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

Magnolia Health Plan

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

Table of Contents

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's., 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's 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 United Healthcare 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).
- **Magnolia Health Plan (Magnolia)** – A coordinated care organization (CCO) participating in the Mississippi Medicaid managed care program.
- **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 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 CCO's plan members. Also known as a delegated vendor.
- **Surplus** – As defined within the 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.
- **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 visit to the Magnolia/Centene St. Louis, Missouri encounter data center, Myers and Stauffer also met with the FAC (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]

[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

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 time frame 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 42 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 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 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) 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.

7) At the time of the Conduent on-site review, the diagnosis-related groups (DRGs) submitted by the CCOs were not being saved or stored. DOM and Conduent worked to resolve this issue and a fix was implemented July 11, 2016.

8) 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.

9) 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.

10) 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.

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

7) The FAC should capture and retain all encounter data as submitted by the CCOs.

8) DOM and the FAC should continue working with the plans to resolve all issues related to CAS codes.

9) 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.

10) 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 CCO's 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 April 27, 2016 at Magnolia's local office in Jackson, Mississippi and from June 6-8, 2016 at the Magnolia (Centene) corporate offices in St. Louis, Missouri. 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. Magnolia personnel were readily available and provided a comprehensive view of their encounter data processes.

Based on Magnolia's responses to the Myers and Stauffer survey, the details provided on the Information System Capability Assessment, 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 Magnolia/Centene 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) There is an opportunity to improve enrollment data in terms of system-to-system validation. The CCO's intake systems may have different member addresses than the Unified Member View (UMV) system. Since the case managers physically visit members and have more updated address information, their system tends to be more up-to-date than the UMV system, which is based

on the 834 file. If a report is pulled from the Enterprise Data Warehouse (EDW), there may be variances in data due to what system is being queried.

2) There is limited oversight and validation of subcontractor encounter submissions. Often, the data is passed through with minimal checks for completion or subsequent validation by Magnolia.

3) The CCO receives acknowledgment of the files from the FAC, but does not receive control totals. Receipt of control totals would enable the CCO to ensure the number of encounters submitted in the files are correctly received and loaded by the FAC.

4) Centene operates two redundant IT systems 40 miles apart. In the event of a power outage, storm, or other issue affecting their main campus facility operations center, it is possible the disaster recovery facility would also be affected and this could hinder Magnolia's ability to resume normal operations in a timely manner.

5) Penetration testing is performed annually for Centene by an outside vendor, CISCO. In 2015, the vendor was able to access the system during testing. Changes were made to security based on the testing.

Recommendations

1) Magnolia should implement a process to conduct system to system validations to help ensure the most accurate and up-to-date information is available across systems.

2) Magnolia should explore implementing a more thorough quality assurance and audit process to verify the completeness and accuracy of encounter data from their subcontractors. 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.

3) The CCO should modify its 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.

4) Magnolia (Centene) should ensure there is sufficient geographic distance between the operations center and disaster recovery center. Centene is scheduled to transition to a disaster recovery site in Rancho Cordova, California on December 9, 2017. So in the future, the primary location will be in Missouri with the backup in Rancho Cordova, which is an eastern suburb of Sacramento. This will alleviate concerns related to the geographic proximity of the data centers.

5) Magnolia should continue to perform penetration testing, since previous testing has identified opportunities for security enhancements.

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 month testing periods of January and October 2015 testing of this report, as inpatient services were carved in 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. The 18.31 percent dental completion percentage calculated in the table on the following page is due to $47,992,518 in dental encounters with plan paid dates of 01-01-0001 being excluded from the calculation for calendar year 2015. A portion of the $47,992,518 most likely pertains to 2015 encounters, but how much is unknown. The March 2017 EDV report reflects a 98.93 percent completion percentage for the dental subcontractor for the period January 2015-December 2016 if the $47,992,518 is included for the two year period. The 2015 completion percentages for each service type are reflected on the next page:

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	$ 390,999,451	$ 391,669,927	100.17%
Dental	$ 34,881,425	$ 6,387,072	18.31%
Pharmacy	$ 217,550,513	$ 205,836,139	94.62%
Total	$ 643,431,389	$ 603,893,138	93.85%

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 establish 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. The dental completion of 0 percent is due to the FAC encounter paid amounts reflecting $0 payments for 28,541 of the 28,933 sample claims with matching MMIS_ICN/TCN_NUMs. 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*	$ 75,672,216	$ (2,752,334)	$72,919,883	$ 67,934,597	107%
Dental	$ 29,626	$ (21,714)	$ 7,912	$ 6,682,088	0%
Pharmacy	$ 27,882,399	$ (749,804)	$27,132,595	$ 34,660,895	78%

**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 $2,752,334 for outpatient and professional claims, $21,714 for dental claims, and $749,804 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/UB04 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 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-CM code	Valid ICD-9-CM or ICD-10-CM 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

Key Data Element	Header/Line Level	Error Rate							
		Outpatient		Professional		Dental		Pharmacy	
		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%				
Header Last DOS	Header Level	0.0%	0.0%	0.0%	0.0%				
Header Paid Amount	Header Level	0.0%	1.8%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Service/Rendering Provider NPI	Header Level	0.0%	0.0%	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%	1.8%	0.0%	0.0%	44.8%	0.0%	0.0%	0.0%
Plan Received Date	Header Level	0.6%	1.8%	0.4%	0.0%	94.2%	0.0%	0.0%	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%	N/A	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		

Error Rate										
		Outpatient		Professional		Dental		Pharmacy	
Key Data Element	Header/Line Level	Invalid	Null	Invalid	Null	Invalid	Null	Invalid	Null
Date Filled	Line Level	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	0.0%	0.0%
Days Supply	Line Level	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	0.0%	0.0%
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:** There were minor invalid values for the Plan Received Date data element values. In addition there were null amounts for the following key data element values: Header Paid Amount; Plan Paid Date; Plan Received Date and Diagnosis codes.

2) **Dental Key Data Elements:** There were invalid values reported for the following required key data element values: Plan Paid Date and Plan Received Date. These were populated with 01/01/0001 values.

3) **Pharmacy Key Data Elements:** All Billing Provider NPI data element values were invalid. All values were a length of 5 or 6 instead of the required 10 character length.

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 as 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 contains 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

Key Data Element	Header/Line Level	Error Rate											
		Outpatient			Professional			Dental			Pharmacy		
		Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous
Type of Bill	Header Level	0%	10%	9%									
Former MMIS Claim ICN	Header Level	0%	78%	16%	0%	146%	34%	2%	216%	98%			
Header First DOS	Header Level	0%	10%	2%	0%	16%	4%	1%	117%	2%			
Header Last DOS	Header Level	0%	10%	5%	0%	16%	4%						
Header Paid Amount	Header Level	0%	10%	8%	0%	17%	16%						
MMIS ICN	Header Level	0%	10%	0%	0%	17%	0%	1%	117%	0%	0%	55%	0%
MMIS Member Number	Header Level	0%	10%	0%	0%	17%	0%	1%	117%	1%	0%	54%	43%
Billing Provider NPI	Header Level	0%	10%	1%	0%	17%	63%	1%	117%	64%	0%	55%	100%
Service/Rendering Provider NPI	Header Level	0%	10%	1%	0%	17%	2%	1%	117%	7%	0%	54%	43%
Service Provider Type	Header Level	0%	10%	17%	0%	17%	34%						
Place of Service	Header Level				0%	17%	4%	1%	117%	4%			
Provider Specialty Code	Header Level							No data to test					
Plan Paid Date	Header Level	0%	10%	4%	0%	17%	1%	1%	117%	99%	0%	55%	99%
Plan Received Date	Header Level	0%	10%	2%	0%	17%	0%	1%	117%	97%	0%	55%	99%
Diagnosis Codes	Header Level	0%	10%	2%	0%	16%	16%						
Surgical Procedure Codes	Header Level	No data to test											

Key Data Element	Header/Line Level	Error Rate											
		Outpatient			Professional			Dental			Pharmacy		
		Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous	Missing[1]	Surplus	Erroneous
Plan Paid Amount	Line Level	0%	11%	4%	0%	15%	11%	1%	113%	98%	0%	53%	49%
Procedure Code	Line Level	0%	12%	27%	0%	17%	1%	2%	116%	2%			
Procedure Modifiers	Line Level	0%	12%	27%	0%	17%	1%						
Revenue Code	Line Level	0%	14%	3%									
Billed Charges	Line Level	0%	14%	0%	0%	16%	1%	2%	116%	2%			
Line FDOS	Line Level	0%	14%	9%	0%	17%	5%						
Line LDOS	Line Level	0%	14%	9%	0%	17%	5%						
Tooth Numbers	Line Level							1%	122%	3%			
Tooth Surfaces	Line Level							Incomplete data to test					
Date Filled	Line Level										0%	53%	45%
Days Supply	Line Level										0%	54%	28%
Dispensed Units	Line Level										0%	54%	38%
NDC	Line Level										0%	54%	44%
Refill Number	Line Level										0%	54%	45%
Prescription Number	Line Level										0%	0%	0%
Overall Error Rate		**0%**	**12%**	**10%**	**0%**	**17%**	**8%**	**1%**	**119%**	**32%**	**0%**	**54%**	**45%**

[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

Key Data Element	Header/ Line Level	Number of Data Elements															
		Outpatient				Professional				Dental				Pharmacy			
		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	79,852	8	7,982	6,957												
Former MMIS Claim ICN	Header Level	5,612	8	4,378	925	27,338	17	39,784	9,404	12,601	217	27,199	12,384				
Header First DOS	Header Level	79,866	8	7,982	1,853	502,620	17	81,443	19,124	29,303	217	34,148	547				
Header Last DOS	Header Level	79,867	8	7,982	3,854	502,730	17	81,443	19,637								
Header Paid Amount	Header Level	79,852	8	7,982	6,215	489,091	17	81,443	76,779								
MMIS ICN	Header Level	79,852	8	7,982	-	488,795	17	81,443	-	29,150	217	34,148	-	405,076	283	223,054	-
MMIS Member Number	Header Level	79,852	8	7,982	25	488,795	17	81,443	124	29,150	217	34,148	405	413,277	283	223,054	177,239
Billing Provider NPI	Header Level	79,852	8	7,982	624	488,798	17	81,443	308,867	29,153	218	34,148	18,665	407,116	283	223,054	406,833
Service/Rendering Provider NPI	Header Level	79,852	8	7,982	624	488,799	17	81,443	11,673	29,153	218	34,148	2,142	413,392	283	223,054	177,285
Service Provider Type	Header Level	79,852	8	7,982	13,815	488,797	17	81,443	168,006								
Place of Service	Header Level					489,552	17	81,443	20,429	29,158	217	34,148	1,053				
Provider Specialty Code	Header Level									No data to test							

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
Plan Paid Date	Header Level	79,858	8	7,982	3,181	488,900	17	81,443	7,197	29,150	217	34,148	28,775	405,594	283	223,720	402,837
Plan Re-ceived Date	Header Level	79,852	8	7,982	1,741	488,795	17	81,443	2,212	29,150	217	34,148	28,279	406,406	283	223,054	400,379
Diagnosis Codes	Header Level	79,877	8	7,982	1,792	515,147	17	81,443	82,642								
Surgical Procedure Codes	Header Level	No data to test															
Plan Paid Amount	Line Level	256,546	7	27,311	8,995	687,345	17	103,566	78,629	91,964	1,346	104,352	90,487	420,746	283	224,725	206,079
Procedure Code	Line Level	427,448	128	51,959	114,006	946,610	27	157,291	8,696	103,325	2,193	120,170	1,725				
Procedure Modifiers	Line Level	427,429	128	51,959	113,958	946,509	27	157,291	8,349								
Revenue Code	Line Level	427,117	126	60,395	11,342												
Billed Charges	Line Level	427,203	128	60,374	1,820	906,333	26	148,204	8,632	102,850	2,042	119,416	2,207				
Line FDOS	Line Level	439,241	128	60,395	37,594	950,989	27	157,291	47,618								
Line LDOS	Line Level	439,240	128	60,395	37,594	951,012	27	157,291	47,631								
Tooth Num-bers	Line Level									31,536	451	38,333	910				
Tooth Surfaces	Line Level									Incomplete data to test							
Date Filled	Line Level													417,475	283	223,054	186,529
Days Supply	Line Level													416,228	283	223,054	116,756

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
Dispensed Units	Line Level													416,286	283	223,054	158,720
NDC	Line Level													413,317	283	223,054	183,124
Refill Number	Line Level													418,817	283	223,054	85,845
Prescription Number	Line Level													406,264	283	223,054	162,075
Total		**3,808,120**	**877**	**472,950**	**366,915**	**11,336,955**	**372**	**1,898,034**	**925,649**	**575,643**	**7,989**	**699,890**	**195,321**	**5,359,994**	**3,679**	**2,902,039**	**2,663,701**

[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 12 percent for outpatient, 17 percent for professional, 119 percent for dental, and 54 percent for pharmacy. 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 89,425 for outpatient/professional and 223,054 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 104,352 surplus paid amount data elements represent 34,148 surplus dental encounters. The surplus dental encounters were slightly impacted by the CCO's original dental subcontractor refusing, or being incapable, of providing claims for January 2015 that should have been included in the claims sample. This dental subcontractor submitted $352,647 of paid encounters in January 2015 based on the EDV reporting. The dental subcontractor did not process any claims payments in October 2015. The total number of surplus encounters and surplus percentage by service type are also reflected 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	658,047	$87,676,991	194,970	$6,184,484	627,847	$ 38,035,383
Encounter Paid Amount for Claims Matched to Sample by ICN	568,622	$75,672,216	90,618	$ 29,626	404,793	$ 27,882,399
Surplus at Encounter Paid Amounts	**89,425**	**$12,004,775**	**104,352**	**$6,154,858**	**223,054**	**$ 10,152,984**
Surplus by Encounter Type						
Final	14,582	$ 1,440,761	29,296	$1,535,783	84,531	$ 9,307,160
Duplicate	8,153	$ 1,251,948	63,758	$3,997,352	2	$ 103
Void	31,248	$ 4,971,548	307	$ (12,639)	4,177	$ 414,878
Denied	7,461	$ -	8,938	$ 513,662	133,347	$ 265,597
Replaced	26,272	$ 3,992,658	662	$ 28,026	985	$ 159,586
Unidentified	1,709	$ 347,860	1,391	$ 92,674	12	$ 5,663

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 Surplus	**89,425**	**$12,004,775**	**104,352**	**$6,154,858**	**223,054**	**$ 10,152,987**
EDV Adjustments		$(10,410,521)		$(4,569,529)		$ (1,237,991)
Surplus at EDV Paid	**89,425**	**$ 1,594,254**	**104,352**	**$ 1,585,329**	**223,054**	**$ 8,914,995**

3) The dollar impact of the surplus encounters for outpatient/professional and dental encounters is less significant after payment adjustments are made for errors related to duplicates, voids, denials and replacements as explained above in the sample month completion table. Because the majority of the surplus encounters in both outpatient/professional and dental service types 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 $10,410,521 for outpatient/professional encounters and $4,569,529 for dental encounters for the two sample months, if the encounter data validation logic is applied to the surplus encounters. The adjusted surplus of outpatient/professional encounters based on paid amounts is $1,594,254 and for dental encounters is $1,585,329. 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. Conversely, the pharmacy surplus encounters contain primarily final encounters excluded from the claim sample submitted by the CCO. 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) **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, 12 percent, and 10 percent, respectively. Procedure Codes and Procedure Code Modifiers experienced the highest error rate of 27 percent for both key data elements. Values which appear to be Revenue Codes are reflected in the Procedure Code field in the claims sample data. Key data elements amounting to 111,404 of the 114,006 errors contained three digit codes, which appear to be Revenue Codes, in the claims sample rather than the five digit procedure codes present in the encounter data. Error rates between the two data elements were similar because the Procedure Code Modifier was tested by joining the Procedure Code with the Procedure Code Modifier to ensure the modifier was assigned to the correct Procedure Code.

5) **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, 17 percent, and 8 percent, respectively. The 63 percent error rate for the Billing Provider NPI data element is primarily due to the Billing Provider NPI in the sample claims data representing the Servicing/Rendering Provider NPI. Key data elements amounting to 297,050 of the 308,867 errors reflect the Billing Provider NPI as the Servicing/Render Provider NPI. The Service Provider Type contained an error rate of 34 percent. This 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 (NPD) 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. Therefore, any service specialty codes not matching exactly were noted as errors. The former MMIS ICN data element also experienced a 34 percent error rate. Of the 9,404 errors noted between the claims sample value and the encounter data value, 6,987 of the encounters did not have a Former MMIS ICN reflected in the FAC encounter data, whereas the matching claim in the sample data had a value in this field.

6) **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 1 percent, 119 percent, and 32 percent, respectively. The Former MMIS ICN produced an error rate of 98 percent in the comparison between the sample claims and the FAC encounter data. Key data elements amounting to 12,368 encounters out of the 12,384 sample claims reflecting a Former MMIS ICN, had no value for the data field in the FAC encounter data. The comparison of Plan Paid Date and Plan Received Dates between the sample claims and the FAC encounter data also resulted in high error rates of 99 percent and 97 percent. Both error rates are the result of the dental subcontractor submitting dates to the FAC of 0001-01-01 for these date fields for 28,279 of the 29,150 claims included in the sample data. The surplus encounters in the FAC encounter data also contained the 0001-01-01 date for these fields.

   An error rate of 98 percent was also noted in the Plan Paid Amount key data component comparison. This error rate is also explained by the FAC encounter data's lack of values for this field in the FAC encounter. As noted in the sample completeness percentage Table 3, paid amounts could only be matched for $29,626 of the total sample dental payments of $5,368,955 which matched between the two data sets based on MMIS_ICN and TCN_NUM. The $5,339,329 in unmatched dental payments included in the sample, may have been paid in subsequent months and are part of the FAC encounter data in another period, or may be part of the surplus encounters. However, the payments do not match with the encounter data based on the MMIS_ICNs provided by the CCO in the sample.

   The 64 percent error rate for the Billing Provider NPI data element is primarily due to the Billing Provider NPI in the sample claims data representing the Servicing/Rendering Provider NPI rather than the Billing Provider NPI. This is consistent with the professional encounters for this data element also. Tooth Surfaces could not be tested between the FAC encounter data and the CCO claims sample due to incomplete data received from the CCO in the claims sample. The sample data contained up to 15 characters for Tooth Surfaces for values which should be one character based on coding guidelines. The encounter data contained one character values where the surfaces were included.

7) **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 0 percent, 54 percent, and 45 percent, respectively. The error rates for all of the pharmacy key data elements are high with the exception of MMIS_ICN, which has a 0 percent error rate. Based on testing, the MMIS_ICN identifiers are inaccurately assigned by the pharmacy subcontractor in its claims system, or inaccurately communicated to the pharmacy subcontractor by the FAC for the January 2015 claims sample resulting in mismatched ICNs with the corresponding encounter data details. Since key data element testing is based on the MMIS_ICN and TCN_NUM match, with the data element matching occurring after the MMIS_ICN to TCN_NUM match, the inaccurate assignment of the MMIS_ICN in the sample data is causing all of the other key data components to reflect the overall 45 percent error rate. The January 2015 claims represented 40 percent of the total sample claims data set, primarily accounting for the overall error rate. When the claims sample and FAC encounter data was matched alternatively based on Prescription Number, MMIS Member Number and Date Filled error rates of less

than 5 percent were reflected for all fields other than Billing Provider NPI, Plan Paid Date, and Plan Received Date.

The Billing Provider NPI comparison resulted in 100 percent error rate as the values in the encounter data were 5 or 6 digit codes whereas the sample data contained 10 digit values, which is standard NPI structure. The Plan Paid Date testing resulted in a 99 percent error rate, as it appears the Plan Paid Date in the claims data is the Date Filled rather than the Plan Paid Date. The Plan Received Date also had a 99 percent error rate. However, in both the FAC encounter data and the claims sample the field is a valid date value. No underlying reason for the error rate was noted in further testing of the key data element correlating to any other dates in the data.

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, and 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) 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 to address errors related to the claims sample data containing values differing from the encounter data. 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.

5) 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.

6) Based on higher error rates and surplus encounters noted for dental and pharmacy service types, the CCO should be required by DOM to increase the oversight of subcontracted vendors and provide DOM with an action plan for improvement in its data. This may include monthly reporting and reconciliations of claims and financial information. The FAC encounter data must include key data

components such as payment dates and payment amounts, both which were erroneous in the dental encounter data in 99 percent and 98 percent respectively of the total claims sample.

7) Due to the importance of the state IDs (ICN/TCN) incorporation into the CCO's data as outlined in the protocol, we recommend further investigation into the pharmacy subcontractor's process for integrating this key data element into its system. Without this unique identifier to link the CCO and FAC data a complete validation of the FAC encounter is unattainable. We also recommend the pharmacy subcontractor incorporate the correct ICNs into its claims processing system to eliminate future issues with resubmissions or replacements containing an incorrect original ICN number.

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.

Volume, Utilization, and Per Member Costs

Volume

As shown in *Table 8: Encounter Expenditures and Volume by Service Type*, Magnolia's encounters comprised $658,587,021 or 51.7 percent of total encounter dollars and 52.2 percent of total MississippiCAN encounters for CY 2015. MississippiCAN spent approximately $1.27 billion 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

	MississippiCAN				Magnolia CAN			
Service Type	CY 2015 Services				CY 2015 Services			
	Expenditures	%	Volume	%	Expenditures	%	Volume	%
Institutional	$304,553,842	23.9%	858,596	8.0%	$155,977,188	23.7%	429,011	7.6%
Professional	$514,390,508	40.4%	5,034,801	46.8%	$266,011,499	40.4%	2,584,702	46.1%
Dental	$69,324,725	5.4%	399,740	3.7%	$30,764,492	4.7%	189,395	3.4%
Pharmacy	$384,640,464	30.2%	4,454,931	41.4%	$205,833,842	31.3%	2,407,374	42.9%
Total	$1,272,909,539	100.0%	10,748,068	100.0%	$658,587,021	100.0%	5,610,482	100.0%
Percentage of MississippiCAN Total					**51.7%**		**52.2%**	

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. Magnolia's utilization was slightly higher with an overall rate of 29.5 encounters per member. The table presents additional data by major service type. More detailed statistics of volume, member utilization, gender, and age are available in *Appendix A: Volume, Member Utilization, Demographic Statistics and Per Member Costs*.

Table 9: Member Utilization

	MississippiCAN	Magnolia CAN	
Utilization by Service Type		Count	Percent of MS CAN
Overview			
Total Member Months	4,524,227	2,284,302	50.5%
Average Number of Members[1]	377,019	190,359	
Total Number of (all) Encounters	10,748,068	5,610,482	52.2%
Encounters (all) Per Member[2]	28.5	29.5	
Institutional Use			
Total Number of Institutional Encounters	858,596	429,011	50.0%
Institutional Encounters Per Member[2]	2.3	2.3	
Professional Use			
Total Number of Professional Encounters	5,034,801	2,584,702	51.3%
Professional Encounters Per Member[2]	13.4	13.6	

Pharmacy Use			
Total Number of Pharmacy Encounters	4,454,931	2,407,374	54.0%
Pharmacy Encounters Per Member[2]	11.8	12.6	
Dental Use			
Total Number of Dental Encounters	399,740	189,395	47.4%
Dental Encounters Per Member[2]	1.1	1.0	

[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 Magnolia per member per year (PMPY) by service type compared to the MississippiCAN Program. In total, the CY 2015 average Magnolia CAN per member per year (PMPY) cost was $3,459.72 and about 2.47 percent higher than the MississippiCAN PMPY of $3,376.25. In both Mississippi CAN and Magnolia CAN, by service type, Professional Services had the highest PMPY and Dental Services had the lowest PMPY. Additional detail 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	Magnolia CAN	Variance	
Service Type	**CY 2015 PMPY[1]**	**CY 2015 PMPY[1]**	**Dollars**	**Percent**
Institutional	$807.79	$819.39	$11.60	1.44%
Professional	$1,364.36	$1,397.42	$33.06	2.42%
Dental	$183.88	$161.61	-$22.27	-12.11%
Pharmacy	$1,020.22	$1,081.30	$61.08	5.99%
Total	$3,376.25	$3,459.72	$83.47	2.47%

[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 Magnolia, 96.5 percent of institutional claims and 97.4 percent of professional claims were processed within the first 30 days. Processing time took 30 days or less for 95.4 percent of Magnolia's dental claims. Approximately 99.8 percent of Magnolia's pharmacy claims were processed within the first 15 days.

Table 11: MississippiCAN and Magnolia CAN - Timeliness of Payment

	MississippiCAN				Magnolia CAN			
Days	Institutional	Professional	Dental	Pharmacy	Institutional	Professional	Dental	Pharmacy
<= 15	91.7%	92.8%	54.5%	99.7%	88.1%	93.1%	92.4%	99.8%
16 - 30	5.5%	4.4%	44.8%	0.2%	8.4%	4.3%	3.0%	0.1%
31 - 60	1.1%	1.1%	0.6%	0.1%	1.7%	1.2%	3.6%	0.1%
61 - 90	0.4%	0.4%	0.1%	0.0%	0.5%	0.4%	0.5%	0.0%
Over 90	1.2%	1.3%	0.1%	0.0%	1.3%	1.1%	0.4%	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 Magnolia, 99.1 percent of initial institutional claims and 97.9 percent of professional claims were submitted within the first 30 days. Submission time took 90 days or longer for 88.0 percent of Magnolia's dental claims. Approximately 14.1 percent of Magnolia's pharmacy claim encounters took 90 days or longer to submit.

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

	MississippiCAN				Magnolia CAN			
Days	Institutional	Professional	Dental	Pharmacy	Institutional	Professional	Dental	Pharmacy
<= 15	87.6%	86.6%	35.3%	39.1%	99.1%	97.6%	6.2%	57.2%
16 - 30	0.8%	1.9%	1.9%	48.7%	0.0%	0.3%	5.8%	25.0%
31 - 60	2.3%	3.3%	6.2%	1.3%	0.0%	0.0%	0.0%	0.1%
61 - 90	2.6%	1.8%	10.7%	2.3%	0.1%	0.0%	0.0%	3.6%
91 - 120	1.7%	0.7%	6.7%	7.1%	0.1%	0.0%	0.0%	11.4%
Over 120	5.0%	5.7%	39.3%	1.6%	0.7%	2.0%	88.0%	2.7%

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

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 Magnolia CAN. As shown in *Table 13: Place of Service by Expenditures and Utilization*, thirty-four percent of the MississippiCAN encounters were rendered in an office setting at a cost of nearly $238 million and 17.9 percent were rendered in a hospital setting at a cost of $344 million. Magnolia was comparable with 33.7 percent of encounters in an office setting at cost of $115.5 million and 18.2 percent of encounters rendered in a hospital setting at a cost of nearly $179 million.

Table 13: Place of Service by Expenditures and Utilization

	MississippiCAN				Magnolia 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%	$115,583,860	25.5%	1,148,123	33.7%
Hospital	$344,340,079	38.8%	1,207,200	17.9%	$178,928,662	39.5%	620,560	18.2%
Independent Laboratory	$15,033,675	1.7%	331,125	4.9%	$8,066,002	1.8%	175,284	5.1%
Rural Health Clinic[1]	$36,530,072	4.1%	394,138	5.9%	$19,689,004	4.3%	205,791	6.0%
Community Mental Health Center	$49,339,921	5.6%	403,598	6.0%	$25,064,235	5.5%	194,286	5.7%
Emergency Room Hospital[2]	$33,003,703	3.7%	571,766	8.5%	$16,339,555	3.6%	296,222	8.7%
All Other	$172,163,859	19.4%	1,535,780	22.8%	$89,081,859	19.7%	765,327	22.5%
Total	$888,261,712		6,728,896		$452,753,179		3,405,593	
Percentage of MississippiCAN Total					**51.0%**		**50.6%**	

**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 therefore there will be discrepancies in the total counts from the amounts reported in Table 8 of page 39 of the Report.

Provider Type

Hospital providers represent 12.2 percent of all Mississippi CCOs' encounters by provider and $230.7 million (26.4 percent) in expenditures. In comparison, 12.6 percent of Magnolia encounters and $125.4 million (28.3 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 million in expenditures. Physicians (36.4 percent) and dentists (5.1 percent) comprise 41.5 percent of all Magnolia institutional, professional, and dental encounters, representing approximately $147 million in expenditures.

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

	MississippiCAN				Magnolia CAN			
Provider Type	Expenditures	%	Volume	%	Expenditures	%	Volume	%
Hospital, General	$230,658,210	26.4%	810,736	12.2%	$125,415,703	28.3%	425,106	12.6%
Physician, MD	$220,654,504	25.2%	2,334,307	35.0%	$117,582,673	26.6%	1,227,594	36.4%
Dentist, Unclassified	$66,960,907[1]	7.7%	390,755	5.9%	$29,780,685	6.7%	172,089	5.1%
Nurse Practitioner	$47,294,729	5.4%	641,913	9.6%	$26,223,145	5.9%	352,738	10.5%
Ind X-ray And Lab	$12,215,560	1.4%	282,437	4.2%	$6,729,530	1.5%	149,822	4.4%
All Other	$296,314,798	33.9%	2,210,615	33.1%	$136,774,663	30.9%	1,042,308	30.9%
Total	$874,098,707		6,670,763		$442,506,398		3,369,657	
Percentage of MississippiCAN Total					**50.6%**		**50.5%**	

[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 nearly $56 million. Magnolia members received 47.7 percent of the services. In terms of dollars, dental services to Magnolia members totaled nearly $30.6 million (or 54.7 percent of total dollars spent). The volume, percentage, and dollar breakdowns for dental categories of services are shown in the next two tables.

Table 15: Dental Expenditures and Visits by Category of Service

	MississippiCAN				Magnolia CAN			
Category of Service	**Expenditures**	**%**	**Volume**	**%**	**Expenditures**	**%**	**Volume**	**%**
Diagnostic	$15,137,322	27.1%	632,158	40.9%	$7,796,871	25.5%	311,019	42.2%
Preventive	$9,472,122	16.9%	513,640	33.2%	$5,020,009	16.4%	231,931	31.5%
Restorative	$15,368,985	27.5%	195,315	12.6%	$8,032,969	26.3%	93,229	12.7%
Oral and Maxillofacial Surgery	$7,715,624	13.8%	100,444	6.5%	$3,949,964	12.9%	49,418	6.7%
Orthodontics	$4,926,315	8.8%	49,507	3.2%	$3,943,841	12.9%	24,118	3.3%
Adjunctive General Services	$1,353,093	2.4%	33,824	2.2%	$746,104	2.4%	17,261	2.3%
Endodontics	$1,904,614	3.4%	18,572	1.2%	$1,047,151	3.4%	8,712	1.2%
All Other	$51,800	0.1%	2,219	0.1%	$29,818	0.1%	1,038	0.1%
Total	$55,929,876[1]		1,545,679		$30,566,726		736,726	
Percentage of MississippiCAN Total					**54.7%**		**47.7%**	

**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. In comparison, for Magnolia, 69.7 percent of the drugs dispensed were for new/original prescriptions and refills were 30.3 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%

	Prescriptions		
Pharmacy Services	**Total**	**New/ Original**	**Refills**
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%**
Magnolia CAN			
Antibiotics	12.0%	11.6%	0.4%
Psychotherapeutic Drugs	11.6%	7.4%	4.2%
Analgesics	8.8%	8.3%	0.5%
Cardiovascular	9.4%	4.0%	5.4%
Antihistamines	6.1%	4.5%	1.6%
Antiasthmatics	5.7%	3.5%	2.2%
Cardiovascular	6.0%	4.1%	2.0%
CNS Drugs	5.0%	2.5%	2.5%
All Other	35.5%	23.8%	11.7%
Magnolia CAN Totals*	**100.0%**	**69.7%**	**30.3%**

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

Findings

1) As identified in Table 11 MississippiCAN and Magnolia CAN - Timeliness of Payment on page 41, the majority of Magnolia's institutional, professional, dental, and pharmacy claims were paid within the first 60 days. A very small percentage of Magnolia's institutional (1.3 percent), professional (1.1 percent), and dental (0.4 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 Magnolia CAN - Timeliness of Submitting Encounters on page 41, encounter records reflect submission dates more than 120 days after the claim payment for all 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 0.7 percent of institutional encounters, 2.0 percent of professional encounters, 88.0 percent of dental encounters, and 2.7 percent of pharmacy encounters that were submitted to the FAC beyond 120 days.

Recommendations

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

2) Magnolia should monitor and ensure subcontractor encounters are submitted to the FAC within contractual requirements. DOM should continue to hold Magnolia 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 outpatient and professional encounters. Pharmacy and dental encounters did not meet the target completeness percentages. 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 service type did not meet the completeness threshold of 98 percent complete for encounter claims submission for the sample period, 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 type:
    a. Outpatient institutional, professional, dental, and pharmacy.
    b. Inpatient institutional claims are not included in this report, as inpatient services were carved in as of 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 service 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

	Error Rate					
Margin of Error	**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. Magnolia 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. Magnolia submitted three medical records that were deemed unusable. A total of 110 medical records, or 25 percent of the sample, were missing for both sampled months. Over half of the missing records were within the dental 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	51	38	20	46	155
October 2015	53	44	24	54	175
Total Records Received	104	82	44	100	330
Number of Records Missing					
January 2015	4	17	35	9	65
October 2015	2	11	31	1	45
Total Records Missing	6	28	66	10	110
Unusable Records					
January 2015	0	0	1	0	1
October 2015	0	1	1	0	2
Total Records Unusable	0	1	2	0	3
Net Usable Records Received					
January 2015	51	38	19	46	154
October 2015	53	43	23	54	173
Total Usable Records	104	81	42	100	327

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	2%	7%	4%	29%	0%	66%	5%	14%
Member DOB	Header Level	Critical	11%	15%	12%	35%	31%	72%	11%	19%
Type of Bill	Header Level	Critical	9%	14%						
Header First DOS	Header Level	Critical	5%	10%	9%	33%	5%	73%	12%	20%
Header Last DOS	Header Level	Critical	17%	22%						
Place of Service	Header Level	Critical			23%	44%	5%	62%		
Procedure Code	Line Level	Critical	32%	36%	33%	50%	27%	60%		
Procedure Modifier 1	Line Level	Critical	83%	84%	99%	99%				
Revenue Code	Line Level	Non-Critical	30%	34%						
Principal Diagnosis Code	Header Level	Non-Critical	13%	17%						
Diagnosis Code 1	Header Level	Non-Critical	10%	15%	26%	45%				
Diagnosis Code 2	Header Level	Non-Critical	13%	16%	21%	39%				
Diagnosis Code 3	Header Level	Non-Critical	15%	20%	20%	41%				
Diagnosis Code 4	Header Level	Non-Critical	14%	18%	18%	44%				

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
Surgical Procedure Code 1	Line Level	Critical	No data to test	No data to test						
Tooth Number 1	Line Level	Critical					29%	52%		
Tooth Number 2	Line Level	Critical					10%	58%		
Tooth Number 3	Line Level	Critical					0%	56%		
Tooth Number 4	Line Level	Critical					0%	67%		
Tooth Number 5	Line Level	Critical					0%	100%		
Tooth Surface 1	Line Level	Critical					17%	65%		
Tooth Surface 2	Line Level	Critical					0%	60%		
Tooth Surface 3	Line Level	Critical					0%	100%		
Tooth Surface 4	Line Level	Critical					0%	100%		
Prescription Number	Header Level	Critical							3%	12%
Refill Number	Line Level	Critical							50%	54%
Quantity	Line Level	Critical							39%	44%
Days Supply	Line Level	Non-Critical							54%	59%
Drug Dispensed	Line Level	Critical							49%	53%

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
Overall Error Rate			27%	30%	29%	47%	18%	68%	28%	34%

1) The overall error rates by service type calculated for unsupported elements, ranged from 18 percent to 29 percent. Including the missing records in the error rate, the overall error rates increased to 30 percent to 68 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 (33 percent; 50 percent) and Procedure Code Modifiers (99 percent; 99 percent). Outpatient institutional claims lacked documentation to support Procedure Code Modifiers (83 percent; 84 percent), Procedure Codes (32 percent; 36 percent) and Revenue Codes (30 percent; 34 percent). None of the sample claims contained Surgical Procedure Codes; therefore, this key data element was not tested. Only 44 out of 110 dental medical records were received from the CCO. Therefore, there was an insufficient number of claims tested for the sample to be statistically valid. The most common error in the dental record claims was related to Date of Birth (31 percent; 72 percent). The highest error rates in the pharmacy claims related to the lack of supporting documentation for the Days Supply (54 percent; 59 percent) and Refill Number (50 percent; 54 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.

2) The inability to obtain records from Magnolia's dental providers represents a significant issue. Without the medical record documentation, it is difficult to affirm that the services being billed were actually performed.

Recommendations

1) We recommend DOM ensure the CCO recoup funds from the providers not submitting medical record documentation to support the sampled claims. Magnolia's policy regarding medical record review, states Magnolia will assess network medical record keeping practices against the established standards at least annually. Physicians sampled must meet 80 percent of the requirements for medical record keeping or be subject to corrective action. Given the high error rates in some categories (over 20 percent), DOM should ensure there is proper oversight by the CCO through program integrity efforts based on policies and provider training and instruct Magnolia to increase their minimum standard from 80 percent to closer to 100 percent. The provider manual states that Magnolia will conduct random medical record audits as part of its Quality Improvement program to monitor compliance with the medical record documentation standards. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services, also may be assessed during a medical record audit. DOM should request supporting documentation from Magnolia regarding how results from this medical record review are incorporated into Magnolia's monitoring system. The incorporation of outside medical record reviews is a requirement in its provider manual.

2) We recommend DOM have additional medical record testing performed to ensure compliance with medical records documentation standards and implement corrective action plans or penalties for non-compliance.

3) Magnolia should examine contracts and processes to ensure medical records are supplied upon request from its providers. One approach may be to strengthen the contract language to increase the requirement reference above, to be closer to 100 percent. Another consideration may be for Magnolia to perform additional audits, more frequently than annually as noted above, to confirm the accessibility and availability of medical records for Magnolia 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	Unsupported Element	Element with Missing/ Unusable Records	Total Elements Sampled	Unsupported Element	Element with Missing/ Unusable Records	Total Elements Sampled	Unsupported Element	Element with Missing/ Unusable Records	Total Elements Sampled	Unsupported Element	Element with Missing/ Unusable Records
Member Name	Header Level	Critical	110	2	6	110	3	29	110	0	68	110	5	10
Member DOB	Header Level	Critical	110	11	6	110	10	29	110	13	68	110	11	10
Type of Bill	Header Level	Critical	110	9	6									
Header First DOS	Header Level	Critical	110	5	6	110	7	29	110	2	68	110	12	10
Header Last DOS	Header Level	Critical	110	18	6									
Place of Service	Header Level	Critical				110	19	29	110	2	68			
Procedure Code	Line Level	Critical	613	187	31	218	54	56	329	35	199			
Procedure Modifier 1	Line Level	Critical	141	116	2	109	78	30						
Revenue Code	Line Level	Non-Critical	703	204	33									
Principal Diagnosis Code	Header Level	Non-Critical	110	13	6									
Diagnosis Code 1	Header Level	Non-Critical	74	7	4	110	21	29						
Diagnosis Code 2	Header Level	Non-Critical	50	6	2	56	9	13						
Diagnosis Code 3	Header Level	Non-Critical	35	5	2	27	4	7						
Diagnosis Code 4	Header Level	Non-Critical	22	3	1	16	2	5						

Number of Data Elements																
			Outpatient			Professional			Dental			Pharmacy		
Key Data Element	Header/ Line Level	Tier Level	Total Elements Sampled	Unsupported Element	Element with Missing/ Unusable Records	Total Elements Sampled	Unsupported Element	Element with Missing/ Unusable Records	Total Elements Sampled	Unsupported Element	Element with Missing/ Unusable Records	Total Elements Sampled	Unsupported Element	Element with Missing/ Unusable Records
Surgical Procedure Code 1	Line Level	Critical	0	-	0									
Tooth Number 1	Line Level	Critical							58	8	30			
Tooth Number 2	Line Level	Critical							24	1	14			
Tooth Number 3	Line Level	Critical							9	0	5			
Tooth Number 4	Line Level	Critical							6	0	4			
Tooth Number 5	Line Level	Critical							3	0	3			
Tooth Surface 1	Line Level	Critical							17	1	11			
Tooth Surface 2	Line Level	Critical							10	0	6			
Tooth Surface 3	Line Level	Critical							2	0	2			
Tooth Surface 4	Line Level	Critical							1	0	1			
Prescription Number	Header Level	Critical										110	3	10
Refill Number	Line Level	Critical										111	50	10
Quantity	Line Level	Critical										111	39	10
Days Supply	Line Level	Non-Critical										111	55	10
Drug Dispensed	Line Level	Critical										111	49	10
Total			**2,298**	**586**	**111**	**976**	**207**	**256**	**899**	**62**	**547**	**884**	**224**	**80**

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 Pages 13-14	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 14	The contract sets forth a single 98 percent completeness standard and two percent error rate for all service types. EQR Protocol 4 recommends states set a specific standards for each service type.	DOM should develop specific standards by service type. See Table 1 on page 16 for examples of EQR Protocol 4 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 14	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 14	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 14	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 15	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 1.7	Activity 1: Review State Requirements Page 15	At the time of the Conduent on-site review, the DRGs submitted by the CCOs were not 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 1.8	Activity 1: Review State Requirements Page 15	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.
Conduent (FAC) Finding 1.9	Activity 1: Review State Requirements Page 15	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 DOM and the CCO to resolve all issues related to replacement transactions.

Entity/Finding #	Activity #/ Page Reference	Finding	Recommendation
Conduent (FAC) Finding 1.10	Activity 1: Review State Requirements Page 15	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 1.11	Activity 1: Review State Requirements Page 15	According to the FAC representatives, there is no oversight or quality assurance check performed on the Truven standard data warehouse 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 DOM.
Magnolia Finding 2.1	Activity 2: Review CCO's Capability Pages 18-19	There is an opportunity to improve enrollment data in terms of system-to-system validation: The CCO's intake systems may have different member addresses than the Unified Member View (UMV) system. Since the case managers physically visit members and have more updated address information, that system is more reliable than the UMV system, which is based on the 834 file. If a report is pulled from the Enterprise Data Warehouse (EDW), there may be variances in data due to what system is being queried.	Magnolia should implement a process to conduct system to system validations to help ensure the most accurate and up-to-date information is available across systems.
Magnolia Finding 2.2	Activity 2: Review CCO's Capability Page 19	There is limited oversight and validation of subcontractor encounter submissions. Often, the data is passed through Magnolia/Centene to Conduent via automated processes with minimal checks for completion or subsequent validation by Magnolia/Centene.	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. The Medicaid Managed Care Final Rule imposes the same expectations for subcontractor encounter data as it does for the CCO. Accordingly, Magnolia needs to hold the subcontracted vendors accountable to the required encounter data submissions standards.
Magnolia and Conduent (FAC) Finding 2.3	Activity 2: Review CCO's Capability Page 19	The CCO receives acknowledgment of the files from the FAC, but does not receive control totals. Receipt of control totals would enable the CCO to ensure the number of encounters submitted in the files are correctly received and loaded by the FAC.	Control totals should be exchanged between the FAC and the CCO.

Entity/Finding #	Activity #/ Page Reference	Finding	Recommendation
Magnolia (Centene – Parent Company) Finding 2.4	Activity 2: Review CCO's Capability Page 19	Centene operates two redundant IT systems 40 miles apart. In the event of a power outage, storm, or other issue affecting their main campus operations center, it is possible the disaster recovery facility would also be affected and this could hinder Magnolia's ability to resume normal operations in a timely manner.	Magnolia (Centene) should ensure there is sufficient geographic distance between the operations center and disaster recovery center. Centene is scheduled to transition to a disaster recovery site in Rancho Cordova, California on December 9, 2017. In the future, the primary location will be in Missouri with the backup in Rancho Cordova, which is an eastern suburb of Sacramento. This will alleviate concerns related to the geographic proximity of the data centers.
Magnolia Finding 2.5	Activity 2: Review CCO's Capability Page 19	Penetration testing is performed annually for Centene by an outside vendor, CISCO. Based on the vendor's ability to penetrate the system, changes were made to security settings.	Magnolia should continue to perform penetration testing, since previous testing has identified opportunities for security enhancements.
DOM and Conduent (FAC) Finding 3.1	Activity 3: Analyze Encounter Data Page 34	Outpatient and Professional Key Data Elements: There were minor invalid values for the Plan Received Date data element values. In addition there were null amounts for the following key data element values: Header Paid Amount; Plan Paid Date; Plan Received Date and Diagnosis codes. Dental Key Data Elements: There were invalid values reported for the following required key data element values: Plan Paid Date and Plan Received Date. These were populated with 01/01/0001 values. Pharmacy Key Data Elements: All Billing Provider NPI data element values were invalid. All values were a length of 5 or 6 instead of the required 10 character length.	Conduent should ensure that all values submitted are valid and at a minimum report these errors to allow for corrections when necessary.
DOM Finding 3.2	Activity 3: Analyze Encounter Data Page 34	No measurement period for the 98 percent encounter submission requirement is noted in the current contract between DOM and Magnolia.	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.
Magnolia and Conduent (FAC) Finding 3.3	Activity 3: Analyze Encounter Data Page 35	Surplus encounters were noted in all service types based on the claims sample received from Magnolia for the sample test months of January and October 2015. Surplus encounters as a percentage of the total sample were 12 percent for outpatient, 17 percent for professional, 119 percent for dental and 54 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.	Magnolia 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 Magnolia for January and October 2015. Encounter data should be updated in the FAC data warehouse for any discrepancies noted during the investigation.

Entity/Finding #	Activity #/ Page Reference	Finding	Recommendation
DOM Finding 3.4	Activity 3: Analyze Encounter Data Page 35	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.
Magnolia, DOM and Conduent (FAC) Finding 3.5	Activity 3: Analyze Encounter Data Pages 35-36	Errors were noted in key data component testing between sample claims and the FAC encounter data.	DOM, Magnolia, and Conduent should review and possibly update 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.
DOM Finding 3.6	Activity 3: Analyze Encounter Data Page 36	The dental subcontractor did not provide claims sample data to use in the FAC encounter data testing.	DOM should include enforceable language in its contracts with third party vendors to provide documentation to support Mississippi Medicaid claims, and include penalties for non-compliance even after the contract has terminated. 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.
DOM and Magnolia Finding 3.7	Activity 3: Analyze Encounter Data Pages 36-37	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 Magnolia.	DOM should require Magnolia to increase oversight of Magnolia's subcontractors related to encounter data to address the high error rates in key data component testing and surplus encounter data. Magnolia should provide DOM an action plan for improvement in its data.
Magnolia and Conduent Finding 3.8	Activity 3: Analyze Encounter Data Page 36	MMIS_ICNs were incorrectly assigned to pharmacy claims by Magnolia or its pharmacy subcontractor for claims paid in January 2015.	Magnolia should investigate its pharmacy subcontractor's process for assigning MMIS_ICNs to its encounters and incorporate the correct MMIS_ICNs into its claims processing system based on the FAC encounter data MMIS_ICNs.
Magnolia and DOM Finding 3.9	Activity 3: Analyze Encounter Data Page 44	As identified in Table 11 MississippiCAN and Magnolia CAN - Timeliness of Payment on page 41, the majority of Magnolia's institutional, professional, and pharmacy claims were paid within the first 60 days. A very small percentage of Magnolia's institutional (1.3 percent), professional (1.1 percent), and dental (0.4 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…"	Magnolia should continue to monitor and ensure subcontractors are processing and paying claims within contractual requirements. DOM should continue to hold Magnolia responsible for contract compliance.

Entity/Finding #	Activity #/ Page Reference	Finding	Recommendation
Magnolia and DOM Finding 3.10	Activity 3: Analyze Encounter Data Page 44	As identified in Table 12 MississippiCAN and Magnolia CAN - Timeliness of Submitting Encounters on page 41, encounter records reflect submission dates more than 120 days after the claim payment for all 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 0.7 percent of institutional encounters, 2.0 percent of professional encounters, 88.0 percent of dental encounters, and 2.7 percent of pharmacy encounters that were submitted to the FAC beyond 120 days.	Magnolia should monitor and ensure subcontractor encounters are submitted to the FAC within contractual requirements. DOM should continue to hold Magnolia responsible for contract compliance.
DOM and Magnolia Finding 4.1	Activity 4: Review of Medical Records Pages 47-51	Medical records chosen as a part the sample were not supplied by Magnolia from providers for testing of proper medical record documentation to support the encounter data in the FAC.	DOM should require Magnolia 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.
DOM and Magnolia Finding 4.2	Activity 4: Review of Medical Records Page 51	Magnolia's policy regarding medical record review requires physician to meet 80 percent of the requirements for medical record review or be subject to corrective action.	DOM should ensure there is proper oversight of medical records documentation and have Magnolia increase its minimum standard of meeting 80 percent of its record keeping requirements to closer to 100 percent.

Entity/Finding #	Activity #/ Page Reference	Finding	Recommendation
DOM and Magnolia Finding 4.3	Activity 4: Review of Medical Records Page 51	Overall error rates in the medical record reviews range from 30 percent to 68 percent including errors related to missing records. Dental claims experienced a 68 percent error rate and professional claims had 47 percent error rate.	DOM should ensure there is proper oversight of Magnolia specific to Magnolia's program integrity efforts and provider training. Magnolia 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. Magnolia 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, Magnolia 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 Magnolia'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.
DOM Finding 4.4	Activity 4: Review of Medical Records Page 51	Magnolia's provider manual requires the results outside medical record reviews be incorporated into its monitoring system.	DOM should request supporting documentation from Magnolia to ensure the results are properly incorporated.

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

The table on page 39 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. 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

	MississippiCAN			Magnolia CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Members						
Member Months						
Ages 0 - 9	1,829,945	929,563	900,382	903,083	457,114	445,969
Ages 10 - 17	1,172,729	592,620	580,109	562,480	283,354	279,126
Ages 18 - 34	843,727	176,469	667,258	435,917	91,014	344,903
Ages 35 - 49	379,373	91,404	287,969	207,504	49,490	158,014
Ages 50 - 64	297,680	122,637	175,043	174,915	71,434	103,481
Ages 65 - 74	773	241	532	403	125	278
Total	**4,524,227**	**1,912,934**	**2,611,293**	**2,284,302**	**952,531**	**1,331,771**
Average Number of Members[1]						
Ages 0 - 9	152,495	77,464	75,032	75,257	38,093	37,164
Ages 10 - 17	97,727	49,385	48,342	46,873	23,613	23,261
Ages 18 - 34	70,311	14,706	55,605	36,326	7,585	28,742
Ages 35 - 49	31,614	7,617	23,997	17,292	4,124	13,168
Ages 50 - 64	24,807	10,220	14,587	14,576	5,953	8,623
Ages 65 - 74	64	20	44	34	10	23
Total	**377,019**	**159,411**	**217,608**	**190,359**	**79,378**	**110,981**
Total Utilization						
Total Number of (all) Services						
Ages 0 - 9	2,869,043	1,550,885	1,318,158	1,411,025	760,149	650,876
Ages 10 - 17	1,732,524	845,715	886,809	817,754	398,420	419,334
Ages 18 - 34	2,424,047	381,556	2,042,491	1,255,069	197,517	1,057,552
Ages 35 - 49	1,745,227	389,036	1,356,191	961,901	205,855	756,046
Ages 50 - 64	1,971,100	711,158	1,259,942	1,161,785	413,832	747,953
Ages 65 - 74	6,127	1,536	4,591	2,948	755	2,193

	MississippiCAN			Magnolia CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Total	**10,748,068**	**3,879,886**	**6,868,182**	**5,610,482**	**1,976,528**	**3,633,954**
Services (all) Per Member[2]						
Ages 0 - 9	18.8	20.0	17.6	18.7	20.0	17.5
Ages 10 - 17	17.7	17.1	18.3	17.4	16.9	18.0
Ages 18 - 34	34.5	25.9	36.7	34.5	26.0	36.8
Ages 35 - 49	55.2	51.1	56.5	55.6	49.9	57.4
Ages 50 - 64	79.5	69.6	86.4	79.7	69.5	86.7
Ages 65 - 74	95.1	76.5	103.6	87.8	72.5	94.7
Total	**28.5**	**24.3**	**31.6**	**29.5**	**24.9**	**32.7**
Institutional Utilization						
Total Number of (all) Services						
Ages 0 - 9	239,640	128,666	110,974	114,410	61,187	53,223
Ages 10 - 17	108,610	50,124	58,486	49,118	22,564	26,554
Ages 18 - 34	235,577	28,727	206,850	118,555	13,965	104,590
Ages 35 - 49	138,746	29,926	108,820	72,430	13,611	58,819
Ages 50 - 64	135,505	47,743	87,762	74,198	25,720	48,478
Ages 65 - 74	518	96	422	300	27	273
Total	**858,596**	**285,282**	**573,314**	**429,011**	**137,074**	**291,937**
Services (all) Per Member[2]						
Ages 0 - 9	1.6	1.7	1.5	1.5	1.6	1.4
Ages 10 - 17	1.1	1.0	1.2	1.0	1.0	1.1
Ages 18 - 34	3.4	2.0	3.7	3.3	1.8	3.6
Ages 35 - 49	4.4	3.9	4.5	4.2	3.3	4.5
Ages 50 - 64	5.5	4.7	6.0	5.1	4.3	5.6
Ages 65 - 74	8.0	4.8	9.5	8.9	2.6	11.8
Total	**2.3**	**1.8**	**2.6**	**2.3**	**1.7**	**2.6**
Professional Utilization						
Total Number of (all) Services						
Ages 0 - 9	1,440,090	785,855	654,235	706,752	384,441	322,311
Ages 10 - 17	840,465	422,620	417,845	401,143	200,852	200,291
Ages 18 - 34	1,204,642	194,416	1,010,226	615,533	100,271	515,262
Ages 35 - 49	735,280	173,763	561,517	395,889	89,223	306,666
Ages 50 - 64	811,434	301,948	509,486	464,102	170,687	293,415
Ages 65 - 74	2,890	669	2,221	1,283	278	1,005
Total	**5,034,801**	**1,879,271**	**3,155,530**	**2,584,702**	**945,752**	**1,638,950**

	MississippiCAN			Magnolia CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Services (all) Per Member[2]						
Ages 0 - 9	9.4	10.1	8.7	9.4	10.1	8.7
Ages 10 - 17	8.6	8.6	8.6	8.6	8.5	8.6
Ages 18 - 34	17.1	13.2	18.2	16.9	13.2	17.9
Ages 35 - 49	23.3	22.8	23.4	22.9	21.6	23.3
Ages 50 - 64	32.7	29.5	34.9	31.8	28.7	34.0
Ages 65 - 74	44.9	33.3	50.1	38.2	26.7	43.4
Total	**13.4**	**11.8**	**14.5**	**13.6**	**11.9**	**14.8**
Dental Utilization						
Total Number of (all) Services						
Ages 0 - 9	162,206	80,936	81,270	77,449	38,299	39,150
Ages 10 - 17	169,046	75,426	93,620	78,283	34,719	43,564
Ages 18 - 34	45,904	9,326	36,578	21,959	4,327	17,632
Ages 35 - 49	14,718	2,799	11,919	7,321	1,347	5,974
Ages 50 - 64	7,853	3,185	4,668	4,378	1,717	2,661
Ages 65 - 74	13	4	9	5	1	4
Total	**399,740**	**171,676**	**228,064**	**189,395**	**80,410**	**108,985**
Services (all) Per Member[2]						
Ages 0 - 9	1.1	1.0	1.1	1.0	1.0	1.1
Ages 10 - 17	1.7	1.5	1.9	1.7	1.5	1.9
Ages 18 - 34	0.7	0.6	0.7	0.6	0.6	0.6
Ages 35 - 49	0.5	0.4	0.5	0.4	0.3	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	0.1	0.1	0.2
Total	**1.1**	**1.1**	**1.0**	**1.0**	**1.0**	**1.0**
Pharmacy Utilization						
Total Number of (all) Services						
Ages 0 - 9	1,027,107	555,428	471,679	512,414	276,222	236,192
Ages 10 - 17	614,403	297,545	316,858	289,210	140,285	148,925
Ages 18 - 34	937,924	149,087	788,837	499,022	78,954	420,068
Ages 35 - 49	856,483	182,548	673,935	486,261	101,674	384,587
Ages 50 - 64	1,016,308	358,282	658,026	619,107	215,708	403,399
Ages 65 - 74	2,706	767	1,939	1,360	449	911
Total	**4,454,931**	**1,543,657**	**2,911,274**	**2,407,374**	**813,292**	**1,594,082**
Services (all) Per Member[2]						

	MississippiCAN			Magnolia CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Ages 0 - 9	6.7	7.2	6.3	6.8	7.3	6.4
Ages 10 - 17	6.3	6.0	6.6	6.2	5.9	6.4
Ages 18 - 34	13.3	10.1	14.2	13.7	10.4	14.6
Ages 35 - 49	27.1	24.0	28.1	28.1	24.7	29.2
Ages 50 - 64	41.0	35.1	45.1	42.5	36.2	46.8
Ages 65 - 74	42.0	38.2	43.7	40.5	43.1	39.3
Total	**11.8**	**9.7**	**13.4**	**12.6**	**10.2**	**14.4**

[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

	MississippiCAN			Magnolia CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Members						
Member Months						
Ages 0 - 9	1,829,945	929,563	900,382	903,083	457,114	445,969
Ages 10 - 17	1,172,729	592,620	580,109	562,480	283,354	279,126
Ages 18 - 34	843,727	176,469	667,258	435,917	91,014	344,903
Ages 35 - 49	379,373	91,404	287,969	207,504	49,490	158,014
Ages 50 - 64	297,680	122,637	175,043	174,915	71,434	103,481
Ages 65 - 74	773	241	532	403	125	278
Total	**4,524,227**	**1,912,934**	**2,611,293**	**2,284,302**	**952,531**	**1,331,771**
Average Number of Members[1]						
Ages 0 - 9	152,495	77,464	75,032	75,257	38,093	37,164
Ages 10 - 17	97,727	49,385	48,342	46,873	23,613	23,261
Ages 18 - 34	70,311	14,706	55,605	36,326	7,585	28,742
Ages 35 - 49	31,614	7,617	23,997	17,292	4,124	13,168
Ages 50 - 64	24,807	10,220	14,587	14,576	5,953	8,623
Ages 65 - 74	64	20	44	34	10	23
Total	**377,019**	**159,411**	**217,608**	**190,359**	**79,378**	**110,981**
Total Utilization ($/Year)						
Total Dollars of (all) Services						
Ages 0 - 9	$ 307,860,482.26	$ 169,368,002.59	$ 138,492,479.67	$ 150,158,430.63	$ 82,072,251.63	$ 68,086,179.00
Ages 10 - 17	$ 202,823,183.21	$ 103,163,415.44	$ 99,659,767.77	$ 94,374,225.62	$ 48,030,431.77	$ 46,343,793.85
Ages 18 - 34	$ 293,909,996.89	$ 51,614,521.67	$ 242,295,475.22	$ 151,109,288.36	$ 26,921,750.34	$ 124,187,538.02
Ages 35 - 49	$ 211,756,697.97	$ 52,505,248.63	$ 159,251,449.34	$ 114,184,111.49	$ 27,325,322.15	$ 86,858,789.34
Ages 50 - 64	$ 255,867,716.27	$ 99,892,956.64	$ 155,974,759.63	$ 148,349,681.39	$ 57,329,932.94	$ 91,019,748.45
Ages 65 - 74	$ 691,462.44	$ 191,348.92	$ 500,113.52	$ 411,283.26	$ 159,133.31	$ 252,149.95

	MississippiCAN			Magnolia CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Total	**$1,272,909,539.04**	**$ 476,735,493.89**	**$ 796,174,045.15**	**$ 658,587,020.75**	**$ 241,838,822.14**	**$ 416,748,198.61**
Average Cost Per Member Per Year[2]						
Ages 0 - 9	$ 2,018.82	$ 2,186.42	$ 1,845.78	$ 1,995.28	$ 2,154.53	$ 1,832.04
Ages 10 - 17	$ 2,075.40	$ 2,088.96	$ 2,061.54	$ 2,013.39	$ 2,034.08	$ 1,992.38
Ages 18 - 34	$ 4,180.17	$ 3,509.82	$ 4,357.45	$ 4,159.76	$ 3,549.57	$ 4,320.78
Ages 35 - 49	$ 6,698.11	$ 6,893.17	$ 6,636.19	$ 6,603.29	$ 6,625.66	$ 6,596.29
Ages 50 - 64	$ 10,314.47	$ 9,774.50	$ 10,692.78	$ 10,177.49	$ 9,630.70	$ 10,554.95
Ages 65 - 74	$ 10,734.22	$ 9,527.75	$ 11,280.76	$ 12,246.65	$ 15,276.80	$ 10,884.17
Total	**$ 3,376.25**	**$ 2,990.60**	**$ 3,658.76**	**$ 3,459.72**	**$ 3,046.69**	**$ 3,755.13**
Institutional Utilization ($/Year)						
Total Dollars for (all) Services						
Ages 0 - 9	$ 69,608,198.16	$ 39,190,236.37	$ 30,417,961.79	$ 33,135,714.52	$ 18,493,241.49	$ 14,642,473.03
Ages 10 - 17	$ 30,493,022.59	$ 14,692,806.27	$ 15,800,216.32	$ 14,094,464.29	$ 6,837,984.77	$ 7,256,479.52
Ages 18 - 34	$ 80,344,406.06	$ 10,700,797.21	$ 69,643,608.85	$ 41,162,519.13	$ 5,340,764.55	$ 35,821,754.58
Ages 35 - 49	$ 56,223,687.90	$ 12,884,549.55	$ 43,339,138.35	$ 29,591,396.28	$ 6,232,288.99	$ 23,359,107.29
Ages 50 - 64	$ 67,708,049.83	$ 26,696,411.55	$ 41,011,638.28	$ 37,890,001.84	$ 14,904,844.59	$ 22,985,157.25
Ages 65 - 74	$ 176,477.47	$ 8,128.86	$ 168,348.61	$ 103,092.08	$ 2,701.18	$ 100,390.90
Total	**$ 304,553,842.01**	**$ 104,172,929.81**	**$ 200,380,912.20**	**$ 155,977,188.14**	**$ 51,811,825.57**	**$ 104,165,362.57**
Average Cost Per Member Per Year[2]						
Ages 0 - 9	$ 456.46	$ 505.92	$ 405.40	$ 440.30	$ 485.48	$ 394.00
Ages 10 - 17	$ 312.02	$ 297.52	$ 326.84	$ 300.69	$ 289.59	$ 311.97
Ages 18 - 34	$ 1,142.71	$ 727.66	$ 1,252.47	$ 1,133.13	$ 704.17	$ 1,246.32
Ages 35 - 49	$ 1,778.42	$ 1,691.55	$ 1,805.99	$ 1,711.28	$ 1,511.16	$ 1,773.95

	MississippiCAN			Magnolia CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Ages 50 - 64	$ 2,729.43	$ 2,612.24	$ 2,811.54	$ 2,599.43	$ 2,503.82	$ 2,665.44
Ages 65 - 74	$ 2,739.62	$ 404.76	$ 3,797.34	$ 3,069.74	$ 259.31	$ 4,333.42
Total	**$ 807.79**	**$ 653.49**	**$ 920.84**	**$ 819.39**	**$ 652.73**	**$ 938.59**
Professional Utilization ($/Year)						
Total Number of (all) Services						
Ages 0 - 9	$ 138,553,147.97	$ 75,017,380.63	$ 63,535,767.34	$ 69,469,326.62	$ 37,434,116.40	$ 32,035,210.22
Ages 10 - 17	$ 79,957,369.12	$ 39,225,215.84	$ 40,732,153.28	$ 38,016,507.35	$ 18,579,937.29	$ 19,436,570.06
Ages 18 - 34	$ 138,695,084.91	$ 20,291,442.41	$ 118,403,642.50	$ 70,512,155.87	$ 10,630,255.04	$ 59,881,900.83
Ages 35 - 49	$ 73,856,387.71	$ 17,703,250.84	$ 56,153,136.87	$ 39,889,772.31	$ 9,099,545.04	$ 30,790,227.27
Ages 50 - 64	$ 83,146,367.72	$ 31,850,824.57	$ 51,295,543.15	$ 48,031,182.21	$ 18,451,641.57	$ 29,579,540.64
Ages 65 - 74	$ 182,150.77	$ 32,213.84	$ 149,936.93	$ 92,554.45	$ 20,551.88	$ 72,002.57
Total	**$ 514,390,508.20**	**$ 184,120,328.13**	**$ 330,270,180.07**	**$ 266,011,498.81**	**$ 94,216,047.22**	**$ 171,795,451.59**
Average Cost Per Member Per Year[2]						
Ages 0 - 9	$ 908.57	$ 968.42	$ 846.78	$ 923.10	$ 982.71	$ 861.99
Ages 10 - 17	$ 818.17	$ 794.27	$ 842.58	$ 811.05	$ 786.86	$ 835.60
Ages 18 - 34	$ 1,972.61	$ 1,379.83	$ 2,129.38	$ 1,941.07	$ 1,401.58	$ 2,083.43
Ages 35 - 49	$ 2,336.16	$ 2,324.18	$ 2,339.97	$ 2,306.83	$ 2,206.40	$ 2,338.29
Ages 50 - 64	$ 3,351.78	$ 3,116.60	$ 3,516.54	$ 3,295.17	$ 3,099.64	$ 3,430.14
Ages 65 - 74	$ 2,827.70	$ 1,604.01	$ 3,382.04	$ 2,755.96	$ 1,972.98	$ 3,108.02
Total	**$ 1,364.36**	**$ 1,155.00**	**$ 1,517.73**	**$ 1,397.42**	**$ 1,186.94**	**$ 1,547.97**
Dental Utilization ($/Year)						
Total Number of (all) Services						
Ages 0 - 9	$ 27,922,457.73	$ 14,061,317.83	$ 13,861,139.90	$ 12,509,476.15	$ 6,230,395.58	$ 6,279,080.57

	MississippiCAN			Magnolia CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Ages 10 - 17	$ 30,534,531.08	$ 13,654,526.53	$ 16,880,004.55	$ 13,437,392.43	$ 5,955,220.85	$ 7,482,171.58
Ages 18 - 34	$ 7,438,940.72	$ 1,691,269.87	$ 5,747,670.85	$ 3,206,279.15	$ 709,579.90	$ 2,496,699.25
Ages 35 - 49	$ 2,113,319.51	$ 425,790.15	$ 1,687,529.36	$ 955,241.91	$ 200,468.45	$ 754,773.46
Ages 50 - 64	$ 1,312,998.82	$ 557,431.63	$ 755,567.19	$ 654,568.50	$ 265,474.38	$ 389,094.12
Ages 65 - 74	$ 2,476.84	$ 271.41	$ 2,205.43	$ 1,533.97	$ 70.79	$ 1,463.18
Total	**$ 69,324,724.70**	**$ 30,390,607.42**	**$ 38,934,117.28**	**$ 30,764,492.11**	**$ 13,361,209.95**	**$ 17,403,282.16**
Average Cost Per Member Per Year[2]						
Ages 0 - 9	$ 183.10	$ 181.52	$ 184.74	$ 166.22	$ 163.56	$ 168.96
Ages 10 - 17	$ 312.45	$ 276.49	$ 349.18	$ 286.67	$ 252.20	$ 321.67
Ages 18 - 34	$ 105.80	$ 115.01	$ 103.37	$ 88.26	$ 93.56	$ 86.87
Ages 35 - 49	$ 66.85	$ 55.90	$ 70.32	$ 55.24	$ 48.61	$ 57.32
Ages 50 - 64	$ 52.93	$ 54.54	$ 51.80	$ 44.91	$ 44.60	$ 45.12
Ages 65 - 74	$ 38.45	$ 13.51	$ 49.75	$ 45.68	$ 6.80	$ 63.16
Total	**$ 183.88**	**$ 190.64**	**$ 178.92**	**$ 161.61**	**$ 168.32**	**$ 156.81**
Pharmacy Utilization ($/Year)						
Total Number of (all) Services						
Ages 0 - 9	$ 71,776,678.40	$ 41,099,067.76	$ 30,677,610.64	$ 35,043,913.34	$ 19,914,498.16	$ 15,129,415.18
Ages 10 - 17	$ 61,838,260.42	$ 35,590,866.80	$ 26,247,393.62	$ 28,825,861.55	$ 16,657,288.86	$ 12,168,572.69
Ages 18 - 34	$ 67,431,565.20	$ 18,931,012.18	$ 48,500,553.02	$ 36,228,334.21	$ 10,241,150.85	$ 25,987,183.36
Ages 35 - 49	$ 79,563,302.85	$ 21,491,658.09	$ 58,071,644.76	$ 43,747,700.99	$ 11,793,019.67	$ 31,954,681.32
Ages 50 - 64	$ 103,700,299.90	$ 40,788,288.89	$ 62,912,011.01	$ 61,773,928.84	$ 23,707,972.40	$ 38,065,956.44
Ages 65 - 74	$ 330,357.36	$ 150,734.81	$ 179,622.55	$ 214,102.76	$ 135,809.46	$ 78,293.30
Total	**$ 384,640,464.13**	**$ 158,051,628.53**	**$ 226,588,835.60**	**$ 205,833,841.69**	**$ 82,449,739.40**	**$ 123,384,102.29**

	MississippiCAN			Magnolia CAN		
Age	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Average Cost Per Member Per Year[2]						
Ages 0 - 9	$ 470.68	$ 530.56	$ 408.86	$ 465.66	$ 522.79	$ 407.10
Ages 10 - 17	$ 632.76	$ 720.68	$ 542.95	$ 614.97	$ 705.43	$ 523.14
Ages 18 - 34	$ 959.05	$ 1,287.32	$ 872.24	$ 997.30	$ 1,350.27	$ 904.16
Ages 35 - 49	$ 2,516.68	$ 2,821.54	$ 2,419.91	$ 2,529.94	$ 2,859.49	$ 2,426.72
Ages 50 - 64	$ 4,180.34	$ 3,991.12	$ 4,312.91	$ 4,237.98	$ 3,982.64	$ 4,414.25
Ages 65 - 74	$ 5,128.45	$ 7,505.47	$ 4,051.64	$ 6,375.27	$ 13,037.71	$ 3,379.57
Total	**$ 1,020.22**	**$ 991.47**	**$ 1,041.27**	**$ 1,081.30**	**$ 1,038.70**	**$ 1,111.76**

Appendix B:

Myers and Stauffer Encounter Reconciliation Report

Dated March 16, 2017

JANUARY 1, 2015 THROUGH DECEMBER 31, 2016

COMPARISON OF MISSISSIPPI COORDINATED CARE ORGANIZATION ENCOUNTER CLAIMS TO CASH DISBURSEMENTS FOR MAGNOLIA HEALTH

MARCH 16, 2017

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

TABLE OF CONTENTS

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 Magnolia Health's 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 11, 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 consists of Mississippi CAN and CHIP encounters and cash disbursement journals (CDJs).

Magnolia Health CAN — Cumulative Completion Percentages		
CCO/Delegated Vendor	**% of Cumulative Total**	**Adjusted % of Cumulative Total**
Entire Plan	97.36%	97.30%
Opticare (Vision Services)	102.79%	100.00%
DentaQuest (Dental Services)	204.12%	100.00%
Dental Health and Wellness (Dental Services)	98.93%	98.93%
Cenpatico (Behavioral Health)	98.30%	98.30%
Univita (DME)	96.45%	96.45%
MTM (NET)	92.94%	92.94%
U. S. Script (Pharmacy Benefits)	95.42%	95.42%
Magnolia Health Fee-for-Service	97.89%	97.89%

Potential issues that may impact the CAN completion percentages are listed below (A full list and description of all potential issues starts on page 11):

1. The Opticare completion percentage exceeding 100 percent (page 18) appears to be due to possible issues with the CDJ transactions. In the third column above, we have limited Opticare to a 100 percent completion rate in order to obtain an adjusted Entire Plan completion rate.
2. The DentaQuest completion percentage exceeding 100 percent (page 19) appears to be due to possible issues with the CDJ transactions. In the third column above, we have limited DentaQuest to a 100 percent completion rate in order to obtain an adjusted Entire Plan completion rate.
3. It is critical that Magnolia properly resubmit the Dental Health and Wellness dental encounters with the paid date issues described in issue 14 on page 12 immediately, or risk the exclusion of the unspecified month encounter totals due to the inability to determine the amount applicable to the report period being analyzed.

Magnolia Health CHIP — Cumulative Completion Percentages		
CCO/Delegated Vendor	**% of Cumulative Total**	**Adjusted % of Cumulative Total**
Entire Plan	77.26%	77.26%
Opticare (Vision)	0.00%	0.00%
Dental Health and Wellness (Dental Services)	30.86%	30.86%
Cenpatico (Behavioral Health)	85.56%	85.56%
U. S. Script (Pharmacy Benefits)	75.82%	75.82%
Magnolia Health Fee-for-Service	91.80%	91.80%

Potential issues that may impact the CHIP completion percentages are listed below (A full list and description of all potential issues starts on page 11):

1. The Opticare completion percentage of 0 percent (page 29) is the result of no CHIP Opticare vision encounters yet appearing in the FAC data warehouse.

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., vision 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 Mississippi CAN and CHIP.

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 CAN CCO paid claims as well as separate vision, dental, DME, non-emergency transportation, behavioral health and pharmacy delegated vendor encounters paid during the period January 1, 2015 through December 31, 2016. We have also included the percentages for the remaining non-vendor CCO paid encounter claims.

Likewise, this analysis now includes these percentages for all CHIP CCO paid claims as well as separate dental, behavioral health and pharmacy delegated vendor encounters paid during the period January 1, 2015 through December 31, 2016.

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 is 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 and DOM, we identified Magnolia Health encounters as follows:

- ***Magnolia Health CAN Encounters***
  - Submitter ID equal to '91473' or MC Prov ID equal to '09253560'.
- ***Magnolia Health CHIP Encounters***
  - Submitter ID equal to '93550' or MC Prov ID equal to '01935367'.
- ***DentaQuest – Dental Services***
  - Plan TCN field contains 'DD' in the first and second positions.
- ***Dental Health and Wellness – Dental Services***
  - Plan Patient Account Number field contains 'DH' in the first and second positions.
- ***Opticare - Vision Services***
  - Plan Patient Account Number field contains 'OC' in the first and second positions.
- ***Cenpatico – Behavioral Health Services***
  - Plan TCN field contains 'MK'.
- ***Univita - DME***
  - Plan TCN field contains 'UN' in the first and second positions.
- ***MTM – Non-emergency Transportation***
  - Plan TCN field contains 'MOM' or 'MIS' in the first through third positions.
- ***U. S. Script - Pharmacy Benefits***
  - These encounters are contained in separate data warehouse tables as a result of pharmacy claim submissions processing.
- ***Magnolia Fee-for-Service***
  - All other plan submitted encounter claims that do not meet the listed criteria.

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 encounter submissions are included in this report beginning on page 26. They cover the CCO paid period of January 1, 2015 through December 31, 2016.
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 encounters 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. Magnolia has confirmed that this date field is populated with the check date. We have completed further analysis and have provided Magnolia with examples where these two dates are not in agreement. Magnolia has reported that U.S. Script is currently reviewing these examples.
7. 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 Magnolia informed us that it is their understanding that Magnolia's CAS codes are properly identifying CCO-denied encounters. We have received a response from DOM iTech stating that a CSR 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. We will continue to monitor this issue.
8. 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 – Magnolia Health CAN Calculated Void and Duplicate Summary on page 16, 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.
9. 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.
10. 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.

11. 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 issues.

12. Monthly completion percentages exceeding 100 percent were noted for the Opticare vision vendor encounter claims. There appears to be an issue with the CDJ transactions. We have provided examples to Magnolia of CDJ transactions that appear to be missing from the previously supplied CDJ files. Magnolia has reported that Opticare is currently reviewing these examples. To prevent artificial inflation of the overall encounter completion percentages, we have included a separate adjusting line titled "Adjustments" in Table 1 – Magnolia Health Total and Table 3 – Magnolia Health Opticare. This line adjusts the cash disbursement totals to account for these missing CDJ transactions and limits the Opticare completion percentages to 100 percent.

13. Monthly completion percentages exceeding 100 percent were noted for the DentaQuest vendor encounter claims. There appears to be an issue with the CDJ transactions. Magnolia has reported that they received information from DentaQuest and are currently comparing to the CDJ information provided to determine discrepancies. To prevent artificial inflation of the overall encounter completion percentages, we have included a separate adjusting line titled "Adjustments" in Table 1 – Magnolia Health Total and Table 4 – Magnolia Health DentaQuest. This line adjusts the cash disbursement totals to limit the DentaQuest completion percentages to 100 percent.

14. The Dental Health and Wellness (DHW) dental encounters have begun to be submitted with valid plan paid dates. However, there is still a significant number of prior encounters having plan paid dates of 1/1/0001. We have included these encounters as a separate adjusting line in Table 1 – Magnolia Health Total and Table 5 – Magnolia Dental Health and Wellness. The line titled "Unspecified Month" denotes that no month can be specified and the line contains an aggregate encounter amount. DHW began as a vendor in January 2015, and therefore we have reasonable assurance that all encounters occurred during this reporting period. However, we will not have this assurance for the subsequent reporting period due to the rolling reporting period and may be excluded from the totals presented. Magnolia has indicated that all DHW encounters with a 1/1/0001 plan paid date have been corrected and resubmitted, however it appears that only relatively few of the encounters have been successfully replaced while the remaining replacement submissions appear to have been denied by Conduent. We will provide Magnolia with requested examples of this issue to assist them in correcting and resubmitting these encounters to the FAC.

15. In prior reporting periods, we noted a significant number of Dental Health and Wellness encounters in which the COB Filing Indicator had a value of 'MC' instead of the required value of 'ZZ' for claims paid by the CCO. Magnolia has indicated that the appropriate COB Filing Indicator has been resubmitted and corrected. Many of these encounters now appear to have been successfully replaced with a value of 'ZZ'. We will continue to monitor this replacement activity until it appears to be completed.

16. The MTM transportation vendor appears to have no paid encounters for the September 2016 paid month. Magnolia has reported that they experienced an issue when submitting the MTM September 2016 encounters. These have since been submitted and should appear in the subsequent report.

17. We are now receiving CHIP Opticare vision CDJ transactions from Magnolia. However, the CHIP Opticare vision vendor encounters are either not identifiable or not present in the FAC data warehouse using the criteria given on page 10. Magnolia has reported that they have not started submitting CHIP encounters for Opticare. They plan to submit them after the CHIP provider file issues are resolved by the State. Beginning with this report, we are providing a new table for the CHIP Opticare vision vendor, Table 13 – Magnolia Health Opticare (Vision).

18. 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.

MAGNOLIA HEALTH CAN – ENTIRE PLAN

Magnolia Health appears to have submitted approximately 97 percent of their encounter data for this period, with a cumulative monthly range between 93 percent and 97 percent.

Table 1 — Magnolia Health 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	$38,340,345	$37,017,118	($1,323,227)	$38,340,345	$37,017,118	($1,323,227)	96.54%	96.54%
February 2015	$37,492,079	$35,920,816	($1,571,263)	$75,832,424	$72,937,934	($2,894,490)	95.80%	96.18%
March 2015	$38,199,530	$36,477,763	($1,721,768)	$114,031,954	$109,415,697	($4,616,258)	95.49%	95.95%
April 2015	$45,633,906	$44,059,322	($1,574,584)	$159,665,860	$153,475,018	($6,190,842)	96.54%	96.12%
May 2015	$44,331,589	$42,148,214	($2,183,375)	$203,997,449	$195,623,232	($8,374,217)	95.07%	95.89%
June 2015	$48,287,264	$45,605,791	($2,681,473)	$252,284,713	$241,229,023	($11,055,690)	94.44%	95.61%
July 2015	$64,901,038	$59,446,218	($5,454,820)	$317,185,752	$300,675,242	($16,510,510)	91.59%	94.79%
August 2015	$61,942,483	$57,050,947	($4,891,536)	$379,128,235	$357,726,188	($21,402,046)	92.10%	94.35%
September 2015	$61,105,587	$56,487,293	($4,618,294)	$440,233,822	$414,213,482	($26,020,340)	92.44%	94.08%
October 2015	$70,937,235	$66,297,277	($4,639,958)	$511,171,056	$480,510,759	($30,660,298)	93.45%	94.00%
November 2015	$62,005,288	$58,475,137	($3,530,151)	$573,176,344	$538,985,896	($34,190,448)	94.30%	94.03%
December 2015	$70,255,045	$64,907,242	($5,347,803)	$643,431,389	$603,893,138	($39,538,251)	92.38%	93.85%
January 2016	$67,742,055	$63,162,463	($4,579,592)	$711,173,444	$667,055,602	($44,117,843)	93.23%	93.79%
February 2016	$83,832,458	$77,557,946	($6,274,511)	$795,005,902	$744,613,548	($50,392,354)	92.51%	93.66%
March 2016	$96,268,544	$91,269,064	($4,999,480)	$891,274,446	$835,882,611	($55,391,835)	94.80%	93.78%
April 2016	$85,360,507	$81,697,987	($3,662,520)	$976,634,953	$917,580,599	($59,054,355)	95.70%	93.95%
May 2016	$78,205,004	$73,559,294	($4,645,710)	$1,054,839,958	$991,139,893	($63,700,065)	94.05%	93.96%
June 2016	$90,911,370	$88,896,743	($2,014,628)	$1,145,751,328	$1,080,036,636	($65,714,693)	97.78%	94.26%
July 2016	$77,940,327	$76,831,288	($1,109,039)	$1,223,691,655	$1,156,867,924	($66,823,731)	98.57%	94.53%
August 2016	$74,588,992	$73,860,982	($728,010)	$1,298,280,648	$1,230,728,906	($67,551,741)	99.02%	94.79%
September 2016	$103,274,219	$100,253,848	($3,020,371)	$1,401,554,867	$1,330,982,754	($70,572,113)	97.07%	94.96%
October 2016	$84,031,929	$81,464,459	($2,567,470)	$1,485,586,796	$1,412,447,213	($73,139,583)	96.94%	95.07%
November 2016	$71,421,371	$69,096,896	($2,324,475)	$1,557,008,167	$1,481,544,109	($75,464,058)	96.74%	95.15%
December 2016	$108,295,031	$91,959,751	($16,335,280)	$1,665,303,198	$1,573,503,860	($91,799,338)	84.91%	94.48%
Unspecified Month[1]		$47,992,518		$1,665,303,198	$1,621,496,378	($43,806,820)		97.36%
Adjustments[2]	$1,053,199			$1,666,356,397	$1,621,496,378	($44,860,019)		97.30%

[1] Unspecified Month represents the Dental Health and Wellness encounters that have plan paid dates of 1/1/0001. They are included in this report but may be excluded from future reports as older paid months begin to roll off. See issue number 14.

[2] The Adjustments line represents an increase in cash disbursements for Opticare and DentaQuest to attain a cumulative completion rate of 100 percent. These vendors' encounters exceed 100 percent of CDJ monthly totals on a consistent basis. See issue numbers 12 and 13.

MAGNOLIA HEALTH CAN
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 these potential duplicates and calculated voids to Magnolia Health to review. Responses received will be incorporated into the next report. Claims having additional questions for Magnolia 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 — Magnolia Health Calculated Void and Duplicate Summary

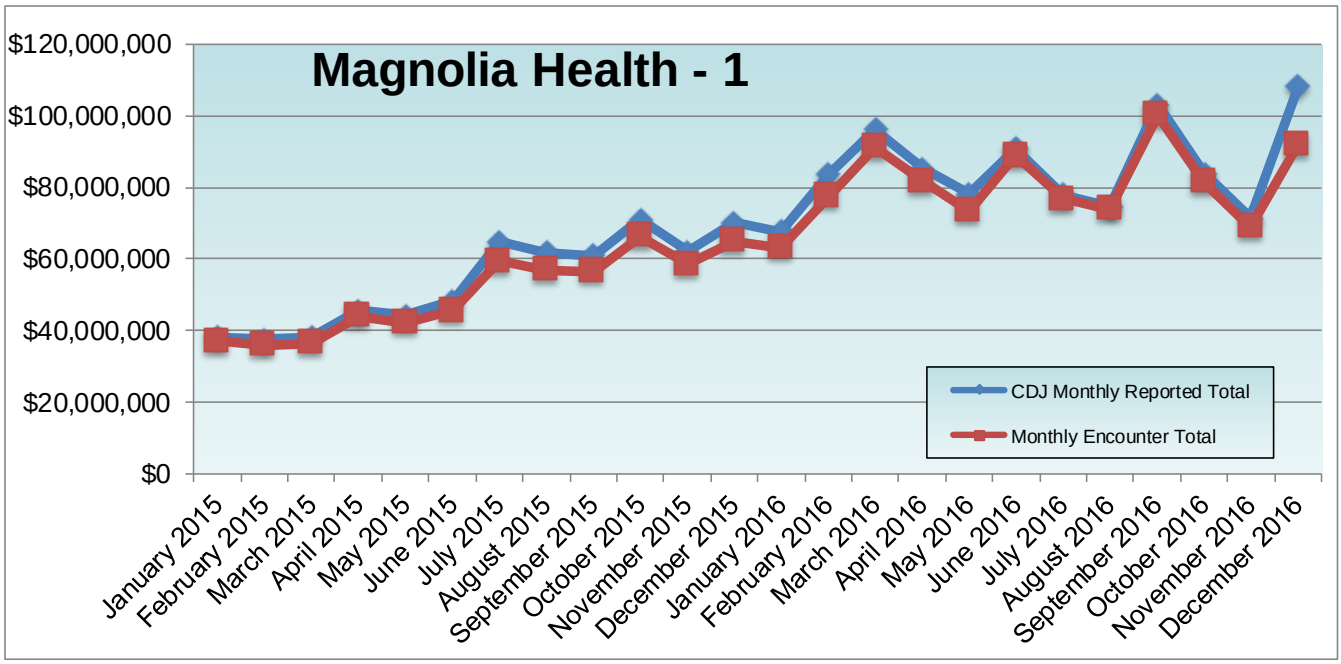
Paid Month	Count of Encounter Claims	Total Sum (CCO Submitted Paid Amount)	Count of CV PDUP Claims	CV PDUP Amount Removed	% of CV PDUP Claim Count	% of CV PDUP Amount Removed
January 2015	354,562	$38,020,695	7,761	$1,003,577	2.19%	2.64%
February 2015	341,317	$36,780,581	7,373	$859,765	2.16%	2.34%
March 2015	356,878	$37,370,342	9,201	$892,579	2.58%	2.39%
April 2015	437,907	$50,240,679	82,355	$6,181,358	18.81%	12.30%
May 2015	410,710	$43,450,793	9,726	$1,302,579	2.37%	3.00%
June 2015	530,142	$48,250,405	15,840	$2,644,614	2.99%	5.48%
July 2015	551,002	$63,282,221	22,012	$3,836,002	3.99%	6.06%
August 2015	521,995	$60,832,175	21,236	$3,781,228	4.07%	6.22%
September 2015	529,682	$60,459,618	22,170	$3,972,325	4.19%	6.57%
October 2015	698,184	$71,604,921	37,750	$5,307,644	5.41%	7.41%
November 2015	574,039	$62,270,087	23,406	$3,794,950	4.08%	6.09%
December 2015	602,608	$68,579,364	22,552	$3,672,122	3.74%	5.35%
January 2016	525,879	$65,540,331	14,686	$2,377,868	2.79%	3.63%
February 2016	606,752	$80,648,525	16,747	$3,090,579	2.76%	3.83%
March 2016	679,972	$94,605,723	16,833	$3,336,660	2.48%	3.53%
April 2016	613,290	$91,408,334	36,580	$9,710,346	5.96%	10.62%
May 2016	606,092	$76,420,708	18,436	$2,861,414	3.04%	3.74%
June 2016	615,157	$91,749,653	10,881	$2,852,910	1.77%	3.11%
July 2016	517,203	$80,146,049	15,136	$3,314,760	2.93%	4.14%
August 2016	533,099	$75,954,174	7,910	$2,093,192	1.48%	2.76%
September 2016	697,312	$102,808,079	10,128	$2,554,231	1.45%	2.48%
October 2016	631,536	$84,350,688	6,551	$2,886,229	1.04%	3.42%
November 2016	609,736	$73,838,533	14,350	$4,741,637	2.35%	6.42%
December 2016	836,857	$97,157,923	18,016	$5,198,173	2.15%	5.35%
Unspecified Month[2]	613,331	$54,801,551	51,689	$6,809,033	8.43%	12.42%
TOTALS	**13,995,242**	**$1,710,572,152**	**519,325**	**$89,075,775**	**3.71%**	**5.21%[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.

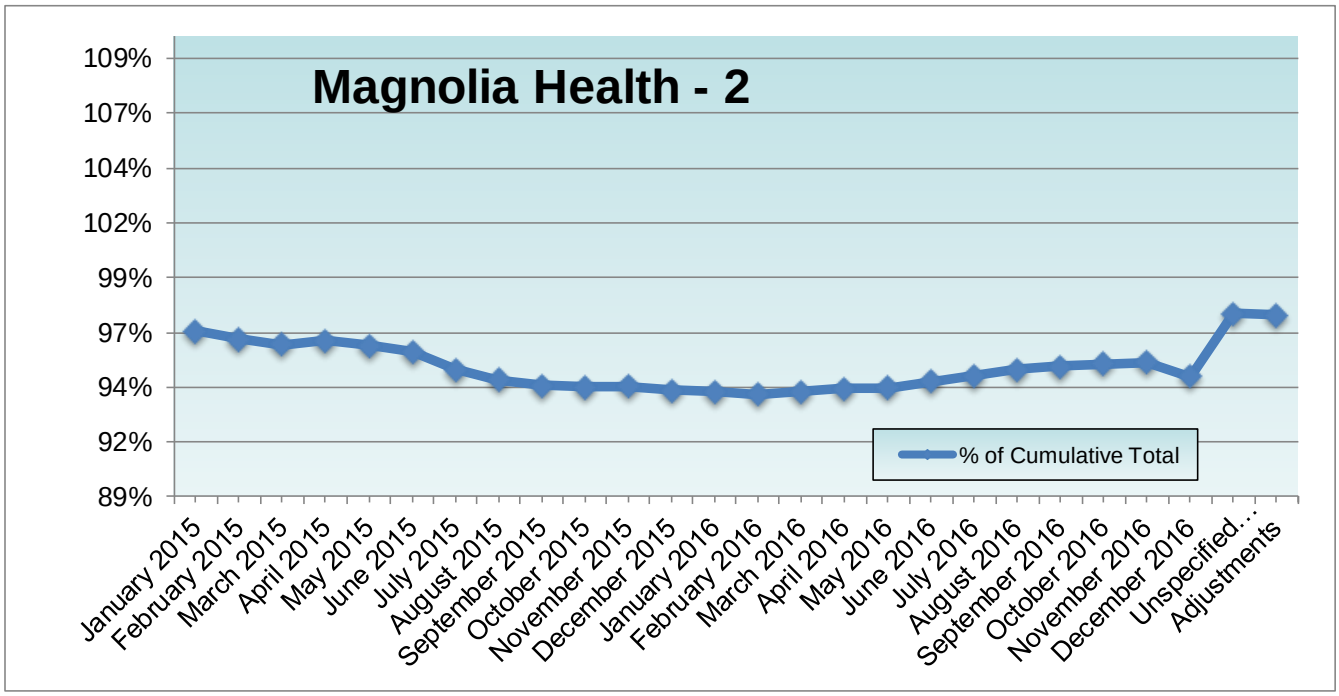
[1] These percentages are somewhat higher than usually expected due to our current methodology which includes system-denied encounters. Please reference potential issue number 8 on page 11.
[2] Unspecified Month represents the Dental Health and Wellness encounters that have plan paid dates of 1/1/0001. They are included in this report but may be excluded from future reports as older paid months begin to roll off. See issue number 14.

MAGNOLIA HEALTH CAN SUMMARY REPORTING CHARTS

Magnolia Health's CDJ totals and encounter totals as reported monthly.



Magnolia Health's cumulative encounter submissions expressed as a percentage of payments submitted to the FAC to reported CCO CDJ payments.



Magnolia Health CAN vendors include Opticare (Vision), DentaQuest (Dental), Dental Health and Wellness (Dental), Cenpatico (BH), Univita (DME), MTM (NET) and U. S. Script (Pharmacy).

MAGNOLIA HEALTH CAN – OPTICARE (VISION)

Magnolia Health appears to have submitted approximately 100 percent of the Opticare vision 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 11 on page 12 for an explanation of the possible causes.

Table 3 — Magnolia Health Opticare (Vision)

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	$633,670	$602,895	($30,775)	$633,670	$602,895	($30,775)	95.14%	95.14%
February 2015	$673,682	$667,210	($6,472)	$1,307,352	$1,270,104	($37,247)	99.03%	97.15%
March 2015	$694,042	$687,311	($6,731)	$2,001,394	$1,957,415	($43,978)	99.03%	97.80%
April 2015	$642,353	$638,902	($3,450)	$2,643,746	$2,596,317	($47,429)	99.46%	98.20%
May 2015	$876,454	$871,917	($4,537)	$3,520,200	$3,468,234	($51,966)	99.48%	98.52%
June 2015	$884,834	$887,836	$3,002	$4,405,034	$4,356,070	($48,964)	100.33%	98.88%
July 2015	$1,154,851	$1,158,555	$3,704	$5,559,885	$5,514,625	($45,260)	100.32%	99.18%
August 2015	$2,352,676	$2,351,612	($1,064)	$7,912,561	$7,866,237	($46,325)	99.95%	99.41%
September 2015	$1,493,251	$1,487,615	($5,636)	$9,405,812	$9,353,851	($51,961)	99.62%	99.44%
October 2015	$1,957,159	$1,949,882	($7,278)	$11,362,972	$11,303,733	($59,239)	99.62%	99.47%
November 2015	$979,105	$1,329,972	$350,868	$12,342,076	$12,633,705	$291,629	135.83%	102.36%
December 2015	$1,048,965	$1,019,884	($29,081)	$13,391,042	$13,653,589	$262,548	97.22%	101.96%
January 2016	$1,475,959	$1,472,017	($3,942)	$14,867,001	$15,125,606	$258,606	99.73%	101.73%
February 2016	$1,597,204	$1,589,927	($7,276)	$16,464,205	$16,715,534	$251,329	99.54%	101.52%
March 2016	$1,510,998	$1,512,555	$1,557	$17,975,203	$18,228,089	$252,886	100.10%	101.40%
April 2016	$1,785,840	$1,702,693	($83,146)	$19,761,042	$19,930,783	$169,740	95.34%	100.85%
May 2016	$1,283,220	$1,279,167	($4,052)	$21,044,262	$21,209,950	$165,688	99.68%	100.78%
June 2016	$803,324	$1,008,695	$205,371	$21,847,587	$22,218,645	$371,058	125.56%	101.69%
July 2016	$1,610,050	$1,610,376	$326	$23,457,636	$23,829,021	$371,385	100.02%	101.58%
August 2016	$1,888,117	$1,879,909	($8,208)	$25,345,753	$25,708,930	$363,177	99.56%	101.43%
September 2016	$1,252,771	$1,963,134	$710,364	$26,598,524	$27,672,064	$1,073,540	156.70%	104.03%
October 2016	$1,454,914	$1,301,093	($153,821)	$28,053,437	$28,973,157	$919,720	89.42%	103.27%
November 2016	$1,286,144	$1,284,758	($1,386)	$29,339,581	$30,257,915	$918,334	99.89%	103.13%
December 2016	$1,229,509	$1,165,522	($63,988)	$30,569,090	$31,423,437	$854,347	94.79%	102.79%
Adjustments[1]	$854,347			$31,423,437	$31,423,437	$0		100.00%

[1] The Adjustments line represents an increase in cash disbursements for Opticare 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 12.

MAGNOLIA HEALTH CAN – DENTAQUEST (DENTAL SERVICES)

Magnolia Health appears to have submitted approximately 100 percent of the DentaQuest encounter data for this period. Monthly percentages exceeded 100 percent during some months of the reporting period. Please reference potential data issue number 11 on page 12 for an explanation of the possible causes.

Table 4 — Magnolia Health DentaQuest (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	$171,047	$352,647	$181,601	$171,047	$352,647	$181,601	206.17%	206.17%
February 2015	($149)	$486	$635	$170,898	$353,133	$182,235	-327.18%	206.63%
March 2015	$9,209	$16,003	$6,794	$180,107	$369,136	$189,029	173.77%	204.95%
April 2015	$8,593	$13,435	$4,843	$188,700	$382,571	$193,871	156.35%	202.74%
May 2015	$3,006	$6,022	$3,016	$191,706	$388,593	$196,888	200.34%	202.70%
June 2015	$0	$1,890	$1,890	$191,706	$390,483	$198,777		203.68%
July 2015	$0	$0	$0	$191,706	$390,483	$198,777		203.68%
August 2015	$0	$0	$0	$191,706	$390,483	$198,777		203.68%
September 2015	($149)	($661)	($512)	$191,556	$389,821	$198,265	443.08%	203.50%
October 2015	($522)	$0	$522	$191,034	$389,821	$198,787	0.00%	204.05%
November 2015	($65)	$0	$65	$190,969	$389,821	$198,853	0.00%	204.12%
December 2015	$0	$0	$0	$190,969	$389,821	$198,853		204.12%
January 2016	$0	$0	$0	$190,969	$389,821	$198,853		204.12%
February 2016	$0	$0	$0	$190,969	$389,821	$198,853		204.12%
March 2016	$0	$0	$0	$190,969	$389,821	$198,853		204.12%
April 2016	$0	$0	$0	$190,969	$389,821	$198,853		204.12%
May 2016	$0	$0	$0	$190,969	$389,821	$198,853		204.12%
June 2016	$0	$0	$0	$190,969	$389,821	$198,853		204.12%
July 2016	$0	$0	$0	$190,969	$389,821	$198,853		204.12%
August 2016	$0	$0	$0	$190,969	$389,821	$198,853		204.12%
September 2016	$0	$0	$0	$190,969	$389,821	$198,853		204.12%
October 2016	$0	$0	$0	$190,969	$389,821	$198,853		204.12%
November 2016	$0	$0	$0	$190,969	$389,821	$198,853		204.12%
December 2016	$0	$0	$0	$190,969	$389,821	$198,853		204.12%
Adjustments[1]	$198,853			$389,821	$389,821	$0		100.00%

[1] The Adjustments line represents an increase in cash disbursements for DentaQuest 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 13.

MAGNOLIA HEALTH CAN – DENTAL HEALTH AND WELLNESS (DENTAL SERVICES)

Magnolia Health appears to have submitted approximately 98 percent of the Dental Health and Wellness encounter data for this period, with a cumulative monthly range between 0 percent and 98 percent. Monthly percentages exceeded 100 percent during some months of the reporting period. Please reference potential data issue number 11 on page 12 for an explanation of the possible causes.

Table 5 — Magnolia Health Dental Health and Wellness (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	$351,630	$3,580	($348,050)	$351,630	$3,580	($348,050)	1.01%	1.01%
February 2015	$636,509	$3,707	($632,802)	$988,139	$7,287	($980,852)	0.58%	0.73%
March 2015	$542,040	$12,439	($529,601)	$1,530,178	$19,726	($1,510,452)	2.29%	1.28%
April 2015	$1,093,967	$11,852	($1,082,115)	$2,624,145	$31,578	($2,592,567)	1.08%	1.20%
May 2015	$1,484,336	$232,352	($1,251,984)	$4,108,481	$263,930	($3,844,551)	15.65%	6.42%
June 2015	$2,078,269	$544,732	($1,533,537)	$6,186,750	$808,661	($5,378,089)	26.21%	13.07%
July 2015	$4,787,394	$634,124	($4,153,270)	$10,974,144	$1,442,785	($9,531,359)	13.24%	13.14%
August 2015	$4,635,201	$722,223	($3,912,979)	$15,609,345	$2,165,008	($13,444,337)	15.58%	13.86%
September 2015	$4,437,769	$891,573	($3,546,196)	$20,047,114	$3,056,581	($16,990,533)	20.09%	15.24%
October 2015	$6,159,933	$1,218,728	($4,941,205)	$26,207,047	$4,275,309	($21,931,738)	19.78%	16.31%
November 2015	$3,616,868	$995,027	($2,621,841)	$29,823,915	$5,270,337	($24,553,579)	27.51%	17.67%
December 2015	$4,866,541	$726,914	($4,139,626)	$34,690,456	$5,997,251	($28,693,205)	14.93%	17.28%
January 2016	$3,967,901	$567,109	($3,400,792)	$38,658,357	$6,564,360	($32,093,997)	14.29%	16.98%
February 2016	$5,035,088	$620,832	($4,414,255)	$43,693,445	$7,185,192	($36,508,253)	12.33%	16.44%
March 2016	$5,953,824	$1,487,524	($4,466,300)	$49,647,269	$8,672,716	($40,974,553)	24.98%	17.46%
April 2016	$4,495,947	$1,587,640	($2,908,307)	$54,143,216	$10,260,356	($43,882,860)	35.31%	18.95%
May 2016	$4,327,495	$642,888	($3,684,607)	$58,470,711	$10,903,244	($47,567,467)	14.85%	18.64%
June 2016	$5,099,759	$4,132,994	($966,765)	$63,570,470	$15,036,238	($48,534,232)	81.04%	23.65%
July 2016	$4,778,778	$5,118,991	$340,214	$68,349,248	$20,155,229	($48,194,018)	107.11%	29.48%
August 2016	$4,884,643	$5,346,331	$461,688	$73,233,891	$25,501,560	($47,732,331)	109.45%	34.82%
September 2016	$5,650,583	$4,936,678	($713,906)	$78,884,474	$30,438,238	($48,446,236)	87.36%	38.58%
October 2016	$4,734,353	$4,927,762	$193,409	$83,618,827	$35,365,999	($48,252,827)	104.08%	42.29%
November 2016	$4,833,098	$4,891,256	$58,158	$88,451,925	$40,257,256	($48,194,669)	101.20%	45.51%
December 2016	$5,149,114	$4,350,016	($799,098)	$93,601,039	$44,607,272	($48,993,768)	84.48%	47.65%
Unspecified Month[1]		$47,992,518		$93,601,039	$92,599,789	($1,001,250)		98.93%

[1] Unspecified Month represents the Dental Health and Wellness encounters that have plan paid dates of 1/1/0001. They are included in this report but may be excluded from future reports as older paid months begin to roll off. See issue number 14.

MAGNOLIA HEALTH CAN – CENPATICO (BEHAVIORAL HEALTH)

Magnolia Health appears to have submitted approximately 98 percent of the Cenpatico behavioral health encounter data for this period, with a cumulative monthly range between 98 percent and 100 percent. Monthly percentages exceeded 100 percent during a few months of the reporting period. Please reference potential data issue number 11 on page 12 for an explanation of the possible causes.

Table 6 — Magnolia Health Cenpatico (Behavioral Health)

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	$2,354,136	$2,343,574	($10,563)	$2,354,136	$2,343,574	($10,563)	99.55%	99.55%
February 2015	$2,104,212	$2,102,191	($2,021)	$4,458,348	$4,445,764	($12,584)	99.90%	99.71%
March 2015	$2,601,365	$2,594,532	($6,833)	$7,059,713	$7,040,296	($19,417)	99.73%	99.72%
April 2015	$2,739,660	$2,779,433	$39,773	$9,799,373	$9,819,730	$20,356	101.45%	100.20%
May 2015	$2,582,687	$2,573,437	($9,250)	$12,382,060	$12,393,167	$11,107	99.64%	100.08%
June 2015	$3,139,895	$3,129,231	($10,664)	$15,521,955	$15,522,397	$443	99.66%	100.00%
July 2015	$5,461,014	$5,439,750	($21,264)	$20,982,968	$20,962,147	($20,821)	99.61%	99.90%
August 2015	$4,055,418	$4,044,057	($11,361)	$25,038,387	$25,006,204	($32,182)	99.71%	99.87%
September 2015	$3,932,562	$3,914,670	($17,892)	$28,970,949	$28,920,875	($50,074)	99.54%	99.82%
October 2015	$5,357,562	$5,294,301	($63,261)	$34,328,511	$34,215,176	($113,335)	98.81%	99.66%
November 2015	$4,263,270	$4,239,887	($23,383)	$38,591,781	$38,455,063	($136,718)	99.45%	99.64%
December 2015	$4,643,588	$4,615,463	($28,125)	$43,235,368	$43,070,526	($164,842)	99.39%	99.61%
January 2016	$4,108,975	$4,076,664	($32,311)	$47,344,343	$47,147,190	($197,154)	99.21%	99.58%
February 2016	$6,181,055	$6,085,383	($95,672)	$53,525,398	$53,232,573	($292,825)	98.45%	99.45%
March 2016	$8,102,847	$7,959,257	($143,590)	$61,628,245	$61,191,830	($436,415)	98.22%	99.29%
April 2016	$6,734,325	$6,836,499	$102,174	$68,362,571	$68,028,330	($334,241)	101.51%	99.51%
May 2016	$6,831,797	$6,784,573	($47,225)	$75,194,368	$74,812,902	($381,466)	99.30%	99.49%
June 2016	$7,214,761	$7,204,442	($10,319)	$82,409,129	$82,017,344	($391,785)	99.85%	99.52%
July 2016	$6,276,493	$6,170,022	($106,470)	$88,685,622	$88,187,367	($498,255)	98.30%	99.43%
August 2016	$5,197,110	$5,074,075	($123,036)	$93,882,732	$93,261,441	($621,291)	97.63%	99.33%
September 2016	$7,664,341	$7,286,215	($378,126)	$101,547,073	$100,547,656	($999,417)	95.06%	99.01%
October 2016	$7,006,638	$6,358,168	($648,470)	$108,553,710	$106,905,824	($1,647,886)	90.74%	98.48%
November 2016	$6,283,762	$6,046,280	($237,482)	$114,837,473	$112,952,104	($1,885,369)	96.22%	98.35%
December 2016	$7,261,002	$7,079,205	($181,798)	$122,098,475	$120,031,309	($2,067,166)	97.49%	98.30%

MAGNOLIA HEALTH CAN – UNIVITA (DME)

Magnolia Health appears to have submitted approximately 96 percent of the Univita 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 11 on page 12 for an explanation of the possible causes.

Table 7 — Magnolia Health Univita (DME)

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	$158,223	$169,851	$11,628	$158,223	$169,851	$11,628	107.34%	107.34%
February 2015	$156,003	$171,149	$15,146	$314,226	$341,000	$26,774	109.70%	108.52%
March 2015	$70,705	$60,569	($10,137)	$384,931	$401,569	$16,638	85.66%	104.32%
April 2015	$157,093	$157,183	$90	$542,024	$558,752	$16,728	100.05%	103.08%
May 2015	$68,426	$85,999	$17,573	$610,450	$644,751	$34,301	125.68%	105.61%
June 2015	$18,913	$32,996	$14,083	$629,363	$677,746	$48,384	174.46%	107.68%
July 2015	$73,271	$0	($73,271)	$702,633	$677,746	($24,887)	0.00%	96.45%
August 2015	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
September 2015	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
October 2015	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
November 2015	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
December 2015	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
January 2016	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
February 2016	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
March 2016	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
April 2016	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
May 2016	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
June 2016	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
July 2016	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
August 2016	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
September 2016	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
October 2016	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
November 2016	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%
December 2016	$0	$0	$0	$702,633	$677,746	($24,887)		96.45%

MAGNOLIA HEALTH CAN – MTM (NET)

Magnolia Health appears to have submitted approximately 92 percent of the MTM non-emergency transportation encounter data for this period, with a cumulative monthly range between 66 percent and 100 percent. Monthly percentages exceeded 100 percent during some months of the reporting period. Please reference potential data issue number 11 on page 12 for an explanation of the possible causes.

Table 8 — Magnolia Health MTM (NET)

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	$531,570	$353,000	($178,571)	$531,570	$353,000	($178,571)	66.40%	66.40%
February 2015	$477,200	$476,794	($406)	$1,008,771	$829,794	($178,977)	99.91%	82.25%
March 2015	$646,664	$644,899	($1,764)	$1,655,434	$1,474,694	($180,741)	99.72%	89.08%
April 2015	$499,661	$499,005	($655)	$2,155,095	$1,973,699	($181,396)	99.86%	91.58%
May 2015	$495,138	$493,090	($2,048)	$2,650,233	$2,466,789	($183,444)	99.58%	93.07%
June 2015	$510,225	$511,032	$807	$3,160,458	$2,977,821	($182,637)	100.15%	94.22%
July 2015	$561,232	$559,374	($1,858)	$3,721,690	$3,537,195	($184,495)	99.66%	95.04%
August 2015	$660,718	$658,498	($2,221)	$4,382,408	$4,195,692	($186,716)	99.66%	95.73%
September 2015	$774,114	$843,221	$69,107	$5,156,522	$5,038,913	($117,609)	108.92%	97.71%
October 2015	$369,883	$622,072	$252,190	$5,526,405	$5,660,986	$134,580	168.18%	102.43%
November 2015	$618,858	$618,868	$10	$6,145,263	$6,279,853	$134,590	100.00%	102.19%
December 2015	$507,500	$609,676	$102,176	$6,652,763	$6,889,529	$236,766	120.13%	103.55%
January 2016	$540,573	$540,062	($511)	$7,193,337	$7,429,592	$236,255	99.90%	103.28%
February 2016	$637,559	$635,163	($2,396)	$7,830,896	$8,064,755	$233,859	99.62%	102.98%
March 2016	$886,627	$884,671	($1,957)	$8,717,523	$8,949,425	$231,902	99.77%	102.66%
April 2016	$593,416	$593,597	$181	$9,310,939	$9,543,022	$232,083	100.03%	102.49%
May 2016	$598,179	$596,263	($1,916)	$9,909,118	$10,139,285	$230,167	99.67%	102.32%
June 2016	$592,577	$590,685	($1,892)	$10,501,695	$10,729,970	$228,275	99.68%	102.17%
July 2016	$770,556	$770,071	($485)	$11,272,250	$11,500,041	$227,791	99.93%	102.02%
August 2016	$655,644	$653,585	($2,059)	$11,927,895	$12,153,626	$225,732	99.68%	101.89%
September 2016	$694,198	$0	($694,198)	$12,622,093	$12,153,626	($468,467)	0.00%	96.28%
October 2016	$630,478	$626,123	($4,356)	$13,252,571	$12,779,749	($472,822)	99.30%	96.43%
November 2016	$848,918	$845,421	($3,497)	$14,101,489	$13,625,170	($476,319)	99.58%	96.62%
December 2016	$1,204,661	$600,866	($603,795)	$15,306,150	$14,226,036	($1,080,114)	49.87%	92.94%

MAGNOLIA HEALTH CAN – U. S. SCRIPT (PHARMACY BENEFITS)

Magnolia Health appears to have submitted approximately 95 percent of the U. S. Script pharmacy benefit encounter data for this period, with a cumulative monthly range between 92 percent and 95 percent.

Table 9 — Magnolia Health U. S. Script (Pharmacy)

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	$13,593,342	$12,740,178	($853,163)	$13,593,342	$12,740,178	($853,163)	93.72%	93.72%
February 2015	$13,195,430	$12,235,804	($959,626)	$26,788,772	$24,975,982	($1,812,789)	92.72%	93.23%
March 2015	$14,240,473	$13,149,560	($1,090,913)	$41,029,245	$38,125,543	($2,903,702)	92.33%	92.92%
April 2015	$15,109,783	$14,012,845	($1,096,938)	$56,139,028	$52,138,388	($4,000,640)	92.74%	92.87%
May 2015	$17,130,890	$16,000,258	($1,130,633)	$73,269,919	$68,138,645	($5,131,273)	93.40%	92.99%
June 2015	$18,588,852	$17,426,763	($1,162,089)	$91,858,770	$85,565,408	($6,293,362)	93.74%	93.14%
July 2015	$20,212,221	$19,006,662	($1,205,559)	$112,070,991	$104,572,071	($7,498,921)	94.03%	93.30%
August 2015	$21,306,645	$20,427,362	($879,283)	$133,377,636	$124,999,432	($8,378,204)	95.87%	93.71%
September 2015	$20,699,923	$19,841,725	($858,199)	$154,077,559	$144,841,157	($9,236,402)	95.85%	94.00%
October 2015	$21,067,553	$20,397,265	($670,288)	$175,145,112	$165,238,422	($9,906,690)	96.81%	94.34%
November 2015	$20,794,444	$19,842,483	($951,961)	$195,939,556	$185,080,905	($10,858,652)	95.42%	94.45%
December 2015	$21,610,957	$20,755,234	($855,723)	$217,550,513	$205,836,139	($11,714,375)	96.04%	94.61%
January 2016	$21,241,397	$20,507,956	($733,441)	$238,791,910	$226,344,094	($12,447,816)	96.54%	94.78%
February 2016	$22,540,077	$21,688,016	($852,061)	$261,331,988	$248,032,110	($13,299,877)	96.21%	94.91%
March 2016	$23,921,166	$23,066,319	($854,847)	$285,253,153	$271,098,429	($14,154,724)	96.42%	95.03%
April 2016	$21,788,348	$20,973,107	($815,242)	$307,041,502	$292,071,536	($14,969,966)	96.25%	95.12%
May 2016	$18,344,703	$17,368,524	($976,179)	$325,386,205	$309,440,060	($15,946,145)	94.67%	95.09%
June 2016	$17,663,685	$16,635,372	($1,028,314)	$343,049,890	$326,075,431	($16,974,459)	94.17%	95.05%
July 2016	$16,559,270	$15,904,568	($654,702)	$359,609,160	$341,979,999	($17,629,161)	96.04%	95.09%
August 2016	$18,526,203	$17,975,008	($551,195)	$378,135,363	$359,955,007	($18,180,356)	97.02%	95.19%
September 2016	$17,806,857	$17,300,047	($506,810)	$395,942,220	$377,255,054	($18,687,166)	97.15%	95.28%
October 2016	$18,174,728	$17,474,317	($700,411)	$414,116,948	$394,729,371	($19,387,577)	96.14%	95.31%
November 2016	$18,501,145	$17,785,368	($715,777)	$432,618,093	$412,514,739	($20,103,354)	96.13%	95.35%
December 2016	$18,297,966	$17,772,262	($525,704)	$450,916,059	$430,287,001	($20,629,059)	97.12%	95.42%

MAGNOLIA HEALTH CAN – FEE-FOR-SERVICE

Magnolia Health appears to have submitted approximately 97 percent of the Magnolia Health fee-for-service encounter data for this period, with a cumulative monthly range between 97 percent and 100 percent. Monthly percentages exceeded 100 percent during some months of the reporting period. Please reference potential data issue number 11 on page 12 for an explanation of the possible causes.

Table 10 — Magnolia Health Fee-for-Service

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	$20,546,727	$20,451,393	($95,335)	$20,546,727	$20,451,393	($95,335)	99.53%	99.53%
February 2015	$20,249,192	$20,263,476	$14,284	$40,795,919	$40,714,869	($81,051)	100.07%	99.80%
March 2015	$19,395,032	$19,312,450	($82,583)	$60,190,952	$60,027,318	($163,634)	99.57%	99.72%
April 2015	$25,382,797	$25,946,665	$563,868	$85,573,749	$85,973,984	$400,235	102.22%	100.46%
May 2015	$21,690,652	$21,885,140	$194,488	$107,264,401	$107,859,123	$594,722	100.89%	100.55%
June 2015	$23,066,277	$23,071,313	$5,036	$130,330,678	$130,930,436	$599,758	100.02%	100.46%
July 2015	$32,651,056	$32,647,754	($3,302)	$162,981,734	$163,578,190	$596,456	99.98%	100.36%
August 2015	$28,931,824	$28,847,195	($84,629)	$191,913,558	$192,425,385	$511,827	99.70%	100.26%
September 2015	$29,768,117	$29,509,151	($258,966)	$221,681,675	$221,934,537	$252,862	99.13%	100.11%
October 2015	$36,025,667	$36,815,029	$789,362	$257,707,342	$258,749,565	$1,042,224	102.19%	100.40%
November 2015	$31,732,808	$31,448,900	($283,909)	$289,440,150	$290,198,465	$758,315	99.10%	100.26%
December 2015	$37,577,494	$37,180,071	($397,423)	$327,017,644	$327,378,536	$360,892	98.94%	100.11%
January 2016	$36,407,250	$35,998,656	($408,594)	$363,424,894	$363,377,192	($47,702)	98.87%	99.98%
February 2016	$47,841,475	$46,938,625	($902,850)	$411,266,369	$410,315,816	($950,553)	98.11%	99.76%
March 2016	$55,893,081	$56,358,738	$465,657	$467,159,450	$466,674,554	($484,896)	100.83%	99.89%
April 2016	$49,962,631	$50,004,451	$41,819	$517,122,081	$516,679,005	($443,077)	100.08%	99.91%
May 2016	$46,819,610	$46,887,879	$68,269	$563,941,692	$563,566,884	($374,808)	100.14%	99.93%
June 2016	$59,537,264	$59,324,555	($212,709)	$623,478,956	$622,891,440	($587,516)	99.64%	99.90%
July 2016	$47,945,181	$47,257,259	($687,922)	$671,424,137	$670,148,699	($1,275,438)	98.56%	99.81%
August 2016	$43,437,275	$42,932,075	($505,200)	$714,861,412	$713,080,774	($1,780,638)	98.83%	99.75%
September 2016	$70,205,469	$68,767,774	($1,437,695)	$785,066,882	$781,848,548	($3,218,333)	97.95%	99.59%
October 2016	$52,030,818	$50,776,996	($1,253,822)	$837,097,700	$832,625,545	($4,472,155)	97.59%	99.46%
November 2016	$39,668,303	$38,243,812	($1,424,491)	$876,766,003	$870,869,357	($5,896,646)	96.40%	99.32%
December 2016	$75,152,778	$60,991,880	($14,160,898)	$951,918,781	$931,861,237	($20,057,544)	81.15%	97.89%

MAGNOLIA HEALTH CHIP
JANUARY 2015 – DECEMBER 2016

MAGNOLIA HEALTH CHIP – ENTIRE PLAN

Magnolia Health appears to have submitted approximately 77 percent of their encounter data for this period, with a cumulative monthly range between 3 percent and 77 percent.

Table 11 — Magnolia Health 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	$841,732	$33,065	($808,667)	$841,732	$33,065	($808,667)	3.92%	3.92%
February 2015	$1,825,008	$1,281,989	($543,020)	$2,666,741	$1,315,054	($1,351,687)	70.24%	49.31%
March 2015	$1,744,530	$1,246,192	($498,338)	$4,411,271	$2,561,246	($1,850,025)	71.43%	58.06%
April 2015	$2,442,152	$1,740,762	($701,390)	$6,853,423	$4,302,008	($2,551,415)	71.27%	62.77%
May 2015	$2,319,387	$1,724,471	($594,916)	$9,172,810	$6,026,479	($3,146,331)	74.35%	65.69%
June 2015	$1,964,848	$1,392,718	($572,131)	$11,137,658	$7,419,196	($3,718,462)	70.88%	66.61%
July 2015	$2,639,400	$1,872,963	($766,437)	$13,777,058	$9,292,159	($4,484,899)	70.96%	67.44%
August 2015	$2,490,293	$1,665,574	($824,719)	$16,267,352	$10,957,734	($5,309,618)	66.88%	67.36%
September 2015	$3,186,420	$2,429,822	($756,598)	$19,453,772	$13,387,556	($6,066,216)	76.25%	68.81%
October 2015	$3,929,540	$2,513,465	($1,416,075)	$23,383,311	$15,901,020	($7,482,291)	63.96%	68.00%
November 2015	$3,026,769	$2,389,422	($637,347)	$26,410,080	$18,290,442	($8,119,638)	78.94%	69.25%
December 2015	$3,439,166	$2,683,279	($755,887)	$29,849,246	$20,973,721	($8,875,525)	78.02%	70.26%
January 2016	$2,823,439	$2,086,300	($737,138)	$32,672,685	$23,060,021	($9,612,663)	73.89%	70.57%
February 2016	$3,299,762	$2,485,677	($814,085)	$35,972,447	$25,545,698	($10,426,749)	75.32%	71.01%
March 2016	$3,960,890	$3,093,394	($867,496)	$39,933,337	$28,639,092	($11,294,244)	78.09%	71.71%
April 2016	$3,621,214	$2,735,466	($885,748)	$43,554,551	$31,374,558	($12,179,992)	75.54%	72.03%
May 2016	$3,185,425	$2,586,004	($599,421)	$46,739,975	$33,960,562	($12,779,413)	81.18%	72.65%
June 2016	$3,689,829	$3,034,070	($655,758)	$50,429,804	$36,994,632	($13,435,171)	82.22%	73.35%
July 2016	$3,472,699	$2,707,337	($765,362)	$53,902,503	$39,701,970	($14,200,534)	77.96%	73.65%
August 2016	$2,882,840	$2,241,259	($641,581)	$56,785,343	$41,943,229	($14,842,115)	77.74%	73.86%
September 2016	$4,157,381	$3,468,086	($689,295)	$60,942,724	$45,411,315	($15,531,409)	83.41%	74.51%
October 2016	$3,625,609	$2,842,294	($783,315)	$64,568,333	$48,253,609	($16,314,724)	78.39%	74.73%
November 2016	$3,161,636	$2,319,436	($842,200)	$67,729,969	$50,573,045	($17,156,924)	73.36%	74.66%
December 2016	$5,205,145	$3,631,993	($1,573,152)	$72,935,114	$54,205,037	($18,730,076)	69.77%	74.31%
Unspecified Month[1]		$2,145,539		$72,935,114	$56,350,577	($16,584,537)		77.26%

[1] Unspecified Month represents the Dental Health and Wellness encounters that have plan paid dates of 1/1/0001. They are included in this report but may be excluded from future reports as older paid months begin to roll off. See issue number 14.

MAGNOLIA HEALTH CHIP
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 these potential duplicates and calculated voids to Magnolia Health to review. Responses received will be incorporated into the next report. Claims having additional questions for Magnolia 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.

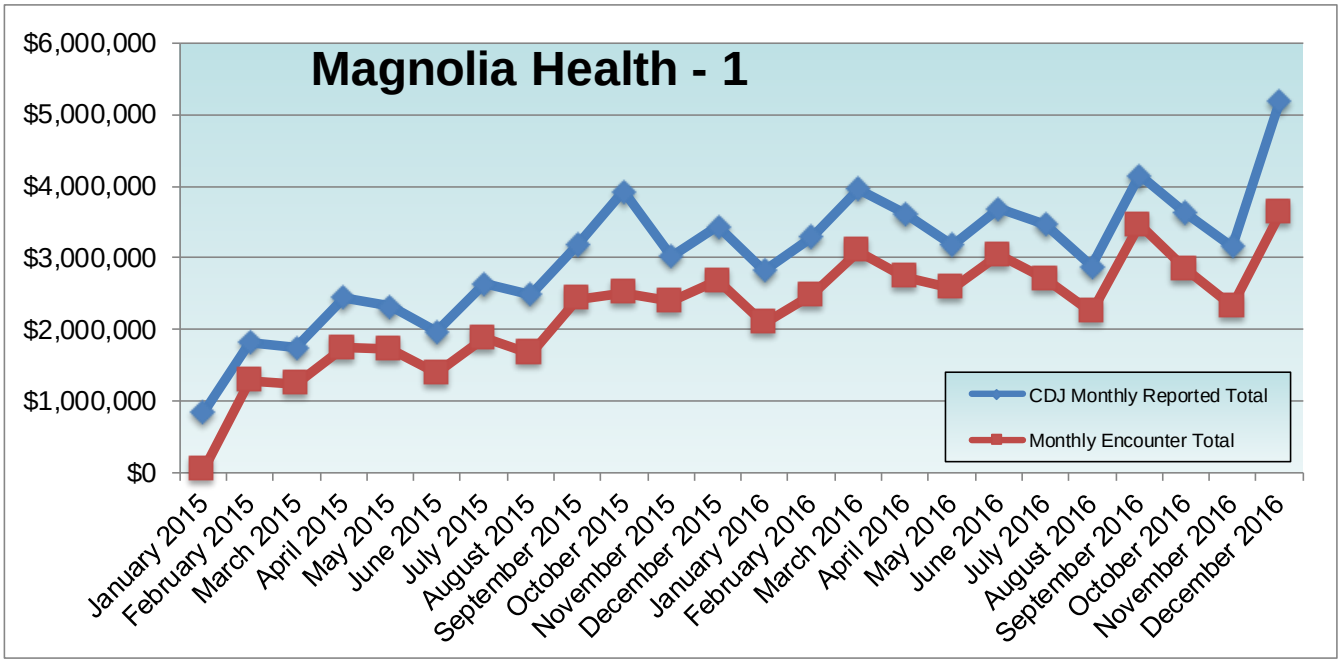
Table 12 — Magnolia Health CHIP Calculated Void and Duplicate Summary

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	461	$35,751	41	$2,686	8.89%	7.51%
February 2015	12,696	$1,327,237	309	$45,248	2.43%	3.41%
March 2015	12,484	$1,302,896	682	$56,704	5.46%	4.35%
April 2015	14,322	$1,877,130	1,008	$136,368	7.04%	7.26%
May 2015	12,971	$1,831,423	1,187	$106,952	9.15%	5.84%
June 2015	10,709	$1,478,092	826	$85,375	7.71%	5.78%
July 2015	12,702	$2,019,216	1,111	$146,253	8.75%	7.24%
August 2015	13,299	$1,746,796	821	$81,222	6.17%	4.65%
September 2015	16,352	$2,577,367	1,089	$147,545	6.66%	5.72%
October 2015	12,127	$2,648,653	1,400	$135,189	11.54%	5.10%
November 2015	19,045	$2,556,319	1,123	$166,897	5.90%	6.53%
December 2015	20,624	$2,815,830	1,391	$132,552	6.74%	4.71%
January 2016	18,208	$2,190,006	1,086	$103,706	5.96%	4.74%
February 2016	19,255	$2,572,881	752	$87,204	3.91%	3.39%
March 2016	24,146	$3,408,475	1,889	$315,081	7.82%	9.24%
April 2016	19,943	$2,873,661	689	$138,195	3.45%	4.81%
May 2016	18,259	$2,677,152	649	$91,148	3.55%	3.40%
June 2016	18,812	$3,178,758	866	$144,688	4.60%	4.55%
July 2016	16,028	$2,895,639	1,065	$188,302	6.64%	6.50%
August 2016	17,289	$2,371,300	506	$130,041	2.93%	5.48%
September 2016	22,743	$3,682,173	940	$214,086	4.13%	5.81%
October 2016	19,371	$3,002,141	781	$159,847	4.03%	5.32%
November 2016	19,040	$2,478,214	473	$158,778	2.48%	6.41%
December 2016	23,420	$3,879,669	808	$247,677	3.45%	6.38%
Unspecified Month[2]	10,370	$2,156,760	51	$11,221	0.49%	0.52%
TOTALS	**404,676**	**$59,583,539**	**21,543**	**$3,232,965**	**5.32%**	**5.43%[2]**

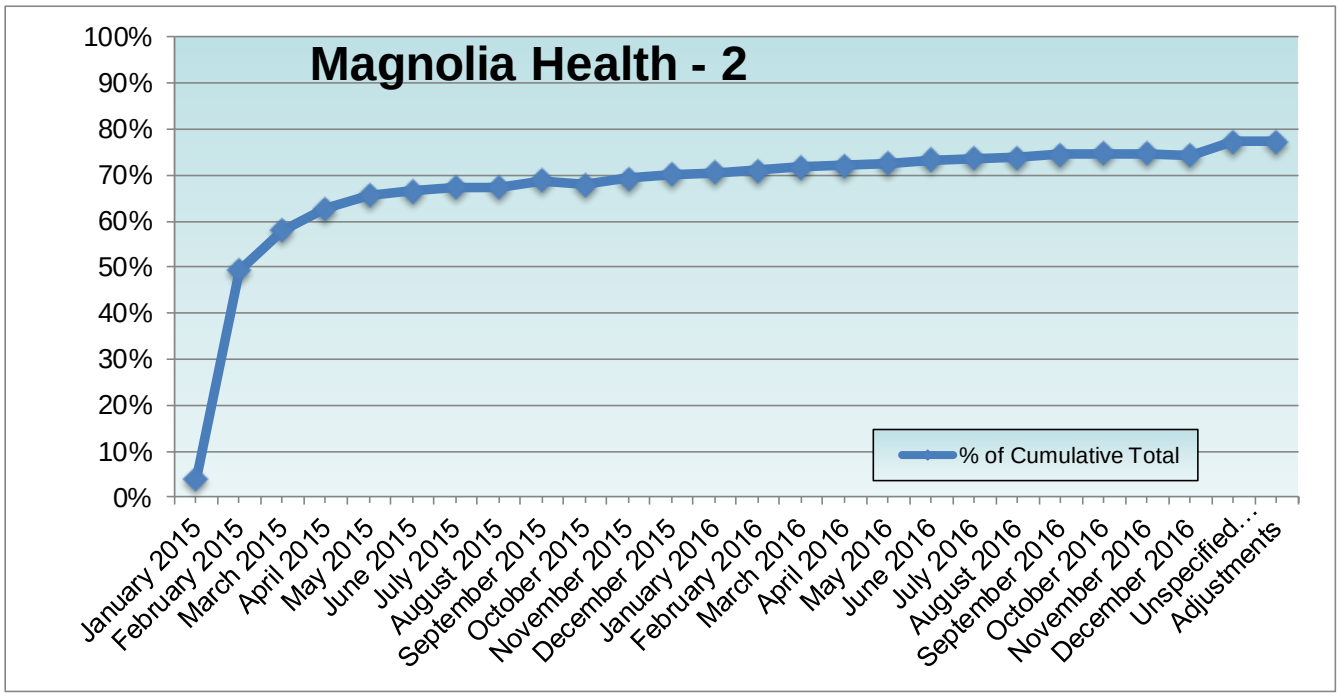
Count of Encounter Claims – The number of claims processed by the FAC (including claims marked as denied by the FAC).
Total Sum (CCO Submitted Paid Amount) – The total paid amount of claims in a month per the encounter data provided by the FAC.
Count of CV PDUP Claims – The number of claims identified 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 8 on page 11.
[2] Unspecified Month represents the Dental Health and Wellness encounters that have plan paid dates of 1/1/0001. They are included in this report but may be excluded from future reports as older paid months begin to roll off. See issue number 14.

Magnolia Health's CDJ totals and encounter totals as reported monthly.



Magnolia Health's cumulative encounter submissions expressed as a percentage of payments submitted to the FAC to reported CCO CDJ payments.



Magnolia Health CHIP vendors include Opticare (Vision), Dental Health and Wellness (Dental), Cenpatico (BH) and U. S. Script (Pharmacy).

MAGNOLIA HEALTH CHIP – OPTICARE (VISION)

Magnolia Health appears to have submitted approximately 0 percent of the Opticare vision encounter data for this period.

Table 13 — Magnolia Health Opticare (Vision)								
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	$35,597	$0	($35,597)	$35,597	$0	($35,597)	0.00%	0.00%
February 2015	$65,594	$0	($65,594)	$101,191	$0	($101,191)	0.00%	0.00%
March 2015	$68,714	$0	($68,714)	$169,905	$0	($169,905)	0.00%	0.00%
April 2015	$62,756	$0	($62,756)	$232,661	$0	($232,661)	0.00%	0.00%
May 2015	$79,498	$0	($79,498)	$312,159	$0	($312,159)	0.00%	0.00%
June 2015	$58,793	$0	($58,793)	$370,952	$0	($370,952)	0.00%	0.00%
July 2015	$71,659	$0	($71,659)	$442,611	$0	($442,611)	0.00%	0.00%
August 2015	$176,569	$0	($176,569)	$619,180	$0	($619,180)	0.00%	0.00%
September 2015	$90,034	$0	($90,034)	$709,214	$0	($709,214)	0.00%	0.00%
October 2015	$128,559	$0	($128,559)	$837,773	$0	($837,773)	0.00%	0.00%
November 2015	$58,752	$0	($58,752)	$896,526	$0	($896,526)	0.00%	0.00%
December 2015	$64,094	$0	($64,094)	$960,620	$0	($960,620)	0.00%	0.00%
January 2016	$115,814	$0	($115,814)	$1,076,434	$0	($1,076,434)	0.00%	0.00%
February 2016	$102,166	$0	($102,166)	$1,178,601	$0	($1,178,601)	0.00%	0.00%
March 2016	$111,252	$0	($111,252)	$1,289,853	$0	($1,289,853)	0.00%	0.00%
April 2016	$127,152	$0	($127,152)	$1,417,004	$0	($1,417,004)	0.00%	0.00%
May 2016	$101,198	$0	($101,198)	$1,518,202	$0	($1,518,202)	0.00%	0.00%
June 2016	$61,415	$0	($61,415)	$1,579,617	$0	($1,579,617)	0.00%	0.00%
July 2016	$135,882	$0	($135,882)	$1,715,499	$0	($1,715,499)	0.00%	0.00%
August 2016	$158,971	$0	($158,971)	$1,874,471	$0	($1,874,471)	0.00%	0.00%
September 2016	$90,244	$0	($90,244)	$1,964,714	$0	($1,964,714)	0.00%	0.00%
October 2016	$106,010	$0	($106,010)	$2,070,725	$0	($2,070,725)	0.00%	0.00%
November 2016	$92,180	$0	($92,180)	$2,162,905	$0	($2,162,905)	0.00%	0.00%
December 2016	$80,614	$0	($80,614)	$2,243,519	$0	($2,243,519)	0.00%	0.00%

MAGNOLIA HEALTH CHIP – DENTAL HEALTH AND WELLNESS (DENTAL SERVICES)

Magnolia Health appears to have submitted approximately 30 percent of the Dental Health and Wellness encounter data for this period, with a cumulative monthly range between 0 percent and 30 percent.

Table 14 — Magnolia Health Dental Health and Wellness (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	$130,386	$0	($130,386)	$130,386	$0	($130,386)	0.00%	0.00%
February 2015	$209,608	$0	($209,608)	$339,994	$0	($339,994)	0.00%	0.00%
March 2015	$245,465	$0	($245,465)	$585,459	$0	($585,459)	0.00%	0.00%
April 2015	$365,875	$0	($365,875)	$951,334	$0	($951,334)	0.00%	0.00%
May 2015	$296,662	$0	($296,662)	$1,247,997	$0	($1,247,997)	0.00%	0.00%
June 2015	$270,150	$0	($270,150)	$1,518,146	$0	($1,518,146)	0.00%	0.00%
July 2015	$439,446	$0	($439,446)	$1,957,592	$0	($1,957,592)	0.00%	0.00%
August 2015	$433,681	$0	($433,681)	$2,391,273	$0	($2,391,273)	0.00%	0.00%
September 2015	$349,185	$0	($349,185)	$2,740,458	$0	($2,740,458)	0.00%	0.00%
October 2015	$585,063	$0	($585,063)	$3,325,521	$0	($3,325,521)	0.00%	0.00%
November 2015	$352,919	$0	($352,919)	$3,678,440	$0	($3,678,440)	0.00%	0.00%
December 2015	$500,310	$0	($500,310)	$4,178,749	$0	($4,178,749)	0.00%	0.00%
January 2016	$434,827	$0	($434,827)	$4,613,576	$0	($4,613,576)	0.00%	0.00%
February 2016	$491,183	$0	($491,183)	$5,104,759	$0	($5,104,759)	0.00%	0.00%
March 2016	$531,321	$4,327	($526,994)	$5,636,080	$4,327	($5,631,753)	0.81%	0.07%
April 2016	$497,745	$2,358	($495,387)	$6,133,825	$6,685	($6,127,140)	0.47%	0.10%
May 2016	$428,681	$1,570	($427,111)	$6,562,507	$8,255	($6,554,251)	0.36%	0.12%
June 2016	$552,765	$138,019	($414,746)	$7,115,271	$146,274	($6,968,997)	24.96%	2.05%
July 2016	$525,020	$171,129	($353,891)	$7,640,292	$317,403	($7,322,888)	32.59%	4.15%
August 2016	$508,787	$178,090	($330,697)	$8,149,078	$495,493	($7,653,585)	35.00%	6.08%
September 2016	$535,199	$144,798	($390,401)	$8,684,277	$640,291	($8,043,986)	27.05%	7.37%
October 2016	$441,506	$134,352	($307,154)	$9,125,783	$774,643	($8,351,140)	30.43%	8.48%
November 2016	$453,462	$141,081	($312,382)	$9,579,245	$915,723	($8,663,522)	31.11%	9.55%
December 2016	$568,860	$70,637	($498,223)	$10,148,105	$986,360	($9,161,745)	12.41%	9.71%
Unspecified Month[1]		$2,145,539		$10,148,105	$3,131,900	($7,016,205)		30.86%

[1] Unspecified Month represents the Dental Health and Wellness encounters that have plan paid dates of 1/1/0001. They are included in this report but may be excluded from future reports as older paid months begin to roll off. See issue number 14.

MAGNOLIA HEALTH CHIP – CENPATICO (BEHAVIORAL HEALTH)

Magnolia Health appears to have submitted approximately 85 percent of the Cenpatico behavioral health encounter data for this period, with a cumulative monthly range between 0 percent and 85 percent. Monthly percentages exceeded 100 percent during a month of the reporting period. Please reference potential data issue number 11 on page 12 for an explanation of the possible causes.

Table 15 — Magnolia Health Cenpatico (Behavioral Health)

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	$5,999	$0	($5,999)	$5,999	$0	($5,999)	0.00%	0.00%
February 2015	$21,448	$10,547	($10,901)	$27,447	$10,547	($16,900)	49.17%	38.42%
March 2015	$34,791	$26,633	($8,159)	$62,238	$37,180	($25,058)	76.54%	59.73%
April 2015	$40,606	$25,789	($14,817)	$102,844	$62,969	($39,875)	63.51%	61.22%
May 2015	$88,830	$78,828	($10,003)	$191,675	$141,797	($49,878)	88.73%	73.97%
June 2015	$56,727	$51,191	($5,536)	$248,402	$192,988	($55,414)	90.24%	77.69%
July 2015	$199,873	$140,536	($59,337)	$448,276	$333,524	($114,751)	70.31%	74.40%
August 2015	$46,834	$29,204	($17,630)	$495,110	$362,729	($132,381)	62.35%	73.26%
September 2015	$98,501	$83,605	($14,896)	$593,610	$446,333	($147,277)	84.87%	75.18%
October 2015	$149,692	$177,897	$28,204	$743,303	$624,230	($119,073)	118.84%	83.98%
November 2015	$74,668	$49,113	($25,555)	$817,971	$673,343	($144,628)	65.77%	82.31%
December 2015	$129,719	$107,327	($22,392)	$947,690	$780,670	($167,020)	82.73%	82.37%
January 2016	$109,196	$97,673	($11,522)	$1,056,886	$878,343	($178,542)	89.44%	83.10%
February 2016	$133,588	$111,222	($22,365)	$1,190,473	$989,565	($200,908)	83.25%	83.12%
March 2016	$147,525	$145,865	($1,660)	$1,337,998	$1,135,430	($202,568)	98.87%	84.86%
April 2016	$165,256	$152,420	($12,837)	$1,503,254	$1,287,850	($215,404)	92.23%	85.67%
May 2016	$133,329	$112,498	($20,831)	$1,636,583	$1,400,348	($236,235)	84.37%	85.56%
June 2016	$167,577	$131,087	($36,491)	$1,804,161	$1,531,435	($272,726)	78.22%	84.88%
July 2016	$153,330	$132,645	($20,685)	$1,957,491	$1,664,080	($293,411)	86.50%	85.01%
August 2016	$100,105	$87,093	($13,012)	$2,057,595	$1,751,173	($306,423)	87.00%	85.10%
September 2016	$138,569	$134,009	($4,560)	$2,196,164	$1,885,182	($310,982)	96.70%	85.83%
October 2016	$119,288	$96,044	($23,244)	$2,315,452	$1,981,226	($334,226)	80.51%	85.56%
November 2016	$144,638	$129,632	($15,006)	$2,460,090	$2,110,858	($349,232)	89.62%	85.80%
December 2016	$146,227	$119,330	($26,897)	$2,606,317	$2,230,188	($376,130)	81.60%	85.56%

MAGNOLIA HEALTH CHIP – U. S. SCRIPT (PHARMACY BENEFITS)

Magnolia Health appears to have submitted approximately 75 percent of the U. S. Script pharmacy benefit encounter data for this period, with a cumulative monthly range between 5 percent and 75 percent.

Table 16 — Magnolia Health U. S. Script (Pharmacy)

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	$599,655	$32,768	($566,887)	$599,655	$32,768	($566,887)	5.46%	5.46%
February 2015	$560,882	$501,180	($59,702)	$1,160,537	$533,948	($626,589)	89.35%	46.00%
March 2015	$475,362	$449,143	($26,219)	$1,635,899	$983,091	($652,808)	94.48%	60.09%
April 2015	$480,484	$403,632	($76,852)	$2,116,383	$1,386,723	($729,660)	84.00%	65.52%
May 2015	$407,087	$336,599	($70,488)	$2,523,470	$1,723,322	($800,148)	82.68%	68.29%
June 2015	$420,819	$337,169	($83,650)	$2,944,289	$2,060,491	($883,798)	80.12%	69.98%
July 2015	$468,183	$361,972	($106,211)	$3,412,472	$2,422,463	($990,009)	77.31%	70.98%
August 2015	$589,646	$465,363	($124,283)	$4,002,117	$2,887,825	($1,114,292)	78.92%	72.15%
September 2015	$642,715	$519,036	($123,679)	$4,644,832	$3,406,862	($1,237,971)	80.75%	73.34%
October 2015	$638,720	$2,623	($636,097)	$5,283,552	$3,409,485	($1,874,068)	0.41%	64.53%
November 2015	$616,264	$526,400	($89,864)	$5,899,816	$3,935,884	($1,963,932)	85.41%	66.71%
December 2015	$618,859	$536,663	($82,196)	$6,518,675	$4,472,548	($2,046,128)	86.71%	68.61%
January 2016	$640,641	$558,104	($82,536)	$7,159,316	$5,030,652	($2,128,664)	87.11%	70.26%
February 2016	$687,251	$569,195	($118,056)	$7,846,567	$5,599,847	($2,246,720)	82.82%	71.36%
March 2016	$758,496	$655,308	($103,188)	$8,605,063	$6,255,155	($2,349,908)	86.39%	72.69%
April 2016	$659,781	$560,012	($99,769)	$9,264,844	$6,815,167	($2,449,677)	84.87%	73.55%
May 2016	$512,488	$436,753	($75,735)	$9,777,332	$7,251,921	($2,525,411)	85.22%	74.17%
June 2016	$463,089	$394,223	($68,866)	$10,240,421	$7,646,144	($2,594,278)	85.12%	74.66%
July 2016	$500,662	$403,094	($97,568)	$10,741,084	$8,049,237	($2,691,846)	80.51%	74.93%
August 2016	$626,821	$517,530	($109,291)	$11,367,905	$8,566,768	($2,801,137)	82.56%	75.35%
September 2016	$571,992	$453,244	($118,748)	$11,939,897	$9,020,012	($2,919,885)	79.23%	75.54%
October 2016	$572,574	$446,802	($125,772)	$12,512,471	$9,466,814	($3,045,657)	78.03%	75.65%
November 2016	$632,226	$486,297	($145,929)	$13,144,697	$9,953,112	($3,191,585)	76.91%	75.71%
December 2016	$629,729	$491,185	($138,545)	$13,774,426	$10,444,296	($3,330,130)	77.99%	75.82%

MAGNOLIA HEALTH CHIP – FEE-FOR-SERVICE

Magnolia Health appears to have submitted approximately 91 percent of the Magnolia Health fee-for-service encounter data for this period, with a cumulative monthly range between 0 percent and 93 percent. Monthly percentages exceeded 100 percent during a month of the reporting period. Please reference potential data issue number 11 on page 12 for an explanation of the possible causes.

Table 17 — Magnolia Health Fee-for-Service

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	$70,095	$297	($69,798)	$70,095	$297	($69,798)	0.42%	0.42%
February 2015	$967,476	$770,261	($197,215)	$1,037,571	$770,559	($267,013)	79.61%	74.26%
March 2015	$920,198	$770,417	($149,781)	$1,957,769	$1,540,975	($416,794)	83.72%	78.71%
April 2015	$1,492,431	$1,311,341	($181,090)	$3,450,200	$2,852,316	($597,884)	87.86%	82.67%
May 2015	$1,447,309	$1,309,044	($138,265)	$4,897,509	$4,161,360	($736,150)	90.44%	84.96%
June 2015	$1,158,360	$1,004,358	($154,002)	$6,055,869	$5,165,717	($890,152)	86.70%	85.30%
July 2015	$1,460,239	$1,370,455	($89,784)	$7,516,108	$6,536,172	($979,936)	93.85%	86.96%
August 2015	$1,243,564	$1,171,007	($72,556)	$8,759,671	$7,707,179	($1,052,492)	94.16%	87.98%
September 2015	$2,005,985	$1,827,181	($178,804)	$10,765,657	$9,534,361	($1,231,296)	91.08%	88.56%
October 2015	$2,427,505	$2,332,945	($94,560)	$13,193,162	$11,867,306	($1,325,856)	96.10%	89.95%
November 2015	$1,924,166	$1,813,909	($110,257)	$15,117,328	$13,681,215	($1,436,113)	94.26%	90.50%
December 2015	$2,126,184	$2,039,289	($86,895)	$17,243,512	$15,720,503	($1,523,008)	95.91%	91.16%
January 2016	$1,522,961	$1,430,523	($92,438)	$18,766,473	$17,151,026	($1,615,447)	93.93%	91.39%
February 2016	$1,885,574	$1,805,260	($80,314)	$20,652,047	$18,956,286	($1,695,761)	95.74%	91.78%
March 2016	$2,412,296	$2,287,894	($124,402)	$23,064,342	$21,244,179	($1,820,163)	94.84%	92.10%
April 2016	$2,171,280	$2,020,677	($150,603)	$25,235,622	$23,264,856	($1,970,766)	93.06%	92.19%
May 2016	$2,009,729	$2,035,182	$25,453	$27,245,351	$25,300,038	($1,945,313)	101.26%	92.86%
June 2016	$2,444,982	$2,370,742	($74,240)	$29,690,333	$27,670,780	($2,019,553)	96.96%	93.19%
July 2016	$2,157,805	$2,000,469	($157,336)	$31,848,138	$29,671,249	($2,176,889)	92.70%	93.16%
August 2016	$1,488,156	$1,458,546	($29,610)	$33,336,294	$31,129,795	($2,206,499)	98.01%	93.38%
September 2016	$2,821,378	$2,736,036	($85,342)	$36,157,672	$33,865,831	($2,291,841)	96.97%	93.66%
October 2016	$2,386,230	$2,165,095	($221,135)	$38,543,902	$36,030,926	($2,512,976)	90.73%	93.48%
November 2016	$1,839,129	$1,562,426	($276,704)	$40,383,032	$37,593,352	($2,789,680)	84.95%	93.09%
December 2016	$3,779,715	$2,950,841	($828,874)	$44,162,747	$40,544,193	($3,618,554)	78.07%	91.80%