,503,537	$1,519,777	($16,240)	98.93%
August 2020	$2,204,945	($946,626)	-43%	$1,258,319	$1,314,556	($56,238)	95.72%
September 2020	$1,375,078	($590,660)	-43%	$784,418	$816,429	($32,011)	96.07%
October 2020	$2,342,908	($1,133,987)	-48%	$1,208,921	$1,225,561	($16,641)	98.64%
November 2020	$2,161,448	($1,010,010)	-47%	$1,151,439	$1,179,325	($27,886)	97.63%
December 2020	$4,846,710	($3,373,618)	-70%	$1,473,092	$1,500,670	($27,579)	98.16%
January 2021	$3,309,059	($2,260,729)	-68%	$1,048,330	$1,066,505	($18,176)	98.29%
February 2021	$2,036,041	($1,076,696)	-53%	$959,345	$990,953	($31,609)	96.81%
March 2021	$1,965,184	($988,556)	-50%	$976,627	$1,009,404	($32,777)	96.75%
April 2021	$1,246,955	($191,255)	-15%	$1,055,700	$1,155,159	($99,458)	91.39%
May 2021	$899,915	($133,130)	-15%	$766,785	$798,182	($31,397)	96.06%
June 2021	$1,646,213	($607,652)	-37%	$1,038,562	$1,133,251	($94,689)	91.64%
July 2021	$1,452,108	($155,791)	-11%	$1,296,317	$1,336,886	($40,569)	96.96%
August 2021	$1,689,247	($708,955)	-42%	$980,292	$1,018,780	($38,488)	96.22%
September 2021	$1,110,576	($19,329)	-2%	$1,091,247	$1,119,453	($28,206)	97.48%
October 2021	$1,222,568	($24,307)	-2%	$1,198,262	$1,228,214	($29,952)	97.56%
November 2021	$1,228,940	($22,813)	-2%	$1,206,127	$1,237,325	($31,198)	97.47%
December 2021	$1,402,397	($23,498)	-2%	$1,378,899	$1,408,391	($29,491)	97.90%
January 2022	$1,089,001	($29,764)	-3%	$1,059,237	$1,103,578	($44,342)	95.98%
February 2022	$963,838	($10,651)	-1%	$953,187	$980,918	($27,731)	97.17%
March 2022	$907,888	($11,059)	-1%	$896,829	$1,054,510	($157,681)	85.04%
April 2022	$980,601	($60,683)	-6%	$919,919	$1,611,645	($691,726)	57.07%
May 2022	$631,477	($3,122)	0%	$628,354	$1,473,272	($844,917)	42.65%
June 2022	$541,104	($348,131)	-64%	$192,973	$1,401,943	($1,208,970)	13.76%
Cumulative Totals	**$39,987,664**	**($14,960,949)**	**-37%**	**$25,026,715**	**$28,684,686**	**($3,657,971)**	**87.24%**
100% Limited Cumulative Total							**N/A**
						Minimum Completeness (%)	**97.00%**
						Non-Compliant	**-9.76%**

ModivCare (NEMT)

Table 3 — Healthy Blue ModivCare (NEMT)							
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
July 2020	$17,597	($2,714)	-15%	$14,882	$18,912	($4,030)	78.69%
August 2020	$10,205	($4,927)	-48%	$5,277	$8,579	($3,301)	61.51%
September 2020	$9,741	($2,188)	-22%	$7,553	$10,756	($3,203)	70.21%
October 2020	$9,547	$0	0%	$9,547	$14,422	($4,876)	66.19%
November 2020	$1,174	$0	0%	$1,174	$3,079	($1,906)	38.11%
December 2020	$1,394	($35)	-3%	$1,359	$9,725	($8,366)	13.97%
January 2021	$4,990	($4,073)	-82%	$917	$2,089	($1,172)	43.89%
February 2021	$316	$0	0%	$316	$316	$0	100.00%
March 2021	$825	$0	0%	$825	$854	($29)	96.58%
April 2021	$43	$0	0%	$43	$1,105	($1,062)	3.92%
May 2021	$3,600	($2,919)	-81%	$681	$1,754	($1,073)	38.84%
June 2021	$186	$0	0%	$186	$186	$0	100.00%
July 2021	$859	($573)	-67%	$286	$572	($286)	49.96%
August 2021	$0	$0	N/A	$0	$0	$0	N/A
September 2021	$591	($591)	-100%	$0	$0	$0	N/A
October 2021	$0	$0	N/A	$0	$0	$0	N/A
November 2021	$264	($170)	-64%	$94	$264	($170)	35.58%
December 2021	$2,218	($1,025)	-46%	$1,193	$2,260	($1,067)	52.77%
January 2022	$261	($261)	-100%	$0	$606	($606)	0.00%
February 2022	$3,274	($3,240)	-99%	$34	$3,274	($3,240)	1.02%
March 2022	$0	$0	N/A	$0	$0	$0	N/A
April 2022	$0	$0	N/A	$0	$0	$0	N/A
May 2022	$0	$0	N/A	$0	$0	$0	N/A
June 2022	$0	$0	N/A	$0	$0	$0	N/A
Cumulative Totals	**$67,084**	**($22,717)**	**-34%**	**$44,366**	**$78,753**	**($34,387)**	**56.33%**
100% Limited Cumulative Total							**N/A**
						Minimum Completeness (%)	**97.00%**
						Non-Compliant	**-40.67%**

Superior Vision

Table 4 — Healthy Blue Superior 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
July 2020	$489,530	($4,790)	-1%	$484,740	$479,647	$5,093	101.06%
August 2020	$494,326	($4,571)	-1%	$489,755	$492,430	($2,675)	99.45%
September 2020	$462,065	($3,519)	-1%	$458,546	$462,021	($3,475)	99.24%
October 2020	$544,238	($2,982)	-1%	$541,256	$540,970	$285	100.05%
November 2020	$541,049	($2,712)	-1%	$538,337	$542,873	($4,535)	99.16%
December 2020	$450,033	($1,837)	0%	$448,196	$448,196	$0	100.00%
January 2021	$479,124	($6,084)	-1%	$473,040	$477,932	($4,892)	98.97%
February 2021	$410,999	($1,722)	0%	$409,277	$408,974	$303	100.07%
March 2021	$549,576	($2,080)	0%	$547,496	$548,740	($1,243)	99.77%
April 2021	$404,726	($2,099)	-1%	$402,627	$405,014	($2,387)	99.41%
May 2021	$472,663	($27,774)	-6%	$444,890	$474,368	($29,478)	93.78%
June 2021	$440,731	($5,532)	-1%	$435,199	$438,483	($3,284)	99.25%
July 2021	$411,864	($17,821)	-4%	$394,042	$399,696	($5,654)	98.58%
August 2021	$584,708	($77,902)	-13%	$506,806	$518,273	($11,467)	97.78%
September 2021	$411,114	($60,529)	-15%	$350,585	$351,345	($760)	99.78%
October 2021	$545,585	($74,201)	-14%	$471,384	$471,281	$103	100.02%
November 2021	$449,612	($60,029)	-13%	$389,583	$390,079	($496)	99.87%
December 2021	$442,707	($62,506)	-14%	$380,200	$380,867	($667)	99.82%
January 2022	$476,060	($73,259)	-15%	$402,801	$403,481	($680)	99.83%
February 2022	$505,177	($76,262)	-15%	$428,915	$418,059	$10,856	102.59%
March 2022	$541,378	($84,770)	-16%	$456,608	$453,310	$3,298	100.72%
April 2022	$482,190	($75,132)	-16%	$407,058	$400,841	$6,218	101.55%
May 2022	$442,333	($46,496)	-11%	$395,837	$422,895	($27,058)	93.60%
June 2022	$394,416	($386)	0%	$394,030	$391,772	$2,258	100.57%
Cumulative Totals	**$11,426,204**	**($774,996)**	**-7%**	**$10,651,208**	**$10,721,546**	**($70,338)**	**99.34%**
100% Limited Cumulative Total							**N/A**
						Minimum Completeness (%)	**97.00%**
						Non-Compliant	**N/A**

DentaQuest (Dental)

Table 5 — Healthy Blue 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
July 2020	$502,565	($41,938)	-8%	$460,627	$493,716	($33,089)	93.29%
August 2020	$574,048	($134,464)	-23%	$439,585	$438,502	$1,083	100.24%
September 2020	$375,890	($31,130)	-8%	$344,761	$342,334	$2,427	100.70%
October 2020	$618,470	($53,407)	-9%	$565,063	$562,528	$2,535	100.45%
November 2020	$461,194	($20,286)	-4%	$440,908	$439,856	$1,052	100.23%
December 2020	$496,172	($30,026)	-6%	$466,146	$509,826	($43,679)	91.43%
January 2021	$1,464,135	($721,513)	-49%	$742,622	$914,047	($171,425)	81.24%
February 2021	$499,691	($83,434)	-17%	$416,257	$450,414	($34,157)	92.41%
March 2021	$464,146	($95,022)	-20%	$369,124	$444,355	($75,230)	83.06%
April 2021	$820,794	($223,812)	-27%	$596,982	$747,387	($150,405)	79.87%
May 2021	$570,783	($119,014)	-21%	$451,769	$564,987	($113,219)	79.96%
June 2021	$1,377,403	($815,859)	-59%	$561,544	$589,743	($28,199)	95.21%
July 2021	$591,575	($157,686)	-27%	$433,890	$646,912	($213,023)	67.07%
August 2021	$1,011,837	($84,295)	-8%	$927,542	$519,262	$408,280	178.62%
September 2021	$468,192	($39,966)	-9%	$428,226	$439,937	($11,711)	97.33%
October 2021	$586,252	($102,541)	-17%	$483,711	$471,785	$11,926	102.52%
November 2021	$564,771	($77,034)	-14%	$487,738	$449,724	$38,014	108.45%
December 2021	$505,073	($23,785)	-5%	$481,287	$493,016	($11,729)	97.62%
January 2022	$436,190	($11,086)	-3%	$425,103	$433,962	($8,858)	97.95%
February 2022	$607,523	($10,901)	-2%	$596,622	$555,037	$41,585	107.49%
March 2022	$613,907	($22,632)	-4%	$591,275	$591,676	($401)	99.93%
April 2022	$478,309	($30,062)	-6%	$448,247	$484,887	($36,641)	92.44%
May 2022	$528,586	($23,370)	-4%	$505,216	$542,140	($36,924)	93.18%
June 2022	$552,719	($47,470)	-9%	$505,250	$445,081	$60,169	113.51%
Cumulative Totals	**$15,170,226**	**($3,000,731)**	**-20%**	**$12,169,495**	**$12,571,115**	**($401,620)**	**96.80%**
100% Limited Cumulative Total							**N/A**
						Minimum Completeness (%)	**97.00%**
						Non-Compliant	**-0.20%**

CVS Health (Pharmacy)

Table 6 — Healthy Blue CVS Health (Pharmacy)							
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
July 2020	$37,063,655	($1,268,833)	-3%	$35,794,823	$35,974,528	($179,706)	99.50%
August 2020	$32,519,856	($1,174,815)	-4%	$31,345,042	$31,255,703	$89,339	100.28%
September 2020	$40,512,349	($826,047)	-2%	$39,686,302	$40,213,300	($526,997)	98.68%
October 2020	$34,958,646	($1,196,002)	-3%	$33,762,644	$33,777,380	($14,736)	99.95%
November 2020	$35,326,390	($978,884)	-3%	$34,347,506	$34,336,499	$11,007	100.03%
December 2020	$43,703,304	($380,953)	-1%	$43,322,351	$43,156,863	$165,488	100.38%
January 2021	$32,913,641	($208,587)	-1%	$32,705,054	$33,522,132	($817,078)	97.56%
February 2021	$34,978,702	($135,463)	0%	$34,843,238	$35,050,627	($207,388)	99.40%
March 2021	$46,249,443	($253,707)	-1%	$45,995,736	$45,431,306	$564,430	101.24%
April 2021	$36,363,583	($259,553)	-1%	$36,104,029	$36,840,033	($736,004)	98.00%
May 2021	$37,223,238	($295,833)	-1%	$36,927,404	$38,012,091	($1,084,687)	97.14%
June 2021	$45,091,491	($263,440)	-1%	$44,828,052	$45,793,365	($965,313)	97.89%
July 2021	$37,616,762	($184,607)	0%	$37,432,155	$37,535,362	($103,208)	99.72%
August 2021	$37,783,013	($152,228)	0%	$37,630,785	$38,084,156	($453,370)	98.80%
September 2021	$45,601,744	($337,868)	-1%	$45,263,876	$43,689,290	$1,574,586	103.60%
October 2021	$38,005,858	($206,374)	-1%	$37,799,484	$37,920,856	($121,372)	99.67%
November 2021	$40,794,035	($373,394)	-1%	$40,420,640	$39,224,511	$1,196,129	103.04%
December 2021	$48,742,924	($312,190)	-1%	$48,430,734	$48,777,201	($346,467)	99.28%
January 2022	$38,209,698	($86,588)	0%	$38,123,111	$38,549,754	($426,644)	98.89%
February 2022	$41,973,064	($66,457)	0%	$41,906,607	$41,465,586	$441,022	101.06%
March 2022	$54,661,097	($192,486)	0%	$54,468,612	$54,194,604	$274,008	100.50%
April 2022	$54,222,235	($10,963,191)	-20%	$43,259,044	$43,241,231	$17,813	100.04%
May 2022	$46,251,928	($70,840)	0%	$46,181,088	$46,337,723	($156,635)	99.66%
June 2022	$55,946,718	($259,470)	0%	$55,687,248	$55,827,820	($140,571)	99.74%
Cumulative Totals	**$996,713,374**	**($20,447,810)**	**-2%**	**$976,265,565**	**$978,211,920**	**($1,946,356)**	**99.80%**
100% Limited Cumulative Total							**N/A**
						Minimum Completeness (%)	**97.00%**
						Non-Compliant	**N/A**

Non-Vendor

Table 7 — Healthy Blue 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
July 2020	$80,783,119	($7,949,865)	-10%	$72,833,254	$75,600,094	($2,766,840)	96.34%
August 2020	$79,227,664	($7,928,790)	-10%	$71,298,874	$62,063,614	$9,235,260	114.88%
September 2020	$76,046,916	($8,109,071)	-11%	$67,937,845	$76,530,023	($8,592,178)	88.77%
October 2020	$102,426,983	($10,789,924)	-11%	$91,637,059	$80,166,811	$11,470,248	114.30%
November 2020	$93,743,596	($10,187,326)	-11%	$83,556,271	$77,340,705	$6,215,566	108.03%
December 2020	$90,945,450	($10,121,134)	-11%	$80,824,316	$78,606,980	$2,217,336	102.82%
January 2021	$69,585,310	($6,940,779)	-10%	$62,644,531	$69,658,076	($7,013,545)	89.93%
February 2021	$81,559,207	($9,896,195)	-12%	$71,663,012	$76,943,435	($5,280,423)	93.13%
March 2021	$84,580,322	($4,490,310)	-5%	$80,090,012	$83,625,569	($3,535,557)	95.77%
April 2021	$74,196,903	($3,579,339)	-5%	$70,617,563	$73,944,036	($3,326,473)	95.50%
May 2021	$90,823,384	($3,660,638)	-4%	$87,162,746	$75,646,515	$11,516,231	115.22%
June 2021	$78,665,806	($4,627,253)	-6%	$74,038,553	$86,295,229	($12,256,676)	85.79%
July 2021	$102,576,033	($7,778,380)	-8%	$94,797,653	$89,752,555	$5,045,099	105.62%
August 2021	$107,522,917	($21,462,492)	-20%	$86,060,425	$92,047,549	($5,987,124)	93.49%
September 2021	$110,468,079	($31,464,064)	-28%	$79,004,015	$83,043,075	($4,039,059)	95.13%
October 2021	$118,454,007	($32,245,076)	-27%	$86,208,931	$87,786,670	($1,577,739)	98.20%
November 2021	$111,142,258	($27,414,635)	-25%	$83,727,623	$88,792,038	($5,064,416)	94.29%
December 2021	$104,380,499	($27,076,869)	-26%	$77,303,629	$82,380,374	($5,076,745)	93.83%
January 2022	$101,263,403	($15,240,056)	-15%	$86,023,347	$88,562,801	($2,539,454)	97.13%
February 2022	$93,791,501	($15,530,815)	-17%	$78,260,686	$82,752,506	($4,491,820)	94.57%
March 2022	$115,558,041	($6,397,463)	-6%	$109,160,578	$97,907,928	$11,252,650	111.49%
April 2022	$87,342,064	($5,561,010)	-6%	$81,781,054	$84,950,998	($3,169,943)	96.26%
May 2022	$88,031,980	($6,429,439)	-7%	$81,602,541	$79,718,873	$1,883,668	102.36%
June 2022	$80,970,275	($5,209,432)	-6%	$75,760,844	$77,053,476	($1,292,632)	98.32%
Cumulative Totals	**$2,224,085,716**	**($290,090,355)**	**-13%**	**$1,933,995,362**	**$1,951,169,929**	**($17,174,567)**	**99.11%**
100% Limited Cumulative Total							**N/A**
						Minimum Completeness (%)	**97.00%**
						Non-Compliant	**N/A**

Appendix A: VAS Monthly Tables

Entire Plan VAS

Table 1V — Healthy Blue 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
July 2020	$1,186,544	($192,109)	-16%	$994,435	$1,064,821	($70,387)	93.38%
August 2020	$988,100	($221,443)	-22%	$766,657	$757,223	$9,435	101.24%
September 2020	$774,506	($122,766)	-16%	$651,740	$705,934	($54,194)	92.32%
October 2020	$1,296,488	($341,174)	-26%	$955,313	$978,468	($23,155)	97.63%
November 2020	$1,104,160	($96,813)	-9%	$1,007,347	$1,090,280	($82,933)	92.39%
December 2020	$998,002	($72,792)	-7%	$925,210	$1,032,221	($107,011)	89.63%
January 2021	$1,995,652	($746,972)	-37%	$1,248,680	$1,395,937	($147,257)	89.45%
February 2021	$1,209,800	($214,006)	-18%	$995,794	$1,076,465	($80,671)	92.50%
March 2021	$918,252	($110,833)	-12%	$807,419	$906,999	($99,580)	89.02%
April 2021	$1,176,964	($234,896)	-20%	$942,068	$1,066,320	($124,251)	88.34%
May 2021	$979,286	($131,737)	-13%	$847,549	$958,775	($111,226)	88.39%
June 2021	$1,720,485	($833,431)	-48%	$887,054	$1,069,125	($182,071)	82.97%
July 2021	$1,052,245	($207,991)	-20%	$844,254	$1,100,504	($256,250)	76.71%
August 2021	$1,385,653	($138,994)	-10%	$1,246,659	$1,218,498	$28,161	102.31%
September 2021	$566,320	($40,613)	-7%	$525,707	$844,948	($319,241)	62.21%
October 2021	$705,779	($107,823)	-15%	$597,957	$969,917	($371,961)	61.65%
November 2021	$664,375	($77,780)	-12%	$586,595	$1,072,151	($485,557)	54.71%
December 2021	$596,025	($24,269)	-4%	$571,756	$1,028,389	($456,633)	55.59%
January 2022	$436,541	($12,599)	-3%	$423,942	$1,049,399	($625,457)	40.39%
February 2022	$729,267	($11,022)	-2%	$718,246	$1,106,327	($388,081)	64.92%
March 2022	$713,731	($25,522)	-4%	$688,209	$1,218,045	($529,836)	56.50%
April 2022	$570,201	($30,874)	-5%	$539,327	$1,143,726	($604,399)	47.15%
May 2022	$625,743	($25,080)	-4%	$600,663	$1,158,767	($558,104)	51.83%
June 2022	$1,085,571	($52,213)	-5%	$1,033,359	$1,017,947	$15,411	101.51%
Cumulative Totals	**$23,479,691**	**($4,073,750)**	**-17%**	**$19,405,941**	**$25,031,186**	**($5,625,245)**	**77.52%**
100% Limited Cumulative Total							**N/A**
						Minimum Completeness (%)	**97.00%**
						Non-Compliant	**-19.48%**

MediTrans VAS

Table 2V — Healthy Blue VAS MediTrans (NEMT)							
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**
July 2020	$125,855	($125,848)	-100%	$7	$0	$7	N/A
August 2020	$78,358	($76,989)	-98%	$1,369	$0	$1,369	N/A
September 2020	$54,659	($54,086)	-99%	$573	$0	$573	N/A
October 2020	$219,825	($219,499)	-100%	$326	$0	$326	N/A
November 2020	$0	$0	N/A	$0	$0	$0	N/A
December 2020	$32	$0	0%	$32	$0	$32	N/A
January 2021	$0	$0	N/A	$0	$0	$0	N/A
February 2021	$60	($42)	-70%	$18	$0	$18	N/A
March 2021	$0	$0	N/A	$0	$0	$0	N/A
April 2021	$0	$0	N/A	$0	$0	$0	N/A
May 2021	$0	$0	N/A	$0	$0	$0	N/A
June 2021	$0	$0	N/A	$0	$0	$0	N/A
July 2021	$1,263	($77)	-6%	$1,186	$0	$1,186	N/A
August 2021	$671	$0	0%	$671	$0	$671	N/A
September 2021	$0	$0	N/A	$0	$0	$0	N/A
October 2021	$1,550	($611)	-39%	$939	$0	$939	N/A
November 2021	$2,393	($746)	-31%	$1,647	$0	$1,647	N/A
December 2021	$0	$0	N/A	$0	$0	$0	N/A
January 2022	$0	$0	N/A	$0	$0	$0	N/A
February 2022	$9,023	($96)	-1%	$8,927	$0	$8,927	N/A
March 2022	$7,717	($307)	-4%	$7,410	$0	$7,410	N/A
April 2022	$2,366	($553)	-23%	$1,813	$15,000	($13,187)	12.08%
May 2022	$272	($15)	-5%	$257	$14,205	($13,948)	1.81%
June 2022	$329	($118)	-36%	$211	$15,547	($15,336)	1.35%
Cumulative Totals	**$504,373**	**($478,987)**	**-95%**	**$25,386**	**$44,752**	**($19,367)**	**56.72%**
100% Limited Cumulative Total							**N/A**
						Minimum Completeness (%)	**97.00%**
						Non-Compliant	**-40.28%**

Superior Vision VAS

Table 3V — Healthy Blue VAS Superior 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
July 2020	$278,765	($2,875)	-1%	$275,890	$278,839	($2,949)	98.94%
August 2020	$269,894	($3,398)	-1%	$266,496	$268,810	($2,314)	99.13%
September 2020	$261,745	($2,739)	-1%	$259,006	$261,975	($2,969)	98.86%
October 2020	$304,090	($1,645)	-1%	$302,445	$301,999	$446	100.14%
November 2020	$304,099	($1,640)	-1%	$302,459	$302,998	($538)	99.82%
December 2020	$260,512	($1,438)	-1%	$259,074	$259,102	($27)	99.98%
January 2021	$271,308	($2,603)	-1%	$268,705	$270,436	($1,732)	99.35%
February 2021	$235,660	($776)	0%	$234,884	$234,657	$227	100.09%
March 2021	$309,106	($1,262)	0%	$307,843	$308,853	($1,009)	99.67%
April 2021	$231,979	($1,602)	-1%	$230,377	$182,882	$47,495	125.97%
May 2021	$227,932	($2,993)	-1%	$224,939	$267,537	($42,598)	84.07%
June 2021	$260,246	($5,047)	-2%	$255,199	$258,583	($3,384)	98.69%
July 2021	$190,711	($997)	-1%	$189,715	$216,732	($27,017)	87.53%
August 2021	$142,791	($1,067)	-1%	$141,724	$255,761	($114,038)	55.41%
September 2021	$93,091	$0	0%	$93,091	$182,359	($89,268)	51.04%
October 2021	$113,981	($49)	0%	$113,931	$238,258	($124,326)	47.81%
November 2021	$91,031	$0	0%	$91,031	$189,409	($98,378)	48.06%
December 2021	$93,226	$0	0%	$93,226	$192,740	($99,514)	48.36%
January 2022	$85,641	($15)	0%	$85,626	$219,422	($133,797)	39.02%
February 2022	$105,340	($25)	0%	$105,315	$224,354	($119,039)	46.94%
March 2022	$83,822	($108)	0%	$83,714	$244,295	($160,581)	34.26%
April 2022	$74,529	($258)	0%	$74,270	$214,865	($140,595)	34.56%
May 2022	$69,110	($318)	0%	$68,792	$242,522	($173,730)	28.36%
June 2022	$132,440	($179)	0%	$132,261	$214,977	($82,716)	61.52%
Cumulative Totals	**$4,491,048**	**($31,035)**	**-1%**	**$4,460,013**	**$5,832,364**	**($1,372,351)**	**76.47%**
100% Limited Cumulative Total							**N/A**
						Minimum Completeness (%)	**97.00%**
						Non-Compliant	**-20.53%**

DentaQuest (Dental) VAS

Table 4V — Healthy Blue VAS 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
July 2020	$502,565	($41,938)	-8%	$460,627	$493,716	($33,089)	93.29%
August 2020	$574,048	($134,464)	-23%	$439,585	$438,492	$1,093	100.24%
September 2020	$375,890	($31,130)	-8%	$344,761	$342,334	$2,427	100.70%
October 2020	$618,470	($53,407)	-9%	$565,063	$562,527	$2,536	100.45%
November 2020	$461,194	($20,286)	-4%	$440,908	$439,662	$1,246	100.28%
December 2020	$496,172	($30,026)	-6%	$466,146	$509,826	($43,679)	91.43%
January 2021	$1,464,135	($721,513)	-49%	$742,622	$913,993	($171,371)	81.25%
February 2021	$499,691	($83,434)	-17%	$416,257	$450,414	($34,157)	92.41%
March 2021	$464,146	($95,022)	-20%	$369,124	$444,340	($75,215)	83.07%
April 2021	$820,794	($223,812)	-27%	$596,982	$747,387	($150,405)	79.87%
May 2021	$570,783	($119,014)	-21%	$451,769	$564,899	($113,130)	79.97%
June 2021	$1,267,361	($778,318)	-61%	$489,043	$589,680	($100,637)	82.93%
July 2021	$591,575	($157,686)	-27%	$433,890	$646,902	($213,012)	67.07%
August 2021	$1,011,837	($84,295)	-8%	$927,542	$519,262	$408,280	178.62%
September 2021	$468,192	($39,966)	-9%	$428,226	$439,937	($11,711)	97.33%
October 2021	$586,252	($102,541)	-17%	$483,711	$471,785	$11,926	102.52%
November 2021	$564,771	($77,034)	-14%	$487,738	$449,724	$38,014	108.45%
December 2021	$505,073	($23,785)	-5%	$481,287	$493,016	($11,729)	97.62%
January 2022	$436,190	($11,086)	-3%	$425,103	$433,962	($8,858)	97.95%
February 2022	$607,523	($10,901)	-2%	$596,622	$555,037	$41,585	107.49%
March 2022	$613,907	($22,632)	-4%	$591,275	$591,632	($357)	99.93%
April 2022	$478,309	($30,062)	-6%	$448,247	$484,887	($36,641)	92.44%
May 2022	$528,586	($23,370)	-4%	$505,216	$542,040	($36,824)	93.20%
June 2022	$552,719	($47,470)	-9%	$505,250	$445,036	$60,214	113.53%
Cumulative Totals	**$15,060,183**	**($2,963,190)**	**-20%**	**$12,096,993**	**$12,570,490**	**($473,496)**	**96.23%**
100% Limited Cumulative Total							**N/A**
						Minimum Completeness (%)	**97.00%**
						Non-Compliant	**-0.77%**

Non-Vendor VAS

Table 5V — Healthy Blue 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
July 2020	$279,360	($21,448)	-8%	$257,911	$292,267	($34,355)	88.24%
August 2020	$65,800	($6,592)	-10%	$59,208	$49,921	$9,287	118.60%
September 2020	$82,211	($34,811)	-42%	$47,400	$101,625	($54,225)	46.64%
October 2020	$154,102	($66,623)	-43%	$87,479	$113,941	($26,462)	76.77%
November 2020	$338,866	($74,887)	-22%	$263,979	$347,620	($83,641)	75.93%
December 2020	$241,285	($41,328)	-17%	$199,957	$263,294	($63,337)	75.94%
January 2021	$260,209	($22,855)	-9%	$237,354	$211,508	$25,846	112.21%
February 2021	$474,390	($129,754)	-27%	$344,635	$391,394	($46,759)	88.05%
March 2021	$145,000	($14,549)	-10%	$130,451	$153,806	($23,355)	84.81%
April 2021	$124,191	($9,482)	-8%	$114,710	$136,051	($21,341)	84.31%
May 2021	$180,571	($9,730)	-5%	$170,841	$126,340	$44,502	135.22%
June 2021	$192,878	($50,066)	-26%	$142,813	$220,862	($78,049)	64.66%
July 2021	$268,696	($49,231)	-18%	$219,465	$236,870	($17,406)	92.65%
August 2021	$230,355	($53,632)	-23%	$176,723	$443,475	($266,752)	39.84%
September 2021	$5,038	($647)	-13%	$4,391	$222,652	($218,261)	1.97%
October 2021	$3,997	($4,621)	-116%	($625)	$259,874	($260,499)	-0.24%
November 2021	$6,179	$0	0%	$6,179	$433,019	($426,840)	1.42%
December 2021	($2,274)	($484)	21%	($2,757)	$342,632	($345,390)	-0.80%
January 2022	($85,289)	($1,498)	2%	($86,788)	$396,014	($482,802)	-21.91%
February 2022	$7,382	$0	0%	$7,382	$326,935	($319,554)	2.25%
March 2022	$8,285	($2,475)	-30%	$5,810	$382,118	($376,307)	1.52%
April 2022	$14,997	$0	0%	$14,997	$428,973	($413,976)	3.49%
May 2022	$27,775	($1,377)	-5%	$26,398	$360,000	($333,602)	7.33%
June 2022	$400,083	($4,446)	-1%	$395,637	$342,388	$53,249	115.55%
Cumulative Totals	**$3,424,087**	**($600,537)**	**-18%**	**$2,823,550**	**$6,583,580**	**($3,760,030)**	**42.88%**
100% Limited Cumulative Total							**N/A**
						Minimum Completeness (%)	***97.00%***
						Non-Compliant	***-54.12%***

Appendix B: Definitions and Acronyms

The following terms are used throughout this document:

- **Cash Disbursement Journal (CDJ) –** A record of 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).
- **DXC Technology (DXC) –** State fiscal agent contractor prior to October 1, 2020. In 2020, DXC was sold to Veritas Capital and ultimately formed a new company, Gainwell Technologies.
- **Fiscal Agent Contractor (FAC) –** A contractor selected to design, develop and maintain the Medicaid Management Information System (MMIS); Gainwell is the current FAC.
- **Gainwell Technologies (Gainwell) –** Current State fiscal agent contractor. Formerly known as DXC Technology.
- **Healthy Louisiana –** The name of Louisiana's Medicaid managed care program as of May 2016.
- **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 UnitedHealthcare Community Plan (UHC).
- **Medicaid Management Information System (MMIS) –** The claims and encounter processing system used by the FAC. MCO submitted encounters are loaded into this system and assigned a unique claim identifier.
- **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.

The following terms are used in the monthly tables throughout this document:

- **100% Limited Completion** - When an individual vendor's cumulative completion percentage exceeds 100 percent, the encounter total is decreased by the variance between the encounter and cash disbursement journal payment amounts. This results in a limited cumulative completion percentage of 100%. For the entire plan, (Tables 1 and 1V), the limited cumulative completion percentage is calculated using the adjusted encounter amounts of all limited vendor and non-vendor results. This adjustment is to ensure that the entire plan completion percentage is not over-stated.
- **CDJ Monthly Reported Total –** The sum of all payments from an MCO or delegated vendor to service providers for the reconciliation period reported in the Cash Disbursement Journal (CDJ).
- **Monthly Completion Percentage –** The "Monthly Encounter Net Total" divided by "CDJ Monthly Reported Total"
- **Monthly Encounter Net Total –** The difference between the "Monthly Encounter Total (FAC Reported)" and "Monthly Encounter Total (Adjustments)"
- **Monthly Encounter Total (Adjustments) –** Total paid amount of encounters identified as denied, calculated void or potential duplicate.
    - State System Denied Encounter – A submitted encounter that is paid by the plan but is denied by the Fiscal Agent Contractor (FAC) due to MMIS Claims Subsystem edits.
    - Health Plan Denied Encounter – A submitted encounter that is denied by the plan. This denied encounter is indicated by a value of 'D' in the second position of the MCO ICN submitted by the plan.
    - Calculated Voids – A pair of paid encounters having the same base patient account number or plan internal control number (ICN) if applicable. One of the encounters may appear to be a replacement of the other without a corresponding void encounter transaction being present. In this case, an adjustment is made to account for the missing void transaction. The magnitude of this adjustment depends upon the plans' response to a listing of potential calculated void encounters.
    - Duplicate Encounters – A pair of paid encounters having identically-billed fields that appear to be duplicates of one another. One of these encounters may be excluded from the analysis depending upon the plans' response to a listing of potential duplicate encounters.
- **Monthly Encounter Total (FAC Reported) –** The sum of all paid amounts on encounters submitted to the MMIS.
- **Monthly Variance –** The difference between the "Monthly Encounter Net Total" and the "CDJ Monthly Reported Total".
- **Percentage of Encounters Adjusted –** The "Monthly Encounter Total (Adjustments)" divided by "Monthly Encounter Total (FAC Reported)"

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 Healthy Blue encounters as follows:

Active Vendors			
Vendor Type	**Vendor Name**	**Identified By**	**Notes**
Non-Emergency Medical Transportation (NEMT)	MediTrans	Characters 3 and 4 of Plan ICN contain "MT"	
Vision Services	Superior Vision	Characters 3 and 4 of Plan ICN contain "BL" Characters 3 through 6 of Plan ICN contain "EQBV"	
Dental Services	DentaQuest	Characters 3 and 4 of Plan ICN contain "DQ"	
Pharmacy Benefits	CVS Health	Claim type code of '12' Dates of service beginning on May 1, 2019	
Non-Vendor	Healthy Blue	All other plan submitted encounters	

Inactive Vendors			
Vendor Type	**Vendor Name**	**Identified By**	**Notes**
Pharmacy Benefits	Express Scripts	Claim type code of '12' Dates of services between February 1, 2015 and April 30, 2019	Replaced by CVS Health – Effective May 1, 2019
Non-Emergency Medical Transportation (NEMT)	ModivCare (formerly LogistiCare)	Characters 3 and 4 of Plan ICN contain "LC"	Replaced by MediTrans – Effective January 22, 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 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. CDJ and encounter payments are analyzed to ensure that positive and negative payments correspond to the record's transaction type. For example, a void should have a negative amount. Additionally, the payment's amount on void and back-out encounters should match the amount on the encounter being adjusted. If detected, the payment is adjusted to the appropriate sign or amount.
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. Due to rounding, the sum of the displayed percentages in this report may not add up to the total.
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 reconciliation reports. This may result in lower completion percentages when reconciling the encounters to CDJ totals.
9. 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	Medical						Dental					
	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	1,431,872	$100,651,402	1,208,040	$79,387,544	2,639,912	$180,038,946	14,712	$605,997	18,687	$726,034	33,399	$1,332,031
Reconciling Adjustment	(66,524)	$0	(41,110)	$0	(107,634)	$0	0	$0	0	$0	0	$0
Net Claims Sample Total	***1,365,348***	***$100,651,402***	***1,166,930***	***$79,387,544***	***2,532,278***	***$180,038,946***	***14,712***	***$605,997***	***18,687***	***$726,034***	***33,399***	***$1,332,031***
Encounter Data												
Total Matched Encounters	1,283,377	$99,610,718	1,093,638	$77,881,414	2,377,015	$177,492,131	13,013	$568,237	16,427	$691,763	29,440	$1,260,000
Less Surplus Encounters	(396)	$0	(86)	$0	(482)	$0	(1)	$0	0	$0	(1)	$0
Payment Adjustments	0	$17,578	0	$12,647	0	$30,225	0	$5,744	0	$9,802	0	$15,546
Net Matched Encounters	***1,282,981***	***$99,628,296***	***1,093,552***	***$77,894,060***	***2,376,533***	***$177,522,357***	***13,012***	***$573,981***	***16,427***	***$701,565***	***29,439***	***$1,275,546***
Encounter Completeness Percentage	***94.0%***	***99.0%***	***93.7%***	***98.1%***	***93.8%***	***98.6%***	***88.4%***	***94.7%***	***87.9%***	***96.6%***	***88.1%***	***95.8%***

Description	Vision						NEMT					
	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	18,198	$545,518	13,336	$403,678	31,534	$949,195	18,746	$1,598,503	20,854	$1,144,402	39,600	$2,742,905
Reconciling Adjustment	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
Net Claims Sample Total	***18,198***	***$545,518***	***13,336***	***$403,678***	***31,534***	***$949,195***	***18,746***	***$1,598,503***	***20,854***	***$1,144,402***	***39,600***	***$2,742,905***
Encounter Data												
Total Matched Encounters	18,141	$545,211	13,217	$403,389	31,358	$948,600	32,093	$1,177,541	20,053	$1,126,089	52,146	$2,303,630
Less Surplus Encounters	0	$0	0	$0	0	$0	(13,977)	($595)	(27)	($404)	(14,004)	($999)
Payment Adjustments	0	($10)	0	$0	0	($10)	0	$375,954	0	($4,196)	0	$371,759
Net Matched Encounters	***18,141***	***$545,202***	***13,217***	***$403,389***	***31,358***	***$948,591***	***18,116***	***$1,552,900***	***20,026***	***$1,121,490***	***38,142***	***$2,674,390***
Encounter Completeness Percentage	***99.7%***	***99.9%***	***99.1%***	***99.9%***	***99.4%***	***99.9%***	***96.6%***	***97.1%***	***96.0%***	***98.0%***	***96.3%***	***97.5%***

Description	Pharmacy					
	October 2020		April 2021		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Claims Sample Data						
Claims Sample Total	674,585	$35,632,777	744,183	$39,522,602	1,418,768	$75,155,379
Reconciling Adjustment	0	$0	0	$0	0	$0
Net Claims Sample Total	***674,585***	***$35,632,777***	***744,183***	***$39,522,602***	***1,418,768***	***$75,155,379***
Encounter Data						
Total Matched Encounters	446,697	$36,790,159	489,482	$40,411,886	936,179	$77,202,044
Less Surplus Encounters	(11)	($48,158)	(20)	($8,543)	(31)	($56,701)
Payment Adjustments	0	($1,017,803)	0	($1,014,045)	0	($2,031,848)
Net Matched Encounters	***446,686***	***$35,724,198***	***489,462***	***$39,389,297***	***936,148***	***$75,113,495***
Encounter Completeness Percentage	***66.2%***	***100.3%***	***65.8%***	***99.7%***	***66.0%***	***99.9%***

Appendix D: Overall Completeness

Description	CDJs	Sample Claims										Total		
		Medical		Dental		Vision		NEMT		Pharmacy				
	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	***$1,395,783,805***	2,639,912	$180,038,946	33,399	$1,332,031	31,534	$949,195	39,600	$2,742,905	1,418,768	$75,155,379	4,163,213	$1,656,002,261	$1,660,165,474
Reconciling Adjustment	$0	(107,634)	$0	0	$0	0	$0	0	$0	0	$0	(107,634)	$0	($107,634)
Net Health Plan Data	***$1,395,783,805***	***2,532,278***	***$180,038,946***	***33,399***	***$1,332,031***	***31,534***	***$949,195***	***39,600***	***$2,742,905***	***1,418,768***	***$75,155,379***	***4,055,579***	***$1,656,002,261***	***$1,660,057,840***
Encounter Data														
Total Matched Encounters	$1,500,280,849	2,377,015	$177,492,131	29,440	$1,260,000	31,358	$948,600	52,146	$2,303,630	936,179	$77,202,044	3,426,138	$1,759,487,254	$1,762,913,392
Surplus/Duplicative Adjustments	$0	(482)	$0	(1)	$0	0	$0	(14,004)	($999)	(31)	($56,701)	(14,518)	($57,700)	($72,218)
Payment Adjustments	($111,518,054)	0	$30,225	0	$15,546	0	($10)	0	$371,759	0	($2,031,848)	0	($113,132,382)	($113,132,382)
Net Matched Encounters	***$1,388,762,795***	***2,376,533***	***$177,522,357***	***29,439***	***$1,275,546***	***31,358***	***$948,591***	***38,142***	***$2,674,390***	936,148	$75,113,495	***3,411,620***	***$1,646,297,173***	***$1,649,708,793***
Encounter Completeness Percentage	***99.5%***	***93.8%***	***98.6%***	***88.1%***	***95.8%***	***99.4%***	***99.9%***	***96.3%***	***97.5%***	***66.0%***	***99.9%***	***84.1%***	***99.4%***	***99.4%***

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

Appendix E: Key Data Element Matching

Medical																					
Key Data Element	October 2020							April 2021							Total						
	Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	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
Admission Date	6,508	6,485	99.6%	23	0.4%	0	0.0%	4,224	4,213	99.7%	11	0.3%	0	0.0%	10,732	10,698	99.7%	34	0.3%	0	0.0%
Bill Type (digits 1 and 2)	608,405	608,333	100.0%	0	0.0%	72	0.0%	341,172	341,133	100.0%	0	0.0%	39	0.0%	949,577	949,466	100.0%	0	0.0%	111	0.0%
Billed Charges	1,283,377	1,275,628	99.4%	0	0.0%	7,749	0.6%	1,093,638	1,088,792	99.6%	0	0.0%	4,846	0.4%	2,377,015	2,364,420	99.5%	0	0.0%	12,595	0.5%
Billing Provider NPI/Number	1,283,377	1,279,960	99.7%	0	0.0%	3,417	0.3%	1,093,638	1,090,007	99.7%	0	0.0%	3,631	0.3%	2,377,015	2,369,967	99.7%	0	0.0%	7,048	0.3%
Diagnosis Codes	1,283,377	1,283,036	100.0%	327	0.0%	14	0.0%	1,093,638	1,093,559	100.0%	69	0.0%	10	0.0%	2,377,015	2,376,595	100.0%	396	0.0%	24	0.0%
First Date of Service	1,283,377	1,283,372	100.0%	0	0.0%	5	0.0%	1,093,638	1,093,638	100.0%	0	0.0%	0	0.0%	2,377,015	2,377,010	100.0%	0	0.0%	5	0.0%
Former/Original Claim ICN	1,283,377	985,367	76.8%	0	0.0%	298,010	23.2%	1,093,638	1,044,325	95.5%	0	0.0%	49,313	4.5%	2,377,015	2,029,692	85.4%	0	0.0%	347,323	14.6%
Health Plan Paid Amount	1,283,377	1,280,539	99.8%	0	0.0%	2,838	0.2%	1,093,638	1,091,682	99.8%	0	0.0%	1,956	0.2%	2,377,015	2,372,221	99.8%	0	0.0%	4,794	0.2%
Health Plan Paid Date	1,283,377	14,920	1.2%	2	0.0%	1,268,455	98.8%	1,093,638	11,961	1.1%	1	0.0%	1,081,676	98.9%	2,377,015	26,881	1.1%	3	0.0%	2,350,131	98.9%
ICN	1,283,377	1,190,714	92.8%	0	0.0%	92,663	7.2%	1,093,638	982,585	89.8%	0	0.0%	111,053	10.2%	2,377,015	2,173,299	91.4%	0	0.0%	203,716	8.6%
Last Date of Service	6,508	6,377	98.0%	0	0.0%	131	2.0%	4,224	4,088	96.8%	0	0.0%	136	3.2%	10,732	10,465	97.5%	0	0.0%	267	2.5%
Member ID (Medicaid ID)	1,283,377	1,282,475	99.9%	0	0.0%	902	0.1%	1,093,638	1,093,078	99.9%	0	0.0%	560	0.1%	2,377,015	2,375,553	99.9%	0	0.0%	1,462	0.1%
Place of Service	674,972	674,972	100.0%	0	0.0%	0	0.0%	752,466	752,461	100.0%	0	0.0%	5	0.0%	1,427,438	1,427,433	100.0%	0	0.0%	5	0.0%
Procedure Code	1,276,869	1,276,869	100.0%	0	0.0%	0	0.0%	1,089,414	1,089,410	100.0%	0	0.0%	4	0.0%	2,366,283	2,366,279	100.0%	0	0.0%	4	0.0%
Procedure Modifiers	1,276,869	1,276,600	100.0%	0	0.0%	269	0.0%	1,089,414	1,089,011	100.0%	0	0.0%	403	0.0%	2,366,283	2,365,611	100.0%	0	0.0%	672	0.0%
Revenue Code	672,206	670,066	99.7%	2,140	0.3%	0	0.0%	379,988	377,384	99.3%	2,593	0.7%	11	0.0%	1,052,194	1,047,450	99.5%	4,733	0.4%	11	0.0%
Service Provider NPI	1,283,377	1,262,145	98.3%	0	0.0%	21,232	1.7%	1,093,638	1,089,358	99.6%	0	0.0%	4,280	0.4%	2,377,015	2,351,503	98.9%	0	0.0%	25,512	1.1%
Service Provider Taxonomy	1,283,377	1,099,028	85.6%	0	0.0%	184,349	14.4%	1,093,638	993,071	90.8%	53	0.0%	100,514	9.2%	2,377,015	2,092,099	88.0%	53	0.0%	284,863	12.0%
Surgical Procedure Codes	6,508	6,508	100.0%	0	0.0%	0	0.0%	4,224	4,224	100.0%	0	0.0%	0	0.0%	10,732	10,732	100.0%	0	0.0%	0	0.0%
Total	***18,645,992***	***16,763,394***	***89.9%***	***2,492***	***0.0%***	***1,880,106***	***10.1%***	***15,695,144***	***14,333,980***	***91.3%***	***2,727***	***0.0%***	***1,358,437***	***8.7%***	***34,341,136***	***31,097,374***	***90.6%***	***5,219***	***0.0%***	***3,238,543***	***9.4%***

Dental																							
Key Data Element	October 2020							April 2021							Total								
	Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	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	13,013	12,477	95.9%	0	0.0%	536	4.1%	16,427	15,634	95.2%	7	0.0%	786	4.8%	29,440	28,111	95.5%	7	0.0%	1,322	4.5%
Billing Provider NPI/Number	13,013	13,013	100.0%	0	0.0%	0	0.0%	16,427	16,427	100.0%	0	0.0%	0	0.0%	29,440	29,440	100.0%	0	0.0%	0	0.0%
First Date of Service	13,013	13,013	100.0%	0	0.0%	0	0.0%	16,427	16,427	100.0%	0	0.0%	0	0.0%	29,440	29,440	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	13,013	13,012	100.0%	N/A		1	0.0%	16,427	16,404	99.9%	N/A		23	0.1%	29,440	29,416	99.9%	N/A		24	0.1%
Health Plan Paid Amount	13,013	12,684	97.5%	0	0.0%	329	2.5%	16,427	16,019	97.5%	0	0.0%	408	2.5%	29,440	28,703	97.5%	0	0.0%	737	2.5%
Health Plan Paid Date	13,013	13,013	100.0%	0	0.0%	0	0.0%	16,427	16,297	99.2%	0	0.0%	130	0.8%	29,440	29,310	99.6%	0	0.0%	130	0.4%
ICN	13,013	12,030	92.4%	0	0.0%	983	7.6%	16,427	13,745	83.7%	0	0.0%	2,682	16.3%	29,440	25,775	87.6%	0	0.0%	3,665	12.4%
Member ID (Medicaid ID)	13,013	8,672	66.6%	0	0.0%	4,341	33.4%	16,427	11,510	70.1%	0	0.0%	4,917	29.9%	29,440	20,182	68.6%	0	0.0%	9,258	31.4%
Place of Service	13,013	13,013	100.0%	0	0.0%	0	0.0%	16,427	16,427	100.0%	0	0.0%	0	0.0%	29,440	29,440	100.0%	0	0.0%	0	0.0%
Procedure Code	13,013	12,606	96.9%	0	0.0%	407	3.1%	16,427	16,003	97.4%	0	0.0%	424	2.6%	29,440	28,609	97.2%	0	0.0%	831	2.8%
Service Provider NPI	13,013	13,013	100.0%	0	0.0%	0	0.0%	16,427	16,427	100.0%	0	0.0%	0	0.0%	29,440	29,440	100.0%	0	0.0%	0	0.0%
Service Provider Taxonomy	13,013	9,406	72.3%	0	0.0%	3,607	27.7%	16,427	12,475	75.9%	0	0.0%	3,952	24.1%	29,440	21,881	74.3%	0	0.0%	7,559	25.7%
Tooth Number	13,013	12,661	97.3%	N/A		352	2.7%	16,427	15,887	96.7%	N/A		540	3.3%	29,440	28,548	97.0%	N/A		892	3.0%
Tooth Surface	14,932	14,932	100.0%	N/A		0	0.0%	19,246	19,246	100.0%	N/A		0	0.0%	34,178	34,178	100.0%	N/A		0	0.0%
Total	***184,101***	***173,545***	***94.3%***	***0***	***0.0%***	***10,556***	***5.7%***	***232,797***	***218,928***	***94.0%***	***7***	***0.0%***	***13,862***	***6.0%***	***416,898***	***392,473***	***94.1%***	***7***	***0.0%***	***24,418***	***5.9%***

[1] Up to five (5) tooth surfaces may be reported on each detail line. For those encounters with more than one tooth surface, each tooth surface was evaluated separately.

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	18,097	99.8%	0	0.0%	44	0.2%	13,195	99.8%	0	0.0%	22	0.2%	31,292	99.8%	0	0.0%	66	0.2%
Billing Provider NPI/Number	18,141	100.0%	0	0.0%	0	0.0%	13,217	100.0%	0	0.0%	0	0.0%	31,358	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	18,138	100.0%	0	0.0%	3	0.0%	13,216	100.0%	0	0.0%	1	0.0%	31,354	100.0%	0	0.0%	4	0.0%
First Date of Service	18,141	100.0%	0	0.0%	0	0.0%	13,217	100.0%	0	0.0%	0	0.0%	31,358	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	18,136	100.0%	N/A		5	0.0%	13,217	100.0%	N/A		0	0.0%	31,353	100.0%	N/A		5	0.0%
Health Plan Paid Amount	18,095	99.7%	0	0.0%	46	0.3%	13,199	99.9%	0	0.0%	18	0.1%	31,294	99.8%	0	0.0%	64	0.2%
Health Plan Paid Date	17,844	98.4%	0	0.0%	297	1.6%	13,074	98.9%	0	0.0%	143	1.1%	30,918	98.6%	0	0.0%	440	1.4%
ICN	18,024	99.4%	0	0.0%	117	0.6%	13,209	99.9%	0	0.0%	8	0.1%	31,233	99.6%	0	0.0%	125	0.4%
Member ID (Medicaid ID)	0	0.0%	0	0.0%	18,141	100.0%	0	0.0%	0	0.0%	13,217	100.0%	0	0.0%	0	0.0%	31,358	100.0%
Place of Service	18,108	99.8%	0	0.0%	33	0.2%	13,214	100.0%	0	0.0%	3	0.0%	31,322	99.9%	0	0.0%	36	0.1%
Procedure Code	18,141	100.0%	0	0.0%	0	0.0%	13,217	100.0%	0	0.0%	0	0.0%	31,358	100.0%	0	0.0%	0	0.0%
Procedure Modifiers	18,141	100.0%	N/A		0	0.0%	13,217	100.0%	N/A		0	0.0%	31,358	100.0%	N/A		0	0.0%
Service Provider NPI	18,141	100.0%	0	0.0%	0	0.0%	13,217	100.0%	0	0.0%	0	0.0%	31,358	100.0%	0	0.0%	0	0.0%
Service Provider Taxonomy	18,141	100.0%	0	0.0%	0	0.0%	13,217	100.0%	0	0.0%	0	0.0%	31,358	100.0%	0	0.0%	0	0.0%
Total	***235,288***	***92.6%***	***0***	***0.0%***	***18,686***	***7.4%***	***171,626***	***92.8%***	***0***	***0.0%***	***13,412***	***7.2%***	***406,914***	***92.7%***	***0***	***0.0%***	***32,098***	***7.3%***
Total Records in the Encounter Dataset	18,141						13,217						31,358					
Number of Key Data Element Evaluated	14						14						14					
Maximum Count	253,974	100.0%					185,038	100.0%					439,012	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	3,021	9.4%	0	0.0%	29,072	90.6%	19,745	98.5%	1	0.0%	307	1.5%	22,766	43.7%	1	0.0%	29,379	56.3%
Billing Provider NPI/Number	30,719	95.7%	0	0.0%	1,374	4.3%	19,755	98.5%	0	0.0%	298	1.5%	50,474	96.8%	0	0.0%	1,672	3.2%
First Date of Service	30,453	94.9%	0	0.0%	1,640	5.1%	19,247	96.0%	0	0.0%	806	4.0%	49,700	95.3%	0	0.0%	2,446	4.7%
Former/Original Claim ICN	32,090	100.0%	N/A		3	0.0%	19,678	98.1%	N/A		375	1.9%	51,768	99.3%	N/A		378	0.7%
Health Plan Paid Amount	3,021	9.4%	0	0.0%	29,072	90.6%	19,745	98.5%	0	0.0%	308	1.5%	22,766	43.7%	0	0.0%	29,380	56.3%
Health Plan Paid Date	31,037	96.7%	0	0.0%	1,056	3.3%	19,746	98.5%	0	0.0%	307	1.5%	50,783	97.4%	0	0.0%	1,363	2.6%
ICN	11,392	35.5%	0	0.0%	20,701	64.5%	18,504	92.3%	0	0.0%	1,549	7.7%	29,896	57.3%	0	0.0%	22,250	42.7%
Member ID (Medicaid ID)	31,053	96.8%	0	0.0%	1,040	3.2%	19,746	98.5%	0	0.0%	307	1.5%	50,799	97.4%	0	0.0%	1,347	2.6%
Procedure Code	17,462	54.4%	0	0.0%	14,631	45.6%	19,746	98.5%	0	0.0%	307	1.5%	37,208	71.4%	0	0.0%	14,938	28.6%
Procedure Modifiers	32,093	100.0%	N/A		0	0.0%	20,053	100.0%	N/A		0	0.0%	52,146	100.0%	N/A		0	0.0%
Service Provider NPI	30,666	95.6%	0	0.0%	1,427	4.4%	19,747	98.5%	0	0.0%	306	1.5%	50,413	96.7%	0	0.0%	1,733	3.3%
Service Provider Taxonomy	0	0.0%	0	0.0%	32,093	100.0%	220	1.1%	0	0.0%	19,833	98.9%	0	0.0%	0	0.0%	52,146	100.0%
Total	***253,007***	***65.7%***	***0***	***0.0%***	***132,109***	***34.3%***	***215,932***	***89.7%***	***1***	***0.0%***	***24,703***	***10.3%***	***468,719***	***74.9%***	***1***	***0.0%***	***157,032***	***25.1%***
Total Records in the Encounter Dataset	32,093						20,053						52,146					
Number of Key Data Element Evaluated	12						12						12					
Maximum Count	385,116	100.0%					240,636	100.0%					625,752	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 Paid Pharmacy Benefits Manager	422,540	94.6%	23,160	5.2%	997	0.2%	459,092	93.8%	29,504	6.0%	886	0.2%	881,632	94.2%	52,664	5.6%	1,883	0.2%
Basis of Reimbursement	13,993	3.1%	144,312	32.3%	288,392	64.6%	17,130	3.5%	159,232	32.5%	313,120	64.0%	31,123	3.3%	303,544	32.4%	601,512	64.3%
Billed Charges	100,630	22.5%	95	0.0%	345,972	77.5%	65,365	13.4%	111	0.0%	424,006	86.6%	165,995	17.7%	206	0.0%	769,978	82.2%
Days Supply	442,230	99.0%	0	0.0%	4,467	1.0%	484,132	98.9%	0	0.0%	5,350	1.1%	926,362	99.0%	0	0.0%	9,817	1.0%
First Date of Service	446,697	100.0%	0	0.0%	0	0.0%	489,482	100.0%	0	0.0%	0	0.0%	936,179	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	444,473	99.5%	N/A		2,224	0.5%	486,847	99.5%	N/A		2,635	0.5%	931,320	99.5%	N/A		4,859	0.5%
Health Plan Paid Amount	445,774	99.8%	0	0.0%	923	0.2%	488,705	99.8%	0	0.0%	777	0.2%	934,479	99.8%	0	0.0%	1,700	0.2%
Health Plan Paid Date	113,878	25.5%	0	0.0%	332,819	74.5%	124,008	25.3%	0	0.0%	365,474	74.7%	237,886	25.4%	0	0.0%	698,293	74.6%
ICN	308,977	69.2%	0	0.0%	137,720	30.8%	356,720	72.9%	0	0.0%	132,762	27.1%	665,697	71.1%	0	0.0%	270,482	28.9%
Member ID (Medicaid ID)	446,637	100.0%	0	0.0%	60	0.0%	489,450	100.0%	0	0.0%	32	0.0%	936,087	100.0%	0	0.0%	92	0.0%
National Drug Code (NDC)	445,842	99.8%	0	0.0%	855	0.2%	488,810	99.9%	0	0.0%	672	0.1%	934,652	99.8%	0	0.0%	1,527	0.2%
Prescribing Provider NPI	302,479	67.7%	144,013	32.2%	205	0.0%	330,289	67.5%	159,011	32.5%	182	0.0%	632,768	67.6%	303,024	32.4%	387	0.0%
Prescription Number	446,697	100.0%	0	0.0%	0	0.0%	489,482	100.0%	0	0.0%	0	0.0%	936,179	100.0%	0	0.0%	0	0.0%
Quantity Dispensed	442,311	99.0%	0	0.0%	4,386	1.0%	484,185	98.9%	0	0.0%	5,297	1.1%	926,496	99.0%	0	0.0%	9,683	1.0%
Refill Number	446,527	100.0%	170	0.0%	0	0.0%	489,374	100.0%	108	0.0%	0	0.0%	935,901	100.0%	278	0.0%	0	0.0%
Total	***5,269,685***	***78.6%***	***311,750***	***4.7%***	***1,119,020***	***16.7%***	***5,743,071***	***78.2%***	***347,966***	***4.7%***	***1,251,193***	***17.0%***	***11,012,756***	***78.4%***	***659,716***	***4.7%***	***2,370,213***	***16.9%***
Total Records in the Encounter Dataset	446,697						489,482						936,179					
Number of Key Data Element Evaluated	15						15						15					
Maximum Count	6,700,455	100.0%					7,342,230	100.0%					14,042,685	100.0%				

Total																					
Key Data Element	October 2020							April 2021							Total						
	Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	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
Admission Date	6,508	6,485	99.6%	23	0.4%	0	0.0%	4,224	4,213	99.7%	11	0.3%	0	0.0%	10,732	10,698	99.7%	34	0.3%	0	0.0%
Amount Paid Pharmacy Benefits Manager	446,697	422,540	94.6%	23,160	5.2%	997	0.2%	489,482	459,092	93.8%	29,504	6.0%	886	0.2%	936,179	881,632	94.2%	52,664	5.6%	1,883	0.2%
Basis of Reimbursement	446,697	13,993	3.1%	144,312	32.3%	288,392	64.6%	489,482	17,130	3.5%	159,232	32.5%	313,120	64.0%	936,179	31,123	3.3%	303,544	32.4%	601,512	64.3%
Bill Type (digits 1 and 2)	608,405	608,333	100.0%	0	0.0%	72	0.0%	341,172	341,133	100.0%	0	0.0%	39	0.0%	949,577	949,466	100.0%	0	0.0%	111	0.0%
Billed Charges	1,793,321	1,409,853	78.6%	95	0.0%	383,373	21.4%	1,632,817	1,202,731	73.7%	119	0.0%	429,967	26.3%	3,426,138	2,612,584	76.3%	214	0.0%	813,340	23.7%
Billing Provider NPI/Number	1,346,624	1,341,833	99.6%	0	0.0%	4,791	0.4%	1,143,335	1,139,406	99.7%	0	0.0%	3,929	0.3%	2,489,959	2,481,239	99.6%	0	0.0%	8,720	0.4%
Days Supply	446,697	442,230	99.0%	0	0.0%	4,467	1.0%	489,482	484,132	98.9%	0	0.0%	5,350	1.1%	936,179	926,362	99.0%	0	0.0%	9,817	1.0%
Diagnosis Codes	1,301,518	1,301,174	100.0%	327	0.0%	17	0.0%	1,106,855	1,106,775	100.0%	69	0.0%	11	0.0%	2,408,373	2,407,949	100.0%	396	0.0%	28	0.0%
First Date of Service	1,793,321	1,791,676	99.9%	0	0.0%	1,645	0.1%	1,632,817	1,632,011	100.0%	0	0.0%	806	0.0%	3,426,138	3,423,687	99.9%	0	0.0%	2,451	0.1%
Former/Original Claim ICN	1,793,321	1,493,078	83.3%	0	0.0%	300,243	16.7%	1,632,817	1,580,471	96.8%	0	0.0%	52,346	3.2%	3,426,138	3,073,549	89.7%	0	0.0%	352,589	10.3%
Health Plan Paid Amount	1,793,321	1,760,113	98.1%	0	0.0%	33,208	1.9%	1,632,817	1,629,350	99.8%	0	0.0%	3,467	0.2%	3,426,138	3,389,463	98.9%	0	0.0%	36,675	1.1%
Health Plan Paid Date	1,793,321	190,692	10.6%	2	0.0%	1,602,627	89.4%	1,632,817	185,086	11.3%	1	0.0%	1,447,730	88.7%	3,426,138	375,778	11.0%	3	0.0%	3,050,357	89.0%
ICN	1,793,321	1,541,137	85.9%	0	0.0%	252,184	14.1%	1,632,817	1,384,763	84.8%	0	0.0%	248,054	15.2%	3,426,138	2,925,900	85.4%	0	0.0%	500,238	14.6%
Last Date of Service	6,508	6,377	98.0%	0	0.0%	131	2.0%	4,224	4,088	96.8%	0	0.0%	136	3.2%	10,732	10,465	97.5%	0	0.0%	267	2.5%
Member ID (Medicaid ID)	1,793,321	1,768,837	98.6%	0	0.0%	24,484	1.4%	1,632,817	1,613,784	98.8%	0	0.0%	19,033	1.2%	3,426,138	3,382,621	98.7%	0	0.0%	43,517	1.3%
National Drug Code (NDC)	446,697	445,842	99.8%	0	0.0%	855	0.2%	489,482	488,810	99.9%	0	0.0%	672	0.1%	936,179	934,652	99.8%	0	0.0%	1,527	0.2%
Place of Service	706,126	706,093	100.0%	0	0.0%	33	0.0%	782,110	782,102	100.0%	0	0.0%	8	0.0%	1,488,236	1,488,195	100.0%	0	0.0%	41	0.0%
Prescribing Provider NPI	446,697	302,479	67.7%	144,013	32.2%	205	0.0%	489,482	330,289	67.5%	159,011	32.5%	182	0.0%	936,179	632,768	67.6%	303,024	32.4%	387	0.0%
Prescription Number	446,697	446,697	100.0%	0	0.0%	0	0.0%	489,482	489,482	100.0%	0	0.0%	0	0.0%	936,179	936,179	100.0%	0	0.0%	0	0.0%
Procedure Code	1,340,116	1,325,078	98.9%	0	0.0%	15,038	1.1%	1,139,111	1,138,376	99.9%	0	0.0%	735	0.1%	2,479,227	2,463,454	99.4%	0	0.0%	15,773	0.6%
Procedure Modifiers	1,327,103	1,326,834	100.0%	0	0.0%	269	0.0%	1,122,684	1,122,281	100.0%	0	0.0%	403	0.0%	2,449,787	2,449,115	100.0%	0	0.0%	672	0.0%
Quantity Dispensed	446,697	442,311	99.0%	0	0.0%	4,386	1.0%	489,482	484,185	98.9%	0	0.0%	5,297	1.1%	936,179	926,496	99.0%	0	0.0%	9,683	1.0%
Refill Number	446,697	446,527	100.0%	170	0.0%	0	0.0%	489,482	489,374	100.0%	108	0.0%	0	0.0%	936,179	935,901	100.0%	278	0.0%	0	0.0%
Revenue Code	672,206	670,066	99.7%	2,140	0.3%	0	0.0%	379,988	377,384	99.3%	2,593	0.7%	11	0.0%	1,052,194	1,047,450	99.5%	4,733	0.4%	11	0.0%
Service Provider NPI	1,346,624	1,323,965	98.3%	0	0.0%	22,659	1.7%	1,143,335	1,138,749	99.6%	0	0.0%	4,586	0.4%	2,489,959	2,462,714	98.9%	0	0.0%	27,245	1.1%
Service Provider Taxonomy	1,346,624	1,126,575	83.7%	0	0.0%	220,049	16.3%	1,143,335	1,018,983	89.1%	53	0.0%	124,299	10.9%	2,489,959	2,145,558	86.2%	53	0.0%	344,348	13.8%
Surgical Procedure Codes	6,508	6,508	100.0%	0	0.0%	0	0.0%	4,224	4,224	100.0%	0	0.0%	0	0.0%	10,732	10,732	100.0%	0	0.0%	0	0.0%
Tooth Number	13,013	12,661	97.3%	0	0.0%	352	2.7%	16,427	15,887	96.7%	0	0.0%	540	3.3%	29,440	28,548	97.0%	0	0.0%	892	3.0%
Tooth Surface	14,932	14,932	100.0%	0	0.0%	0	0.0%	19,246	19,246	100.0%	0	0.0%	0	0.0%	34,178	34,178	100.0%	0	0.0%	0	0.0%
Total	***26,169,638***	***22,694,919***	***86.7%***	***314,242***	***1.2%***	***3,160,477***	***12.1%***	***23,695,845***	***20,683,537***	***87.3%***	***350,701***	***1.5%***	***2,661,607***	***11.2%***	***49,865,483***	***43,378,456***	***87.1%***	***664,943***	***1.2%***	***5,822,084***	***11.7%***

Appendix F: Per Member Utilization and Paid Amounts

SFY 2021										
Description	**Healthy Louisiana**				**HB**				**Percentage of Healthy Louisiana**	
Members										
Total member Months	18,643,240				3,613,459				19.4%	
Average Number of Members[1]	1,553,603				301,122					
									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	7,581,728	4.9	$372,286,331	$240	1,484,626	4.9	$66,082,201	$219	0.0%	-8.8%
Dental	682,468	0.4	$30,598,844	$20	138,059	0.5	$6,081,342	$20	25.0%	0.0%
Inpatient	2,492,771	1.6	$1,591,091,198	$1,024	533,054	1.8	$326,386,467	$1,084	12.5%	5.9%
NEMT	955,188	0.6	$42,246,297	$27	188,392	0.6	$9,775,314	$32	0.0%	18.5%
Outpatient	18,692,115	12.0	$1,162,312,174	$748	3,791,690	12.6	$235,557,993	$782	5.0%	4.5%
Pharmacy	26,390,029	17.0	$2,023,471,285	$1,302	4,958,126	16.5	$449,203,270	$1,492	-2.9%	14.6%
Primary Care	15,499,565	10.0	$536,281,269	$345	2,909,778	9.7	$100,434,033	$334	-3.0%	-3.2%
Specialty	12,423,567	8.0	$920,683,657	$593	2,493,979	8.3	$185,436,302	$616	3.8%	3.9%
Vision	1,543,458	1.0	$54,507,039	$35	257,876	0.9	$9,966,133	$33	-10.0%	-5.7%
Total Services [3]	***86,260,889***	***55.5***	***$6,733,478,093***	***$4,334***	***16,755,580***	***55.8***	***$1,388,923,055***	***$4,612***	***0.5%***	***6.4%***

[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

SFY 2021													
Encounter Type	15 Business Days 90%		30 Calendar Days 100%			60 Calendar Days 100%			Over 60 Calendar Days			Total Count	Average Calendar Days
		Percentage		Percentage			Percentage			Percentage			
	Count	Absolute	Count	Absolute	Cumulative	Count	Absolute	Cumulative	Count	Absolute	Cumulative		
Medical	12,803,293	86.7%	1,008,854	6.8%	93.5%	245,099	1.7%	95.2%	707,646	4.8%	100.0%	14,764,892	17
Dental	231,984	91.5%	10,907	4.3%	95.8%	1,367	0.5%	96.4%	9,200	3.6%	100.0%	253,458	11
Vision	194,575	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	194,575	0
NEMT	535,365	99.3%	2,240	0.4%	99.7%	383	0.1%	99.8%	1,103	0.2%	100.0%	539,091	15
Pharmacy	5,532,238	98.3%	34,075	0.6%	98.9%	15,222	0.3%	99.2%	45,571	0.8%	100.0%	5,627,106	9
Total	***19,297,455***	***90.3%***	***1,056,076***	***4.9%***	***95.2%***	***262,071***	***1.2%***	***96.4%***	***763,520***	***3.6%***	***100.0%***	***21,379,122***	***14***

Appendix H: Timely Encounter Submissions

SFY 2021													
Encounter Type	30 Days		60 Days			90 Days			Over 90 Days			Total Count	Average Days
		Percentage		Percentage			Percentage			Percentage			
	Count	Absolute	Count	Absolute	Cumulative	Count	Absolute	Cumulative	Count	Absolute	Cumulative		
Medical	13,166,416	89.2%	418,283	2.8%	92.0%	147,805	1.0%	93.0%	1,032,388	7.0%	100.0%	14,764,892	28
Dental	156,224	61.6%	7,806	3.1%	64.7%	16,960	6.7%	71.4%	72,468	28.6%	100.0%	253,458	90
Vision	181,650	93.4%	7,391	3.8%	97.2%	1,027	0.5%	97.7%	4,507	2.3%	100.0%	194,575	20
NEMT	113,054	21.0%	115,506	21.4%	42.4%	72,770	13.5%	55.9%	237,761	44.1%	100.0%	539,091	117
Pharmacy	5,568,190	99.0%	14,676	0.3%	99.2%	11,795	0.2%	99.4%	32,445	0.6%	100.0%	5,627,106	7
Total	***19,185,534***	***89.7%***	***563,662***	***2.6%***	***92.4%***	***250,357***	***1.2%***	***93.5%***	***1,379,569***	***6.5%***	***100.0%***	***21,379,122***	***26***

Appendix I: Medical Records Validity Rate

	Medical					Dental					Vision				
	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	78	77	98.7%	1	1.3%	1	1	100.0%	0	0.0%	3	3	100.0%	0	0.0%
Member DOB	78	72	92.3%	6	7.7%	1	1	100.0%	0	0.0%	3	3	100.0%	0	0.0%
Admit Date	1	1	100.0%	0	0.0%			N/A					N/A		
Date of Service - First	78	76	97.4%	2	2.6%	1	1	100.0%	0	0.0%	3	3	100.0%	0	0.0%
Date of Service - Last	1	1	100.0%	0	0.0%			N/A					N/A		
Diagnosis Codes	178	165	92.7%	13	7.3%			N/A			4	4	100.0%	0	0.0%
Billing Provider	78	72	92.3%	6	7.7%	1	1	100.0%	0	0.0%	3	3	100.0%	0	0.0%
Type of Bill Code	29	26	89.7%	3	10.3%			N/A					N/A		
Revenue Code	38	33	86.8%	5	13.2%			N/A					N/A		
Place of Service	49	47	95.9%	2	4.1%	1	1	100.0%	0	0.0%	3	3	100.0%	0	0.0%
Procedure Code	74	71	95.9%	3	4.1%	1	1	100.0%	0	0.0%	3	3	100.0%	0	0.0%
Procedure Modifiers	42	40	95.2%	2	4.8%			N/A			1	1	100.0%	0	0.0%
Servicing Provider	78	73	93.6%	5	6.4%	1	1	100.0%	0	0.0%	3	3	100.0%	0	0.0%
Surgical Procedure Codes	4	1	25.0%	3	75.0%			N/A					N/A		
Tooth Number			N/A			0	0	0.0%	0	0.0%			N/A		
Tooth Surfaces			N/A			0	0	0.0%	0	0.0%			N/A		
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	***806***	***755***	***93.7%***	***51***	***6.3%***	***7***	***7***	***100.0%***	***0***	***0.0%***	***26***	***26***	***100.0%***	***0***	***0.0%***

Note: 131 of the 150 medical records requested were submitted and tested.

	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	49	49	100.0%	0	0.0%	131	130	99.2%	1	0.8%
Member DOB	49	49	100.0%	0	0.0%	131	125	95.4%	6	4.6%
Admit Date	N/A					1	1	100.0%	0	0.0%
Date of Service - First	49	49	100.0%	0	0.0%	131	129	98.5%	2	1.5%
Date of Service - Last	N/A					1	1	100.0%	0	0.0%
Diagnosis Codes	N/A					182	169	92.9%	13	7.1%
Billing Provider	49	48	98.0%	1	2.0%	131	124	94.7%	7	5.3%
Type of Bill Code	N/A					29	26	89.7%	3	10.3%
Revenue Code	N/A					38	33	86.8%	5	13.2%
Place of Service	N/A					53	51	96.2%	2	3.8%
Procedure Code	N/A					78	75	96.2%	3	3.8%
Procedure Modifiers	N/A					43	41	95.3%	2	4.7%
Servicing Provider	N/A					82	77	93.9%	5	6.1%
Surgical Procedure Codes	N/A					4	1	25.0%	3	75.0%
Tooth Number	N/A					0	0	0.0%	0	0.0%
Tooth Surfaces	N/A					0	0	0.0%	0	0.0%
Prescription Number	49	49	100.0%	0	0.0%	49	49	100.0%	0	0.0%
National Drug Code (NDC)	49	48	98.0%	1	2.0%	49	48	98.0%	1	2.0%
Quantity Dispensed	49	49	100.0%	0	0.0%	49	49	100.0%	0	0.0%
Days Supply	49	48	98.0%	1	2.0%	49	48	98.0%	1	2.0%
Prescribing Provider	49	49	100.0%	0	0.0%	49	49	100.0%	0	0.0%
Total	***441***	***438***	***99.3%***	***3***	***0.7%***	***1,280***	***1,226***	***95.8%***	***54***	***4.2%***

Note: 131 of the 150 medical records requested were submitted and tested.

Health Plan Response

Activity 3: Analyze Electronic Encounter Data
Sample Months: Oct 2020 and April 2021

Activity	Finding	Recommendation	Slide	Action Required?
3-A	**Completeness – CDJs**: The health plan's monthly completion percentages were at or about 97% threshold for 7 out of 12 month measurement period. For SFY 2021, the health plan's completion percentage was above 97% threshold (99.5 %).	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.	10	Address variances at monthly HBL data log meeting; use internal checkbook to monitor financial completeness and address missing data or duplicate data issues
3-B	**Completeness - Sample Claims Count**: The vision encounters completeness percentage, based on sample counts, was about the 97% threshold. Medical, dental, NEMT and pharmacy encounter counts were below the threshold.	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.	11, 55, 57	Pharmacy - In sample claim extract, perhaps in month reversals were included. That may explain why the sample counts are higher than encounter data. HBL will incorporate additional review of the sample claim extracts to ensure no unwanted reversals were unintentionally included causing the variance. Medical, Dental, NEMT- In sample claim extract, we believe all claim versions (originals, adjustments and voids) were included. That explains why the sample counts are higher than encounter data.HBL will incorporate additional review of the sample claim extracts to ensure only the recent version of the claims were included.
3-C	**Completeness - Sample Claims Paid Amount**: Encounter completion percentages, based on sample claims amounts, were at or above the 97% threshold for medical, vision, NEMT and pharmacy encounters. Dental encounters were below the threshold.	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.	11, 55	Dental -In sample claim, we believe all claim versions (originals, adjustments and voids) were included. That explains why the sample paid amounts are higher than encounter data.HBL will incorporate additional review of the sample claim extracts to ensure only the recent version of the claims were included.

Activity 3: Analyze Electronic Encounter Data
Sample Months: Oct 2020 and April 2021

Activity	Finding	Recommendation	Slide	Action Required?
3-D	**Accuracy - Billed Charges**: Dental, NEMT, Pharmacy **Health Plan Paid Amount**: NEMT **Procedure Code**: NEMT Both the sample claims data and the encounter data reflect valid values and the values do not agree	The health plan/delegated vendor should ensure it is properly capturing and maintaing encounter data elements within the claims system and data warehouse and be able to submit this information in the encounter submission and on future claim sample submissions and/or ad hoc reporting. Additionally, the FAC, the health plan and /or its delegated vendors should work together to ensure key data elements are properly submitted and captured in encounter data.	12	Many of the discrepancies are due to differences in how the sample data is pulled compared to how the encounter data is generated. HBL will incorporate additional review of the sample claim dataset to ensure attributes are mapped based on LA audit requirements.
3-E	**Accuracy – Date of Service: NEMT** **Health Plan Paid Date:** Medical and Pharmacy The encounter date is before and/or after the sample claim date	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 submission and on future claim sample submissions and/or ad hoc reporting. Additionally, the FAC, the health plan and /or its delegated vendors should work together to ensure key data elements are properly submitted and captured in encounter data.	12	Many of the discrepancies are due to differences in how the sample data is pulled compared to how the encounter data is generated. HBL will incorporate additional review of the sample claim dataset to ensure attributes are mapped based on LA audit requirements.
3-F	**Accuracy – Prescribing Provider NPI, Amount Paid Pharmacy Benefits Manager** and **Basis of Reibmursement**: Pharmacy - The sample claim reflects a value and the encounter value is not populated or both the sample claims data and the encounter data reflect valid values and the values do 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 submission and on future claim sample submissions and/or ad hoc reporting. Additionally, the FAC, the health plan and /or its delegated vendors should work together to ensure key data elements are properly submitted and captured in encounter data.	12	Many of the discrepancies are due to differences in how the sample data is pulled compared to how the encounter data is generated. HBL will incorporate additional review of the sample claim dataset to evaluate if any of these critical elements were excluded causing a variance with the encounter data.
3-G	**Accuracy – Former/Original Claim ICN**: Medical The sample claim reflects a value and the encounter value is not populated, or both the sample claims data and the encounter data reflect valid values and the values do not agree.	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.	13	Migrated to Edifecs in 2021 and remapped/revalidated ICN mapping. Issue with order of loading the conversion claims so that is potentially impacting ICNs and we receive a reject for adj not valid.

Activity 3: Analyze Electronic Encounter Data
Sample Months: Oct 2020 and April 2021

Activity	Finding	Recommendation	Slide	Action Required?
3-H	**Accuracy – Member (Medicaid ID)**: Dental and Vision - The sample claims is not populated or the sample claims data appears to reflect the health plans member ID	The member ID is a proprietary number assigned by the health plan to identify members enrolled with the health plan. The Medicaid ID verifies the the member's Medicaid eligibility. The health plan/delegated vendor should ensure there is a crosswalk in place to link the health plan/delegated vendor's assigned member ID to the recipients Medicaid ID and be able to provider either or both upon request.	13	Sample claim mapped in incorrect Member ID. Add QC process to validate sample claim mapping for future audits.
3-I	**Accuracy – MMIS ICN**: Medical, Dental, NEMT and Pharmacy - The sample claim value is not populated or the sample claims data appears to reflect and original claim MMIS ICN and the encounter ICN reflects an adjustment or replacement encounter ICN or vice versa. For example, the claim reflects a MMIS ICN of 1070123****** and the encounter reflects an ICN with a Juian date of 0309117******.	The health plan/delegated vendor should ensure that appropriate audit trails are in place and it is properly capturing and storing all ICNs assigned by the FAC and returned to the health plan/delegate vendor on the 835 or proprietary response files.	13	Pulled ICN from MDE for the sample claim extract but encounter may contain a more recent version. Add QC process to validate ICN for future audits. The Edifecs migration in Aug/Sep 2021 could also have contributed to ICN difference. Pharmacy - ICN data may not have been included in the sample claim extract. Add QC process to validate ICN for future audits.
3-J	**Accuracy – Servicing/Attending/Rendering Provider Taxonomy: Dental and NEMT** - The sample claim value is not populated or both the sample claims data and the encounter data reflect valid values but do not agree.	The health plan/delegated vendor should ensure it is properly capturing and maintaining provider data within the claims system and data warehouse and be able to submit this information in the encounter submission. Additionally, the FAC and the health plan should work together to ensure provider regulated values are properly submitted and captured in encounter data.	14	Many of the discrepancies are due to differences in the how the sample data is pulled compared to how the encounter data is generated. HBL will incorporate additional review of the sample claim dataset to ensure attributes are mapped based on LA audit requirements.
3-K	**Timely Payment of claims**: The health plan met the 15 business day level of timeliness for the payment of claims and did not meet the 30 and 60 calendar day requirements.	The health plan should continue to regularly monitor its claims processing system and delegated vendors to ensure claims are processed promptlu and within the contractual timeframes.		

Activity 3: Analyze Electronic Encounter Data
Sample Months: Oct 2020 and April 2021

Activity	Finding	Recommendation	Slide	Action Required?
3-L	**Timely Encounter Submissions**: The health plan submitted 92.4% of encounters (both paid and denied) with SFY 2021 dates of services within 60 days. Dental and NEMT encounters diluted values with 64.7% nd 42.4% respectively, submitted within 60 days. Dental encounters were submitted, on average, within 90 days and NEMT within 117 days.	The health plan should review its encounter submission process to ensure encounters rejected by the FAC are quickly resolved and resubmitted. Additionally, the health plan should regularly monitor its delegated vendors encounter submission processes to ensure encounters are submitted timely.	16	MediTrans was delayed to implement after Edifecs. Dental had a change on File Type due to which we had to void and resubmit old encounters. Currently working on provider registry rejections for FAC and vendor encounters and the remediation of the rejections will impact timeliness. Internal dashboards measuring Q1 2023 timeliness between date of service and submission date : Dental is 97.29% Transportation is 98.88%