

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
Finding 1.1	DOM		<b>02/14/18 - This change has already been made; however, changes need to be made in System, which may cause errors. A CSR is in place for current and new Contracts. Keith to work with Saranne to address contract related recommendations.</b>	Activity 1: Review State Requirements	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.
Finding 1.2	DOM		<b>02/14/18 - DOM Finance will develop a standard for each Service Type as recommended in the audit submitted in December. Will prepare individual rates for review and approval. Finance will draft contract amendments. Target date for completion is April 30, 2018.</b>	Activity 1: Review State Requirements	The contract sets forth a single 98 percent completeness standard and two percent error rate for all service types. EQR Protocol 4 guidelines recommend states set specific standards for each service type.	DOM should develop specific standards by service type. See Table 1 on page 12 for Protocol 4 examples of service types for which the state should develop acceptable error rates.  DOM should continue ensuring quality encounter data submissions via periodic reconciliation of paid encounter files to cash disbursement journals.  DOM should require CCOs to submit all encounter iterations: originals, adjustments, and voids.
Finding 1.3	DOM	Yes	<b>3/19/18 - DOM iTech disagrees with this Finding. Deferred to Peter Montgomery for any additional response. Peter's response: "The data dictionaries development was driven by the system where the data is utilized. Currently there is no requirement for the data tables, nor do the data elements to have the very same naming convention. It must be remembered that the MMIS and the Data Warehouse were designed, developed and implemented independently of each other and by different vendors. Consolidation of the various data tables is not an effort that DOM will be undertaking with the current MMIS and DSS platforms."</b>	Activity 1: Review State Requirements	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.
Finding 1.4	DOM		<b>03/19/18 - DOM update - DOM agrees. DOM is moving forward to work out this process for attestations to be sent to Conduent from the CCOs.</b>	Activity 1: Review State Requirements	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.
	UHC		DOM noted during the meeting on 10/18/17 that they are working on a template and will send to UHC once complete. Once that is received, we will work with DOM to finalize the template and implement a process.			
Finding 1.5	DOM		<b>02/14/18 - DOM agrees. DOM will include the corrected code reference in a future contract amendment.</b>	Activity 1: Review State Requirements	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.

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
Finding 1.6	Conduent (FAC)		<p><b>3/19/18 - DOM update - Zeddie Parker has provided a way to identify the CCO's delegated vendor within the CCO claim number.</b></p> <p><b>3/20/18 - Myers and Stauffer will follow-up with Zeddie Parker.</b></p> <p><b>5/16/18 - UHC already completed the assessment and estimated a 6 month timeline. UHC is awaiting the official requirement from DOM in the form of a Companion Guide change. Myers and Stauffer is also evaluating the information provided by Zeddie Parker to see if this will allow for the identification of the vendors.</b></p>	Activity 1: Review State Requirements	Encounters cannot be identified for all of the CCOs' delegated vendors. This poses challenges with reconciling encounters with CDJ's.	Conduent should continue working with DOM and the CCOs to determine whether the CCOs' TCNs may be modified to include a prefix to denote the delegated vendors in the encounter data.
Finding 1.7	Conduent (FAC)	Yes	<p><b>02/14/18 - DOM disagrees. The Conduent file size is not the issue. CCOs have been told that they can submit more files at once; need to max out. CCOs are not submitting the maximum allowed amount per day/week.</b></p>	Activity 1: Review State Requirements	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.
Finding 1.8	Conduent (FAC)		<p><b>3/19/18 - DOM iTech will review the 837 files to see what DOM is requiring to insure all needed fields are noted on the companion guide and respond accordingly.</b></p>	Activity 1: Review State Requirements	At the time of the Conduent on-site review, the DRGs submitted by the health plans were not being saved or stored. DOM and Conduent worked to resolve this issue and a fix was implemented July 11, 2016.	The FAC should capture and retain all encounter data as submitted by the CCOs.

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
Finding 1.9	Conduent (FAC)		<b>3/19/18 - DOM agrees. United has not sent email regarding CAS codes. CSR-16884 has been opened to resolve this issue. iTech will take a different approach of ownership of CAS codes. One recommendation: If the paid amount is greater than zero, make CAS code "paid" status, instead of "denied".</b>	Activity 1: Review State Requirements	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.
Finding 1.10	Conduent (FAC)		<b>3/19/18 - DOM agrees. CSR-RI 17822 has been submitted to research and advise what changes are needed in order to allow the CCOs to adjust or void a denied encounter. The findings are still under review by DOM.</b>	Activity 1: Review State Requirements	There are instances where the claim adjustment back out to an encounter is successful, but the corresponding replacement transaction is denied by the FAC. This results in multiple encounter data issues:  · Effectively removes paid encounters from the FAC's data warehouse that the CCO may have intended to replace. · Subsequent CCO replacement transactions (to replace the encounter record, are denied due to the original claim already having been removed. As a result, the CCO must send the transaction as a new unrelated original encounter in order to have it accepted. This process can produce encounters that may not reflect the CCO's actual claim adjustment activity.  DOM, the FAC, and the CCOs have been working to resolve these issues. During the most recent encounter reconciliation cycles, fewer occurrences of these adjustment transactions were observed.	The FAC should continue working with the CCO to resolve all issues related to replacement transactions.
Finding 1.11	Conduent (FAC)	Yes	<b>3/19/18 - DOM disagrees. The 835 cannot be modified because it is a standard transaction and limits the amount of information that can be sent to the CCO regarding the processing of the encounter. If Magnolia is not able to use the weekly claims data extract, DOM should be advised so we can discontinue the distribution the file.</b>	Activity 1: Review State Requirements	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.

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
Finding 1.12	Conduent (FAC)		<p><b>3/19/18 - iTech agrees with Truven's response and does not have any issues with processing these reports. To ensure Quality Control procedures, request from Conduent: (a) What quality controls are in place? (b) How does Conduent verify that Truven is providing accurate data?</b></p> <p><b>We do check/verify counts and amounts for monthly MARS reports. We have automated Cognos balancing (weekly, monthly) reports that verifies all MARS report tables match MMIS report totals i.e. RX053, RX140, RX141, and RX240. We verify the following MARS reports: MAM250A, MAM270A, MRO01, MRO02, MRO03, MRO43, MRO47, MRO48, MRO52, MRO60, MRO64EXP, MRO89, MRO91, and MRO94. All MARS reports are verified for accuracy before uploading to Mississippi Reports Online for DOM access. Also, we send Myers and Stauffer copies of MRO01, MRO01ENC, File Counts, and Recipient COE Counts for validation, along with all MS Medicaid monthly data extracts. Both Conduent and IBM Watson have access to the data warehouse tables and the reports listed above which are utilized for the check and balance.</b></p>	Activity 1: Review State Requirements	According to the FAC representatives, there is no oversight or quality assurance check performed on the Truven data warehouse standard reports that are submitted to the state (e.g., checking/verifying code, etc.).	The FAC should implement a quality control system or method of checking the code and verifying the accuracy of the standard Truven data warehouse reports submitted to the state.
Finding 2.1	UHC	Yes	<p>NEMIS IT has processes in place to check provider files and feeds via CSP, TrueXC, VendorDB, in addition to submission/response reconciliation to and from the State. NEMIS IT does internal audit tracking on vendor feeds, including claim total checks/balances. UHC reconciles the 999, 277CA and 835 responses from the FAC, Conduent, to UHC encounter submissions. UHC also reconciles inbound vendor files and claim uploads via tracking and reconciliation reporting. The supporting documentation outlines examples of reconciliation/claim totals for both inbound and outbound processing.</p> <p><b>3/19/18 - iTech accepts UHC response.</b></p>	Activity 2: Review CCO's Capability	Control totals are not sent to the FAC by UHC to ensure the number of encounters submitted in the files are correctly received and loaded by the FAC. Additionally, UHC receives acknowledgment of the files from Conduent, but no control totals.	The CCO should modify their processes as necessary to ensure all data files, especially subcontractor data files, are complete. This may include, but not be limited to, exchange of control totals for both inbound and outbound subcontractor files. Additionally, control totals should be exchanged between the FAC and the CCO.
Finding 2.2	UHC			Activity 2: Review CCO's Capability	Dashboards containing operational metrics used to meet state reporting requirements are automatically refreshed when the data warehouse is refreshed and new claims are accepted from the claims system. During the on-site interviews, UHC personnel indicated many reports are automated and a quality assurance check is not completed on report creation.	A quality assurance process should be developed to ensure all updated data from the dashboards gets reflected in the reports prepared for and submitted to DOM.

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
Finding 2.3	UHC		<p>UHC acknowledges the recommendation and will work to implement a claims review audit for all vendors delegated to process claims. This claim audit will review a claim sample from each delegated vendor to validate adjudication accuracy and data elements such as the following:</p> <ul style="list-style-type: none"> <li>• Member eligibility</li> <li>• Member benefit accuracy</li> <li>• Provider participation status</li> <li>• Denial accuracy</li> <li>• Timeliness</li> <li>• Reimbursement accuracy</li> </ul> <p><b>12/13/17 Update - UHC is putting claim audit process in place for delegated vendors. DOM may wish to consider requiring UHC to submit a detailed plan and timeline for implementing the claim audit process for delegated vendors.</b></p> <p><b>3/19/18 - Awaiting response from DOM.</b></p> <p><b>05/04/18 - DOM Response - DOM agrees that a detailed plan and timeline for the claims audit process for delegated vendors is required.</b></p>	Activity 2: Review CCO's Capability	UHC representatives noted during the on-site review that UHC completes high level audits of delegated vendors; however, there is no auditing of delegated vendors on a claim detail level.	UHC should evaluate the benefits of conducting a more comprehensive audit of delegated vendors by including audits at the claim level detail as part of the audit process.
Finding 2.4	UHC		<p>NEMIS IT has processes in place to check provider files and feeds via CSP, TrueXC, VendorDB, in addition to submission/response reconciliation to and from the State. NEMIS IT does internal audit tracking on vendor feeds, including claim total checks/balances. UHC reconciles the 999, 277CA and 835 responses from the FAC, Conduent, to UHC encounter submissions. UHC also reconciles inbound vendor files and claim uploads via tracking and reconciliation reporting. The supporting documentation outlines examples of reconciliation/claim totals for both inbound and outbound processing.</p> <p><b>02/14/18 - DOM response - Yes. United's response is acceptable. CCO needs to develop a process to ensure accuracy of data files, particularly the subcontractor data files. Coordinated Care will request a defined timeframe from the CCOs.</b></p>	Activity 2: Review of CCO's Capability	There is limited oversight and validation of subcontractor encounter data. Often, the data is passed through UHC to Conduent via automated processes with minimal checks for completion or subsequent validation by UHC.	<p>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.</p> <p>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.</p>
Finding 3.1	DOM		<p><b>3/19/18 - Evelyn will review emails to see if Claim Examples have been received from Myers &amp; Stauffer. Conduent has been asked to provide the edit disposition for review by iTech and the Office of Coordinated Care, which may eliminate this issue.</b></p> <p><b>3/19/18 - Myers and Stauffer response - examples were provided via FTP on 10/26/17. Please advise if Myers and Stauffer needs to retransmit the claims examples.</b></p>	Activity 3: Analyze Encounter Data	<p><u>Outpatient and Professional Key Data Elements:</u> The Principal Diagnosis Code for professional claims is null 100 percent of the time, however the Diagnosis Code 1 data element is populated with valid values.</p> <p><u>Dental Key Data Elements:</u> The Tooth Numbers data element had a 0.1 percent invalid error rate identified.</p> <p><u>Pharmacy Key Data Elements:</u> Billing Provider NPI reflected a 100 percent invalid error rate because the field does not contain an NPI number. All values are length of five and six instead of the required ten character length. In addition the Plan Received date had a 100 percent invalid error date due to the field being populated with a date of 01/01/0001.</p>	Conduent should ensure that all values submitted are valid and at a minimum report these errors to allow for corrections when necessary.
	Conduent (FAC)					

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
Finding 3.2	DOM		<p><b>03/19/18 - DOM agrees. CCOs are not meeting the overall 98% measurement, which is defined in the Contract. DOM will amend Contract language to include that each subcontractors are held to the 98% measurement as the CCOs. Will include in the Contract amendment a defined measurement period. Finance will draft contract amendment. Target date for completion is April 30, 2018.</b></p>	Activity 3: Analyze Encounter Data	No measurement period for the 98 percent encounter submission requirement is noted in the current contract between DOM and UHC.	DOM should stipulate the measurement period required to be utilized to measure compliance with the 98 percent encounter submission requirement and stipulate if the percentage should be measured by service type and whether a separate measurement should be applied by subcontractor.
Finding 3.3	UHC	Yes	<p>UHC researched all encounters Myers &amp; Stauffer labeled as "Surplus", "Missing", and "Erroneous". UHC was able to identify valid encounters labeled as either "surplus", "missing", and "erroneous". UHC request Myers &amp; Stauffer review the sample claims data supplied, as well as the supporting claim documentation included in this response for January and October 2015. In addition, 22 encounters were MSCHIP and only MSCAN encounter data was supplied for the Protocol 4 audit. UHC requests that all MSCHIP encounters be excluded as they were not included in the original data set. UHC will continue to collaborate with Conduent and implement any new or change requirements including creating an action plan.</p> <p>12/13/17 Myers and Stauffer Response - It appears UHC may not have understood the erroneous sample tab, which represents 180 of the 266 example encounters. The issue on the erroneous tab isn't whether or not the encounter/claim was found in the UHC system. The issue is that the particular data component being tested didn't agree between value or count in the FAC encounter data and the UHC claim. This doesn't appear to be addressed in their excel documentation or the response language in the word document.</p> <p>As far as the 50 surplus example encounters, the documentation UHC provided doesn't address whether the encounter was included in UHC's sample claims. If UHC found the encounters in its system, they weren't included in the claims sample they provided to Myers and Stauffer. They need to address why they were excluded.</p> <p>Lastly, the 36 missing example encounters, included 20 (based on our analysis) CHIP claims that were reflected as missing in our queries because they were not MSCAN claims. We addressed that by adding a note in the results that missing encounters may be due to UHC submitting CHIP claims in the MSCAN claims data sample submission. Per our analysis, the 13 of the missing encounters were due to missing or incorrect data in the FAC encounter data warehouse. The remaining 3 encounters were not found at all in the FAC data warehouse.</p> <p>Myers and Stauffer does not believe it would be appropriate to rerun any queries to account for the CCO's inaccurate sample submission or data missing from the FAC data warehouse.</p> <p>2/5/18 UHC's Response: Is it not uncommon for multiple encounter records to exist for a single claim due to corrections, resubmissions, or claim adjustments which subsequently occur after the original claim adjudication. UHC does not consider these to be surplus nor represent erroneous data.</p> <p><b>3/18/19 - DOM accepts UHC's response.</b></p> <p><b>3/20/18 - Myers and Stauffer response - We agree there may be multiple iterations of an encounter; however we requested all iterations of a claim from UHC to align with the encounters.</b></p>	Activity 3: Analyze Encounter Data	Surplus encounters were noted in all service types based on the claims sample received from UHC for the sample test months of January and October 2015. Surplus encounters as a percentage of the total sample were 15 percent for outpatient, 20 percent for professional, 118 percent for dental, and 26 percent for pharmacy. Also, a minimal amount of encounters were missing from the FAC encounter data based on the January and October 2015 claims sample.	UHC and Conduent should investigate the causes of surplus and missing encounters that appear to be present or missing in the FAC encounter data based on the sample claims data provided by UHC for January and October 2015. Encounter data should be updated in the FAC data warehouse for any discrepancies noted during the investigation.

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
	Conduent (FAC)	Yes	<p>Evelyn: Myers &amp; Stauffer has been asked to provide examples and also explain how they determined surplus.</p> <p>12/13/17 Myers and Stauffer Update - Examples have been uploaded to Evelyn's FTP folder. Surplus was determined by comparing the "Claims sample" provided by CCO to the Truven Encounter Database for encounters with paid dates within the two sample months (January &amp; October 2015). Matching between the sample claims and the encounter data was based on TCN/ICN. If the CCO only provided the final iteration of the claim then there would be surplus generated in the encounters because of the multiple submissions, which would have been included as unique ICNs in the encounter data. These may be identified as duplicates in our encounter data validation (EDV) process based on the MSLC duplicate logic. Please refer to Table 7 of the Reports where we breakdown the Surplus by Encounter type based on the status of each encounter according to the EDV reporting. The ones that are marked "Final" are concerning because we didn't receive a claim that matched the encounter.</p>			
Finding 3.4	DOM	Yes	<b>02/14/18 - Milliman is currently receiving all the claims information from Truven and can reconcile payments accordingly.</b>	Activity 3: Analyze Encounter Data	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.
Finding 3.5	UHC		<p>In October 2017, UHC determined the root cause for the omission of transactions from the CDJ report. Specifically, UHC identified that some providers billed for services using an out of state payee ID while only claims which were billed with a MS payee ID were included in the CDJ report.</p> <p>The necessary revisions to the CDJ file logic has been completed and the new logic was used to generate the October CDJ report (September transaction dates). UHC is currently working to regenerate past reports back to July 2015 transaction dates.</p> <p><b>3/19/18 - DOM Finance will continue to monitor this situation with the United Dental CDJ submissions. The fix noted by UHC has not solved the issue of completion percentages exceeding 100%. The Dental completion percentage on the 2/18/18 report for the period 11/1/2005-10/31/2017 was 111.84%.</b></p>	Activity 3: Analyze Encounter Data	The 2015 annual completion percentage for dental claims is 113.18 percent which may signify inaccurate CDJ information supplied by UHC.	We recommend DOM require UHC to utilize cash disbursements from its accounting records as the source of its CDJ data, and provide documentation regarding how the data is extracted from the system as well as what mechanism it utilizes to ensure all transactions are properly included in the CDJ.
Finding 3.6	UHC	Yes	<p>A UHC project fix deployed on 5/20/2016, first submission file was 5/23/2016. The fix corrected the defect on all encounters submitted 5/23/2016 forward, reflecting accurate amounts at the line level and reconciling to the header. UHC also performed additional testing after deployment of the fix with expected results at the line and header level.</p> <p><b>3/19/18 - iTech accepts UHC's response.</b></p>	Activity 3: Analyze Encounter Data	The line level Plan Paid Amounts for outpatient and professional service types have been noted as errors in the sample testing as well as in the EDV bi-monthly reporting. The total of line level payments do not equal the header paid amount.	According to UHC, it corrected the line level issue in June 2016 on a prospective basis. Additional testing should be performed to ensure the solution is adequate. Ideally, we recommend the solution be applied retroactively to ensure payments are properly captured at both the line level and the header level for reporting and analysis purposes.

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
	Conduent (FAC)	Yes	Raj - The CCO's corrected the issue and started reporting the Encounter Line level payments, as stated... Currently MMIS does not support mass adjustment of encounter claims and it is up to the CCO's to retroactively re-submit the problematic claims to ensure that the Line level payments are captured correctly in MMIS.			
Finding 3.7	UHC		UHC is committed to supporting DOM and Conduent in their efforts to clarify and/or correct definitions of data elements. This collaborative effort is expected to achieve process and reporting improvements that will positively impact claim to encounter crosswalks, as well as associated reporting.	Activity 3: Analyze Encounter Data	Errors were noted in key data component testing between sample claims and the FAC encounter data.	DOM, UHC, and Conduent should review and possibly update of the data dictionary to address errors related to the claims sample data containing values differing from the encounter data. A crosswalk between the UB04 and 1500 claim forms to the encounter data should be summarized to ensure proper fields are utilized in reporting.
	DOM		<p>3/19/18 - DOM response - The 837 transaction is very large and it would be difficult to provide the MMIS values and DSS values. iTech recommends the 837 transaction sets be provided to Myers &amp; Stauffer which details the fields the CCOs are required to transmit. iTech requests Myers &amp; Stauffer identify the specific fields that are in question if the 837 transaction set does not provide the needed information.</p> <p>3/20/18 - Myers and Stauffer response - Our report highlighted examples of errors or differences in claim sample values versus what was in the encounter data. We were not questioning whether the CCOs should be required to transmit additional fields. We are happy to work with iTech to explore further if necessary.</p>			
	Conduent (FAC)	Yes				

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
Finding 3.8	DOM	Yes	<p><b>02/14/18 - DOM agrees. Need actual project specifications from CCOs. Coordinated Care will follow-up.</b></p> <p><b>03/20/18 - Conduent offers the additional following response regarding Myers &amp; Stauffer UHC Finding 3.8. We also ask that the response be taken into consideration regarding applicable future pharmacy findings as they are identified.</b></p> <p><b>Encounter submission of denied pharmacy claims: DOM requires the CCOs submit their denied claims in addition to their paid claims. These were originally denied by the CCO, and are sent to the Conduent POS system for informational purposes only, at DOM's request. We coded edit 4828 to show that the encounter claim was originally denied by the CCO. Any encounter claim receiving edit 4828 and/or having NCPDP reject 6E on the response should not be considered a CCO paid claim that was denied/rejected as an encounter, because it was never a paid claim by the CCO.</b></p> <p><b>Compound pharmacy claims: MS DOM doesn't accept NCPDP claims for compound drugs from the point-of-sale interface. Instead, all pharmacy-billed compound claims must go through the web portal. There is no batch interface for NCPDP encounters to be submitted through the web portal. Initially felt that we might ask DOM to set edit 4304 to pay-and-report for encounter claims, so that compound encounter claims would not deny. But this will not work, as edit 4304 hits in the parser program, which is before exception control is built. So allowing encounter compound claims to not deny with edit 4304 would involve a bit of coding and testing. If DOM wishes to proceed, Conduent will need a CSR.</b></p> <p><b>3/20/18 - Myers and Stauffer response - previous comments relate to oversight of subcontractor data and UHC providing an action plan to DOM for improvement in its data.</b></p>	Activity 3: Analyze Encounter Data	Higher error rates and surplus encounters were noted in dental and pharmacy service types when compared with other service types. Both of these are subcontracted vendors for UHC.	DOM should require UHC to increase oversight of UHC's subcontractors related to encounter data to address the high error rates in key data component testing and surplus encounter data. UHC should provide DOM an action plan for improvement in its data.
	UHC	Yes	<p>UHC researched all encounters Myers &amp; Stauffer labeled as "Surplus", "Missing", and "Erroneous". UHC was able to identify valid encounters labeled as either "surplus", "missing", and "erroneous". UHC request Myers &amp; Stauffer review the sample claims data supplied, as well as the supporting claim documentation included in this response for January and October 2015. In addition, 22 encounters were MSCHIP and only MSCAN encounter data was supplied for the Protocol 4 audit. UHC requests that all MSCHIP encounters be excluded as they were not included in the original data set. UHC will continue to collaborate with Conduent and implement any new or change requirements including creating an action plan.</p> <p>12/13/17 Myers and Stauffer Response - The additional documentation UHC supplied doesn't include all 266 example encounters and it doesn't include the ICNs, so it is difficult to determine which encounters are excluded from UHC's research. The narrative UHC provided doesn't speak to the recommendation of increased oversight for the subcontractors because it didn't address the erroneous sample. It also stated only MSCAN encounter data was supplied for the sample in the Protocol 4 audit, which is incorrect due to identifying CHIP claims in the sample data UHC provided to Myers and Stauffer. Because we did exclude CHIP from our analysis, those claims were noted as missing. We do not believe it is appropriate to rerun any queries because of the CCO's inaccurate sample submission. We still recommend UHC provide an action plan to DOM on steps to be taken to improve its data.</p>			

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
Finding 3.9	UHC		UHC maintains compliance to our contractual standards as referenced within supporting document 3.9_Claims Management Process MSCAN. UHC will continue to monitor performance to ensure clean claims are adjudicated and paid within contractual requirements as follows: <ul style="list-style-type: none"> <li>• pay at least ninety percent (90%) of all Clean Claims for covered services, within thirty (30) calendar days of receipt</li> <li>• pay at least ninety-nine percent (99%) of all Clean Claims within ninety (90) calendar days of receipt</li> <li>• claims pending or suspended for additional information must be processed (paid or denied) by the thirtieth (30th) calendar day following the receipt of information requested</li> </ul>	Activity 3: Analyze Encounter Data	As identified in Table 11 MississippiCAN and UHC CAN - Timeliness of Payment on page 41, all of UHC's dental and pharmacy claims were paid within the first 60 days. A very small percentage of UHC's institutional (1.1 percent) and professional (1.4 percent) claims took over 90 days to process and therefore fell outside the contractual requirement which states, "The contractor will be responsible for processing claims within ninety calendar days of receipt..."	UHC should continue to monitor and ensure subcontractors are processing and paying claims within contractual requirements. DOM should continue to hold UHC responsible for contract compliance.
	DOM	<p><b>3/18/19 - DOM response - It is Compliance's understanding that Finance will request actual/total % of claims that took over 90 days to process.</b></p> <p><b>3/20/18 - Myers and Stauffer response - We believe Table 11 contains the information DOM is seeking. We are happy to discuss further.</b></p>				
Finding 3.10	UHC	Yes	<p><b>RX Encounters could not be found with the TCN supplied by Myers &amp; Stauffer. The TCNs supplied are for rejected Pharmacy claims. A process improvement was put in place on 7/1/2016 to send the State all rejected RX claims, a contractual State requirement. Those are not encountered claims, claim payment was not made and they cannot be included in any RX calculations. UHC requests that all RX data files or data sets being used by Myers &amp; Stauffer in their calculations be scrubbed to not include rejected RX claims.</b></p> <p><b>The majority of medical encounters submitted outside the 90-day requirement bypassed due to the billing/servicing/rendering provider failing to have a valid Medicaid ID. Since that time, UHC implemented a process improvement July, 2017, for all encounters with a missing or invalid Billing/Servicing/Rendering Medicaid ID. These encounters no longer hit a Medicaid ID bypass and are directly submitted to the State, falling in line with the 90-day submission requirement. Any date files analyzed after 7/2017 would reflect the process improvement and compliance to the 90-day submission requirement.</b></p> <p><b>12/13/17 Myers and Stauffer Update - Research indicates these may be plan-denied per the CLM_EXC_CD value of 4828 – ENCOUNTER DENIED BY CCO. UHC calls these "rejects" and does not consider them to be encounters. Also, it does not sound like these cases are in UHC's NEMIS system. Since the CCO is now required (7/1/2016) to submit them, it seems appropriate for them to be included in the timeliness</b></p>	Activity 3: Analyze Encounter Data	As identified in Table 12 MississippiCAN and UHC CAN - Timeliness of Submitting Encounters on page 41, encounter records reflect submission dates more than 120 days after the claim payment for institutional, professional, and dental service types. According to the contract, encounter records are required to be submitted by the last day of the 3rd month after the payment/adjudication calendar month in which the contractor paid/adjudicated the claim. There were 9.5 percent of institutional encounters, 9.7 percent of professional encounters, and 31.7 percent of dental encounters that were submitted to the FAC beyond 120 days.	UHC should monitor and ensure subcontractor encounters are submitted to the FAC within contractual requirements. DOM should continue to hold UHC responsible for contract compliance.

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
			<p>submission calculations. We do not believe re-running the analysis will alter the overall finding, which is the importance of UHC monitoring/verifying subcontractor data.</p> <p>2/5/18 UHC Response: Per a request from MS Division of Medicaid, UHC began submitting a separate file to DOM as of 7/2016 that consists only of pharmacy claims rejected at the Point of Sale (POS). This data represents POS transactions that did not complete and are not plan-denied claims. In these cases members did not receive services/prescriptions and no payment was made. An example of a POS reject would be when a pharmacy tech mistypes the Member's ID and the pharmacy benefit manager does not authorize the prescription for this reason.</p> <p>The POS rejects do not have a CLM_EXC_CD value of 4828 – ENCOUNTER DENIED BY CCO, they are identified with a code of 4091. Because these claims are not plan-denied, they are never encountered or adjudicated claims and we believe they should not be part of any analysis or timeliness calculation.</p> <p>5/16/18 - This finding is being closed out. No additional benefit to be derived from re-running the timeliness analysis. Issues pertaining to pharmacy are already being addressed through the encounter to CDJ reconciliation process.</p>			
	DOM	Yes				

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
Finding 4.1	DOM		<p><b>DOM response 02/14/18 - DOM should send a strong letter to CCOs regarding recoupment of funds from the Providers for not submitting medical record documentation to support the encounter data submitted to the FAC. Compliance is working on this letter.</b></p> <p><b>For UHC: Why UHC cannot go back past 365 days to recoup funds? This is in violation for the Contract Agreement.</b></p> <p><b>Both CCOs: All documents should be available for 10-years from the final date of the Contract period or from the date of completion of any audit to comply with the Managed Care final rule.</b></p>	Activity 4: Review of Medical Records	Medical records chosen as a part the sample were not supplied by UHC from providers for testing of proper medical record documentation to support the encounter data in the FAC.	DOM should require UHC to recoup the funds from the providers not submitting medical record documentation to support the sampled claims. DOM should include enforceable language in its contracts requiring vendors to provide documentation to support Mississippi Medicaid claims, and include penalties for non-compliance. All documents should be available for 10 years from the final date of the contract period or from the date of the completion of any audit, whichever is later to comply with the Managed Care final rule.
	UHC	<p>UHC has reviewed the list of claims where medical records were not submitted and has found that none of the claims are within our timeframe for recoveries. UHC standard practice is to allow for 365 days to identify recoveries. The dates of service in question are from 2014 and 2015. UHC typically does not extend the lookback period this far but will apply existing operational process to pursue payment recovery upon DOM directive to do so.</p> <p><b>12/13/17 Update - UHC is awaiting direction from DOM regarding whether to pursue recoupments older than 1 year.</b></p>				
Finding 4.2	DOM	Yes	<p><b>3/19/18 - DOM response - PI receives weekly a report from UHC on providers subject to be audited in relation to program integrity related efforts. Medical record review results are reported to PI as UHC's cases progress. Efforts are coordinated between both CCOs and PI with PI providing guidance on the CCOs' reviews and findings. PI is in constant communication United's SIU team by way of monthly meetings to ensure that UHC and PI have an understanding of the audits conducted by UHC and to address any concerns/questions. PI is currently working to ensure that all of UHC's audits relating to Program Integrity are provided to DOM as outlined in the contract and PI's SOP.</b></p>	Activity 4: Review of Medical Records	Overall error rates in the medical record reviews range from 20 percent to 38 percent including errors related to missing records. Professional claims experienced a 38 percent error rate and pharmacy claims had 22 percent error rate.	DOM should ensure there is proper oversight of UHC specific to UHC's program integrity efforts and provider training. UHC should conduct medical record reviews including targeting specific service types with high error rates and implement corrective action plans or penalties for non-compliance with documentation standards. Medical record review results should be shared with DOM. UHC should evaluate and strengthen where appropriate their provider's contractual provisions that define the maximum tolerable error rates and the potential monetary and/or legal consequences for failure to properly document services rendered to its members. Further, UHC should have a provision to verify whether the services that were represented as delivered were actually received by Mississippi Medicaid enrollees. In accordance with the Medicaid final rule, the application of this verification should occur on a regular basis. DOM's and UHC's program integrity sections should coordinate efforts to ensure that DOM has the ability to direct specific reviews and/or independently review the results from these medical record reviews to maintain proper oversight and monitoring in accordance with the Medicaid Managed Care Final Rule requirements.

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
	UHC	Yes	<p>UHC performs both prospective (before claims are paid) and retrospective (after claims have been paid) fraud, waste, and abuse activities "FWA" in order to comply with contractual and regulatory requirements. UHC regularly reports new provider investigations/complaints to DOM, as well as participates in regularly scheduled, recurring meetings with DOM Payment Integrity staff to address specific questions regarding proposed or pending investigations and review regulatory reporting.</p> <p>UHC consistently communicates the results of preliminary investigations to DOM, which may include questionable billing practices by providers, falsification or alteration of documents and misrepresentation of services or diagnoses. In addition to the detection, investigation, payment prevention and recovery efforts, UHC takes corrective action when FWA is discovered. Corrective action may include, and is not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Notifying and educating the offending provider or member</li> <li>• Referring a matter to law enforcement officials or prosecutors for criminal prosecution or outside counsel for civil litigation</li> <li>• Reporting providers to state professional licensing authorities and medical boards</li> </ul> <p>UHC employs multiple detection methodologies to detect FWA, including analytical tools, electronic data analytics and provider audits. These methodologies are intended to identify aberrant and excessive billing practices and trends, inappropriate treatment, fictitious and unqualified providers, and fictitious and ineligible members.</p> <p>Analytical Tools: To facilitate analysis, UHC uses a powerful software detection tool which allows us to identify and scrutinize questionable claims before making payments and conduct detailed post-payment reviews. We identify FWA committed by members and providers, which includes providers who should be put on prepayment review status. These efforts enable us to perform a more detailed investigation into potential improper activities.</p> <p>Electronic Data Analytics: Electronic data analysis or mining of claims data are generally regarded as the most effective method of prospectively detecting suspected FWA. We use algorithms and queries to electronically mine claims data and various other databases to detect suspected FWA.</p> <p>Provider Medical Record Audits: A detailed provider medical record audit can detect FWA or other improper billing practices. We perform selective audits and review medical records on certain providers to look for potential FWA. Additionally, providers may be selected for a medical record audit using various sampling criteria (e.g., random, statistical, on-site) as part of a provider monitoring program. UHC also performs provider medical record audits and quarterly medical cost trend reviews as a component of retrospective FWA investigations.</p>			

Finding Number	Entity	Item Complete (Y / N)	Status (Date / Progress)	EQR Protocol 4 Activity Number	Finding	Recommendation
			<p>Currently UHC has the following programs in place which routinely request medical records in response to suspected Fraud, Waste, Abuse, or Error.</p> <ul style="list-style-type: none"> <li>• Pre-Payment Provider Flagging (P1): Pre-payment analytics that identify and stop claims for specific providers. These provider-centric analytics identify and stop claims for medical record review. Reviews are conducted by a team comprised of RNs, LPNs, and certified coders and are aimed at determining whether the codes billed were indeed in line with the services performed.</li> <li>• Pre-Payment Review (P2): Pre-payment analytics designed to identify claims that represent a high risk of fraud, waste or abuse. These claim-centric analytics identify claims that are outliers as determined by irregular or odd patterns, which is accomplished by creating data driven peer groups. When these claims are identified, they are denied for further review. We then send the provider a request for medical records to support an administrative review. Reviews are conducted by a team comprised of RNs, LPNs, and Certified Coders and aimed at determining whether the codes billed were indeed the services performed. Review outcome information is captured to allow for refinement and enhancement of this analytic.</li> <li>• Pre-payment Provider Trending: Identifies claim level provider billing patterns based on pre-payment claims data to detect MS providers whose billing patterns make them outliers. These providers will in turn be submitted to the DOM as tips and/or referrals.</li> <li>• Retrospective Investigations: Retrospective claims data are used to identify irregular or suspicious practices or billing patterns. Retrospective claims analysis is performed on adjudicated claims for services which were previously rendered. Providers' coding and billing practices are compared to peer providers, per coding guidelines, by specialty and region, to determine patterns of inappropriate and irregular billing.</li> </ul> <p>Prospective Payment Prevention: When UHC believes providers have engaged in fraud, waste or abuse, we flag prospective provider payments. These flags prevent payments to these providers until the flags are modified or removed. Provider activity is continually monitored and reviewed to determine how long the flags should remain in place and whether they should be modified or removed.</p> <p>Retrospective Recovery: Retrospective recovery activity results from situations that are believed to provide sufficient grounds to seek recovery of money paid to providers that induced payment on fraudulent, wasteful or abusive grounds. UHC may take legal action where the amount at stake is enough to justify the resource expenditures.</p>			