MYERS AND STAUFFER LC
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CERTIFIED PUBLIC ACCOUNTANTS

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
MISSISSIPPI DIVISION OF MEDICAID

External Quality Review (EQR) Protocol 4

Summary of Findings

UnitedHealthcare Community Plan

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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Overview

CMS EQR Validation - Guidance and Requirements

> The Centers for Medicare & Medicaid Services (CMS) strongly encourages states to contract with qualified entities to implement *EQR Protocol 4 Validation of Encounter Data Reported by the MCO* (EQR Protocol 4) due to the need for valid and reliable encounter data as part of any state quality improvement efforts. The CMS EQR Protocol 4 guidelines state: "as federal programs transition toward payment reform for demonstrated quality of care, the validation of encounter data in the use of performance data will become increasingly significant. Validation of encounter data can help states reach the goals of transparency and payment reform to support their efforts in quality measurement and improvement."

The Role and Importance of Encounter Data

Encounter data are a replica of claims that have been adjudicated by the Coordinated Care Organization (CCO) or their subcontracted vendors (e.g., vision, pharmacy, and dental) to health care providers that have provided health care services to members enrolled with the CCO. These encounter claims are submitted to DOM via the Fiscal Agent Contractor (FAC). Validated encounter data has many uses such as rate setting, federal reporting program management and oversight, and for tracking, accounting and other ad-hoc analyses. In addition, the new federal regulatory requirements clearly state that incomplete or inaccurate encounter data will no longer be accepted. All states are at risk for loss of federal financial participation reimbursement dollars for having inaccurate or incomplete encounter data.

EQR Protocol 4, while not federally mandated, has been identified by CMS as an excellent management tool that offers much of what DOM was searching for to assist in its monitoring of the encounter data submissions and also assists with meeting new federal mandates regarding encounter data validation. The basis of the encounter data validation is to assess the level of completeness and accuracy of the MississippiCAN encounter data submissions. It provides the ability to assess whether the encounter data can be used to determine program effectiveness, accurately evaluate utilization, identify service gaps, and make sound management decisions. In addition, the protocol evaluates both departmental policies, as well as the policies, procedures, and systems of the CCO to identify strengths and opportunities to enhance oversight.

Background of MississippiCAN

Mississippi's Coordinated Access Network (MississippiCAN) was implemented in January 2011 with the goals of improving access to needed medical services, improving the quality of care for Medicaid beneficiaries and to achieve cost efficiencies in the delivery of that care. Since its inception, enrollment has grown to nearly half a million members. In December 2012, the MississippiCAN program was expanded to include additional categories of eligibility, mental (behavioral) health services, and mandatory enrollment for certain categories. A large number of children were transitioned into the program during the period May through July 2015. Inpatient hospital services were added in December 2015.

Purpose, Scope, Methodology, and Value of the Myers and Stauffer LC Review

The Mississippi DOM was in search of a robust and comprehensive approach to help assist with their current managed care oversight responsibilities and capabilities. Therefore, in August, 2015, the Mississippi DOM engaged Myers and Stauffer LC to undertake this project to validate encounter data submitted to the FAC by the Medicaid contracted CCOs and to perform an EQR using the CMS EQR Protocol 4.

An EQR Protocol 4 review is a resource intensive and time consuming project requiring extensive coordination with CCO personnel in order to obtain the appropriate data necessary to analyze. It entails both the procurement of large datasets and medical records through multiple requests to acquire all required data elements in a certain specified format, as well as the capacity and time necessary to process and analyze this information in order to provide usable and comparable results. As part of the protocol, each participating CCO was required to provide a sample of claims data adjudicated in January 2015 and October 2015 to be used to match against the encounter data to test the quality of the encounter data received by the FAC. In addition, summary analytics were performed on all encounter data submitted by the CCO to the FAC for calendar year (CY) 2015 dates of service to evaluate completeness and identify other data quality issues. The analytics performed by Myers and Stauffer LC represents a robust review into the encounter data including tracing encounter data elements back to the source medical records documentation for a sample of members. This medical records acquisition process for the sampled members also required extensive time and coordination efforts with the CCOs. The results of such a detailed encounter data analysis were previously not available to the state and now provides a complete audit trail of the medical service information obtained from the medical records to the sample claims adjudicated by the CCOs to the submitted encounter claims data currently residing in the FAC data warehouse. These analytics along with findings and recommendations related to the EQR Protocol 4 activities are included within this report.

DOM intends to utilize the results, findings, and recommendations from this review to generate enforceable corrective action plans specifying the steps to mitigate the concerns identified, timetables for resolution, and identify the person(s) responsible from the CCOs and FAC for ensuring all issues are satisfactorily resolved. We strongly agree with this corrective action plan methodology.

In addition to completing the EQR Protocol 4 Review, Myers and Stauffer has been working closely with DOM and the CCOs to perform on-going bi-monthly encounter reconciliations since March 2016 to identify deficiencies and propose solutions that will result in high quality and reliable encounter data being submitted. Many of the previously identified issues have already been addressed, while the more challenging deficiencies continue to be addressed through an on-going collaboration effort between the CCOs, DOM, and the FAC, with the ultimate goal to provide complete, accurate, and useable encounter data. Encounter data serves as a leading tool for stakeholders to make informed decisions about medical management, care coordination, program integrity Issues, quality improvement, financial and actuarial calculations, and performance evaluations.

CMS has established formal encounter validation requirements because many states did not maintain a complete and accurate encounter data set to be utilized for these purposes. Since the bi-monthly encounter reconciliations were initiated a year ago, Mississippi health plans have increased their required completion percentages from significantly below contract required levels to at or near contract required levels.

With this proactive approach and monitoring, DOM can both identify issues for correction and if necessary, assess liquidated damages as appropriate. Encounter data is an area in which many state Medicaid programs continue to struggle. DOM has demonstrated great awareness of the new federal requirements as evidenced by their initiation of encounter data validation well in advance of the federal requirement. The results of the encounter reviews will yield future cost savings and fiscal accountability, stronger oversight and program integrity opportunities, and much more accurate data critical for important activities such as actuarial sound rate setting. A limited number of states have undertaken the initiative to validate encounter data with an EQR Protocol 4 review and bi-monthly encounter reconciliations to cash disbursement journals. This places Mississippi as a leader among its peers in this area and serves as a best practices model for other states to follow.

Included below for reference are the current federal requirements:

Federal Requirements Related to Validation of Encounter Data

- ***Federal External Quality Review (EQR) Requirements under the Centers for Medicare and Medicaid Services (CMS) Final Rule on Medicaid Managed Care (42 CFR 438)***

  The final Medicaid Managed Care Rule[1] 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, including but not limited to, the performance of managed care operations and management in the areas of claims management and information systems. Additionally, Mississippi is required through the new federal regulations to provide accurate financial and encounter data to its actuary as well as to CMS as part of the Transformed Medicaid Statistical Information System (T-MSIS) project. This data must be audited no less than once every three years.

[1] Electronic Code of Federal Regulations. https://www.ecfr.gov/cgi-bin/text-idx?SID=888e7bb305afac68ec3793a21b77a4ba&mc=true&node=pt42.4.438&rgn=div5

Glossary

- **834 file** – A benefit enrollment and maintenance document.
- **835 file** – Healthcare claim payment/advice.
- **837 file** – The standard format used by institutional providers and health care professionals and suppliers to transmit health care claims electronically.
- **277 CA** – A healthcare claim acknowledgement.
- **999** – The 999 Implementation Acknowledgement, is a required standard transaction to acknowledge initial receipt of an electronic claim file and whether it was accepted or rejected.
- **NCPDP** – The NCPDP Provider Identification number provides pharmacies with a unique, national identifier to assist pharmacies in their interactions with pharmacy payers and claims processors. The NCPDP Provider ID is a seven-digit numbering system that is assigned to every licensed pharmacy and qualified Non-Pharmacy Dispensing Sites (NPDS) in the United States.
- **5010** – Refers to the revised set of HIPAA electronic transaction standards adopted to replace the Version 4010/4010A standards. All HIPAA covered entities should have transitioned to Version 5010 as of **January 1, 2012**. Any electronic transaction for which a standard has been adopted must be submitted using Version 5010; otherwise, the transaction is not compliant with HIPAA and will be rejected.
- **Acceptable Error Rate** – The Division of Medicaid (DOM) established maximum tolerance, stated as a percentage, of missing, surplus, or erroneous encounter records the state accepts.
- **Adjudication** – The process of determining if a claim should pay or deny.
- **American Dental Association (ADA)** – The recognized leading source of oral health related information for dentists and their patients.
- **Ancillary Services** – Diagnostic or therapeutic services requested by a health care provider as a supplement to basic medical services.
- **Benchmark** – A standard or reference by which to measure or judge.
- **Calculated Void Encounter (CV)** – An encounter that Myers and Stauffer LC has identified as being a replacement encounter that does not appear to have a corresponding void of the original encounter in the FAC data warehouse.
- **Cash Disbursement Journal (CDJ)** – A journal used to record and track cash payments by an entity.
- **Cash Disbursement Journal (CDJ) Monthly Reported Total** – The sum of all payments from a CCO or delegated vendor to service providers for a given month as reported by the CCO to the DOM.
- **CDJ Cumulative Reported Total** – The sum of all payments from a CCO or delegated vendor to service providers for the reconciliation period as reported by the CCO to the DOM. This amount is inclusive of all amounts reported in prior months.

- **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 Managed Care Final Rule** – This final rule 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.
- **CFR** – Code of Federal Regulations.
- **Children's Health Insurance Program (CHIP)** – This program provides insurance coverage for uninsured children up to age 19 whose family does not qualify for Medicaid and whose income does not exceed 200 percent of the federal poverty level.
- **Claims Adjustment Reason Code (CAS)** – Codes used to explain why a claim or service line was paid differently than it was billed.
- **Clean Encounter** – An encounter submitted without any complications that might cause delays in processing.
- **Conduent (formerly known as Xerox)** – The fiscal agent contractor for the state of Mississippi.
- **Coordinated Care Organization (CCO)** – A private organization that has entered into a risk-based contractual arrangement with the Mississippi DOM to obtain and finance care for enrolled Medicaid members. CCOs receive a capitation or per member per month (PMPM) payment from the DOM for each enrolled member. Magnolia Health Plan (Magnolia Health) and UnitedHealthcare Community Plan (UHC) are the two CCOs operating under contract in Mississippi.
- **Cumulative Encounter Total** – The sum of all encounter submissions stored in the fiscal agent contractor's (FAC) encounter data warehouse. This amount is inclusive of all amounts submitted in prior months.
- **Cumulative Variance** – The difference between the cumulative encounter total and the CDJ cumulative reported total.
- **Data Warehouse (DW)** – A central repository for storing, retrieving, and managing large amounts of current and historical 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).
- **Division of Medicaid (DOM)** – The Division under the Office of the Governor within the state of Mississippi that oversees and administers Medicaid and the state's Children's Health Insurance Program.

- **Encounter** – A medical service provided 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 CCOs or subcontracted vendors (e.g., vision, pharmacy, dental) to health care providers that have provided health care services to members enrolled with the CCO. These claims are submitted to DOM via the Fiscal Agent Contractor (FAC) for the DOM's use in rate setting, federal reporting, program oversight and management, tracking, accounting, 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 CCOs, or their contractors, furnish to Medicaid recipients.
- **Erroneous** – As defined within the Centers for Medicare & Medicaid Services (CMS) *EQR Protocol 4 Validation of Encounter Data Reported by the MCO* (Protocol 4) document: Encounter data represented by an encounter record that contains incorrect data elements.
- **Fiscal Agent Contractor (FAC)** – A contractor selected to design, develop, and maintain the claims processing Medicaid Management Information System (MMIS); Conduent is the current FAC. Also known as a fiscal intermediary (FI).
- **Healthcare Effectiveness Data and Information Set (HEDIS)** – A set of performance measures used in the managed care industry.
- **The 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).
- **Medicaid Management Information System (MMIS)** – The claims processing system used by the FAC to adjudicate Mississippi Medicaid claims. CCO submitted encounters are loaded into this system and assigned a unique claim identifier.
- **Missing Encounters** – As defined within the CMS *EQR Protocol 4 Validation of Encounter Data Reported by the MCO* (Protocol 4) document: Encounters that occurred but are not represented by an encounter record within the MMIS data warehouse data.
- **Mississippi Coordinated Access Network (MississippiCAN)** – The state of Mississippi's Medicaid managed care program. Effective July 1, 2014, the Mississippi DOM started a new contract with two CCOs, who are responsible for coordinating services for Mississippi Medicaid beneficiaries.
- **Monthly Encounter Record Total** – The sum of all encounter submissions for a given month stored in the FAC's encounter data warehouse.
- **Monthly Variance** – The difference between the monthly encounter total and the CDJ monthly reported total.

- **National Committee for Quality Assurance (NCQA)** – A non-profit organization dedicated to improving health care quality, which accredits health care organizations, and develops and maintains HEDIS measures.
- **Non-Emergency Transportation (NET)** – A ride, or reimbursement for a ride, provided so that a member with no other transportation resources can receive services from a medical provider. NET does not include emergency or ambulance transportation.
- **Per Member Per Month (PMPM)** – The amount paid to a CCO each month for each person for whom the CCO is responsible for providing health care services under a capitation agreement.
- **Potential Duplicate Encounter (PDUP)** – An encounter that Myers and Stauffer LC has identified as being a potential duplicate of another encounter in the FAC's data warehouse.
- **Protocol 4** – A Centers for Medicare & Medicaid Services (CMS)-developed, voluntary EQR protocol that is used to validate encounter data submitted to state Medicaid agencies by MCOs (or CCOs).
- **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 CCO paid under a capitated system and shares a portion of the CCO's capitated premium.
- **Subcontractor** – A vendor to whom the CCO has contractually delegated responsibility for the provision and oversight of approval, payment, and administration of medical services to the Medicaid CCOs plan members. Also known as a delegated vendor.
- **Surplus** – As defined within the Centers for Medicare & Medicaid Services (CMS) *EQR Protocol 4 Validation of Encounter Data Reported by the MCO* (Protocol 4) document: Encounter records which did not occur or which duplicated other records.
- **TCN (or ICN)** – Transaction (or Internal) Control Number or Transaction (or Internal) Claim Number, a numerical mechanism used to track health care claims and encounters.
- **Truven Health Analytics (Truven)** – Subcontractor to the state's fiscal agent contractor responsible for the encounter data warehouse.
- **UnitedHealthcare Community Plan (United or UHC)** – A CCO participating in the Mississippi Medicaid managed care program.
- **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.

Activity 1: Review State Requirements

DOM provides a set of requirements to each CCO that specifies the expected structure of the encounter data, submission times, error correction, and other related submission information. Activity 1 of the protocol allows for the state requirements to be reviewed in order to determine if additional or updated requirements are needed to ensure encounter data is complete and accurate.

The protocol suggests the following items are reviewed as part of Activity 1:

1) The state's requirements for collection and submission of encounter data by CCOs (these typically are specifications in the contracts between the state and the CCO).
2) The data submission format specified by the state for CCO use.
3) Requirements for the types of encounters that must be validated.
4) The state's data dictionary.
5) A description of the information flow from the CCO to the state, including the role of any contractors or data intermediaries.
6) State standards for encounter data completeness and accuracy.
7) A list and description of edit checks built into the state's MMIS that identifies how the system treats data that fails an edit check.
8) The timeframes for data submission.
9) Prior years' EQR report on validating encounter data (if available).
10) Any other information relevant to encounter data validation.[2]

Methodology

Detail was gathered from both the DOM website and DOM representatives to determine what information was necessary to complete this activity. Documents including contracts and companion guides were also obtained from DOM.

In addition to the on-site visits to United's Minnesota corporate offices and encounter data center, Myers and Stauffer also met with Conduent to discuss the encounter data submission process and their system capabilities.

Based on the information and documentation received, as well as the on-site visit to Conduent, DOM's data standards were reviewed for: completeness and accuracy; file transfer protocols; certification policies; collection and submission requirements; and processes, claims, and encounter submission requirements. We also reviewed the DOM-CCO contract in effect for the period under review, as well as the

[2] From *EQR Protocol 4 Validation of Encounter Data Reported by the MCO, Activity 1*

DOM-CCO proposed contract amendment dated March 20, 2017 for compliance with the encounter data requirements in the federal Medicaid Managed Care rule.[3]

State Requirements

1) *Claims and Encounters Standards:*
The claim processing timeliness standard requires that 90 percent of clean claims be paid within 30 calendar days from receipt, and 99 percent of clean claims be paid within 90 calendar days from receipt.

2) *Error Types, Acceptable Error Rates, and Data Element Validity Requirements:*
According to the contract between DOM and the CCOs, the acceptable encounter error rate is two percent, as measured by a comparison of encounters to cash disbursements. The CCOs are expected to submit 98 percent of all encounter data.

3) *Data Collection and Submission:*
According to the contract Section 10, sub-section R, item 3: "Encounter Records sent to DOM's Agent by the Contractor are considered acceptable when they pass all the Division's Agent's edits. Encounter Records that deny or suspend due to Division's Agent's edits are returned to the Contractor and the Contractor must make the requested corrections. The Contractor shall resubmit denied Encounter Records as a "new" Encounter Record if appropriate and within the defined timeframe referenced above. The Contractor shall correct and resubmit suspended Encounter Records as an adjustment within the time frame referenced above. Corrections and resubmissions must pass all edits before they are accepted by the Division's Agent."

   Submissions by the CCOs are required under CFR 438.606 to be certified by the CCO's CEO, CFO, or an individual who has delegated authority to sign for, and who reports to either. According to the contract: "The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the data and to the accuracy completeness and truthfulness of the documents. The Contractor must submit the certification in writing with the signature of the appropriate certifier, at the time the certified data, documents, reports, records, encounter data, or other information is submitted to the Division." Data transfers must occur using a secure and HIPAA-compliant FTP over a VPN connection.

4) *Conduent and Truven Health Analytics*
Conduent was the FAC for the Mississippi Medicaid program during the review period. Truven was the FAC subcontractor responsible for the encounter data warehouse. The Truven data warehouse was the source used by Myers and Stauffer for the encounter data. As the FAC, Conduent held responsibility for maintenance of the MMIS, adjudication of Medicaid fee-for-service (FFS) claims, and intake and storage (data warehouse) of the Mississippi Medicaid managed care encounter data. In accordance with EQR Protocol 4, Myers and Stauffer conducted a site visit on April 26, 2016 with staff members from Conduent and Truven to discuss the encounter

[3] U.S. Government Publishing Office, Electronic Code of Federal Regulations as of July 14, 2017, available at https://www.ecfr.gov/cgi-bin/text-idx?SID=5b6858ff72af7923d2556e76de6559f6&mc=true&node=pt42.4.438&rgn=div5#sp42.4.438.f

process and to gain an understanding of their systems and processes currently in place for the Mississippi Medicaid managed care program.

Findings

1) DOM encounter submission standards appear to be generally stated and could potentially be subject to interpretation. Developing standards specific to encounter data submissions may improve the quality of the encounter data and generate the accuracy and completeness required for DOM oversight and other analyses performed using the encounter data.

   For example, the contract contains language related to the frequency of encounter submissions. According to the contract Section 10, sub-section R: "The Contractor must submit complete, accurate, and timely Encounter Data to the Division that meets Federal requirements and allows the Division to monitor the program at least monthly following the month in which they were processed (paid or denied)." Under contract section 10, sub-section R, item 3: "All encounter records must be submitted and determined acceptable by the FAC on or before the last calendar day of the third month after the payment/adjudication calendar month in which the CCO paid/adjudicated the claim."

2) The contract between DOM and the CCOs sets forth a single 98 percent completeness standard and a single two percent error rate for all service types. EQR Protocol 4 guidelines recommend the states set specific standards for each service type to be reported.

3) The state's data dictionaries are similar to what Myers and Stauffer has observed in other states, however, there is an opportunity to enhance user friendliness, detail, and completeness. For example, Myers and Stauffer identified challenges with tracing some fields from the 837s and NCPDPs to their final location in the data warehouse. There was no document or crosswalk to show that mapping. To trace the data points, we had to specifically ask the state/Conduent about some fields. Oftentimes, the data dictionaries are machine generated from the database. The best examples seen in other states appear to be generated by a database administrator or an information technology (IT) professional.

4) The CCOs are not providing a formal attestation or certification to DOM related to encounter data submissions as required by their contracts. Federal regulation 42 CFR 438.606 requires that the entity attest to the accuracy, completeness, and truthfulness of each encounter data submission.

5) In April 2016, CMS issued a major update to the federal Medicaid Managed Care rules in 42 CFR 438. A key component of the rule is increased state and federal oversight in the form of monitoring and reporting. The rule requirements impact encounter data and are phased in over three years with many of the provisions becoming effective on or after July 1, 2017. The DOM proposed CCO contract amendment dated March 20, 2017 appears to include the necessary language to address the rule's encounter data requirements including direct reference to the specific regulatory section. The only issue identified is in Section 11 on Program Integrity on page 150 in Item 2:

   Data on the basis of which the State certifies the actuarial soundness of capitation rates to the Contractor under §438.3, including base data described in §438.5 (c) is generated by the Contractor.

The reference to actuarial soundness of the capitation rates is incorrectly cited as §438.3 of the rule. The correct reference is to §438.4.

We noted the following potential risk areas during the on-site visit to Conduent:

6) Encounters cannot be identified for all of the CCOs' delegated vendors. This poses challenges with reconciling encounters with CDJs.
7) Conduent has a file limitation of 1,000 claims per file. Conduent can process up to 48,000 claims per day, per CCO. This creates obstacles and potentially limits the ability of the CCOs to meet submission compliance standards, particularly when the CCOs have to submit or re-submit large batches of claims.
8) At the time of the Conduent on-site review, the diagnosis-related groups (DRGs) submitted by the health plans were not being saved or stored. DOM and Conduent worked to resolve this issue and a fix was implemented July 11, 2016.
9) Initial encounter reconciliation reviews identified an issue with claim adjustment reason (CAS) code differences and coordination of CAS codes with the CCOs. We found instances where the CCOs submitted a paid encounter with a CAS code that was processed by the FAC as CCO-denied. This suggested that the FAC's denial adjustment reason code (ARC) table may not contain the same CAS codes that the CCO is intending to use to identify denied encounters. DOM has been working with the CCOs and the FAC to review and update CAS codes to ensure CCO-denied encounters are processing correctly.
10) Under the current system, DOM and the FAC may not be capturing accurate encounter information on adjustments. There are claim adjustment instances in the encounters where the claim adjustment back out is successful, but the corresponding replacement transaction is denied by the FAC. This is creating a series of problems with the encounter data. First, these instances effectively remove paid encounters from the FAC's data warehouse that the CCO may have intended to replace. Additionally, when a CCO submits subsequent replacement transactions (to replace the encounter record), these are denied due to the original claim already having been removed. As a result, the CCO must send the transaction as a new, unrelated original encounter in order to have it accepted. This process can produce encounters that may not reflect the CCO's actual claim adjustment activity. DOM has been working with the FAC and the CCOs to resolve issues caused by incorrect CAS codes.
11) DOM has created a supplemental file on the claims/encounter side because the 835 does not give sufficient detail to allow the CCOs to identify the reason for denial. DOM essentially provides a type of crosswalk with details on the edits, so the CCOs can reconcile and better work the files. The MississippiCAN edits are sent weekly.
12) According to Conduent representatives, there is no oversight or quality assurance check performed on the Truven data warehouse standard reports that are submitted to the state (e.g., checking/verifying code, etc.).

Recommendations

1) DOM should update the standards and requirements specific to encounter data submission to include more details. This may include a specific day or date for submitting initial encounters. For

example, DOM may want to change the contract for submission standards to read that the CCO is required to submit encounter data within 60 days of claims payment (paid date). According to DOM representatives, this provision will be part of the next contract amendment.

2) With respect to service types, error types, and acceptable error rates, the EQR Protocol 4 encourages states to specify acceptable error rates for each encounter and error type as illustrated below.

Table 1: EQR Protocol 4 Potential Encounter and Error Types for Which Acceptable Error Rates May be Defined

Example Service Types	Error Type*	Acceptable Error Rate *(To Be Defined by State)*
Institutional Inpatient Institutional Outpatient	Missing, Surplus, Erroneous	< %
Behavioral Health	Missing, Surplus, Erroneous	< %
Professional	Missing, Surplus, Erroneous	< %
Vision	Missing, Surplus, Erroneous	< %
Dental	Missing, Surplus, Erroneous	< %
Prescription	Missing, Surplus, Erroneous	< %
Other Types of Encounters as Specified by the State (e.g., laboratory, physical therapy, office visit, etc.)	Missing, Surplus, Erroneous	< %

***** *See Glossary for definitions.*

3) DOM may wish to consider whether a database administrator or an IT professional could help develop more detailed data dictionaries that facilitate completeness and the ability to trace data from the 837s and NCPDPs to their final location in the data warehouse.

4) DOM should require a standard written attestation from the CCOs for all encounter data submissions. Even though this requirement is specified in the contract, interviews with CCO representatives indicated this does not occur as a regular practice. DOM should monitor encounter data submissions to ensure the attestation is included and completed by the appropriate CCO representatives.

5) DOM should fix the following reference in the proposed March 20, 2017 CCO contract language located in Section 11 on Program Integrity on page 150 in Item 2:

Data on the basis of which the State certifies the actuarial soundness of capitation rates to the Contractor under §438.3, including base data described in §438.5 (c) is generated by the Contractor.

The reference to actuarial soundness of the capitation rates is incorrectly cited as §438.3 of the rule. The correct reference is to §438.4.

6) DOM is currently working with the CCOs to determine whether the CCOs' claim numbers may be modified to include a prefix to denote the delegated vendors in the encounter data.

7) DOM and Conduent should explore whether expansion of Conduent's file and volume capacity is feasible or whether such a change would be cost prohibitive.

8) The FAC should capture and retain all encounter data as submitted by the CCOs.
9) DOM and the FAC should continue working with the plans to resolve all issues related to CAS codes.
10) DOM should evaluate whether the 835s could be modified to include sufficient information on denials to enable the CCO to reconcile and better work the files.
11) Conduent should implement a quality control system or method of checking the code and verifying the accuracy of the standard Truven data warehouse reports submitted to the state.

Activity 2: Review CCO's Capability

This activity assesses the ability of the CCO's information system and controls to collect and submit complete and accurate encounter data.

Methodology

A survey was developed, documentation requested, and on-site activities were performed at each CCO to assess their system capabilities.

The survey consisted of two parts. The first section requested information about the CCO, its parent company, and the local CCO environment, where applicable. Questions regarding encounter submissions, the Information System Capabilities Assessment (ISCA), and subcontractor relationships were included, as well as questions regarding any accreditation process. The CCO engaged a third party to perform an ISCA or a HEDIS Roadmap Assessment, which evaluates the systems within a health plan as part of the National Committee for Quality Assurance (NCQA) accreditation process. The second part of the survey included questions found in Appendix 5, Attachment B of CMS EQR Protocol 4, regarding claim types, code sets, enrollment systems, data systems, controls, and reporting mechanisms.

Requested documentation included work flows, policies, and procedures for handling encounter data, subcontractor information, key contacts, organization charts, and other related documents. The documentation was used to gain an understanding of the CCOs' processes and to determine the appropriate staff to interview and questions to ask during the on-site visit.

On-site activities were performed at the CCO encounter data center. DOM sent a notification letter to the CCO describing the activities and proposed dates for the on-site visit in January 2016. Planning conference calls were held during February and March 2016 to discuss logistics, questions, and other pre-visit activities.

On-site activities were conducted May 23 through 25, 2016 at UHC's corporate offices in Minnetonka, Minnesota. Individuals identified from the CCO's organization chart were interviewed and asked about encounter data operations. Additional individuals identified during the interview process were added to the list of interviewees. UHC personnel were readily available and provided a comprehensive view of their encounter data processes.

Based on UHC's responses to the Myers and Stauffer survey, the details provided on the ISCA, a review of the 2015 EQRO report, and on-site interviews, there were no significant issues or concerns noted by Myers and Stauffer pertaining to the overall ability of UHC's systems to produce accurate and complete encounter data. Our findings in this area were consistent with the 2015 EQRO review conducted by the Carolinas Center for Medical Excellence.

Findings

1) Control totals are not sent to the FAC by UHC to ensure the number of encounters submitted in the files are correctly received and loaded by the FAC. Additionally, UHC receives acknowledgment of the files from Conduent, but no control totals.
2) Dashboards containing operational metrics used to meet state reporting requirements are automatically refreshed when the data warehouse is refreshed and new claims are accepted from the claims processing system. During the on-site interviews, UHC personnel indicated many reports are automated and a quality assurance check is not completed on report creation.
3) UHC representatives noted that UHC completes high-level audits of delegated vendors, however, there is no auditing of delegated vendors on a claim detail level.
4) There is limited oversight and validation of subcontractor encounter data. Often, the data is passed through UHC to Conduent via automated processes with minimal checks for completion or subsequent validation by UHC.

Recommendations

1) The CCO should modify their processes, as necessary, to ensure all data files, especially subcontractor data files, are complete. This may include, but not be limited to, exchange of control totals for both inbound and outbound subcontractor files. Additionally, control totals should also be exchanged between the FAC and the CCO.
2) A quality assurance process should be developed to ensure all updated data from the dashboards gets reflected in the reports prepared for and submitted to DOM.
3) UHC should evaluate the benefits of conducting a more comprehensive audit of delegated vendors by including audits at the claim level detail as part of the audit process.
4) The Medicaid Managed Care Final Rule imposes the same expectations for subcontractor encounter data as it does for the CCO. Accordingly, the CCO needs to hold the subcontracted vendors accountable to the required encounter data submission standards.

Activity 3: Analyze Electronic Encounter Data

This activity is the core process to determine the validity of the encounter data. It is designed to assist the state in determining whether the data can be used for additional analysis, including Activity 4: Medical Record Review.

The Activity is comprised of four steps:

1) Developing a quality test plan;
2) Verifying the integrity of the CCO encounter data files;
3) Generating and reviewing analytic reports; and
4) Comparing findings to State-identified standards.

Step 1: Test Plan

The testing plan for MississippiCAN encounter data encompassed testing all service types since Activity 3 had not been performed previously on the Mississippi Medicaid encounter data. CHIP data was excluded from testing due to the encounter submissions provided to the FAC from the CCO being incomplete.

Calendar year 2015 encounter data and CDJs were utilized in performing the encounter data testing and analysis. Additionally, two distinct measurement sample periods were selected by Myers and Stauffer and approved by DOM for use in testing; January 1, 2015 through January 31, 2015 and October 1, 2015 through October 31, 2015. Cash disbursement journals were submitted by the CCO and its subcontractors, and encounter data was provided by the FAC. The CCO and subcontractors were instructed to include all claims payments, adjustments, or voids made during the 2015 calendar year related to MississippiCAN, excluding any sub-capitated amounts in the CDJ. The detailed 2015 CDJs were submitted on a monthly basis to Myers and Stauffer. The 2015 encounter data provided by the FAC contains all encounters submitted by the CCO to the FAC regardless of whether the encounter was paid or denied. The CCO submitted claims data extracts, based on paid (adjudication) date, from its claims processing systems and from each subcontracted vendor's claims processing systems for the sample months. Each extract included the following service types covered under the Mississippi Medicaid program for the sample periods: outpatient institutional, professional, pharmacy, and dental claims. All encounter types processed within the CCO or subcontractor's claims processing system (e.g., paid, denied, adjusted, subcontracted vendor, sub-capitated provider, etc.) were included in the extract. Inpatient institutional claims are not included in the sample testing of this report, as inpatient services were carved during December 2015.

The cumulative 2015 totals from the CDJs and encounter data were used to test the completeness of the encounter data. The samples were utilized to test the quality of the encounter data received from the FAC at a claim (header) or a line level of detail for both completeness and accuracy. The sample testing was based on receiving a full set of claims data for the testing period from the CCO to determine missing, surplus, and erroneous encounters contained within the FAC encounter data by comparing the claims data set to the FAC encounter data.

Step 2: Verifying the Integrity of the CCO Encounter Data Files

Verifying the integrity of the CCO encounter data files requires verifying both the completeness of the encounter data and the accuracy of the encounter data.

Verification of Completeness

In determining the completeness of the encounter data, DOM's contract with the CCO stipulates the CCO is required to submit 98 percent of all encounter data, including those of subcontractors or delegated vendors, and the percentage completion will be validated by utilizing the CDJs of the CCO and its subcontractors. Myers and Stauffer performs a bi-monthly reconciliation of the CDJ to the FAC encounter data on DOM's behalf to measure the encounter data completeness. The contract between DOM and the CCO does not stipulate the measurement period required to be utilized to measure compliance nor does it stipulate if the percentage should be measured by service type, or if a separate measurement should be applied by subcontractor. The bi-monthly reconciliation report reflects 24 months of data with monthly, as well as cumulative totals, and contains a separate report for each subcontractor, if identifiable.

Completeness of encounter data can also be measured based on the number of encounters to ensure denials, resubmissions, and zero pay encounters related to sub-capitated providers are included in the encounter data in addition to paid encounters. However, because this methodology does not focus on CCO payments, which is necessary when utilizing the encounter data for the establishment of future capitation rates, DOM uses the CDJ reconciliation methodology. Also, the risk of missing zero pay encounters related to sub-capitated providers does not exist in this instance, as the CCO does not contract with sub-capitated providers.

For the purposes of the EQR Protocol 4 report, CY 2015 CDJs and encounters are included in the completeness measurement from the Encounter Data Validation Report issued March, 2017. As demonstrated in the completion percentages in the following tables, the encounter payments are in excess of the total cash disbursements for the dental service type (113.18 percent), which may indicate the CDJs are understated if the FAC encounters are valid.

Table 2: Cumulative Completeness Percentage by Service Type for Calendar Year 2015

Paid Amount based on Encounter Data Validation (EDV) March 2017 Report			
Service Type	**Total CDJ Paid Amount**	**Total Encounter Paid Amount**	**Cumulative Completeness Percentage**
Institutional/Professional	$ 366,031,625	$ 360,565,484	98.50%
Dental	$ 31,614,693	$ 35,781,840	113.18%
Pharmacy	$ 179,411,342	$ 178,806,675	99.66%
Total	$ 577,057,659	$ 575,153,999	99.67%

**May not sum due to rounding.*

Completeness of the two months of sample data received from the CCO was also measured based on a comparison of the sample data payments segregated by medical (institutional and professional), dental, and pharmacy claims to the CDJ for the sample months. This comparison was originally performed to es-

tablish whether the quality of the encounter data for the sample periods was sufficient to continue with Activity 4, the medical records review. However, after conversation with DOM, it was determined necessary to proceed with the medical record review regardless of the completeness or accuracy percentages contained in Activity 3. This was done to assess the adequacy of the medical record documentation required by the CCO and maintained by the providers. See Table 3 below for the January and October completeness percentages.

Table 3: Completeness Percentage by Service Type for Sample Periods

Paid Amount based on Encounter Data Validation (EDV) March 2017 Report					
Service Type	**Total Sample Paid Amount Matched by ICN to Encounter Data**	**Total Paid Amount Change based on EDV Logic**	**Total Paid Amount**	**Total CDJ Paid Amount Per EDV Report**	**Completeness Percentage**
Outpatient/ Professional*	$ 61,844,950	$ (7,848,300)	$53,996,650	$ 59,542,115	91%
Dental	$ 4,623,827	$ (1,976,181)	$ 2,647,646	$ 5,615,640	47%
Pharmacy	$ 29,891,675	$ (1,937,659)	$27,954,017	$ 27,059,839	103%

**Inpatient services were not available during the sample periods.*

It is important to note the encounter paid amounts used in comparison of the CCO and subcontractor CDJs are adjusted in some instances to account for errors noted in analyzing the encounter data during the bi-monthly encounter data verification performed by Myers and Stauffer. Payment adjustments are made for items such as denied claims reflecting a paid amount in the encounter data (possibly due to shadow pricing), adjustment credit encounters reflecting a debit payment rather than a credit adjustment, and duplicate encounters noted within the encounter data. As reflected in the table above, the sample paid claim amounts submitted by the CCOs for January and October were adjusted by $7,848,300 for outpatient and professional claims, $1,976,181 for dental claims, and $1,937,659 for pharmacy claims.

Verification of Accuracy

For the purpose of verifying the integrity of the FAC encounter data, the claims data from the two sample periods of January and October 2015 were compared with the encounter data for key data components chosen for testing. The MMIS Internal Control Number (ICN) field and the Transaction Control Number (TCN) field were utilized as the unique identifiers (IDs) in the comparison of the CCO claims data and FAC encounter data for all service types. This unique ID is populated by the FAC and communicated to the CCO in the X12 835 response file and serves as the link between the data sets. The EQR Protocol 4 guidelines require the EQRO to verify the accurate incorporation of the state's IDs into the CCO information system. The use of other identifiers such as a CCO claim number or account number can result in multiple encounters matching one claim number, which eliminates the uniqueness of the ID. Additionally, CCO claim numbers may not be unique between all CCOs in the state.

Key data elements were measured on either a claim (header) or a line level of detail, depending on the characteristic of the element. This approach causes the number of data elements tested to vary by key element. For key data elements such as diagnosis code or tooth number, there may be multiple items to

test for one MMIS_ICN number. The individual key data element error and missing rates are calculated based on the number of items in the sample excluding claims which have no value for the key data element for data elements tested at the line level. For header key data elements, claims with missing header elements are included in the error rate because all header elements are required. An exception, is the former MMIS claim ICN, which is tested at the header level, but not required on each claim since it would only be applicable to replacement or adjustments. Therefore, the total sample is limited to the claims with values. However, in calculating the surplus, all surplus claims were considered surplus, which causes an unusually high surplus percentage for the data element.

Valid Value Testing

Analysis was performed to determine the validity for key data element values in the encounter data for the paid months of January and October 2015.

Testing Assumptions:

1) All encounters contained in the FAC data warehouse for the paid months of January and October 2015, were included.
2) The claims were divided into the following service types:
    a. Outpatient institutional, professional, dental, and pharmacy.
    b. Inpatient institutional claims are not included in this report, as inpatient services were carved in during December 2015.
3) Key data elements were reviewed based on frequency of invalid and null values.
    a. Reference *Table 4a*: *Key Data Element Valid Values Criteria by Service Type* for testing criteria defined for each key data element and service type.
4) Performed other consistency checks, such as verifying key data elements contain expected values in the correct format and specificity, and values were consistent across elements.

Findings

The following table outlines all key data elements tested and the error rates reported based on validity and null values by service type.

Table 4a: Key Data Element Valid Values Criteria by Service Type

Valid Values Criteria					
Key Data Element	**Header/Line Level**	**Outpatient**	**Professional**	**Dental**	**Pharmacy**
Type of Bill	Header Level	Character value defined on UB92/UB0404 claim form			
Former MMIS Claim ICN	Header Level	Character value of length 17 with leading zeros	Character value of length 17 with leading zeros	Character value of length 17 with leading zeros	
Header First DOS	Header Level	Valid date value > 1/1/2000	Valid date value > 1/1/2000		
Header Last DOS	Header Level	Valid date value > 1/1/2000	Valid date value > 1/1/2000		
Header Paid Amount	Header Level	Numeric value with two decimal places	Numeric value with two decimal places		
MMIS ICN	Header Level	Character value of length 17 with leading zeros	Character value of length 17 with leading zeros	Character value of length 17 with leading zeros	Character value of length 17 with leading zeros
MMIS Member Number	Header Level	Character value of length 14 with leading zeros	Character value of length 14 with leading zeros	Character value of length 14 with leading zeros	Character value of length 14 with leading zeros
Billing Provider NPI	Header Level	Character value of length 10	Character value of length 10	Character value of length 10	Character value of length 10
Service/ Rendering Provider NPI	Header Level	Character value of length 10	Character value of length 10	Character value of length 10	Character value of length 10
Service Provider Taxonomy	Header Level	Taxonomy code of length 10	Taxonomy code of length 10		
Place of Service	Header Level		Valid CMS POS value	Valid CMS POS code value	
Provider Specialty Code	Header Level			No data to test	
Plan Paid Date	Header Level	Valid date value > 1/1/2000	Valid date value > 1/1/2000	Valid date value > 1/1/2000	Valid date value > 1/1/2000
Plan Received Date	Header Level	Valid date value > 1/1/2000	Valid date value > 1/1/2000	Valid date value > 1/1/2000	Valid date value > 1/1/2000
Diagnosis Codes	Header Level	Valid ICD-9-CM or ICD-10-PCS code	Valid ICD-9-CM or ICD-10-PCS code		
Surgical Procedure Codes	Header Level	Valid ICD-9-CM or ICD-10-PCS code	Valid ICD-9-CM or ICD-10-PCS code		
Plan Paid Amount	Line Level	Numeric value with two decimal places	Numeric value with two decimal places	Numeric value with two decimal places	Numeric value with two decimal places
Procedure Code	Line Level	Valid CPT-4 code	Valid CPT-4 code	Valid CPT-4 code	
Procedure Modifiers	Line Level	Valid Level I (AMA) or Level II (CMS) code	Valid Level I (AMA) or Level II (CMS) code		

Valid Values Criteria					
Key Data Element	**Header/Line Level**	**Outpatient**	**Professional**	**Dental**	**Pharmacy**
Revenue Code	Line Level	Character value defined on UB92/UB04 claim form			
Billed Charges	Line Level	Numeric value with two decimal places	Numeric value with two decimal places	Numeric value with two decimal places	
Line FDOS	Line Level	Valid date value > 1/1/2000	Valid date value > 1/1/2000	Valid date value > 1/1/2000	
Line LDOS	Line Level	Valid date value > 1/1/2000	Valid date value > 1/1/2000		
Tooth Numbers	Line Level			Valid ADA System code	
Tooth Surfaces	Line Level			Valid ADA System code	
Date Filled	Line Level				Valid date value > 1/1/2000
Days Supply	Line Level				Numeric value with no decimal places
Dispensed Units	Line Level				Numeric value
NDC	Line Level				Character value of length 11
Refill Number	Line Level				Numeric value with no decimal places
Prescription Number	Line Level				Numeric value with no decimal places

Table 4b: Key Data Element Valid Values Error Rates by Service Type

Error Rate									
		Outpatient		**Professional**		**Dental**		**Pharmacy**	
Key Data Element	**Header/ Line Level**	**Invalid**	**Null**	**Invalid**	**Null**	**Invalid**	**Null**	**Invalid**	**Null**
Type of Bill	Header Level	0.0%	0.0%						
Former MMIS Claim ICN	Header Level	0.0%	N/A	0.0%	N/A	0.0%	N/A		
Header First DOS	Header Level	0.0%	0.0%	0.0%	0.0%				

Error Rate									
		Outpatient		Professional		Dental		Pharmacy	
Key Data Element	Header/ Line Level	Invalid	Null	Invalid	Null	Invalid	Null	Invalid	Null
Header Last DOS	Header Level	0.0%	0.0%	0.0%	0.0%				
Header Paid Amount	Header Level	0.0%	0.0%	0.0%	0.0%				
MMIS ICN	Header Level	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
MMIS Member Number	Header Level	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Billing Provider NPI	Header Level	0.0%	0.2%	0.0%	0.0%	No data to test		100.0%	0.0%
Service/ Rendering Provider NPI	Header Level	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Service Provider Taxonomy	Header Level	0.0%	0.0%	0.0%	0.0%				
Place of Service	Header Level			0.0%	0.0%	0.0%	0.0%		
Provider Specialty Code	Header Level					No data to test			
Plan Paid Date	Header Level	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Plan Received Date	Header Level	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Diagnosis Codes	Header Level	0.0%	0.0%	0.0%	100.0%				
Surgical Procedure Codes	Header Level	No data to test		No data to test					
Plan Paid Amount	Line Level	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Procedure Code	Line Level	0.0%	N/A	0.0%	0.0%	0.0%	0.0%		
Procedure Modifiers	Line Level	0.0%	N/A	0.0%	N/A				
Revenue Code	Line Level	0.0%	0.0%						
Billed Charges	Line Level	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
Line FDOS	Line Level	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
Line LDOS	Line Level	0.0%	0.0%	0.0%	0.0%				
Tooth Numbers	Line Level					0.1%	N/A		
Tooth Surfaces	Line Level					0.0%	N/A		
Date Filled	Line Level							0.0%	0.0%
Days Supply	Line Level							0.0%	0.0%

Error Rate										
		Outpatient		Professional		Dental		Pharmacy	
Key Data Element	Header/ Line Level	Invalid	Null	Invalid	Null	Invalid	Null	Invalid	Null
Dispensed Units	Line Level	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	0.0%	0.0%
NDC	Line Level	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	0.0%	0.0%
Refill Number	Line Level	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	0.0%	0.0%
Prescription Number	Line Level	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	0.0%	0.0%

1) **Outpatient and Professional Key Data Elements:** The Principal Diagnosis Code for professional claims is null 100 percent of the time, however the Diagnosis Code 1 data element is populated with valid values.

2) **Dental Key Data Elements:** The Tooth Numbers data element had a 0.1 percent invalid error rate identified.

3) **Pharmacy Key Data Elements:** Billing Provider NPI reflected a 100 percent invalid error rate because the field does not contain an NPI number. All values are length of five and six instead of the required ten character length. In addition the Plan Received date had a 100 percent invalid error date due to the field being populated with a date of 01/01/0001.

Recommendations

1) Conduent should ensure that all values submitted are valid and at a minimum report these errors to allow for corrections when necessary.

Key Data Elements Matching

Table 5: Data Elements and Matching Error Rate by Service Type displays each key data element and error rate by service type. Additionally, *Table 6: Number of Data Elements and Matching Error Rate by Service Type* displays the number of data elements tested as well and the number of errors by service type. The error rates were segregated to reflect the following:

- Missing: Claims included in the sample that are not present in FAC encounter data.
- Surplus: Encounters present in the FAC, based on adjudication date, which were not included in the claims data sample.
- Erroneous: FAC encounters that are represented in the claims sample data that contain incorrect data elements based on comparison with the sample claims data.

The error rates were calculated and shown in total for the sampled months of January and October 2015.

Table 5: Data Elements and Matching Error Rate by Service Type

Error Rate													
		Outpatient			Professional			Dental			Pharmacy		
Key Data Element	Header/ Line Level	Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous
Type of Bill	Header Level	0%	15%	6%									
Former MMIS Claim ICN	Header Level	0%	76%	0%	0%	52%	0%	0%	108%	0%			
Header First DOS	Header Level	0%	15%	1%	0%	21%	0%	0%	109%	1%			
Header Last DOS	Header Level	0%	15%	1%	0%	21%	1%						
Header Paid Amount	Header Level	0%	15%	78%	0%	21%	76%						
MMIS ICN	Header Level	0%	15%	0%	0%	21%	0%	0%	109%	0%	1%	26%	0%
MMIS Member Number	Header Level	0%	15%	0%	0%	21%	0%	0%	109%	0%	1%	26%	0%
Billing Provider NPI	Header Level	0%	15%	71%	0%	21%	81%	0%	109%	71%	1%	26%	99%
Service/Rendering Provider NPI	Header Level	0%	15%	100%	0%	21%	100%	0%	109%	63%	1%	26%	1%
Service Provider Type	Header Level	0%	15%	13%	0%	21%	26%						
Place of Service	Header Level				0%	21%	0%	0%	109%	3%			
Provider Specialty Code	Header Level							No data to test					
Plan Paid Date	Header Level	0%	15%	4%	0%	21%	4%	0%	109%	0%	1%	26%	0%

Error Rate													
		Outpatient			Professional			Dental			Pharmacy		
Key Data Element	Header/ Line Level	Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous
Plan Received Date	Header Level	0%	15%	0%	0%	21%	0%	0%	109%	0%	1%	26%	99%
Diagnosis Codes	Header Level	0%	15%	0%	0%	21%	0%						
Surgical Procedure Codes	Header Level	No data to test											
Plan Paid Amount	Line Level	0%	13%	97%	0%	14%	95%	0%	124%	99%	1%	26%	94%
Procedure Code	Line Level	0%	15%	0%	0%	19%	1%	0%	124%	9%			
Procedure Modifiers	Line Level	0%	15%	18%	0%	19%	14%						
Revenue Code	Line Level	0%	15%	0%									
Billed Charges	Line Level	0%	15%	5%	0%	20%	5%	0%	124%	9%			
Line FDOS	Line Level	0%	15%	0%	0%	19%	1%						
Line LDOS	Line Level	0%	15%	1%	0%	19%	1%						
Tooth Numbers	Line Level							0%	127%	10%			
Tooth Surfaces	Line Level							0%	135%	61%			
Date Filled	Line Level										1%	26%	0%

Error Rate													
		Outpatient			Professional			Dental			Pharmacy		
Key Data Element	Header/ Line Level	Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous
Days Supply	Line Level										1%	26%	3%
Dispensed Units	Line Level										1%	26%	3%
NDC	Line Level										1%	26%	0%
Refill Number	Line Level										1%	26%	29%
Prescription Number	Line Level										1%	26%	0%
Overall Error Rate		0%	15%	12%	0%	20%	13%	0%	118%	26%	1%	26%	25%

[1] *"Missing" encounters may include instances in which CHIP claims were presented by the CCO as CAN claims within the sample dataset and may result in inflated counts and percentages.*

Table 6: Number of Data Elements and Matching Error Rate by Service Type

Number of Data Elements																	
		Outpatient				Professional				Dental				Pharmacy			
Key Data Element	Header/ Line Level	Total Elements Sampled	Missing[1]	Surplus	Erroneous	Total Elements Sampled	Missing[1]	Surplus	Erroneous	Total Elements Sampled	Missing[1]	Surplus	Erroneous	Total Elements Sampled	Missing[1]	Surplus	Erroneous
Type of Bill	Header Level	76,476	18	11,230	4,463												
Former MMIS Claim ICN	Header Level	7,530	18	5,704	-	48,705	69	25,224	1	22,727	6	24,589	-				
Header First DOS	Header Level	77,257	18	11,230	781	432,893	69	91,457	841	41,597	6	45,192	388				
Header Last DOS	Header Level	77,254	18	11,230	778	432,880	69	91,457	2,336								
Header Paid Amount	Header Level	76,476	18	11,230	60,022	432,053	69	91,457	327,365								
MMIS ICN	Header Level	76,476	18	11,230	-	432,053	69	91,457	-	41,209	6	44,785	-	350,866	3,201	92,865	-
MMIS Member Number	Header Level	76,476	18	11,230	28	432,053	69	91,457	219	41,209	6	44,785	23	350,866	3,201	92,865	108
Billing Provider NPI	Header Level	76,476	18	11,230	54,162	432,053	69	91,457	351,261	41,209	6	44,785	29,234	350,866	3,201	92,865	347,665
Service/ Rendering Provider NPI	Header Level	76,476	18	11,230	76,445	432,053	69	91,457	431,984	41,209	6	44,785	26,064	350,866	3,201	92,865	3,760
Service Provider Type	Header Level	76,476	18	11,230	10,144	432,053	69	91,457	114,006								

Number of Data Elements																	
		Outpatient				Professional				Dental				Pharmacy			
Key Data Element	Header/ Line Level	Total Elements Sampled	Missing[1]	Surplus	Erroneous	Total Elements Sampled	Missing[1]	Surplus	Erroneous	Total Elements Sampled	Missing[1]	Surplus	Erroneous	Total Elements Sampled	Missing[1]	Surplus	Erroneous
Place of Service	Header Level					432,844	69	91,457	791	41,209	6	44,785	1,325				
Provider Specialty Code	Header Level									No data to test							
Plan Paid Date	Header Level	76,729	18	11,230	2,728	432,853	69	91,457	15,702	41,209	6	44,785	-	350,866	3,201	92,865	1,638
Plan Received Date	Header Level	76,476	18	11,230	-	432,053	69	91,457	-	41,209	6	44,785	8	350,866	3,201	92,865	347,665
Diagnosis Codes	Header Level	76,476	18	11,230	-	432,053	69	91,457	2								
Surgical Procedure Codes	Header Level	No data to test															
Plan Paid Amount	Line Level	220,542	11	28,540	214,652	592,646	2	81,281	563,523	125,623	20	155,616	124,545	350,866	3,201	92,865	330,194
Procedure Code	Line Level	349,385	70	52,158	1,594	860,914	134	164,739	5,811	139,221	36	172,905	13,010				
Procedure Modifiers	Line Level	345,293	70	52,158	63,457	860,651	134	164,739	123,111								
Revenue Code	Line Level	409,643	85	61,119	1,973												
Billed Charges	Line Level	408,991	84	61,086	20,606	813,867	133	161,813	41,112	138,993	36	172,890	13,068				
Line FDOS	Line Level	409,805	85	61,119	1,973	851,052	134	164,739	5,811								
Line LDOS	Line Level	409,618	85	61,119	4,111	850,929	134	164,739	8,786								

Number of Data Elements																	
		Outpatient				Professional				Dental				Pharmacy			
Key Data Element	Header/ Line Level	Total Elements Sampled	Missing[1]	Surplus	Erroneous	Total Elements Sampled	Missing[1]	Surplus	Erroneous	Total Elements Sampled	Missing[1]	Surplus	Erroneous	Total Elements Sampled	Missing[1]	Surplus	Erroneous
Tooth Numbers	Line Level									45,275	18	57,310	4,725				
Tooth Surfaces	Line Level									12,770	2	17,236	7,742				
Date Filled	Line Level													350,866	3,201	92,865	-
Days Supply	Line Level													350,866	3,201	92,865	10,247
Dispensed Units	Line Level													350,880	3,201	92,878	10,931
NDC	Line Level													350,866	3,201	92,898	97
Refill Number	Line Level													350,481	3,201	92,865	100,362
Prescription Number	Line Level													350,866	3,201	92,865	1,175
Total		3,480,331	724	517,763	517,917	10,066,658	1,568	2,024,758	1,992,662	814,669	166	959,233	220,132	4,560,887	41,613	1,207,291	1,153,842

[1] *"Missing" encounters may include instances in which CHIP claims were presented by the CCO as CAN claims within the sample dataset and may result in inflated counts and percentages.*

Findings

1) **Measuring Completeness:** The contract between DOM and the CCO does not stipulate the measurement period required to be utilized to measure compliance with the 98 percent encounter submission minimum, nor does it stipulate if the percentage should be measured by service type, or if a separate measurement should be applied by subcontractor.

2) **Surplus Encounters (All Service Types):** Surplus encounters across all service types are an area of concern in the FAC encounter data based on the claim set submitted by the CCO for the sample months of January and October 2015. Surplus encounters, based on number of encounters, range from 26 percent for pharmacy, 15 percent for outpatient, 20 percent for professional, and 118 percent for dental. The surplus encounters, based on paid amounts and number of encounters, are summarized by encounter and service type below.

   The paid amount for outpatient/professional and pharmacy is at the header level. Therefore, the total surplus of 102,687 for outpatient/professional and 92,865 for pharmacy represents the number of surplus encounters for these two service types. For dental claims, the paid amount is reflected at the line level. The 155,616 surplus paid amount data elements represent 44,785 surplus dental encounters. The total number of surplus encounters and surplus percentage by service type are also reflected above in *Table 5: Data Elements and Matching Error Rate by Service Type* and *Table 6: Number of Data Elements and Matching Errors by Service Type*.

Table 7: Encounter Surplus Reconciliation

Description	Service Type					
	Outpatient/Professional		Dental		Pharmacy	
	Number of Data Elements	Paid Amount	Number of Data Elements	Paid Amount	Number of Data Elements	Paid Amount
Total Encounter Paid Amount	611,129	$ 77,447,146	281,219	$ 13,396,801	440,530	$ 37,938,101
Encounter Paid Amount for Claims Matched to Sample by ICN	508,442	$ 61,844,950	125,603	$ 4,623,827	347,665	$ 29,891,675
Surplus at Encounter Paid Amounts	**102,687**	**$ 15,602,196**	**155,616**	**$ 8,772,974**	**92,865**	**$ 8,046,426**
Surplus by Encounter Type						
Final	17,891	$ 2,140,985	1,933	$ 95,354	78,331	$ 6,689,956
Duplicate	61,963	$ 9,795,240	152,636	$ 8,632,919	2	$ 1,540
Void	18,898	$ 3,251,991	179	$ (12,724)	3,738	$ 345,159
Denied	2,711	$ 2,674	838	$ 54,843	325	$ 145,422
Replaced	777	$ 36,328	30	$ 2,582	10,467	$ 863,448
Unidentified	447	$ 374,977	-	$ -	2	$ 901
Total Surplus	**102,687**	**$ 15,602,196**	**155,616**	**$ 8,772,974**	**92,865**	**$ 8,046,426**

Description	Service Type					
	Outpatient/Professional		Dental		Pharmacy	
	Number of Data Elements	Paid Amount	Number of Data Elements	Paid Amount	Number of Data Elements	Paid Amount
EDV Adjustments		$ (9,939,834)		$ (5,062,327)		$ (838,180)
Surplus at EDV Paid	102,687	$ 5,662,363	155,616	$ 3,710,646	92,865	$ 7,208,246

3) The dollar impact of the surplus encounters for outpatient/professional, dental, and pharmacy encounters is less significant after payment adjustments are made for errors related to duplicates, voids, denials, and replacements as explained above in Table 3: Completeness Percentage by Service Type for Sample Periods. Because the majority of the surplus encounters relate to these non-final (void, replaced, denied) encounter types which require adjustment to the raw encounter data paid amounts, the surplus encounters paid amounts would be adjusted by $9,939,834 for outpatient/professional encounters, $5,062,327 for dental encounters, and $838,180 for pharmacy encounters for the two sample months, if the encounter data validation logic is applied to the surplus encounters. The adjusted surplus based on paid amounts is: $5,662,363 for outpatient/professional encounters; $3,710,646 for dental encounters; and $7,208,246 for pharmacy encounters. Although there were non-final encounter types included in the CCO's two months of sample claims data, the claims sample was primarily comprised of final claims. The surplus could be overstated for any of the service types if the CCO didn't provide a complete claim set for the January and October 2015 sample months.

4) As identified in *Table 3: Completeness Percentage by Service Type for Sample Periods* on page 21, the 2015 annual completion percentage for dental claims is 113.18 percent which may signify inaccurate CDJ information supplied by UHC.

5) **Outpatient Key Data Elements:** The overall missing, surplus, and error rates related to outpatient encounters in the two sample months of January and October 2015 were 0 percent, 15 percent, and 12 percent, respectively. Header Paid Amount, Billing Provider NPI, and Service/Rendering Provider NPI experienced the highest error rates of 78 percent, 71 percent, and 100 percent respectively, for the key data elements. Billing Provider and Service/Rendering Provider NPI values are reflecting a high error rate due to the sample not containing values to test. There were 47,729 of the Billing Provider fields and 48,984 of the Service/Rendering Provider NPI fields out of the total sample of 76,476 claims that were blank. These blank fields are included as errors due to the field being a required value. The encounter data reflected values for these fields for all but 17 encounters. The Header Paid Amount's 78 percent error rate is primarily attributable to the CCO submitting payment amounts as whole dollars (no cents) in the sample. 58,083 of the 60,022 payment errors noted had variances less than $1, which are most likely due to the rounded sample value payments provided by the CCO. The remaining 1,939 of the 60,022 errors were due to either negative rounded dollar payment amounts in the sample with corresponding positive payments with dollars and cents in the encounter data or had a variance larger than $1, and could not be explained. Plan Paid Amount, tested at the line level, reflected an error rate of 97 percent. This error rate is partially attributable to the sample payment amounts being submitted in whole dollars values. However, there are additional issues noted when comparing the line

level detail paid amounts with the header paid amount which are not explained by rounding. Based on conversations with DOM and the FAC, the line level payments are not reliable, as the 97 percent error rate reflects.

The Service Provider Type is not a required field on the claim form, but is utilized by some CCOs or Medicaid agencies to apply edits for servicing/rendering physicians billing for codes outside of the physician's designated specialty based on the specialty codes the physician registers when applying for a National Provider Identification (NPI) number. The codes are updated twice a year by the National Uniform Claim Committee. The service provider specialty taxonomy contains more than one taxonomy per Medicare specialty code. For the purposes of the key data element testing the Service Provider Type was tested at the taxonomy code level of specificity.

6) **Professional Key Data Elements:** The overall missing, surplus, and error rates related to professional encounters in the two sample months of January and October 2015 were 0 percent, 20 percent, and 13 percent, respectively. Header Paid Amount, Billing Provider NPI, and Service/Rendering Provider NPI experienced the highest error rates of 76 percent, 81 percent, and 100 percent respectively, for the key data elements. Billing Provider and Service/Rendering Provider NPI values are reflecting a high error rate due to the sample not containing values to test. There were 299,376 of the Billing Provider fields and 431,984 of the Service/Rendering Provider NPI fields out of the total sample of 432,053 claims that were blank. These blank fields are reported as errors due to the field being a required value. The encounter data reflected values for these fields all claims. The Header Paid Amount's 76 percent error rate is primarily attributable to the CCO submitting rounded whole dollar payment values as whole dollars (no cents) in the sample rather than the actual payment. There were 317,722 errors with a variance of less than $1 each. Key data elements amounting to 9,643 of the 327,365 errors contained either negative rounded dollar payment amounts in the sample with corresponding positive payments with dollars and cents in the encounter data or had a variance larger than $1. Plan Paid Amount, tested at the line level, reflected an error rate of 95 percent. This error rate is partially attributable to the sample payment amounts being submitted in whole dollar values. However, there are additional issues noted when comparing the line level Detail Paid Amounts with the Header Paid Amount which not explained by rounding. Based on conversations with DOM and the FAC, the line level payments are not reliable, as the 95 percent error rate reflects.

   The Service Provider Type was tested for professional claims using the same methodology as the outpatient claims.

7) **Dental Key Data Elements:** The overall missing, surplus, and error rates related to dental encounters in the two sample months of January and October 2015 were 0 percent, 118 percent, and 26 percent, respectively. Billing Provider and Service/Rendering Provider NPI values are reflecting error rates of 71 percent and 63 percent due the value of '88888888888' being reported in the sample data or the value is null. There were 16,202 errors related to the inclusion of '88888888888' in the sample data and an additional 11,310 errors are due to no value being reflected in the sample out of the 29,234 total errors noted in the Billing Provider field. 23,097 of the 26,064 errors for the Service/Rendering Provider NPI data element are due to the '88888888888' value being present in the sample data. The Plan Paid Amount's error rate of 99 percent is partially attributable to the CCO submitting values as whole dollars (no cents) for amounts reported in the sample. However, the variance of $2,404,679 between total Plan Paid Amount, matching on MMIS_ICN/TCN_NUM, in the sample of $6,843,410 and the encounter data total of

$4,438,731 cannot be explained merely by rounding differences. Tooth Surfaces experienced an error rate of 61 percent due to the encounter data storing up to five fields for tooth surfaces, compared to the sample reporting only one tooth surface.

8) **Pharmacy Key Data Elements:** The overall missing, surplus, and error rates related to pharmacy encounters in the two sample months of January and October 2015 were one percent, 26 percent, and 25 percent, respectively. The Billing Provider NPI reflects an error rate of 99 percent, this is due to the provider numbers in the encounter data reported as five digits and reported as 10 digits in the sample data. The Plan Received Date has dates reported in the encounter data as 0001-01-01 thus causing an error rate of 99 percent. Plan Paid Amount, tested at the line level, reflected an error rate of 94 percent. 329,879 of the 330,194 errors resulted in less than $1 difference between the sample and the encounter payment due to sample payments being reported in whole dollars rather than actual dollars and cents. Lastly, the refill numbers were erroneous in 29 percent of the sample date. All but 67 of the errors could be eliminated if the FAC encounter data refill number was divided by 10. The encounter data included an unnecessary 0 after the refill number causing the error rate.

Recommendations

1) We recommend DOM stipulate the measurement period (e.g., monthly, annually) required to be utilized to measure compliance with the 98 percent encounter submission requirement. DOM should also stipulate if the percentage should be measured by service type and whether a separate measurement should be applied by subcontractor.

2) We recommend DOM require the CCO and its subcontractors, in conjunction with the FAC, to investigate the causes of surplus and missing encounters that appear to be present or missing in the FAC raw data based on the sample claims data provided for January and October 2015. Any issues noted during the investigation requiring encounter data revisions should be incorporated into the FAC encounter data for use in future reporting or rate development.

3) We recommend payment adjustments related to FAC encounter data for each rate setting period be quantified and communicated to DOM's actuary to ensure duplicates, voids, and denied claims are accurately accounted for in the rate setting process. Additionally, encounter data analysis performed by DOM or other outside entities must incorporate a factor to account for any confirmed surplus encounters. The bi-monthly electronic data validation process will assist in providing this information.

4) We recommend DOM require the CCO to utilize cash disbursements from its accounting records as the source of its CDJ data, and provide documentation regarding how the data is extracted from the system as well as what mechanism it utilizes to ensure all transactions are properly included in the CDJ. This should assist in explaining the encounter payment amounts which exceed cash disbursements for the 2015 calendar year. Additionally, seeking to obtain an encounter-level identifier from the CCO which bridges the cash disbursement records with the encounter data would improve the level of detailed analysis that could be performed between the CDJ and encounter data and provide DOM, with greater assurance regarding the validity of the FAC encounter data.

5) The line level Plan Paid Amounts for outpatient and professional service types have been noted as errors in the sample testing and the EDV bi-monthly reporting. According to the CCO, it cor-

rected the line level issue in June 2016 on a prospective basis. Additional testing should be performed to ensure the solution is adequate. Ideally we recommend the solution be applied retroactively to ensure payments are properly captured at both the line level and the header level for reporting and analysis purposes.

6) To improve the accuracy of the key data elements with high testing errors noted in the above narratives, a review and possible update of the data dictionary with the CCO and subcontractors is recommended to address errors related to the claims sample data containing values differing from the encounter data. Based on the high error rates, emphasis should be placed on verifying Plan Paid Amounts. It is necessary to establish a crosswalk between the UB04 and 1500 claim forms to the encounter data. Doing so will help determine where the discrepancies exist in the data and ensure the key data components in the encounter data can be relied on for reporting and various analysis including rate setting, utilization analysis, and population health trends.

7) Based on higher error rates noted for the pharmacy and dental service types and the significant amount of surplus dental claims in the FAC encounter data, the CCO should be required by DOM to increase the oversight of the subcontracted vendors and provide DOM with an action plan for improvement in their data. This may include monthly reporting and reconciliations of claims and financial information. Based on the January and October 2015 claims sample, the FAC encounter data contains over double the number of dental encounters the claims sample supported. Also, pharmacy encounters had three required data components (Plan Paid Amount, Plan Received Date, Billing Provider NPI) exceeding 90 percent error rates.

8) We recommend DOM ensure the CCO has enforceable language to require third party vendors to provide all necessary documentation to support Mississippi Medicaid claims, and include penalties for non-compliance even after the contract has terminated. The Medicaid managed care final rule provides CMS the right to audit or inspect any documents or records in any format of the subcontractor for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. Contract language should be included to meet this requirement.

Steps 3 and 4: Generating and Reviewing Analytical Reports and Comparing Findings to State-Identified Standards

Data Assumptions

As reported in the Step 1, the same CY 2015 encounters and CDJ data obtained for our encounter to CDJ reconciliations was utilized in the utilization analysis and statistics presented below. The totals presented in the separately issued reconciliation reports represent an estimate of the total incurred claim payments based on submitted final claims, net of adjustments, made to providers for a given *payment* period. The encounter reconciliation process is tied to cash flow over time. It is not focused on identifying payments for specific beneficiary visits to provide an assessment on the completeness of the encounter data for the period. Whereas, the data presented for the utilization statistics is based upon specific beneficiary visits with CY 2015 *dates of services*. We have compared the totals from these reports to the data utilized for this analysis and believe that they are comparable and represent a similar percentage of the plan's claims. However, it should be noted that there are many assumptions made during the reconciliation process regarding the individual encounter data submissions that could potentially result in discrepancies when compared to the CCO's encounter claim warehouse. These include assumptions such as the identification and status flagging of duplicate encounter submissions and non-submitted voided encounters, which were removed from our analysis. As a result, the figures presented below represent Myers and Stauffer's best interpretation of encounter data submissions based on current known data limitations and is not meant to represent precise information, as there may be yet to be discovered data limitations and issues.

Volume, Utilization, and Per Member Costs

Volume

As shown in *Table 8: Encounter Expenditures and Volume by Service Type*, UHC's encounters comprised $614.3 million or 48.3 percent of total encounter dollars and 47.8 percent of total MississippiCAN encounters for CY 2015. MississippiCAN spent approximately $1.27 billion on services and had over 10.7 million encounters for CY 2015. An encounter is defined as a service provided to a member, by a unique provider, for a particular date of service. For example, a dentist providing a cleaning and two fillings to the same member on a date of service would count as one encounter service.

Table 8: Encounter Expenditures and Volume by Service Type

Service Type	MississippiCAN				UHC CAN			
	CY 2015 Services				CY 2015 Services			
	Expenditures	%	Volume	%	Expenditures	%	Volume	%
Institutional	$304,553,842	23.9%	858,596	8.0%	$148,576,654	24.2%	429,585	8.4%
Professional	$514,390,508	40.4%	5,034,801	46.8%	$248,379,009	40.4%	2,450,099	47.7%
Dental	$69,324,725	5.4%	399,740	3.7%	$38,560,233	6.3%	210,345	4.1%
Pharmacy	$384,640,464	30.2%	4,454,931	41.4%	$178,806,622	29.1%	2,047,557	39.9%
Total	$1,272,909,539	100.0%	10,748,068	100.0%	$614,322,518	100.0%	5,137,586	100.0%
Percentage of MississippiCAN Total					**48.3%**		**47.8%**	

Utilization

To evaluate per member utilization, Myers and Stauffer calculated the total member months for CY 2015 (i.e., the sum of all months each member was covered by the CCO). Total member months were then divided by twelve (12) to determine the average number of members for the year. As detailed in *Table 9: Member Utilization*, overall, members had an average total utilization of 28.5 encounters during this time period. UHC's total utilization was slightly lower at 27.5 encounters per member. The table below presents additional data by major service type. More detailed statistics on volume, member utilization, gender, and age are available in *Appendix A: Volume, Member Utilization, Demographic Statistics and Per Member Costs*.

Table 9: Member Utilization

Utilization by Service Type for CY 2015	Mississippi CAN	UHC CAN	
		Count	Percent of Mississippi CAN
Overview			
Total Member Months	4,524,227	2,239,925	49.5%
Average Number of Members[1]	377,019	186,660	
Total Number of (all) Encounters	10,748,068	5,137,586	47.8%
Encounters (all) Per Member[2]	28.5	27.5	
Institutional Use			
Total Number of Institutional Encounters	858,596	429,585	50.0%
Institutional Encounters Per Member[2]	2.3	2.3	
Professional Use			
Total Number of Professional Encounters	5,034,801	2,450,099	48.7%
Professional Encounters Per Member[2]	13.4	13.1	
Pharmacy Use			
Total Number of Pharmacy Encounters	4,454,931	2,047,557	46.0%
Pharmacy Encounters Per Member[2]	11.8	11.0	
Dental Use			
Total Number of Dental Encounters	399,740	210,345	52.6%
Dental Encounters Per Member[2]	1.1	1.1	

[1] *The average number of members was calculated by dividing the total number of member months by 12.*

[2] *Encounters per member were calculated by dividing the number of encounters by the average number of members.*

Per Member Costs

Table 10: Per Member Per Year Cost by Service Type summarizes the CY 2015 UHC per member per year (PMPY) cost by service type compared to the MississippiCAN Program. In total, the CY 2015 average UHC CAN PMPY cost was $3,291.12 and about 2.52 percent lower than the MississippiCAN PMPY of $3,376.25. In both MississippiCAN and UHC CAN, by service type, Professional Services had the highest PMPY and Dental Services had the lowest PMPY. Additional details on PMPY costs by age and gender are presented in *Appendix A: Volume, Member Utilization, Demographic Statistics and Per Member Costs*.

Table 10: Per Member Per Year Cost by Service Type

	MississippiCAN	UHC CAN	Variance	
Service Type	**CY 2015 PMPY[1]**	**CY 2015 PMPY[1]**	**Dollars**	**Percent**
Institutional	$807.79	$795.97	-$11.82	-1.46%
Professional	$1,364.36	$1,330.65	-$33.72	-2.47%
Dental	$183.88	$206.58	$22.70	12.35%
Pharmacy	$1,020.22	$957.92	-$62.29	-6.11%
Total	$3,376.25	$3,291.12	-$85.12	-2.52%

[1] These are actual costs for the CCO and are not risk adjusted for the costs associated with categories of eligibility (COEs) that receive capitated risk based adjustment premiums.

Utilization Indicators

Myers and Stauffer analyzed encounter data for other volume/consistency dimensions including prompt payment, timeliness of encounter submissions, provider type, type of service, and other dimensions such as dental categories of service and pharmacy services. The most notable findings related to adjudication timeliness.

Timeliness

Complete data takes into account time to pay a claim and timely turnaround and submission of encounters. Inconsistent processing may indicate problems within the CCO's information systems. To evaluate how timely the CCO paid claims and turned around and submitted encounters to the FAC, Myers and Stauffer looked at two scenarios. The first scenario analyzed how quickly the CCO is adjudicating claims. As shown in the next table, for MississippiCAN, the majority of institutional (97.2 percent) and professional claims (97.2 percent) were processed within the first 30 days. The majority of dental claims under MississippiCAN were paid within 30 days (99.3 percent) and pharmacy claims were most commonly processed within the first 15 days (99.7 percent).

For UHC, 98.1 percent of institutional claims and 97.2 percent of professional claims were processed within the first 30 days. Processing time took 30 days or less for 99.9% of UHC dental claims. Almost all of UHC's pharmacy claims were processed within the first 15 days (99.5 percent).

Table 11: MississippiCAN and UHC CAN - Timeliness of Payment

	MississippiCAN				UHC CAN			
Days	Institutional	Professional	Dental	Pharmacy	Institutional	Professional	Dental	Pharmacy
<= 15	91.7%	92.8%	54.5%	99.7%	95.5%	92.6%	48.6%	99.5%
16 - 30	5.5%	4.4%	44.8%	0.2%	2.6%	4.6%	51.3%	0.4%
31 - 60	1.1%	1.1%	0.6%	0.1%	0.5%	1.0%	0.1%	0.1%
61 - 90	0.4%	0.4%	0.1%	0.0%	0.3%	0.4%	0.0%	0.0%
Over 90	1.2%	1.3%	0.1%	0.0%	1.1%	1.4%	0.0%	0.0%

**Percentages may be slightly off due to rounding.*
***There were 132,956 dental encounters excluded from this analysis due to missing paid date information.*

The second scenario looked at how long it takes the CCO to get the *initial encounter submissions* into the MMIS system. As shown in the next table, for MississippiCAN, the majority of institutional (88.4 percent) and professional claims (88.5 percent) were submitted into the MMIS system within the first 30 days. Dental and pharmacy encounters took the longest with 46.0 percent and 8.7 percent, respectively, taking over 90 days to submit the encounters.

For UHC, 77.1 percent of initial institutional claims and 78.4 percent of professional claims were submitted within the first 30 days. Submission time took 90 days or longer for 39.4 percent of UHC dental claims. All of UHC's pharmacy claim encounters were submitted within the first 60 days (100.0 percent).

Table 12: MississippiCAN and UHC CAN - Timeliness of Submitting Encounters

	MississippiCAN				UHC CAN			
Days	Institutional	Professional	Dental	Pharmacy	Institu-tional	Profes-sional	Dental	Pharmacy
<= 15	87.6%	86.6%	35.3%	39.1%	75.6%	74.8%	39.8%	9.6%
16 – 30	0.8%	1.9%	1.9%	48.7%	1.5%	3.6%	1.3%	87.3%
31 – 60	2.3%	3.3%	6.2%	1.3%	4.7%	6.8%	7.1%	3.1%
61 – 90	2.6%	1.8%	10.7%	2.3%	5.2%	3.6%	12.3%	0.0%
91– 120	1.7%	0.7%	6.7%	7.1%	3.5%	1.5%	7.7%	0.0%
Over 120	5.0%	5.7%	39.3%	1.6%	9.5%	9.7%	31.7%	0.0%

**Percentages may be slightly off due to rounding.*

Place of Service

Myers and Stauffer performed a comparison of utilization by place of service/facility type for institutional, professional, and dental services for MississippiCAN and UHC CAN. Thirty-four percent of services and $237.8 million of the MississippiCAN encounters were rendered in an office setting and 17.9 percent of services and $344.3 million in payments were rendered in a hospital setting. UHC's encounters were consistent with 34.2 percent of services and over $122.2 million in payments rendered in an office setting and 17.7 percent of services and over $165.4 million in payments in a hospital setting.

Table 13: Place of Service by Expenditures and Utilization

	MississippiCAN				UHC CAN			
Place of Service/ Facility Type	**Expenditures[3]**	**%**	**Volume[3]**	**%**	**Expenditures[3]**	**%**	**Volume[3]**	**%**
Office	$237,850,404	26.8%	2,285,289	34.0%	$122,266,544	28.1%	1,137,166	34.2%
Hospital	$344,340,079	38.8%	1,207,200	17.9%	$165,411,417	38.0%	586,640	17.7%
Independent Laboratory	$15,033,675	1.7%	331,125	4.9%	$6,967,673	1.6%	155,841	4.7%
Rural Health Clinic[1]	$36,530,072	4.1%	394,138	5.9%	$16,841,067	3.9%	188,347	5.7%
Community Mental Health Center	$49,339,921	5.6%	403,598	6.0%	$24,275,685	5.6%	209,312	6.3%
Emergency Room Hospital[2]	$33,003,703	3.7%	571,766	8.5%	$16,664,147	3.8%	275,544	8.3%
All Other	$172,163,859	19.4%	1,535,780	22.8%	$83,082,000	19.1%	770,453	23.2%
Total	$888,261,712		6,728,896		$435,508,533		3,323,303	
Percentage of MississippiCAN Total					**49.0%**		**49.4%**	

**Numbers may be slightly off due to rounding*

[1] Rural Health Clinic totals do not include Federally Qualified Health Centers.

[2] Note: There are claims on the institutional form related to Emergency Room.

[3] Note: Place of Service Expenditures and Volume were analyzed at the claim level versus an encounter level and excludes Pharmacy, therefore there will be discrepancies in the total counts reported in Table 8 of page 38 of the Report.

Provider Type

Hospital providers represent 12.2 percent of all Mississippi CCOs' encounters by provider type and $230.7 million (26.4 percent) in expenditures. In comparison, 11.7 percent of UHC encounters and $105.2 million (24.4 percent) in expenditures were for hospital providers. CCOs were not required to submit institutional inpatient encounters until December 2015.

Physicians (35.0 percent) and dentists (5.9 percent) comprise 40.9 percent of all MississippiCAN's institutional, professional, and dental encounters, representing over $287.6 million in expenditures. Physicians (33.5 percent) and dentists (6.6 percent) comprise 40.1 percent of all UHC institutional, professional, and dental encounters, representing approximately $140.2 million in expenditures.

Table 14: Provider Type by Utilization – Dollars, Volume, and Percentages

	MississippiCAN				UHC CAN			
Provider Type	**Expenditures**	**%**	**Volume**	**%**	**Expenditures**	**%**	**Volume**	**%**
Hospital, General	$230,658,210	26.4%	810,736	12.2%	$105,242,507	24.4%	385,630	11.7%
Physician, MD	$220,654,504	25.2%	2,334,307	35.0%	$103,071,831	23.9%	1,106,713	33.5%
Dentist, Unclassified	$66,960,907[1]	7.7%	390,755	5.9%	$37,180,223	8.6%	218,666	6.6%
Nurse Practitioner	$47,294,729	5.4%	641,913	9.6%	$21,071,584	4.9%	289,175	8.8%
Ind X-ray And Lab	$12,215,560	1.4%	282,437	4.2%	$5,486,030	1.3%	132,615	4.0%
All Other	$296,314,798	33.9%	2,210,615	33.1%	$159,540,135	37.0%	1,168,307	35.4%
Total	$874,098,707		6,670,763		$431,592,310		3,301,106	

	MississippiCAN				UHC CAN			
Provider Type	**Expenditures**	**%**	**Volume**	**%**	**Expenditures**	**%**	**Volume**	**%**
Percentage of MississippiCAN Total						**49.4%**		**49.5%**

[1] Note that this total is significantly more than the $55,929,876 identified in Table 15: Dental Expenditures and Visits by Category of Service. This is due to the utilization of the header paid amount in Table 14: Provider Type by Utilization – Dollars, Volume, and Percentages versus procedure codes at the line level in Table 15 where there was not always an accurate amount present. This illustrates a significant data limitation in the encounter data.

Dental Services

Over 1.5 million dental services were provided under the MississippiCAN program in CY 2015 at a cost of $55.9 million. UHC members were recipients of 52.3 percent of the services. In terms of dollars, UHC dental services comprised over $25.3 million (45.3 percent). The volume, percentage, and dollar break-downs for dental categories of services are shown in the next table.

Table 15: Dental Expenditures and Visits by Category of Service

	MississippiCAN				UHC CAN			
Category of Service	**Expenditures**	**%**	**Volume**	**%**	**Expendi-tures**	**%**	**Volume**	**%**
Diagnostic	$15,137,322	27.1%	632,158	40.9%	$7,340,450	28.9%	321,139	39.7%
Preventive	$9,472,122	16.9%	513,640	33.2%	$4,452,113	17.6%	281,709	34.8%
Restorative	$15,368,985	27.5%	195,315	12.6%	$7,336,016	28.9%	102,086	12.6%
Oral and Maxillofacial Surgery	$7,715,624	13.8%	100,444	6.5%	$3,765,659	14.9%	51,026	6.3%
Orthodontics	$4,926,315	8.8%	49,507	3.2%	$982,475	3.9%	25,389	3.1%
Adjunctive General Ser-vices	$1,353,093	2.4%	33,824	2.2%	$606,989	2.4%	16,563	2.0%
Endodontics	$1,904,614	3.4%	18,572	1.2%	$857,464	3.4%	9,860	1.2%
All Other	$51,800	0.1%	2,219	0.1%	$21,982	0.1%	1,181	0.1%
Total	$55,929,876[1]		1,545,679		$25,363,149		808,953	
Percentage of MississippiCAN Total					**45.3%**		**52.3%**	

**Numbers may be slightly off due to rounding.*

[1] Note that this total is significantly less than the $66,960,907 identified in Table 14. This is due to the utilization of the procedure codes at the line level in Table 15 where there was not always an amount present versus the header paid amount in Table 14. This illustrates a significant data limitation in the encounter data.

Pharmacy Services

To evaluate prescriptions, Myers and Stauffer utilized claim-level pharmacy data to identify new/original prescriptions. Any prescriptions filled after the date of the new/original prescription was considered a refill. Approximately 69.8 percent of the drugs dispensed for MississippiCAN were for new/original prescriptions and refills were 30.2 percent of prescriptions. For UHC, 70.1 percent of the drugs dispensed were for new/original prescriptions with refills averaging 29.9 percent.

Table 16: Pharmacy Prescriptions by Drug Group

Prescriptions			
Pharmacy Services	**Total**	**New / Original**	**Refills**
MississippiCAN			
Antibiotics	13.3%	12.9%	0.4%
Psychotherapeutic Drugs	11.7%	7.5%	4.2%
Analgesics	8.8%	8.4%	0.4%
Cardiovascular	8.6%	3.6%	5.1%
Antihistamines	6.4%	4.7%	1.7%
Antiasthmatics	5.9%	3.5%	2.4%
Gastrointestinal	5.6%	3.7%	1.9%
CNS Drugs	4.9%	2.4%	2.5%
All Other	34.8%	23.3%	11.6%
MississippiCAN Totals*	**100.0%**	**69.8%**	**30.2%**
UHC CAN			
Antibiotics	15.4%	15.0%	0.4%
Psychotherapeutic Drugs	11.8%	7.5%	4.3%
Analgesics	8.9%	8.6%	0.3%
Cardiovascular	7.4%	2.9%	4.6%
Antihistamines	6.9%	5.0%	1.9%
Antiasthmatics	6.2%	3.6%	2.7%
Cardiovascular	4.9%	3.1%	1.9%
CNS Drugs	4.7%	2.2%	2.5%
All Other	33.7%	22.3%	11.3%
UHC CAN Totals*	**100.0%**	**70.1%**	**29.9%**

***Total percentages may be slightly off due to rounding.*

Findings

1) As identified in Table 11 MississippiCAN and UHC CAN - Timeliness of Payment on page 41, all of UHC's dental and pharmacy claims were paid within the first 60 days. A very small percentage of UHC's institutional (1.1 percent) and professional (1.4 percent) claims took over 90 days to process and therefore fell outside the contractual requirement which states, "The contractor will be responsible for processing claims within ninety calendar days of receipt…"

2) As identified in Table 12 MississippiCAN and UHC CAN - Timeliness of Submitting Encounters on page 41, encounter records reflect submission dates more than 120 days after the claim payment for institutional, professional, and dental service types. According to the contract, encounter records are required to be submitted by the last day of the 3rd month after the payment/adjudication

calendar month in which the contractor paid/adjudicated the claim. There were 9.5 percent of institutional encounters, 9.7 percent of professional encounters, and 31.7 percent of dental encounters that were submitted to the FAC beyond 120 days.

Recommendations

1) UHC should continue to monitor and ensure subcontractors are processing and paying claims within contractual requirements. DOM should continue to hold UHC responsible for contract compliance.

2) UHC should monitor and ensure subcontractor encounters are submitted to the FAC within contractual requirements. DOM should continue to hold UHC responsible for contract compliance.

Activity 4: Review of Medical Records

Methodology

The purpose of this activity is to confirm findings from the analysis of encounter data by reviewing medical records for data components where the medical record is the primary source of information. In adherence with the protocol guidelines, the quality of the encounter data was adequate, based on the sample completeness percentage (*Table 3*: *Completeness Percentage by Service Type for Sample Periods*) to be used for analysis for pharmacy encounters. To accomplish the medical record review, the sample claims data submitted by the CCO was used to identify encounters that met the list of assumptions below. These assumptions were used to impact how the sample was designed and drawn.

Sample Assumptions:

1) Claim detail records were combined into appropriate claim (header) level. The sample was determined based on claim level counts.
2) Claims submitted by the CCO for January 2015 and October 2015, and traced through to the FAC data warehouse encounter data, are included. Claims submitted by the CCO not found in the encounter data were excluded from medical records sampling since the purpose of the medical record review is to confirm the Activity 3 encounter data findings.
3) If a particular claim type did not meet the completeness threshold of 98 percent complete for encounter claims submission for the months identified, it was excluded from the medical record review, per the EQR Protocol 4 guidelines (pages 6-7), which states “If the EQRO is unsure of the quality of the encounter data at the completion of Activity 3, it should not proceed to the medical record review activity (Activity 4).”
    a. This limitation was discussed with DOM, however DOM determined it necessary to proceed with the medical record review regardless of the completeness or accuracy percentages contained in Activity 3 to assess the adequacy of the medical record documentation required by the CCO and maintained by the providers.
4) The claims were divided into the following service types:
    a. Outpatient institutional, professional, dental, and pharmacy.
    b. Inpatient institutional claims are not included in this report, as inpatient services were carved in during December 2015.
5) Key data elements were reviewed based on a tiered designation of either “critical” or “non-critical”. The approach, approved by DOM, for determining the severity of an error was based on the Medicaid reimbursement impact of each data component and claim type, refer to *Table 19: Data Elements and Associated Tier Level and Error Rate by Service Type* below.
6) Key data elements were measured on either a claim (header) or a line level of detail, dependent on the characteristic of the element. This approach causes the number of data elements tested to vary by key element. This distinction is displayed in Table 19 below.

As shown in the following table (*Table 17: Statistically Valid Sample Size*), a five percent Error Rate and a 95 percent Confidence Level was utilized to determine the minimum sample size required for a statistically valid sample. To ensure an adequate number of records were received to meet the minimum sample

size, a total of 110 medical records were requested for each service type. As indicated below, the minimum statistically valid sample size is 73. The calculation of the minimum sample size was performed in consultation with a qualified statistician.

Table 17: Statistically Valid Sample Size

Margin of Error	Error Rate					
	0.05	**0.1**	**0.2**	**0.3**	**0.4**	**0.5**
0.01	1,825	3,457	6,147	8,067	9,220	9,604
0.02	456	867	1,537	2,017	2,305	2,401
0.03	203	384	683	896	1,024	1,067
0.05	**73**	138	246	323	369	384
0.1	18	35	61	81	92	96
0.2	5	9	15	20	23	24

For each CCO service type, random sampling was used to select the claims for medical record review. The sample list with recipient and provider information was forwarded to the CCO for medical record retrieval. The request stated to submit each medial record for the sample date of service in its entirety. Upon receipt of the sample, the CCO worked with its providers to obtain the medical record supporting the claim identified in the sample.

Upon Myers and Stauffer's receipt, the medical records were assessed for usability and verified as being part of the requested claim sample. Clinical and professional staff compared the medical record and the claims data to validate all key data elements were supported by the medical record documentation, as shown in *Table 19: Data Elements and Associated Tier Level and Error Rate by Service Type*. There were several instances where the documentation received was deemed incomplete. As a result, an additional information request was sent to the CCO which outlined specific pieces of the record needed to support the key elements. The same processes were followed, as referenced above, to request and submit additional data. All additional information submitted to Myers and Stauffer by March 31, 2017 was incorporated into the report.

Findings

Evaluation of encounter data on the basis of medical record review is dependent on the ability of the provider to locate and submit complete and accurate medical records. The EQR Protocol 4 guidelines state it is inappropriate to substitute a record that cannot be located, unless it is out of the office for legal review (for example). If the CCO provided an acceptable reason for not submitting the requested medical record, that particular claim was removed from the sample exceptions and total amounts. UHC attested that no medical records were out of the office for legal review. Therefore, all missing records are included in the error rate calculation.

Table 19 displays each key data element, corresponding tier level and error rate by service type. The error rates were segregated in the table to reflect the following:

- Unsupported Element: Claims for which a medical record was received, but lacked documentation to support the key data element.
- Unsupported Element including Missing/Unusable Records: Claims for which a medical record was or was not received, which resulted in the lack of documentation to support the key data element.

Both error rates were reported to highlight whether the errors stemmed from non-supported key data elements in the medical records or from the inability of the CCO/provider to submit medical record documentation. The rates were calculated and shown in total for the sampled months of January and October 2015. UHC submitted one medical record that was deemed unusable. A total of 27 medical records were missing for both sampled months. Half of the missing records were within the professional service type. The following table (*Table 18: Summary of Medical Records*) summarizes the number of medical records requested, received, missing, or deemed unusable.

Table 18: Summary of Medical Records

Medical Records					
	Outpatient	**Professional**	**Dental**	**Pharmacy**	**Total**
Number of Records Required for a Statistically Valid Sample	73	73	73	73	292
Number of Records Requested					
January 2015	55	55	55	55	220
October 2015	55	55	55	55	220
Total Records Requested	110	110	110	110	440
Number of Records Received					
January 2015	52	46	52	51	201
October 2015	53	51	55	53	212
Total Records Received	105	97	107	104	413
Missing Records					
January 2015	3	9	3	4	19
October 2015	2	4	0	2	8
Total Records Missing	5	13	3	6	27
Unusable Records					
January 2015	0	0	0	1	1
October 2015	0	0	0	0	0
Total Records Unusable	0	0	0	1	1
Net Usable Records Received					
January 2015	52	46	52	50	200
October 2015	53	51	55	53	212
Total Usable Records	105	97	107	103	412

Error Rate Calculations:
Unsupported Element *= Key Data Element Fields Deemed Unsupported Compared to Medical Records/Total Key Data Element Fields excluding Missing and Unusable Records.*
Unsupported Element including Missing/Unusable Records *= Key Data Element Fields Deemed Unsupported Compared to Medical Records + Key Data Element Fields with Missing and Unusable Records/Total Key Data Element Fields.*
Black Cell *= Key Data Element Field not applicable for Service type.*

Table 19: Data Elements and Associated Tier Level and Error Rate by Service Type

Key Data Element	Header/ Line Level	Tier Level	Error Rate							
			Outpatient		Professional		Dental		Pharmacy	
			Unsupported Element	Unsupported Element including Missing/ Unusable Records	Unsupported Element	Unsupported Element including Missing/ Unusable Records	Unsupported Element	Unsupported Element including Missing/ Unusable Records	Unsupported Element	Unsupported Element including Missing/ Unusable Records
Member Name	Header Level	Critical	0%	5%	3%	15%	1%	4%	1%	7%
Member DOB	Header Level	Critical	1%	5%	12%	23%	43%	45%	18%	24%
Type of Bill	Header Level	Critical	0%	5%						
Header First DOS	Header Level	Critical	0%	5%	10%	21%	3%	5%	16%	21%
Header Last DOS	Header Level	Critical	1%	5%						
Place of Service	Header Level	Critical			7%	18%	18%	20%		
Procedure Code	Line Level	Critical	21%	25%	43%	48%	25%	27%		
Procedure Modifier 1	Line Level	Critical	39%	39%	78%	80%				
Revenue Code	Line Level	Non-Critical	21%	25%						
Principal Diagnosis Code	Header Level	Non-Critical	13%	17%						
Diagnosis Code 1	Header Level	Non-Critical	18%	23%	20%	29%				
Diagnosis Code 2	Header Level	Non-Critical	31%	35%	17%	24%				
Diagnosis Code 3	Header Level	Non-Critical	32%	37%	19%	24%				
Diagnosis Code 4	Header Level	Non-Critical	38%	44%	17%	29%				

Error Rate										
			Outpatient		Professional		Dental		Pharmacy	
Key Data Element	Header/ Line Level	Tier Level	Unsupported Element	Unsupported Element including Missing/ Unusable Records	Unsupported Element	Unsupported Element including Missing/ Unusable Records	Unsupported Element	Unsupported Element including Missing/ Unusable Records	Unsupported Element	Unsupported Element including Missing/ Unusable Records
Surgical Procedure Code 1	Line Level	Critical	No data to test	No data to test						
Tooth Number 1	Line Level	Critical					10%	11%		
Tooth Number 2	Line Level	Critical					21%	21%		
Tooth Number 3	Line Level	Critical					33%	33%		
Tooth Number 4	Line Level	Critical					38%	38%		
Tooth Number 5	Line Level	Critical					43%	43%		
Tooth Surface 1	Line Level	Critical					0%	0%		
Tooth Surface 2	Line Level	Critical					0%	0%		
Tooth Surface 3	Line Level	Critical					0%	0%		
Tooth Surface 4	Line Level	Critical					0%	0%		
Prescription Number	Header Level	Critical							9%	15%
Refill Number	Line Level	Critical							37%	41%
Quantity	Line Level	Critical							11%	16%
Days Supply	Line Level	Non-Critical							24%	29%

Error Rate										
			Outpatient		Professional		Dental		Pharmacy	
Key Data Element	Header/ Line Level	Tier Level	Unsupported Element	Unsupported Element including Missing/ Unusable Records	Unsupported Element	Unsupported Element including Missing/ Unusable Records	Unsupported Element	Unsupported Element including Missing/ Unusable Records	Unsupported Element	Unsupported Element including Missing/ Unusable Records
Drug Dispensed	Line Level	Critical							20%	25%
Overall Error Rate			**16%**	**20%**	**31%**	**38%**	**19%**	**21%**	**17%**	**22%**

1) As shown in *Table 18: Summary of Medical Records*, medical records chose as part of the sample were not supplied by UHC from providers for testing of proper medical documentation to support the encounter data in the FAC.

2) The overall error rates by service type calculated for unsupported elements, ranged from 16 percent to 31 percent. Including the missing records in the error rate, the overall error rates increased to 20 percent to 38 percent across the four service types. The professional claims had the highest error rate by service type and on individual key data components for procedure codes (43 percent; 48 percent) and Procedure Code Modifiers (78 percent; 80 percent). Outpatient institutional claims lacked documentation to support Procedure Code Modifiers (39 percent) and some secondary Diagnosis Codes (18-44 percent). None of the sample claims contained Surgical Procedure Codes, therefore, this key data element was not tested. For dental encounters, the most common error was related to Date of Birth (43 percent; 45 percent). The highest error rates in the pharmacy claims related to the lack of supporting documentation for the Refill Number (37 percent; 41 percent). Overall the outpatient institutional claims contained the most complete medical record documentation. In most cases, the medical record documentation received from the CCO was limited to the date of service in the sample selection. If the entire medical record had been submitted, it may have contained additional supporting documentation.

Recommendations

1) We recommend DOM ensure the CCO recoup funds from the providers not submitting medical record documentation to support the sampled claims. Policy NQM-025, Ambulatory Medical Record Review Process, the policy of UHC Mississippi is to require member medical records be maintained in a manner that is current, detailed, and organized, and permits effective and confidential patient care and quality review. Standards will be in accordance with state and federal regulations as well as any applicable accreditation standards. DOM may consider additional medical record testing to ensure compliance with medical records documentation standards and implement corrective action plans or penalties for non-compliance.

2) Additionally, given the high error rates in some categories, we recommend that DOM provide proper oversight of the CCO through program integrity efforts and provider training. DOM may want to consider requesting support from UHC and monitor how results from this review are incorporated. Special emphasis may be appropriate for professional encounters due to the higher overall error rates compared to the other service types.

3) UHC should examine contracts and processes to ensure medical records are supplied upon request from its providers. If need be, language may need to be strengthened to increase the requirement and penalties for not being able to supply medical records. UHC may need to perform additional medical record audits to confirm the accessibility and availability of medical records for UHC CAN members.

The table on the following pages includes the detail of key data element totals by service types.

Table 20: Number of Data Elements and Associated Tier Level and Errors by Service Type

Number of Data Elements																
			Outpatient			Professional			Dental			Pharmacy		
Key Data Element	Header/ Line Level	Tier Level	Total Elements Sampled	Unsup-ported Element	Element with Missing / Unusable Records	Total Elements Sampled	Unsup-ported Element	Element with Missing / Unusable Records	Total Elements Sampled	Unsup-ported Element	Element with Missing / Unusable Records	Total Elements Sampled	Unsup-ported Element	Element with Missing / Unusable Records
Member Name	Header Level	Critical	110	-	5	110	3	13	110	1	3	110	1	7
Member DOB	Header Level	Critical	110	1	5	110	12	13	110	46	3	110	19	7
Type of Bill	Header Level	Critical	110	-	5									
Header First DOS	Header Level	Critical	110	-	5	110	10	13	110	3	3	110	16	7
Header Last DOS	Header Level	Critical	110	1	5									
Place of Service	Header Level	Critical				110	7	13	110	19	3			
Procedure Code	Line Level	Critical	480	96	26	328	125	34	324	78	8			
Procedure Modifier 1	Line Level	Critical	85	33	0	166	122	10						
Revenue Code	Line Level	Non-Critical	577	112	32									
Principal Di-agnosis Code	Header Level	Non-Critical	110	14	5									
Diagnosis Code 1	Header Level	Non-Critical	66	11	4	110	19	13						
Diagnosis Code 2	Header Level	Non-Critical	37	11	2	38	6	3						

Number of Data Elements																
			Outpatient			Professional			Dental			Pharmacy		
Key Data Element	Header/ Line Level	Tier Level	Total Elements Sampled	Unsup-ported Element	Element with Missing / Unusable Records	Total Elements Sampled	Unsup-ported Element	Element with Missing / Unusable Records	Total Elements Sampled	Unsup-ported Element	Element with Missing / Unusable Records	Total Elements Sampled	Unsup-ported Element	Element with Missing / Unusable Records
Diagnosis Code 3	Header Level	Non-Critical	27	8	2	17	3	1						
Diagnosis Code 4	Header Level	Non-Critical	18	6	2	7	1	1						
Surgical Procedure Code 1	Line Level	Critical	0	-	0									
Tooth Num-ber 1	Line Level	Critical							70	7	1			
Tooth Num-ber 2	Line Level	Critical							24	5	0			
Tooth Num-ber 3	Line Level	Critical							12	4	0			
Tooth Num-ber 4	Line Level	Critical							8	3	0			
Tooth Num-ber 5	Line Level	Critical							7	3	0			
Tooth Sur-face 1	Line Level	Critical							10	0	0			
Tooth Sur-face 2	Line Level	Critical							6	0	0			
Tooth Sur-face 3	Line Level	Critical							3	0	0			
Tooth Sur-face 4	Line Level	Critical							0	0	0			
Prescription Number	Header Level	Critical										110	9	7

Number of Data Elements																
			Outpatient			Professional			Dental			Pharmacy		
Key Data Element	Header/ Line Level	Tier Level	Total Elements Sampled	Unsup-ported Element	Element with Missing / Unusable Records	Total Elements Sampled	Unsup-ported Element	Element with Missing / Unusable Records	Total Elements Sampled	Unsup-ported Element	Element with Missing / Unusable Records	Total Elements Sampled	Unsup-ported Element	Element with Missing / Unusable Records
Refill Num-ber	Line Level	Critical										110	38	7
Quantity	Line Level	Critical										110	11	7
Days Supply	Line Level	Non-Critical										110	25	7
Drug Dis-pensed	Line Level	Critical										110	21	7
Total			**1,950**	**293**	**98**	**1,106**	**308**	**114**	**904**	**169**	**21**	**880**	**140**	**56**

Activity 5: Summary of Findings

The table below summarizes the findings and recommendations related to Activities 1-4.

Table 21: Summary of Findings

Entity/Finding #	Activity #/ Page Reference	Finding	Recommendation
DOM Finding 1.1	Activity 1: Review State Requirements Page 13	DOM encounter submissions standards appear to be generally stated and could potentially be subject to interpretation. Developing standards specific to encounter data submissions may improve the quality of the encounter data and generate the accuracy and completeness required for DOM oversight and other analyses performed using the encounter data.	DOM should update the detailed standards and requirements specific to the encounter data submission. This may include a specific day or date for submitting initial encounters. For example, DOM may want to amend the contract to read that the CCO is required to submit encounter data within 60 days of claims payment (paid date). According to DOM representatives, this provision will be part of the next contract amendment.
DOM Finding 1.2	Activity 1: Review State Requirements Page 13	The contract sets forth a single 98 percent completeness standard and two percent error rate for all service types. EQR Protocol 4 guidelines recommend states set specific standards for each service type.	DOM should develop specific standards by service type. See Table 1 on page 15 for EQR Protocol 4 examples of service types for which the state should develop acceptable error rates. DOM should continue ensuring quality encounter data submissions via periodic reconciliation of paid encounter files to cash disbursement journals. DOM should require CCOs to submit all encounter iterations: originals, adjustments, and voids.
DOM Finding 1.3	Activity 1: Review State Requirements Page 13	There is an opportunity to enhance the state's data dictionaries to enhance detail, completeness, and user friendliness.	DOM may wish to consider whether a database administrator or an information technology professional could help develop more detailed data dictionaries that facilitate completeness and the ability to trace data from the 837s and NCPDPs to their final location in the data warehouse.
DOM/CCOs Finding 1.4	Activity 1: Review State Requirements Page 13	The CCOs are not providing a formal attestation or certification to DOM related to encounter data submissions as required by 42 CFR 438.606. This federal provision requires that the managed care entity attest to the accuracy, completeness, and truthfulness of the data.	DOM should require, monitor, and enforce submission of a standard written attestation from the CCOs for all encounter data submissions.

Entity/Finding #	Activity #/ Page Reference	Finding	Recommendation
DOM Finding 1.5	Activity 1: Review State Requirements Page 13	The reference to actuarial soundness of the capitation rates is incorrectly cited as §438.3 of the rule in the proposed March 20, 2017 CCO contract language located in Section 11 on Program Integrity on page 150, Item 2.	DOM should update the reference within the contract language to §438.4.
Conduent (FAC) Finding 1.6	Activity 1: Review State Requirements Page 14	Encounters cannot be identified for all of the CCOs' delegated vendors. This poses challenges with reconciling encounters with CDJ's.	Conduent should continue working with DOM and the CCOs to determine whether the CCOs' TCNs may be modified to include a prefix to denote the delegated vendors in the encounter data.
Conduent (FAC) Finding 1.7	Activity 1: Review State Requirements Page 14	Conduent has a file limitation of 1,000 claims per file. Conduent can process up to 48,000 claims per day per CCO. The file and volume limitations create obstacles for the CCOs to be compliant with submission requirements, particularly when the CCOs have to submit or re-submit large batches of claims.	Conduent and DOM should explore whether expansion of Conduent's capacity is feasible or whether such a change would be cost prohibitive.
Conduent (FAC) Finding 1.8	Activity 1: Review State Requirements Page 14	At the time of the Conduent on-site review, the DRGs submitted by the health plans were not being saved or stored. DOM and Conduent worked to resolve this issue and a fix was implemented July 11, 2016.	The FAC should capture and retain all encounter data as submitted by the CCOs.
Conduent (FAC) Finding 1.9	Activity 1: Review State Requirements Page 14	Initial encounter reconciliation reviews identified an issue with CAS code differences and coordination of CAS codes with the CCOs. There were instances where the CCOs submitted a paid encounter with a CAS code that was processed by the FAC as CCO-denied. This suggested that the FAC's denial adjustment reason code (ARC) table may not contain the same CAS codes that the CCO is intending to use to identify denied encounters. DOM has been working with the CCOs and the FAC to review and update CAS codes to ensure CCO-denied encounters are processing correctly.	The FAC should continue working with DOM and the CCOs to resolve all issues related to CAS codes.

Entity/Finding #	Activity #/ Page Reference	Finding	Recommendation
Conduent (FAC) Finding 1.10	Activity 1: Review State Requirements Page 14	There are instances where the claim adjustment back out to an encounter is successful, but the corresponding replacement transaction is denied by the FAC. This results in multiple encounter data issues: • Effectively removes paid encounters from the FAC's data warehouse that the CCO may have intended to replace. • Subsequent CCO replacement transactions (to replace the encounter record, are denied due to the original claim already having been removed. As a result, the CCO must send the transaction as a new unrelated original encounter in order to have it accepted. This process can produce encounters that may not reflect the CCO's actual claim adjustment activity. DOM, the FAC, and the CCOs have been working to resolve these issues. During the most recent encounter reconciliation cycles, fewer occurrences of these adjustment transactions were observed.	The FAC should continue working with the CCO to resolve all issues related to replacement transactions.
Conduent (FAC) Finding 1.11	Activity 1: Review State Requirements Page 14	DOM has created a supplemental file on the claims/encounter side because the 835 does not give sufficient detail to allow the CCOs to identify the reason for denial.	Conduent should work with DOM to evaluate whether the 835s could be modified to include sufficient information on denials to enable the CCO to reconcile and better work the files.
Conduent (FAC) Finding 1.12	Activity 1: Review State Requirements Page 14	According to the FAC representatives, there is no oversight or quality assurance check performed on the Truven data warehouse standard reports that are submitted to the state (e.g., checking/verifying code, etc.).	The FAC should implement a quality control system or method of checking the code and verifying the accuracy of the standard Truven data warehouse reports submitted to the state.
UHC Finding 2.1	Activity 2: Review CCO's Capability Page 18	Control totals are not sent to the FAC by UHC to ensure the number of encounters submitted in the files are correctly received and loaded by the FAC. Additionally, UHC receives acknowledgment of the files from Conduent, but no control totals.	The CCO should modify their processes as necessary to ensure all data files, especially subcontractor data files, are complete. This may include, but not be limited to, exchange of control totals for both inbound and outbound subcontractor files. Additionally, control totals should be exchanged between the FAC and the CCO.

Entity/Finding #	Activity #/ Page Reference	Finding	Recommendation
UHC Finding 2.2	Activity 2: Review CCO's Capability Page 18	Dashboards containing operational metrics used to meet state reporting requirements are automatically refreshed when the data warehouse is refreshed and new claims are accepted from the claims system. During the on-site interviews, UHC personnel indicated many reports are automated and a quality assurance check is not completed on report creation.	A quality assurance process should be developed to ensure all updated data from the dashboards gets reflected in the reports prepared for and submitted to DOM.
UHC Finding 2.3	Activity 2: Review CCO's Capability Page 18	UHC representatives noted during the on-site review that UHC completes high level audits of delegated vendors; however, there is no auditing of delegated vendors on a claim detail level.	UHC should evaluate the benefits of conducting a more comprehensive audit of delegated vendors by including audits at the claim level detail as part of the audit process.
UHC Finding 2.4	Activity 2: Review of CCO's Capability Page 18	There is limited oversight and validation of subcontractor encounter data. Often, the data is passed through UHC to Conduent via automated processes with minimal checks for completion or subsequent validation by UHC.	The CCO should modify their processes, as necessary, to ensure all data files, especially subcontractor data files, are complete. This may include exchange of control totals for both inbound and outbound subcontractor files. The CCO should explore implementing a more thorough quality assurance and audit process to verify the completeness and accuracy of encounter data from their subcontractors.
DOM and Conduent (FAC) Finding 3.1	Activity 3: Analyze Encounter Data Page 26	Outpatient and Professional Key Data Elements: The Principal Diagnosis Code for professional claims is null 100 percent of the time, however the Diagnosis Code 1 data element is populated with valid values. Dental Key Data Elements: The Tooth Numbers data element had a 0.1 percent invalid error rate identified. Pharmacy Key Data Elements: Billing Provider NPI reflected a 100 percent invalid error rate because the field does not contain an NPI number. All values are length of five and six instead of the required ten character length. In addition the Plan Received date had a 100 percent invalid error date due to the field being populated with a date of 01/01/0001.	Conduent should ensure that all values submitted are valid and at a minimum report these errors to allow for corrections when necessary.

Entity/Finding #	Activity #/ Page Reference	Finding	Recommendation
DOM Finding 3.2	Activity 3: Analyze Encounter Data Page 33	No measurement period for the 98 percent encounter submission requirement is noted in the current contract between DOM and UHC.	DOM should stipulate the measurement period required to be utilized to measure compliance with the 98 percent encounter submission requirement and stipulate if the percentage should be measured by service type and whether a separate measurement should be applied by subcontractor.
UHC and Conduent (FAC) Finding 3.3	Activity 3: Analyze Encounter Data Pages 33-34	Surplus encounters were noted in all service types based on the claims sample received from UHC for the sample test months of January and October 2015. Surplus encounters as a percentage of the total sample were 15 percent for outpatient, 20 percent for professional, 118 percent for dental, and 26 percent for pharmacy. Also, a minimal amount of encounters were missing from the FAC encounter data based on the January and October 2015 claims sample.	UHC and Conduent should investigate the causes of surplus and missing encounters that appear to be present or missing in the FAC encounter data based on the sample claims data provided by UHC for January and October 2015. Encounter data should be updated in the FAC data warehouse for any discrepancies noted during the investigation.
DOM Finding 3.4	Activity 3: Analyze Encounter Data Page 34	Adjustments to encounter payments in the FAC are necessary in reconciling payments to the cash disbursements journal to account for adjusted, void, denied, and replacement encounters.	Payment adjustments related to FAC encounter data for each rate setting period should be quantified and communicated to DOM's actuary to ensure duplicates, voids, and denied claims are accurately accounted for in the rate setting process.
UHC Finding 3.5	Activity 3: Analyze Encounter Data Page 34	The 2015 annual completion percentage for dental claims is 113.18 percent which may signify inaccurate CDJ information supplied by UHC.	We recommend DOM require UHC to utilize cash disbursements from its accounting records as the source of its CDJ data, and provide documentation regarding how the data is extracted from the system as well as what mechanism it utilizes to ensure all transactions are properly included in the CDJ.
UHC and Conduent (FAC) Finding 3.6	Activity 3: Analyze Encounter Data Pages 34-35	The line level Plan Paid Amounts for outpatient and professional service types have been noted as errors in the sample testing as well as in the EDV bi-monthly reporting. The total of line level payments do not equal the header paid amount.	According to UHC, it corrected the line level issue in June 2016 on a prospective basis. Additional testing should be performed to ensure the solution is adequate. Ideally, we recommend the solution be applied retroactively to ensure payments are properly captured at both the line level and the header level for reporting and analysis purposes.
UHC, DOM and Conduent (FAC) Finding 3.7	Activity 3: Analyze Encounter Data Pages 34-36	Errors were noted in key data component testing between sample claims and the FAC encounter data.	DOM, UHC, and Conduent should review and possibly update of the data dictionary to address errors related to the claims sample data containing values differing from the encounter data. A crosswalk between the UB04 and 1500 claim forms to the encounter data should be summarized to ensure proper fields are utilized in reporting.

Entity/Finding #	Activity #/ Page Reference	Finding	Recommendation
DOM and UHC Finding 3.8	Activity 3: Analyze Encounter Data Pages 35-36	Higher error rates and surplus encounters were noted in dental and pharmacy service types when compared with other service types. Both of these are subcontracted vendors for UHC.	DOM should require UHC to increase oversight of UHC's subcontractors related to encounter data to address the high error rates in key data component testing and surplus encounter data. UHC should provide DOM an action plan for improvement in its data.
UHC and DOM Finding 3.9	Activity 3: Analyze Encounter Data Page 44	As identified in Table 11 MississippiCAN and UHC CAN - Timeliness of Payment on page 41, all of UHC's dental and pharmacy claims were paid within the first 60 days. A very small percentage of UHC's institutional (1.1 percent) and professional (1.4 percent) claims took over 90 days to process and therefore fell outside the contractual requirement which states, "The contractor will be responsible for processing claims within ninety calendar days of receipt…"	UHC should continue to monitor and ensure subcontractors are processing and paying claims within contractual requirements. DOM should continue to hold UHC responsible for contract compliance.
UHC and DOM Finding 3.10	Activity 3: Analyze Encounter Data Pages 44-45	As identified in Table 12 MississippiCAN and UHC CAN - Timeliness of Submitting Encounters on page 41, encounter records reflect submission dates more than 120 days after the claim payment for institutional, professional, and dental service types. According to the contract, encounter records are required to be submitted by the last day of the 3rd month after the payment/adjudication calendar month in which the contractor paid/adjudicated the claim. There were 9.5 percent of institutional encounters, 9.7 percent of professional encounters, and 31.7 percent of dental encounters that were submitted to the FAC beyond 120 days.	UHC should monitor and ensure subcontractor encounters are submitted to the FAC within contractual requirements. DOM should continue to hold UHC responsible for contract compliance.
DOM and UHC Finding 4.1	Activity 4: Review of Medical Records Page 52	Medical records chosen as a part the sample were not supplied by UHC from providers for testing of proper medical record documentation to support the encounter data in the FAC.	DOM should require UHC to recoup the funds from the providers not submitting medical record documentation to support the sampled claims. DOM should include enforceable language in its contracts requiring vendors to provide documentation to support Mississippi Medicaid claims, and include penalties for non-compliance. All documents should be available for 10 years from the final date of the contract period or from the date of the completion of any audit, whichever is later to comply with the Managed Care final rule.

Entity/Finding #	Activity #/ Page Reference	Finding	Recommendation
DOM and UHC Finding 4.2	Activity 4: Review of Medical Records Page 52	Overall error rates in the medical record reviews range from 20 percent to 38 percent including errors related to missing records. Professional claims experienced a 38 percent error rate and pharmacy claims had 22 percent error rate.	DOM should ensure there is proper oversight of UHC specific to UHC's program integrity efforts and provider training. UHC should conduct medical record reviews including targeting specific service types with high error rates and implement corrective action plans or penalties for non-compliance with documentation standards. Medical record review results should be shared with DOM. UHC should evaluate and strengthen where appropriate their provider's contractual provisions that define the maximum tolerable error rates and the potential monetary and/or legal consequences for failure to properly document services rendered to its members. Further, UHC should have a provision to verify whether the services that were represented as delivered were actually received by Mississippi Medicaid enrollees. In accordance with the Medicaid final rule, the application of this verification should occur on a regular basis. DOM's and UHC's program integrity sections should coordinate efforts to ensure that DOM has the ability to direct specific reviews and/or independently review the results from these medical record reviews to maintain proper oversight and monitoring in accordance with the Medicaid Managed Care Final Rule requirements.

Appendix A: Volume, Member Utilization, Demographic Statistics and Per Member Costs

The table on page 38 showed summary encounters by type with an encounter defined by a combination of a plan, a member, a provider, a date, and a claim type (institutional, professional, dental). In the services/utilization tables, the same criteria was used, but gender and age were also added. Cases were identified where both gender and age caused the identification of 562 additional encounters and a slight variation in the total dollars. Denied encounters were not excluded for either analysis. Documentation indicates the denied encounters are the primary cause of the variance. They have been intentionally left in the analysis because we are showing what services were rendered, even if they were not paid for.

Table 22: Utilization Compared by Age and Gender

	MS CAN			UHC CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Members						
Member Months						
Ages 0 - 9	1,829,945	929,563	900,382	926,862	472,449	454,413
Ages 10 - 17	1,172,729	592,620	580,109	610,249	309,266	300,983
Ages 18 - 34	843,727	176,469	667,258	407,810	85,455	322,355
Ages 35 - 49	379,373	91,404	287,969	171,869	41,914	129,955
Ages 50 - 64	297,680	122,637	175,043	122,765	51,203	71,562
Ages 65 - 74	773	241	532	370	116	254
Total	**4,524,227**	**1,912,934**	**2,611,293**	**2,239,925**	**960,403**	**1,279,522**
Average Number of Members[1]						
Ages 0 - 9	152,495	77,464	75,032	77,239	39,371	37,868
Ages 10 - 17	97,727	49,385	48,342	50,854	25,772	25,082
Ages 18 - 34	70,311	14,706	55,605	33,984	7,121	26,863
Ages 35 - 49	31,614	7,617	23,997	14,322	3,493	10,830
Ages 50 - 64	24,807	10,220	14,587	10,230	4,267	5,964
Ages 65 - 74	64	20	44	31	10	21
Total	**377,019**	**159,411**	**217,608**	**186,660**	**80,034**	**106,627**
Total Utilization						
Total Number of (all) Services						
Ages 0 - 9	2,869,043	1,550,885	1,318,158	1,458,018	790,736	667,282
Ages 10 - 17	1,732,524	845,715	886,809	914,770	447,295	467,475
Ages 18 - 34	2,424,047	381,556	2,042,491	1,168,978	184,039	984,939
Ages 35 - 49	1,745,227	389,036	1,356,191	783,326	183,181	600,145
Ages 50 - 64	1,971,100	711,158	1,259,942	809,315	297,326	511,989

	MS CAN			UHC CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Ages 65 - 74	6,127	1,536	4,591	3,179	781	2,398
Total	**10,748,068**	**3,879,886**	**6,868,182**	**5,137,586**	**1,903,358**	**3,234,228**
Services (all) Per Member[2]						
Ages 0 - 9	18.8	20.0	17.6	18.9	20.1	17.6
Ages 10 - 17	17.7	17.1	18.3	18.0	17.4	18.6
Ages 18 - 34	34.5	25.9	36.7	34.4	25.8	36.7
Ages 35 - 49	55.2	51.1	56.5	54.7	52.4	55.4
Ages 50 - 64	79.5	69.6	86.4	79.1	69.7	85.9
Ages 65 - 74	95.1	76.5	103.6	103.1	80.8	113.3
Total	**28.5**	**24.3**	**31.6**	**27.5**	**23.8**	**30.3**
Institutional Utilization						
Total Number of (all) Services						
Ages 0 - 9	239,640	128,666	110,974	125,230	67,479	57,751
Ages 10 - 17	108,610	50,124	58,486	59,492	27,560	31,932
Ages 18 - 34	235,577	28,727	206,850	117,022	14,762	102,260
Ages 35 - 49	138,746	29,926	108,820	66,316	16,315	50,001
Ages 50 - 64	135,505	47,743	87,762	61,307	22,023	39,284
Ages 65 - 74	518	96	422	218	69	149
Total	**858,596**	**285,282**	**573,314**	**429,585**	**148,208**	**281,377**
Services (all) Per Member[2]						
Ages 0 - 9	1.6	1.7	1.5	1.6	1.7	1.5
Ages 10 - 17	1.1	1.0	1.2	1.2	1.1	1.3
Ages 18 - 34	3.4	2.0	3.7	3.4	2.1	3.8
Ages 35 - 49	4.4	3.9	4.5	4.6	4.7	4.6
Ages 50 - 64	5.5	4.7	6.0	6.0	5.2	6.6
Ages 65 - 74	8.0	4.8	9.5	7.1	7.1	7.0
Total	**2.3**	**1.8**	**2.6**	**2.3**	**1.9**	**2.6**
Professional Utilization						
Total Number of (all) Services						
Ages 0 - 9	1,440,090	785,855	654,235	733,338	401,414	331,924
Ages 10 - 17	840,465	422,620	417,845	439,322	221,768	217,554
Ages 18 - 34	1,204,642	194,416	1,010,226	589,109	94,145	494,964
Ages 35 - 49	735,280	173,763	561,517	339,391	84,540	254,851
Ages 50 - 64	811,434	301,948	509,486	347,332	131,261	216,071
Ages 65 - 74	2,890	669	2,221	1,607	391	1,216

	MS CAN			UHC CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Total	**5,034,801**	**1,879,271**	**3,155,530**	**2,450,099**	**933,519**	**1,516,580**
Services (all) Per Member[2]						
Ages 0 - 9	9.4	10.1	8.7	9.5	10.2	8.8
Ages 10 - 17	8.6	8.6	8.6	8.6	8.6	8.7
Ages 18 - 34	17.1	13.2	18.2	17.3	13.2	18.4
Ages 35 - 49	23.3	22.8	23.4	23.7	24.2	23.5
Ages 50 - 64	32.7	29.5	34.9	34.0	30.8	36.2
Ages 65 - 74	44.9	33.3	50.1	52.1	40.4	57.4
Total	**13.4**	**11.8**	**14.5**	**13.1**	**11.7**	**14.2**
Dental Utilization						
Total Number of (all) Services						
Ages 0 - 9	162,206	80,936	81,270	84,757	42,637	42,120
Ages 10 - 17	169,046	75,426	93,620	90,763	40,707	50,056
Ages 18 - 34	45,904	9,326	36,578	23,945	4,999	18,946
Ages 35 - 49	14,718	2,799	11,919	7,397	1,452	5,945
Ages 50 - 64	7,853	3,185	4,668	3,475	1,468	2,007
Ages 65 - 74	13	4	9	8	3	5
Total	**399,740**	**171,676**	**228,064**	**210,345**	**91,266**	**119,079**
Services (all) Per Member[2]						
Ages 0 - 9	1.1	1.0	1.1	1.1	1.1	1.1
Ages 10 - 17	1.7	1.5	1.9	1.8	1.6	2.0
Ages 18 - 34	0.7	0.6	0.7	0.7	0.7	0.7
Ages 35 - 49	0.5	0.4	0.5	0.5	0.4	0.5
Ages 50 - 64	0.3	0.3	0.3	0.3	0.3	0.3
Ages 65 - 74	0.2	0.2	0.2	0.3	0.3	0.2
Total	**1.1**	**1.1**	**1.0**	**1.1**	**1.1**	**1.1**
Pharmacy Utilization						
Total Number of (all) Services						
Ages 0 - 9	1,027,107	555,428	471,679	514,693	279,206	235,487
Ages 10 - 17	614,403	297,545	316,858	325,193	157,260	167,933
Ages 18 - 34	937,924	149,087	788,837	438,902	70,133	368,769
Ages 35 - 49	856,483	182,548	673,935	370,222	80,874	289,348
Ages 50 - 64	1,016,308	358,282	658,026	397,201	142,574	254,627
Ages 65 - 74	2,706	767	1,939	1,346	318	1,028
Total	**4,454,931**	**1,543,657**	**2,911,274**	**2,047,557**	**730,365**	**1,317,192**

	MS CAN			UHC CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Services (all) Per Member[2]						
Ages 0 - 9	6.7	7.2	6.3	6.7	7.1	6.2
Ages 10 - 17	6.3	6.0	6.6	6.4	6.1	6.7
Ages 18 - 34	13.3	10.1	14.2	12.9	9.8	13.7
Ages 35 - 49	27.1	24.0	28.1	25.8	23.2	26.7
Ages 50 - 64	41.0	35.1	45.1	38.8	33.4	42.7
Ages 65 - 74	42.0	38.2	43.7	43.7	32.9	48.6
Total	**11.8**	**9.7**	**13.4**	**11.0**	**9.1**	**12.4**

[1] The average number of members was calculated by dividing the total number of member months by 12.
[2] Services per member were calculated by dividing the number of encounters by the average number of members.

Table 23: Utilization Costs in Dollars – By Age Group for Total Utilization, Institutional, Professional, Dental and Pharmacy

	MS CAN			UHC CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Total Utilization ($/Year)						
Total Dollars of (all) Services						
Ages 0 - 9	$ 307,860,482.26	$ 169,368,002.59	$ 138,492,479.67	$ 157,702,051.63	$ 87,295,750.96	$ 70,406,300.67
Ages 10 - 17	$ 202,823,183.21	$ 103,163,415.44	$ 99,659,767.77	$ 108,448,957.59	$ 55,132,983.67	$ 53,315,973.92
Ages 18 - 34	$ 293,909,996.89	$ 51,614,521.67	$ 242,295,475.22	$ 142,800,708.53	$ 24,692,771.33	$ 118,107,937.20
Ages 35 - 49	$ 211,756,697.97	$ 52,505,248.63	$ 159,251,449.34	$ 97,572,586.48	$ 25,179,926.48	$ 72,392,660.00
Ages 50 - 64	$ 255,867,716.27	$ 99,892,956.64	$ 155,974,759.63	$ 107,518,034.88	$ 42,563,023.70	$ 64,955,011.18
Ages 65 - 74	$ 691,462.44	$ 191,348.92	$ 500,113.52	$ 280,179.18	$ 32,215.61	$ 247,963.57
Total	**$1,272,909,539.04**	**$476,735,493.89**	**$ 796,174,045.15**	**$ 614,322,518.29**	**$234,896,671.75**	**$ 379,425,846.54**
Average Cost Per Member Per Year[2]						
Ages 0 - 9	$ 2,018.82	$ 2,186.42	$ 1,845.78	$ 2,041.75	$ 2,217.27	$ 1,859.27
Ages 10 - 17	$ 2,075.40	$ 2,088.96	$ 2,061.54	$ 2,132.55	$ 2,139.25	$ 2,125.67
Ages 18 - 34	$ 4,180.17	$ 3,509.82	$ 4,357.45	$ 4,201.98	$ 3,467.48	$ 4,396.69
Ages 35 - 49	$ 6,698.11	$ 6,893.17	$ 6,636.19	$ 6,812.58	$ 7,209.03	$ 6,684.71
Ages 50 - 64	$ 10,314.47	$ 9,774.50	$ 10,692.78	$ 10,509.64	$ 9,975.12	$ 10,892.10
Ages 65 - 74	$ 10,734.22	$ 9,527.75	$ 11,280.76	$ 9,086.89	$ 3,332.65	$ 11,714.81
Total	**$ 3,376.25**	**$ 2,990.60**	**$ 3,658.76**	**$ 3,291.12**	**$ 2,934.98**	**$ 3,558.45**
Institutional Utilization ($/Year)						
Total Dollars for (all) Services						
Ages 0 - 9	$ 69,608,198.16	$ 39,190,236.37	$ 30,417,961.79	$ 36,472,483.64	$ 20,696,994.88	$ 15,775,488.76
Ages 10 - 17	$ 30,493,022.59	$ 14,692,806.27	$ 15,800,216.32	$ 16,398,558.30	$ 7,854,821.50	$ 8,543,736.80
Ages 18 - 34	$ 80,344,406.06	$ 10,700,797.21	$ 69,643,608.85	$ 39,181,886.93	$ 5,360,032.66	$ 33,821,854.27

Table 23: Utilization Costs in Dollars – By Age Group for Total Utilization, Institutional, Professional, Dental and Pharmacy

	MS CAN			UHC CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Ages 35 - 49	$ 56,223,687.90	$ 12,884,549.55	$ 43,339,138.35	$ 26,632,291.62	$ 6,652,260.56	$ 19,980,031.06
Ages 50 - 64	$ 67,708,049.83	$ 26,696,411.55	$ 41,011,638.28	$ 29,818,047.99	$ 11,791,566.96	$ 18,026,481.03
Ages 65 - 74	$ 176,477.47	$ 8,128.86	$ 168,348.61	$ 73,385.39	$ 5,427.68	$ 67,957.71
Total	**$ 304,553,842.01**	**$104,172,929.81**	**$ 200,380,912.20**	**$ 148,576,653.87**	**$ 52,361,104.24**	**$ 96,215,549.63**
Average Cost Per Member Per Year[2]						
Ages 0 - 9	$ 456.46	$ 505.92	$ 405.40	$ 472.21	$ 525.69	$ 416.59
Ages 10 - 17	$ 312.02	$ 297.52	$ 326.84	$ 322.46	$ 304.78	$ 340.63
Ages 18 - 34	$ 1,142.71	$ 727.66	$ 1,252.47	$ 1,152.95	$ 752.68	$ 1,259.05
Ages 35 - 49	$ 1,778.42	$ 1,691.55	$ 1,805.99	$ 1,859.48	$ 1,904.55	$ 1,844.95
Ages 50 - 64	$ 2,729.43	$ 2,612.24	$ 2,811.54	$ 2,914.65	$ 2,763.49	$ 3,022.80
Ages 65 - 74	$ 2,739.62	$ 404.76	$ 3,797.34	$ 2,380.07	$ 561.48	$ 3,210.60
Total	**$ 807.79**	**$ 653.49**	**$ 920.84**	**$ 795.97**	**$ 654.24**	**$ 902.36**
Professional Utilization ($/Year)						
Total Number of (all) Services						
Ages 0 - 9	$ 138,553,147.97	$ 75,017,380.63	$ 63,535,767.34	$ 69,083,821.35	$ 37,583,264.23	$ 31,500,557.12
Ages 10 - 17	$ 79,957,369.12	$ 39,225,215.84	$ 40,732,153.28	$ 41,940,861.77	$ 20,645,278.55	$ 21,295,583.22
Ages 18 - 34	$ 138,695,084.91	$ 20,291,442.41	$ 118,403,642.50	$ 68,182,929.04	$ 9,661,187.37	$ 58,521,741.67
Ages 35 - 49	$ 73,856,387.71	$ 17,703,250.84	$ 56,153,136.87	$ 33,966,615.40	$ 8,603,705.80	$ 25,362,909.60
Ages 50 - 64	$ 83,146,367.72	$ 31,850,824.57	$ 51,295,543.15	$ 35,115,185.51	$ 13,399,183.00	$ 21,716,002.51
Ages 65 - 74	$ 182,150.77	$ 32,213.84	$ 149,936.93	$ 89,596.32	$ 11,661.96	$ 77,934.36
Total	**$ 514,390,508.20**	**$184,120,328.13**	**$ 330,270,180.07**	**$ 248,379,009.39**	**$ 89,904,280.91**	**$ 158,474,728.48**
Average Cost Per Member Per Year[2]						
Ages 0 - 9	$ 908.57	$ 968.42	$ 846.78	$ 894.42	$ 954.60	$ 831.86

Table 23: Utilization Costs in Dollars – By Age Group for Total Utilization, Institutional, Professional, Dental and Pharmacy

	MS CAN			UHC CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Ages 10 - 17	$ 818.17	$ 794.27	$ 842.58	$ 824.73	$ 801.07	$ 849.04
Ages 18 - 34	$ 1,972.61	$ 1,379.83	$ 2,129.38	$ 2,006.31	$ 1,356.67	$ 2,178.53
Ages 35 - 49	$ 2,336.16	$ 2,324.18	$ 2,339.97	$ 2,371.57	$ 2,463.25	$ 2,342.00
Ages 50 - 64	$ 3,351.78	$ 3,116.60	$ 3,516.54	$ 3,432.43	$ 3,140.25	$ 3,641.49
Ages 65 - 74	$ 2,827.70	$ 1,604.01	$ 3,382.04	$ 2,905.83	$ 1,206.41	$ 3,681.94
Total	**$ 1,364.36**	**$ 1,155.00**	**$ 1,517.73**	**$ 1,330.65**	**$ 1,123.33**	**$ 1,486.26**
Dental Utilization ($/Year)						
Total Number of (all) Services						
Ages 0 - 9	$ 27,922,457.73	$ 14,061,317.83	$ 13,861,139.90	$ 15,412,981.58	$ 7,830,922.25	$ 7,582,059.33
Ages 10 - 17	$ 30,534,531.08	$ 13,654,526.53	$ 16,880,004.55	$ 17,097,138.65	$ 7,699,305.68	$ 9,397,832.97
Ages 18 - 34	$ 7,438,940.72	$ 1,691,269.87	$ 5,747,670.85	$ 4,232,661.57	$ 981,689.97	$ 3,250,971.60
Ages 35 - 49	$ 2,113,319.51	$ 425,790.15	$ 1,687,529.36	$ 1,158,077.60	$ 225,321.70	$ 932,755.90
Ages 50 - 64	$ 1,312,998.82	$ 557,431.63	$ 755,567.19	$ 658,430.32	$ 291,957.25	$ 366,473.07
Ages 65 - 74	$ 2,476.84	$ 271.41	$ 2,205.43	$ 942.87	$ 200.62	$ 742.25
Total	**$ 69,324,724.70**	**$ 30,390,607.42**	**$ 38,934,117.28**	**$ 38,560,232.59**	**$ 17,029,397.47**	**$ 21,530,835.12**
Average Cost Per Member Per Year[2]						
Ages 0 - 9	$ 183.10	$ 181.52	$ 184.74	$ 199.55	$ 198.90	$ 200.22
Ages 10 - 17	$ 312.45	$ 276.49	$ 349.18	$ 336.20	$ 298.74	$ 374.69
Ages 18 - 34	$ 105.80	$ 115.01	$ 103.37	$ 124.55	$ 137.85	$ 121.02
Ages 35 - 49	$ 66.85	$ 55.90	$ 70.32	$ 80.86	$ 64.51	$ 86.13
Ages 50 - 64	$ 52.93	$ 54.54	$ 51.80	$ 64.36	$ 68.42	$ 61.45
Ages 65 - 74	$ 38.45	$ 13.51	$ 49.75	$ 30.58	$ 20.75	$ 35.07
Total	**$ 183.88**	**$ 190.64**	**$ 178.92**	**$ 206.58**	**$ 212.78**	**$ 201.93**

Table 23: Utilization Costs in Dollars – By Age Group for Total Utilization, Institutional, Professional, Dental and Pharmacy

	MS CAN			UHC CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Pharmacy Utilization ($/Year)						
Total Number of (all) Services						
Ages 0 - 9	$ 71,776,678.40	$ 41,099,067.76	$ 30,677,610.64	$ 36,732,765.06	$ 21,184,569.60	$ 15,548,195.46
Ages 10 - 17	$ 61,838,260.42	$ 35,590,866.80	$ 26,247,393.62	$ 33,012,398.87	$ 18,933,577.94	$ 14,078,820.93
Ages 18 - 34	$ 67,431,565.20	$ 18,931,012.18	$ 48,500,553.02	$ 31,203,230.99	$ 8,689,861.33	$ 22,513,369.66
Ages 35 - 49	$ 79,563,302.85	$ 21,491,658.09	$ 58,071,644.76	$ 35,815,601.86	$ 9,698,638.42	$ 26,116,963.44
Ages 50 - 64	$ 103,700,299.90	$ 40,788,288.89	$ 62,912,011.01	$ 41,926,371.06	$ 17,080,316.49	$ 24,846,054.57
Ages 65 - 74	$ 330,357.36	$ 150,734.81	$ 179,622.55	$ 116,254.60	$ 14,925.35	$ 101,329.25
Total	**$ 384,640,464.13**	**$158,051,628.53**	**$ 226,588,835.60**	**$ 178,806,622.44**	**$ 75,601,889.13**	**$ 103,204,733.31**
Average Cost Per Member Per Year[2]						
Ages 0 - 9	$ 470.68	$ 530.56	$ 408.86	$ 475.58	$ 538.08	$ 410.59
Ages 10 - 17	$ 632.76	$ 720.68	$ 542.95	$ 649.16	$ 734.65	$ 561.31
Ages 18 - 34	$ 959.05	$ 1,287.32	$ 872.24	$ 918.17	$ 1,220.27	$ 838.08
Ages 35 - 49	$ 2,516.68	$ 2,821.54	$ 2,419.91	$ 2,500.67	$ 2,776.73	$ 2,411.63
Ages 50 - 64	$ 4,180.34	$ 3,991.12	$ 4,312.91	$ 4,098.21	$ 4,002.96	$ 4,166.35
Ages 65 - 74	$ 5,128.45	$ 7,505.47	$ 4,051.64	$ 3,770.42	$ 1,544.00	$ 4,787.21
Total	**$ 1,020.22**	**$ 991.47**	**$ 1,041.27**	**$ 957.92**	**$ 944.63**	**$ 967.91**

Appendix B:

Myers and Stauffer Encounter Reconciliation Report

Dated March 20, 2017

JANUARY 1, 2015 THROUGH DECEMBER 31, 2016

COMPARISON OF MISSISSIPPI COORDINATED CARE ORGANIZATION ENCOUNTER CLAIMS TO CASH DISBURSEMENTS FOR UNITEDHEALTHCARE COMMUNITY PLAN

MARCH 20, 2017

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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EXECUTIVE SUMMARY

Overview and Use of Encounter Data

The Mississippi Division of Medicaid (DOM) requires that each of the CCOs submit encounter claims data to the DOM's fiscal agent contractor (FAC). To ensure complete and accurate encounter data is being received, Myers and Stauffer provides bi-monthly encounter reconciliations (to test completeness). As part of this process, Myers and Stauffer analyzes Medicaid encounter data that has been submitted by the CCOs to Conduent and completes a comparison of the encounters to cash disbursement journals provided by each CCO. For purposes of this analysis, "encounter data" are claims that have been paid by CCOs or delegated vendors (e.g., vision and pharmacy) to health care providers that have provided health care services to members enrolled with the CCO.

Myers and Stauffer is working closely with DOM and the CCOs to identify deficiencies and propose solutions that will result in high quality and reliable encounter data being submitted and available to the state agency to use to measure and monitor its Medicaid managed care program. Validated encounter data has many uses such as utilization by actuaries as part of their rate setting analyses as well as fulfilling the federal reporting requirements related to the Medicaid Managed Care Final Rule, to provide program management and oversight, and for tracking, accounting and other ad hoc analyses. Section 10.R.6 of the contract between DOM and the CCO states, "*The Contractor shall submit ninety-eight percent (98%) of all Encounter Data, including those of subcontractors or delegated vendors as provided for in the contract Section, both for the original and any adjustment or void… The Contractor's failure to comply may be subject to liquidated damages as outlined in Section 15.E, Liquidated Damages, of the Contract… Ninety-eight percent (98%) of the records in the Contractor's encounter batch submission must pass X12 EDI compliance edits and the Mississippi Medicaid MMIS threshold and repairable compliance edits.*"

The bi-monthly encounter reconciliations also help fulfill part of the work requirements set forth in step number 3 of the Center for Medicare and Medicaid's (CMS) External Quality Review (EQR) Protocol 4, which require a determination of the completeness, accuracy and quality of the encounter data being submitted by each CCO. CMS' External Quality Review, Protocol 4, is an excellent way to assess whether the encounter data can be used to determine program effectiveness, accurately evaluate utilization, identify service gaps and make strong management decisions. In addition, the Protocol evaluates both departmental policies, as well as the policies, procedures and systems of the health plans to identify strengths and opportunities to enhance oversight. The full results of our Protocol 4 work will be issued as a separate report.

March 2017 Encounter Reconciliation Report

The March 2017 Mississippi Encounter Reconciliation report is an analysis of UnitedHealthcare Community Plan's (UHC) fee-for-service and delegated vendors' claims identified in the encounter data compared to the payments to service providers in the cash disbursement journals. Below is a summary of the cumulative completion percentages for all delegated vendors and non-vendor (fee-for-service) encounter paid claims submitted to Conduent (FAC) for the reporting period of January 1, 2015 through December 31, 2016.

Included in this report, starting on page 10, are the potential data issues and assumptions utilized during the completion of this report, as well as our recommendations to the CCO, FAC, and DOM to help identify and correct the root causes of the issues identified. The current methodology utilized to actively engage and promote communication between the aforementioned parties is the usage of a separately provided crosswalk document of the issues, which allows for the capture of the responses and actions being pursued by each party. These responses are incorporated into subsequently issued reports to monitor the status of each issue. We further recommend that the Division of Medicaid utilize these reports as a management oversight tool to track the progress made by the CCO over time and to monitor the CCO's contract compliance with providing complete and accurate encounter information.

This report currently consists of only MississippiCAN encounters and cash disbursement journals (CDJs).

The CHIP encounters in the FAC's data warehouse seem to be near the same level as our last report with almost no paid encounters beyond January 2016. UHC's CHIP cumulative encounter total appears to be approximately 24 percent of the CDJ cumulative total for the paid period, January 1, 2015 through December 31, 2016. It was confirmed by the DOM that UHC has been in the process of submitting historical CHIP encounters and working forward into the reporting period. As these encounters become more complete, we intend to include an analysis of the CHIP encounters in subsequent comparison reports.

UnitedHealthcare Community Plan — Cumulative Completion Percentages		
CCO/Delegated Vendor	**% of Cumulative Total**	**Adjusted % of Cumulative Total**
Entire Plan	96.52%	96.04%
UHC Dental (Dental Services)	108.91%	100.00%
OptumRx (Pharmacy Benefits)	97.26%	97.26%
UHC Fee-for-Service and Other Vendors	95.24%	95.24%

Potential issues that may impact the completion percentages are listed below (A full list and description of all potential issues starts on page 10):

1. The UHC Dental completion percentages exceeding 100 percent (page 16) appear to be due to possible issues with the CDJ transactions and/or encounters. In the third column in the above table, we have limited UHC Dental to a 100 percent completion rate in order to obtain an adjusted Entire Plan completion rate.

DEFINITIONS AND ACRONYMS

The following terms are used throughout this document:

- **Calculated Void Encounter (CV)** – An encounter that Myers and Stauffer LC has identified as being a replacement encounter that does not appear to have a corresponding void of the original encounter in the FAC's data warehouse.
- **Cash Disbursement Journal (CDJ) Monthly Reported Total** – The sum of all payments from a CCO or delegated vendor to service providers for a given month as reported by the CCO to the DOM.
- **CDJ Cumulative Reported Total** – The sum of all payments from a CCO or delegated vendor to service providers for the reconciliation period as reported by the CCO to the DOM. This amount is inclusive of all amounts reported in prior months.
- **Children's Health Insurance Program (CHIP)** – This program provides insurance coverage for uninsured children up to age 19 whose family does not qualify for Medicaid and whose income does not exceed 200% of the federal poverty level. CHIP became a coordinated care program on January 1, 2015, with the two CCOs, UHC and Magnolia Health, being responsible for coordinating services.
- **Coordinated Care Organization (CCO)** – A private organization that has entered into a risk-based contractual arrangement with the Mississippi Division of Medicaid (DOM) to obtain and finance care for enrolled Medicaid members. CCOs receive a capitation or per member per month (PMPM) payment from the DOM for each enrolled member. There are two CCOs operating in Mississippi under a contract that was effective July 1, 2014, Magnolia Health Plan (Magnolia Health) and UnitedHealthcare Community Plan (UHC).
- **Conduent** - State fiscal agent contractor, formerly known as Xerox Health Solutions.
- **Cumulative Encounter Total** – The sum of all encounter submissions stored in the fiscal agent contractor's (FAC) encounter data warehouse. This amount is inclusive of all amounts submitted in prior months.
- **Cumulative Variance** – The difference between the cumulative encounter total and the CDJ cumulative reported total.
- **Fiscal Agent Contractor (FAC)** – A contractor selected to design, develop and maintain the claims processing system (Medicaid Management Information System); Conduent (formerly known as Xerox Health Solutions) is the current FAC.
- **Medicaid Management Information System (MMIS)** – The claims processing system used by the FAC to adjudicate Mississippi Medicaid claims. CCO submitted encounters are loaded into this system and assigned a unique claim identifier.
- **Mississippi Coordinated Access Network (MississippiCAN)** – The state of Mississippi's Medicaid managed care program. Effective July 1, 2014, the Mississippi Division of Medicaid (DOM) started a new contract with two coordinated care organizations, who are responsible for coordinating services for Mississippi Medicaid beneficiaries.
- **Mississippi Division of Medicaid (DOM)** – The division in the Office of the Governor that is responsible for administering Medicaid in Mississippi.
- **Monthly Encounter Total** – The sum of all encounter submissions for a given month stored in the FAC's encounter data warehouse.

- **Monthly Variance** – The difference between the monthly encounter total and the CDJ monthly reported total.
- **Potential Duplicate Encounter (PDUP)** – An encounter that Myers and Stauffer LC has identified as being a potential duplicate of another encounter in the FAC's data warehouse.
- **Truven Health Analytics (Truven)** — Subcontractor to the state's fiscal agent contractor responsible for the encounter data warehouse.

STUDY PURPOSE

The Mississippi Division of Medicaid (DOM) engaged Myers and Stauffer LC to analyze Medicaid encounter data that has been submitted by the coordinated care organizations (CCOs) to Conduent (FAC) and complete a comparison of the encounters to cash disbursement journals provided by each CCO. For purposes of this analysis, "encounter data" are claims that have been paid by CCOs or delegated vendors (e.g., dental and pharmacy) to health care providers that have provided health care services to members enrolled with the CCO. Such claims are submitted to DOM via the FAC for DOM's use in rate setting, federal reporting, program management and oversight, tracking, accounting and other ad hoc analyses. Section 10.R.6 of the contract between DOM and the CCO states, "*The Contractor shall submit ninety-eight percent (98%) of all Encounter Data, including those of subcontractors or delegated vendors as provided for in the contract Section, both for the original and any adjustment or void… The Contractor's failure to comply may be subject to liquidated damages as outlined in Section 15.E, Liquidated Damages, of the Contract… Ninety-eight percent (98%) of the records in the Contractor's encounter batch submission must pass X12 EDI compliance edits and the Mississippi Medicaid MMIS threshold and repairable compliance edits.*"

The Medicaid encounter data encompasses both MississippiCAN and CHIP. However, the CHIP encounters existing in the FAC's data warehouse are still relatively low as of the cutoff date for this report. Therefore, this report includes only MississippiCAN encounter to cash disbursement comparisons. Subsequent reports will include CHIP encounter to cash disbursement comparisons.

DOM requested that, for this study, we estimate the percentage of each CCO delegated vendor paid encounter claims that appear to be included in the FAC's data warehouse. This analysis includes these percentages for all CCO paid claims as well as separate dental and pharmacy delegated vendor encounters paid during the period January 1, 2015 through December 31, 2016. We have also included the percentages for the combined total of remaining vendor and non-vendor CCO paid encounter claims. The remaining vendor encounters that cannot be identified consist of non-emergency transportation, vision and behavioral health.

DATA SOURCES

Myers and Stauffer LC receives encounter data on a monthly basis from the FAC's subcontracted data warehouse vendor, Truven Health Analytics. The data are in a standardized extract containing CCO institutional, medical, and pharmacy encounter claims. These encounter data extracts include claims from the two CCOs, Magnolia Health and UHC, having plan paid dates starting with October 1, 2013.

The data used for this report includes encounter claims received and accepted by the FAC and transmitted to Myers and Stauffer LC through January 30, 2017.

Myers and Stauffer LC also requested cash disbursement journals from each CCO ranging in dates from January 1, 2015 through December 31, 2016 in a standardized monthly format.

ANALYSIS

Encounter claims 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 CCO paid date, CCO identification number and specific delegated vendor criteria. Cash disbursements submitted by the CCO were summarized by paid date and delegated vendor 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 CCO, we identified UHC encounters as follows:

- ***UHC Dental – Dental Services***
  - Claim Type Code value of 'D'.

- ***OptumRx - Pharmacy Benefit***
  - These encounters are contained in separate data warehouse tables as a result of pharmacy claim submissions processing.

- ***UHC - Fee-for-Service and Other Vendors***
  - All other plan submitted encounter claims that do not meet the listed criteria. This includes UHC non-vendor (fee-for-service) and the following delegated vendors that at the present time cannot be separately identified:
    - ***MTM (non-emergency transportation)***
    - ***VSP (vision services)***
    - ***Optum Behavioral (behavioral health services)***

POTENTIAL DATA ISSUES AND ANALYSIS ASSUMPTIONS

1. We assume that all data provided to Myers and Stauffer LC is complete and accurate.
2. This analysis only included encounter information that was submitted by the CCOs to the FAC and loaded into the FAC's data warehouse. Encounters submitted by any CCO that were rejected by the FAC for errors in submission or other reasons are excluded from this analysis.
3. The CHIP encounters appearing in the FAC's data warehouse remain near the completion levels in the last report. There appear to be no CHIP pharmacy encounters submitted for the paid period, January 1, 2015 through December 31, 2016. As CHIP encounters continue to be submitted by the CCO, we intend to include an analysis of them in subsequent reports.
4. Voided encounter claims contained within the encounter submissions were coded to match the associated adjustment claim's paid date to allow for the proper matching of cash disbursements that occurred due to this void transaction. However, we were unable to assign a paid date to the void transactions in which there was not an associated adjustment claim.
5. We identified potential duplicate encounter claims. We analyzed the encounter and CDJ submissions to conclude that some of these potential duplicates appear to be partial payments, some are actual duplicate submissions, and some are replacement claims without a matching void. We have attempted to adjust our totals to reflect the actual payment made and have removed duplicate payments from our analysis.
6. We have continued the utilization of the dispense date as the plan paid date for the pharmacy encounters within this reconciliation report. However, we recently identified an additional field within the encounter data that could possibly be the actual delegated vendor's paid date. The field, PYR_ID_DT, in the Truven warehouse encounter table, PHA_HDR_PYR, is defined as the day the CCO paid the claim. This field is located within the MSCAN NCPDP payer sheet at field # 443-E8 OTHER PAYER DATE. UHC has confirmed that this date field is populated with the check date from the claim file provided by OptumRx. They have also confirmed that the transaction date on the CDJ is populated with the check date. We have completed further analysis and have provided UHC with examples where these two dates are not in agreement. UHC is currently reviewing these samples.
7. There are claim adjustment instances in the encounters where the claim adjustment backout is successful, but the corresponding replacement transaction is denied by the FAC. This is creating a series of problems with the encounter data. First, these instances effectively remove paid encounters from the FAC's data warehouse that the CCO may have intended to replace. Additionally, when a CCO submits subsequent replacement transactions (to replace the replacement claim), these are denied due to the original claim already having been removed. As a result, the plan must send the transaction as a new unrelated original encounter in order to have it accepted. This process can produce encounters that may not reflect the CCO's actual claim adjustment activity. According to DOM iTech, this issue was being caused by incorrect CAS codes on the list used to set denial status. UHC provided an updated list of CAS codes on 10/18/16. This list is currently under review by iTech. Once this is completed, either a file maintenance CSR will be submitted to make necessary changes to the list or UHC will be contacted with additional questions. Since our last report, we continue to observe fewer new occurrences of these adjustment transactions.
8. There appear to be instances where the CCO submitted a paid encounter with a claim adjustment reason (CAS) code that was processed by the FAC as CCO-denied. This suggests that the FAC's denial adjustment reason code (ARC) table may not contain the same CAS codes that the CCO is intending to use to identify denied encounters. DOM and UHC have reviewed the list of CAS codes and have informed us that CCO-denied encounters should now be processing correctly. DOM iTech is submitting a CSR that will be submitted to change the process to not set the line and header statuses to deny if the MC encounter paid amount is present. Since our last report, we have observed fewer instances of encounters that were paid by the CCO but processed as CCO-denied.

9. We excluded encounters that were truly denied by the CCO. Encounters denied by the FAC were included and subjected to our potential duplicate encounter logic process which attempts to identify and remove these claims appropriately. However, this methodology artificially inflates the percentages of claim counts and amounts removed as identified in Table 2 - UHC Calculated Void and Duplicate Summary on page 14, since some of these were likely already marked correctly as denied for this very duplicate issue. This is currently the only fair and representative way to ensure that the actual CCO paid encounters remain in our analysis.

10. We instructed the CCOs to exclude referral fees, management fees and other non-encounter related fees from the CDJ data submitted to Myers and Stauffer LC.

11. Interest amounts do not appear to be included in the CCO paid amounts. We have therefore excluded the separately itemized interest expense from the CDJ totals.

12. There are instances where the monthly completion percentages in the entire plan, delegated vendor and/or fee-for-service completion tables on the following pages exceeded 100 percent during some months of the reporting period. These overstated monthly completion rates may be due to a variety of reasons such as encounters included without a corresponding matching CDJ transaction or certain claim voids and replacements that were absent from the encounter data, but were accounted for in the CDJ. Additionally, duplicate claims may have existed in the encounter data that we were unable to identify and remove. Also, CDJ payment dates may not have matched the payment dates that were reported in the encounter data resulting in potential timing differences.

13. As mentioned in the analysis section on page 9, we are not able to identify all of the delegated vendors in the encounters. This may be facilitated by additional identification in the CCO's transaction control number (TCN) that is submitted on the encounter. However, no identification of this type currently exists in the UHC encounters. We are currently working with the DOM to add vendor identification to the encounters.

14. There are significant instances in UHC's encounters where the sum of the claim line paid amounts does not equal the header paid amount. The FAC and UHC have confirmed that we should use the header paid amount in these instances. According to UHC, this issue has been corrected with a fix deployed in June 2016. This fix is on a go-forward basis only.

15. Monthly completion percentages exceeding 100 percent were noted for the UHC Dental vendor encounter claims. To prevent artificial inflation of the overall encounter completion percentages, we have included a separate adjusting line titled "Adjustments" in Table 1 – UHC Total and Table 3 – UHC Dental. This line adjusts the cash disbursement totals to limit the UHC Dental completion percentages to 100 percent. UHC indicated that they have identified several errors during their review and intend to supply us with a corrected CDJ file. This file has not been resubmitted as of this report date.

16. There are numerous instances in the UHC Dental CDJ where an original transaction and its corresponding adjustment void transaction are not found in the FAC's encounter data warehouse. This creates concerns as to whether the FAC is receiving all encounter transactions even if the net paid amount for these transactions is $0. This may also affect the individual monthly completion percentages due to the timing of the transactions. UHC Dental appears to have made a change to the claim number in the CDJ transactions beginning with the October 2016 file. This new claim number is now 18 characters in length. Since the last report, we have also observed a significant increase in the number of UHC Dental encounters having plan claim numbers consisting of 18 characters. UHC indicated that they have identified several errors during their review and intend to supply us with a corrected CDJ file. This file has not been submitted as of this report date.

17. We identified instances in the Medical/Optum Behavioral CDJ files where a behavioral health transaction and a medical transaction appear to have the same plan claim number. The corresponding encounters in the FAC's data warehouse also suggest that these transactions are included as part of the same encounter. We provided examples to UHC and discussed with them how these can occur. The UHC claim adjudication system "tags" claims and claim lines as belonging to Optum Behavioral (UBH) based on a mixed-service protocol between UBH and UHC. The result is that UBH and UHC can potentially have claim lines within the same claim. We have completed an analysis on the

prevalence of this issue using the CDJ transactions and have found that it occurs infrequently and has not occurred since the paid month of December 2015.

18. Every transaction date in the VSP vision CDJ files is four to six days prior to the corresponding encounter plan paid date contained within the FAC's data warehouse. We would expect that the CDJ transaction date would not be prior to the plan's paid date. This implies that the provider is being paid before the claim is adjudicated. UHC has reported that VSP has two paid date definitions. The first definition is the date the claim was processed and submitted for payment. The second definition is the actual date the payment was sent to the provider. Per VSP, the CDJ file was using the first date definition and intends to start utilizing the second date definition. The encounter data is currently using the second date definition, however the encounter data should be using the first date definition. UHC has reported that they are changing to March Vision effective 1/1/2017. They will make the proposed change to the VSP CDJ to use the date the payment was sent to the provider. They will not be able to make the proposed change to the encounter data before the end of the contract. UHC will work with March Vision to ensure the proposed date changes are made for both the CDJ and encounter submissions.

19. Analysis of the encounter data and cash disbursement journals, as well as interactions with the CCOs, DOM and the FAC have resulted in the identification of opportunities for improving the encounter reconciliation process. 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.

UnitedHealthcare Community Plan – Entire Plan

UnitedHealthcare Community Plan appears to have submitted approximately 96 percent of their encounter data for this period, with a cumulative monthly range between 95 percent and 100 percent. Monthly percentages exceeded 100 percent during some months of the reporting period. Please reference potential data issue number 12 on page 11 for an explanation of the possible causes.

Table 1 — UHC Entire Plan

Paid Month	CDJ Monthly Reported Total	Monthly Encounter Total	Monthly Variance	CDJ Cumulative Reported Total	Cumulative Encounter Total	Cumulative Variance	% of Monthly Claims	% of Cumulative Total
January 2015	$32,379,707	$31,983,353	($396,354)	$32,379,707	$31,983,353	($396,354)	98.77%	98.77%
February 2015	$30,519,525	$29,687,401	($832,124)	$62,899,232	$61,670,754	($1,228,478)	97.27%	98.04%
March 2015	$33,896,114	$31,196,112	($2,700,002)	$96,795,346	$92,866,866	($3,928,480)	92.03%	95.94%
April 2015	$38,554,999	$38,397,705	($157,294)	$135,350,345	$131,264,571	($4,085,775)	99.59%	96.98%
May 2015	$40,759,669	$38,836,982	($1,922,687)	$176,110,014	$170,101,553	($6,008,461)	95.28%	96.58%
June 2015	$41,369,718	$42,000,418	$630,699	$217,479,732	$212,101,970	($5,377,762)	101.52%	97.52%
July 2015	$58,192,217	$57,991,999	($200,217)	$275,671,949	$270,093,969	($5,577,979)	99.65%	97.97%
August 2015	$57,427,499	$57,390,283	($37,216)	$333,099,447	$327,484,252	($5,615,195)	99.93%	98.31%
September 2015	$60,594,088	$61,196,412	$602,324	$393,693,535	$388,680,664	($5,012,871)	100.99%	98.72%
October 2015	$59,837,887	$62,152,686	$2,314,799	$453,531,422	$450,833,350	($2,698,072)	103.86%	99.40%
November 2015	$61,480,049	$58,867,671	($2,612,378)	$515,011,471	$509,701,021	($5,310,450)	95.75%	98.96%
December 2015	$62,046,188	$65,452,978	$3,406,790	$577,057,659	$575,153,999	($1,903,660)	105.49%	99.67%
January 2016	$66,083,493	$68,076,980	$1,993,487	$643,141,153	$643,230,979	$89,826	103.01%	100.01%
February 2016	$79,025,899	$76,815,168	($2,210,732)	$722,167,052	$720,046,147	($2,120,905)	97.20%	99.70%
March 2016	$87,969,136	$87,259,773	($709,363)	$810,136,188	$807,305,920	($2,830,269)	99.19%	99.65%
April 2016	$79,379,431	$75,315,044	($4,064,387)	$889,515,619	$882,620,963	($6,894,656)	94.87%	99.22%
May 2016	$77,419,579	$72,225,808	($5,193,771)	$966,935,198	$954,846,771	($12,088,427)	93.29%	98.74%
June 2016	$79,298,500	$75,438,017	($3,860,484)	$1,046,233,699	$1,030,284,788	($15,948,911)	95.13%	98.47%
July 2016	$78,038,352	$72,579,936	($5,458,416)	$1,124,272,050	$1,102,864,724	($21,407,327)	93.00%	98.09%
August 2016	$78,471,717	$75,533,646	($2,938,071)	$1,202,743,767	$1,178,398,370	($24,345,398)	96.25%	97.97%
September 2016	$84,505,725	$78,120,360	($6,385,365)	$1,287,249,492	$1,256,518,730	($30,730,762)	92.44%	97.61%
October 2016	$78,944,996	$71,243,647	($7,701,349)	$1,366,194,488	$1,327,762,377	($38,432,111)	90.24%	97.18%
November 2016	$78,254,575	$73,438,611	($4,815,965)	$1,444,449,063	$1,401,200,988	($43,248,076)	93.84%	97.00%
December 2016	$90,981,344	$80,869,920	($10,111,424)	$1,535,430,407	$1,482,070,908	($53,359,499)	88.88%	96.52%
Adjustments[1]	$7,749,850			$1,543,180,257	$1,482,070,908	($61,109,349)		96.04%

[1] The Adjustments line represents an increase in cash disbursements for UHC Dental to attain a cumulative completion rate of 100 percent. Their encounters exceed 100 percent of CDJ monthly totals on a consistent basis. See issue number 15.

UNITEDHEALTHCARE COMMUNITY PLAN
CALCULATED VOID AND DUPLICATE SUMMARY

The calculated void (CV) and potential duplicate (PDUP) claims that have been identified through the encounter reconciliation analysis are indicated below. These claims have been removed from the encounter reconciliation totals. We will send the potential duplicates and calculated voids to UHC to review. Responses received will be incorporated into the next report. Claims having additional questions for UHC will remain on the list for two consecutive report cycles. After that time, any claims without responses will be marked confirmed as a calculated void or duplicate.

Table 2 — UHC Calculated Void and Duplicate Summary

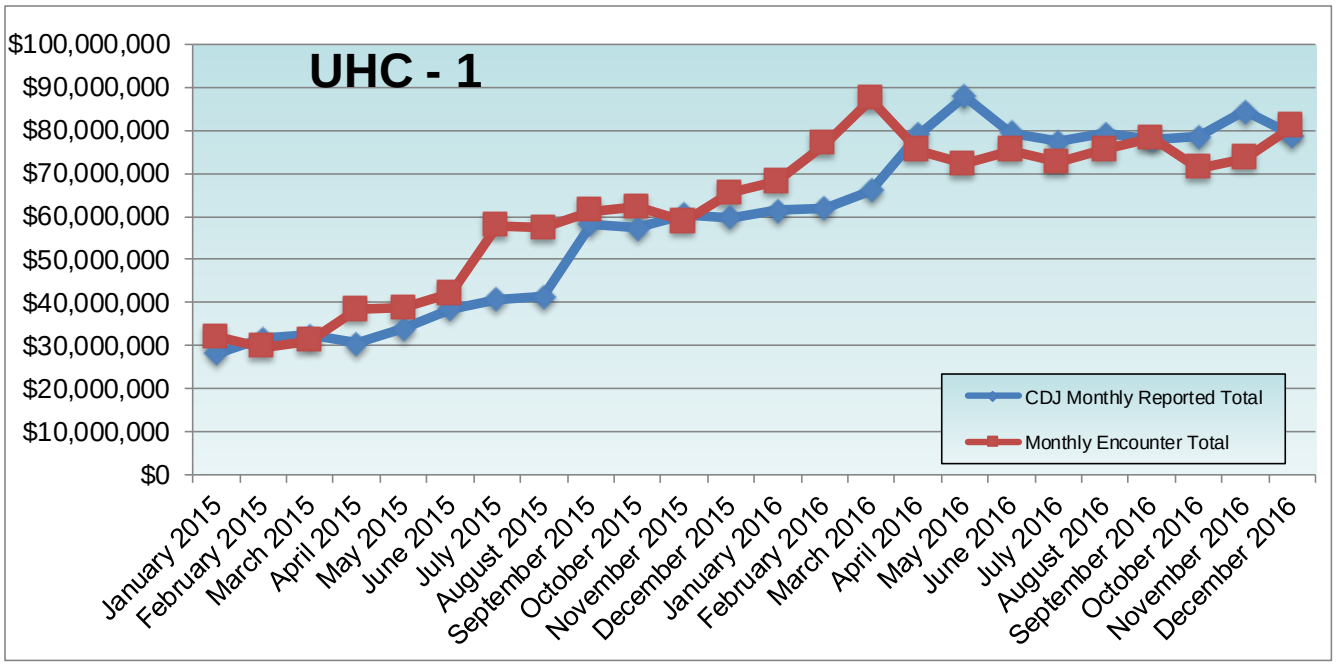
Paid Month	Count of Encounter Claims	Total Sum (CCO Submitted Paid Amount)	Count of CV PDUP Claims	CV PDUP Amount Removed	% of CV PDUP Claim Count	% of CV PDUP Amount Removed
January 2015	344,895	$39,072,036	62,852	$7,088,683	18.22%	18.14%
February 2015	319,361	$34,202,255	43,941	$4,514,854	13.76%	13.20%
March 2015	344,132	$40,181,711	102,742	$8,985,599	29.86%	22.36%
April 2015	464,790	$54,491,653	185,680	$16,093,949	39.95%	29.53%
May 2015	435,014	$49,200,925	101,196	$10,363,944	23.26%	21.06%
June 2015	448,850	$52,997,693	101,747	$10,997,275	22.67%	20.75%
July 2015	597,633	$76,150,474	161,346	$18,158,475	27.00%	23.85%
August 2015	647,724	$77,039,113	193,947	$19,648,830	29.94%	25.51%
September 2015	608,007	$70,882,300	115,131	$9,685,889	18.94%	13.66%
October 2015	640,016	$74,411,240	134,146	$12,258,553	20.96%	16.47%
November 2015	661,383	$76,902,104	257,553	$18,034,433	38.94%	23.45%
December 2015	694,769	$85,591,149	241,283	$20,138,171	34.73%	23.53%
January 2016	561,112	$84,088,595	91,990	$16,011,615	16.39%	19.04%
February 2016	605,438	$97,010,839	96,855	$20,195,672	16.00%	20.82%
March 2016	651,395	$101,880,609	65,541	$14,620,836	10.06%	14.35%
April 2016	640,336	$84,811,555	94,171	$9,496,511	14.71%	11.20%
May 2016	593,907	$76,861,767	37,689	$4,635,960	6.35%	6.03%
June 2016	584,453	$79,638,731	34,317	$4,200,714	5.87%	5.27%
July 2016	551,776	$78,204,712	49,471	$5,624,776	8.97%	7.19%
August 2016	644,974	$79,738,238	44,060	$4,204,593	6.83%	5.27%
September 2016	654,269	$84,357,290	73,181	$6,236,930	11.19%	7.39%
October 2016	650,666	$76,402,178	40,303	$5,158,531	6.19%	6.75%
November 2016	611,290	$76,800,736	26,472	$3,362,125	4.33%	4.38%
December 2016	590,216	$85,247,813	36,353	$4,377,893	6.16%	5.14%
TOTALS	**13,546,406**	**1,736,165,716**	**2,391,967**	**254,094,811**	**17.66%**	**14.64%[1]**

Count of Encounter Claims – The number of claims processed by the FAC (including claims marked as denied by the FAC).
Total Sum (CCO Submitted Paid Amount) – The total paid amount of claims in a month per the encounter data provided by the FAC.
Count of CV PDUP Claims – The number of claims identified by Myers and Stauffer LC as potential calculated voids and duplicates as well as calculated voids and duplicates confirmed by the CCO.
CV PDUP Amount Removed – The paid amount removed from the Monthly Encounter Total based on Myers and Stauffer LC's analysis of calculated void and duplicate claims.
% of CV PDUP Claim Count – The percentage of CV PDUP claims out of the total number of encounter claims.
% of CV PDUP Amount Removed – The percentage of paid amount removed from the total CCO submitted paid amount.

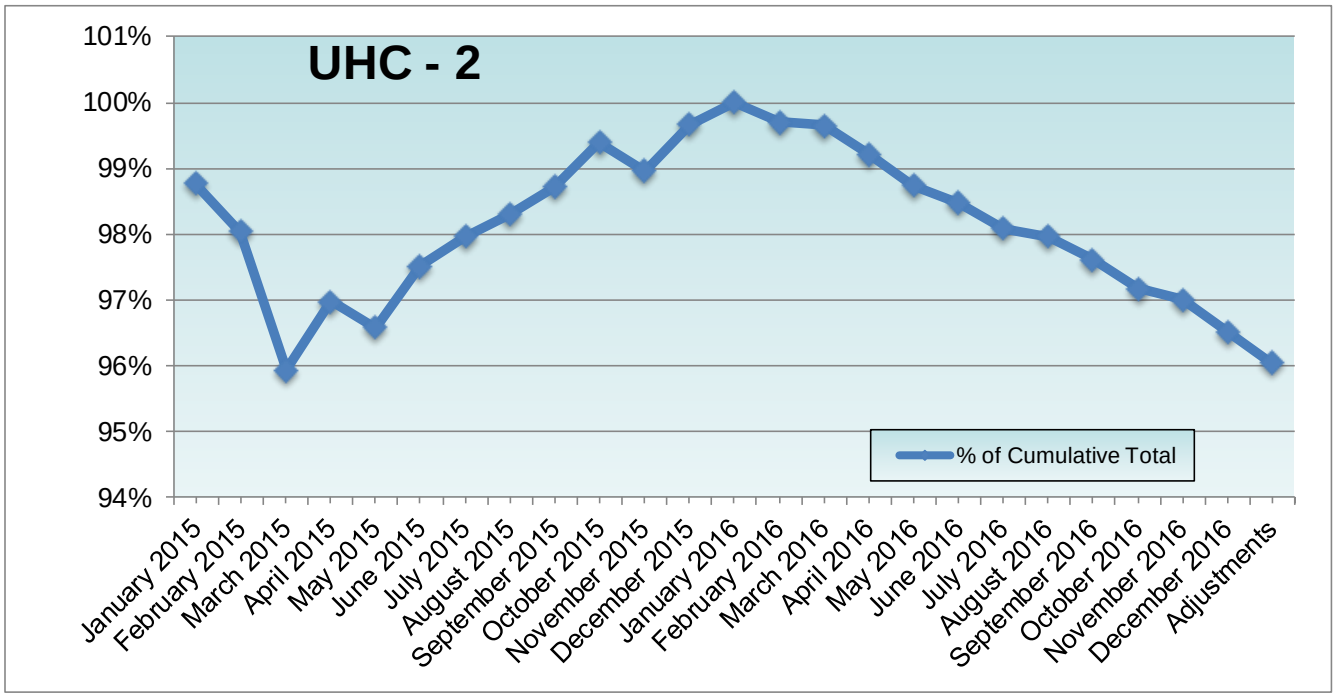
[1] These percentages are somewhat higher than usually expected due to our current methodology which includes system-denied encounters. Please reference potential issue number 9 on page 11.

UNITEDHEALTHCARE COMMUNITY PLAN SUMMARY REPORTING CHARTS

UHC's CDJ totals and encounter totals as reported monthly.



UHC's cumulative encounter submissions expressed as a percentage of payments submitted to the FAC to reported MCO CDJ payments.



Reported UHC vendors include UHC Dental (Dental) and OptumRx (Pharmacy).

UnitedHealthcare Community Plan – UHC Dental (Dental Services)

UnitedHealthcare Community Plan appears to have submitted approximately 100 percent of the UHC Dental encounter data for this period, with a cumulative monthly range between 86 percent and 100 percent. Monthly percentages exceeded 100 percent during some months of the reporting period. Please reference potential data issue number 12 on page 11 for an explanation of the possible causes.

Table 3 — UHC Dental (Dental)

Paid Month	CDJ Monthly Reported Total	Monthly Encounter Total	Monthly Variance	CDJ Cumulative Reported Total	Cumulative Encounter Total	Cumulative Variance	% of Monthly Claims	% of Cumulative Total
January 2015	$1,049,019	$907,641	($141,378)	$1,049,019	$907,641	($141,378)	86.52%	86.52%
February 2015	$702,529	$774,965	$72,436	$1,751,548	$1,682,606	($68,942)	110.31%	96.06%
March 2015	$719,569	$770,002	$50,433	$2,471,117	$2,452,609	($18,508)	107.00%	99.25%
April 2015	$883,060	$994,616	$111,556	$3,354,177	$3,447,225	$93,047	112.63%	102.77%
May 2015	$1,379,885	$1,548,365	$168,480	$4,734,062	$4,995,589	$261,527	112.20%	105.52%
June 2015	$2,134,512	$2,426,900	$292,388	$6,868,574	$7,422,490	$553,916	113.69%	108.06%
July 2015	$4,124,694	$4,740,359	$615,665	$10,993,268	$12,162,848	$1,169,580	114.92%	110.63%
August 2015	$4,409,738	$5,173,978	$764,241	$15,403,006	$17,336,827	$1,933,821	117.33%	112.55%
September 2015	$2,961,220	$3,370,239	$409,019	$18,364,226	$20,707,066	$2,342,840	113.81%	112.75%
October 2015	$4,566,621	$5,189,308	$622,687	$22,930,847	$25,896,373	$2,965,526	113.63%	112.93%
November 2015	$4,162,796	$4,747,494	$584,697	$27,093,644	$30,643,867	$3,550,224	114.04%	113.10%
December 2015	$4,521,049	$5,137,972	$616,923	$31,614,693	$35,781,840	$4,167,147	113.64%	113.18%
January 2016	$4,005,477	$4,703,288	$697,811	$35,620,170	$40,485,128	$4,864,958	117.42%	113.65%
February 2016	$4,158,749	$4,843,096	$684,347	$39,778,919	$45,328,224	$5,549,305	116.45%	113.95%
March 2016	$4,151,320	$3,470,588	($680,733)	$43,930,239	$48,798,812	$4,868,572	83.60%	111.08%
April 2016	$5,232,266	$5,686,175	$453,909	$49,162,505	$54,484,987	$5,322,482	108.67%	110.82%
May 2016	$4,372,379	$3,715,726	($656,652)	$53,534,883	$58,200,713	$4,665,830	84.98%	108.71%
June 2016	$3,491,672	$3,755,737	$264,065	$57,026,556	$61,956,450	$4,929,894	107.56%	108.64%
July 2016	$4,922,562	$5,280,902	$358,340	$61,949,117	$67,237,352	$5,288,235	107.27%	108.53%
August 2016	$6,425,995	$7,044,020	$618,025	$68,375,112	$74,281,372	$5,906,260	109.61%	108.63%
September 2016	$5,365,460	$5,811,700	$446,240	$73,740,572	$80,093,072	$6,352,500	108.31%	108.61%
October 2016	$4,259,713	$4,554,496	$294,783	$78,000,285	$84,647,568	$6,647,283	106.92%	108.52%
November 2016	$4,381,610	$4,858,523	$476,914	$82,381,895	$89,506,091	$7,124,196	110.88%	108.64%
December 2016	$4,562,698	$5,188,352	$625,654	$86,944,593	$94,694,443	$7,749,850	113.71%	108.91%
Adjustments[1]	$7,749,850			$94,694,443	$94,694,443	$0		100.00%

[1] The Adjustments line represents an increase in cash disbursements for UHC Dental to attain a cumulative completion rate of 100 percent. Their encounters exceed 100 percent of CDJ monthly totals on a consistent basis. See issue number 15.

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UnitedHealthcare Community Plan – OptumRx (Pharmacy Benefits)

UnitedHealthcare Community Plan appears to have submitted approximately 97 percent of the OptumRx pharmacy benefit encounter data for this period, with a cumulative monthly range between 96 percent and 100 percent. Monthly percentages exceeded 100 percent during some months of the reporting period. Please reference potential data issue number 12 on page 11 for an explanation of the possible causes.

Table 4 — UHC OptumRx (Pharmacy Benefits)

Paid Month	CDJ Monthly Reported Total	Monthly Encounter Total	Monthly Variance	CDJ Cumulative Reported Total	Cumulative Encounter Total	Cumulative Variance	% of Monthly Claims	% of Cumulative Total
January 2015	$10,335,156	$10,281,666	($53,490)	$10,335,156	$10,281,666	($53,490)	99.48%	99.48%
February 2015	$8,627,420	$10,348,895	$1,721,476	$18,962,576	$20,630,561	$1,667,985	119.95%	108.79%
March 2015	$13,545,917	$11,277,801	($2,268,116)	$32,508,492	$31,908,362	($600,131)	83.25%	98.15%
April 2015	$11,414,290	$11,120,848	($293,441)	$43,922,782	$43,029,210	($893,572)	97.42%	97.96%
May 2015	$13,638,858	$12,570,298	($1,068,560)	$57,561,640	$55,599,508	($1,962,132)	92.16%	96.59%
June 2015	$14,263,134	$14,744,148	$481,015	$71,824,774	$70,343,656	($1,481,118)	103.37%	97.93%
July 2015	$16,673,163	$16,698,722	$25,559	$88,497,937	$87,042,378	($1,455,559)	100.15%	98.35%
August 2015	$18,395,316	$17,983,633	($411,683)	$106,893,252	$105,026,011	($1,867,241)	97.76%	98.25%
September 2015	$17,879,070	$18,329,497	$450,427	$124,772,322	$123,355,509	($1,416,814)	102.51%	98.86%
October 2015	$16,724,683	$18,508,455	$1,783,772	$141,497,006	$141,863,964	$366,958	110.66%	100.25%
November 2015	$21,740,306	$18,189,057	($3,551,249)	$163,237,312	$160,053,021	($3,184,291)	83.66%	98.04%
December 2015	$16,174,030	$18,753,654	$2,579,624	$179,411,342	$178,806,675	($604,666)	115.94%	99.66%
January 2016	$16,925,583	$19,098,913	$2,173,330	$196,336,924	$197,905,588	$1,568,664	112.84%	100.79%
February 2016	$20,174,405	$19,652,987	($521,418)	$216,511,330	$217,558,575	$1,047,246	97.41%	100.48%
March 2016	$17,835,657	$20,687,578	$2,851,921	$234,346,987	$238,246,153	$3,899,166	115.98%	101.66%
April 2016	$16,772,892	$15,230,572	($1,542,320)	$251,119,879	$253,476,725	$2,356,846	90.80%	100.93%
May 2016	$15,458,208	$14,979,222	($478,986)	$266,578,087	$268,455,947	$1,877,860	96.90%	100.70%
June 2016	$14,919,079	$14,401,921	($517,158)	$281,497,166	$282,857,868	$1,360,703	96.53%	100.48%
July 2016	$16,186,156	$14,150,987	($2,035,170)	$297,683,322	$297,008,855	($674,467)	87.42%	99.77%
August 2016	$15,852,546	$16,053,139	$200,593	$313,535,868	$313,061,994	($473,874)	101.26%	99.84%
September 2016	$18,310,092	$15,305,803	($3,004,289)	$331,845,960	$328,367,797	($3,478,163)	83.59%	98.95%
October 2016	$18,811,974	$14,734,709	($4,077,265)	$350,657,934	$343,102,505	($7,555,428)	78.32%	97.84%
November 2016	$15,638,427	$16,002,443	$364,016	$366,296,361	$359,104,948	($7,191,413)	102.32%	98.03%
December 2016	$18,862,006	$15,534,800	($3,327,207)	$385,158,368	$374,639,748	($10,518,620)	82.36%	97.26%

Other UHC vendors that cannot be identified in the encounters include MTM (Non-Emergency Transportation), VSP (Vision) and Optum Behavioral (Behavioral Health).

UnitedHealthcare Community Plan – Fee-for-Service and Other Vendors

UnitedHealthcare Community Plan appears to have submitted approximately 95 percent of the UHC fee-for-service encounter data for this period, with a cumulative monthly range between 93 percent and 99 percent. Monthly percentages exceeded 100 percent during a few months of the reporting period. Please reference potential data issue number 12 on page 11 for an explanation of the possible causes.

Table 5 — UHC Fee-for-Service and Other Vendors

Paid Month	CDJ Monthly Reported Total	Monthly Encounter Total	Monthly Variance	CDJ Cumulative Reported Total	Cumulative Encounter Total	Cumulative Variance	% of Monthly Claims	% of Cumulative Total
January 2015	$20,995,531	$20,794,046	($201,486)	$20,995,531	$20,794,046	($201,486)	99.04%	99.04%
February 2015	$21,189,577	$18,563,541	($2,626,036)	$42,185,108	$39,357,587	($2,827,521)	87.60%	93.29%
March 2015	$19,630,628	$19,148,309	($482,319)	$61,815,737	$58,505,896	($3,309,841)	97.54%	94.64%
April 2015	$26,257,649	$26,282,240	$24,591	$88,073,386	$84,788,136	($3,285,250)	100.09%	96.26%
May 2015	$25,740,926	$24,718,319	($1,022,606)	$113,814,312	$109,506,455	($4,307,856)	96.02%	96.21%
June 2015	$24,972,072	$24,829,369	($142,704)	$138,786,384	$134,335,824	($4,450,560)	99.42%	96.79%
July 2015	$37,394,360	$36,552,919	($841,441)	$176,180,744	$170,888,743	($5,292,001)	97.74%	96.99%
August 2015	$34,622,445	$34,232,672	($389,774)	$210,803,189	$205,121,414	($5,681,775)	98.87%	97.30%
September 2015	$39,753,798	$39,496,676	($257,123)	$250,556,987	$244,618,090	($5,938,897)	99.35%	97.62%
October 2015	$38,546,582	$38,454,923	($91,659)	$289,103,569	$283,073,013	($6,030,557)	99.76%	97.91%
November 2015	$35,576,946	$35,931,120	$354,174	$324,680,516	$319,004,133	($5,676,383)	100.99%	98.25%
December 2015	$41,351,109	$41,561,351	$210,242	$366,031,625	$360,565,484	($5,466,141)	100.50%	98.50%
January 2016	$45,152,434	$44,274,779	($877,655)	$411,184,058	$404,840,263	($6,343,795)	98.05%	98.45%
February 2016	$54,692,745	$52,319,085	($2,373,660)	$465,876,804	$457,159,348	($8,717,456)	95.66%	98.12%
March 2016	$65,982,159	$63,101,607	($2,880,551)	$531,858,962	$520,260,955	($11,598,007)	95.63%	97.81%
April 2016	$57,374,273	$54,398,296	($2,975,976)	$589,233,235	$574,659,252	($14,573,984)	94.81%	97.52%
May 2016	$57,588,993	$53,530,859	($4,058,134)	$646,822,228	$628,190,111	($18,632,117)	92.95%	97.11%
June 2016	$60,887,749	$57,280,359	($3,607,391)	$707,709,977	$685,470,469	($22,239,508)	94.07%	96.85%
July 2016	$56,929,634	$53,148,048	($3,781,586)	$764,639,611	$738,618,517	($26,021,094)	93.35%	96.59%
August 2016	$56,193,176	$52,436,486	($3,756,689)	$820,832,787	$791,055,003	($29,777,784)	93.31%	96.37%
September 2016	$60,830,173	$57,002,857	($3,827,315)	$881,662,960	$848,057,861	($33,605,099)	93.70%	96.18%
October 2016	$55,873,309	$51,954,443	($3,918,866)	$937,536,269	$900,012,303	($37,523,966)	92.98%	95.99%
November 2016	$58,234,538	$52,577,645	($5,656,894)	$995,770,807	$952,589,948	($43,180,859)	90.28%	95.66%
December 2016	$67,556,640	$60,146,769	($7,409,871)	$1,063,327,447	$1,012,736,717	($50,590,730)	89.03%	95.24%