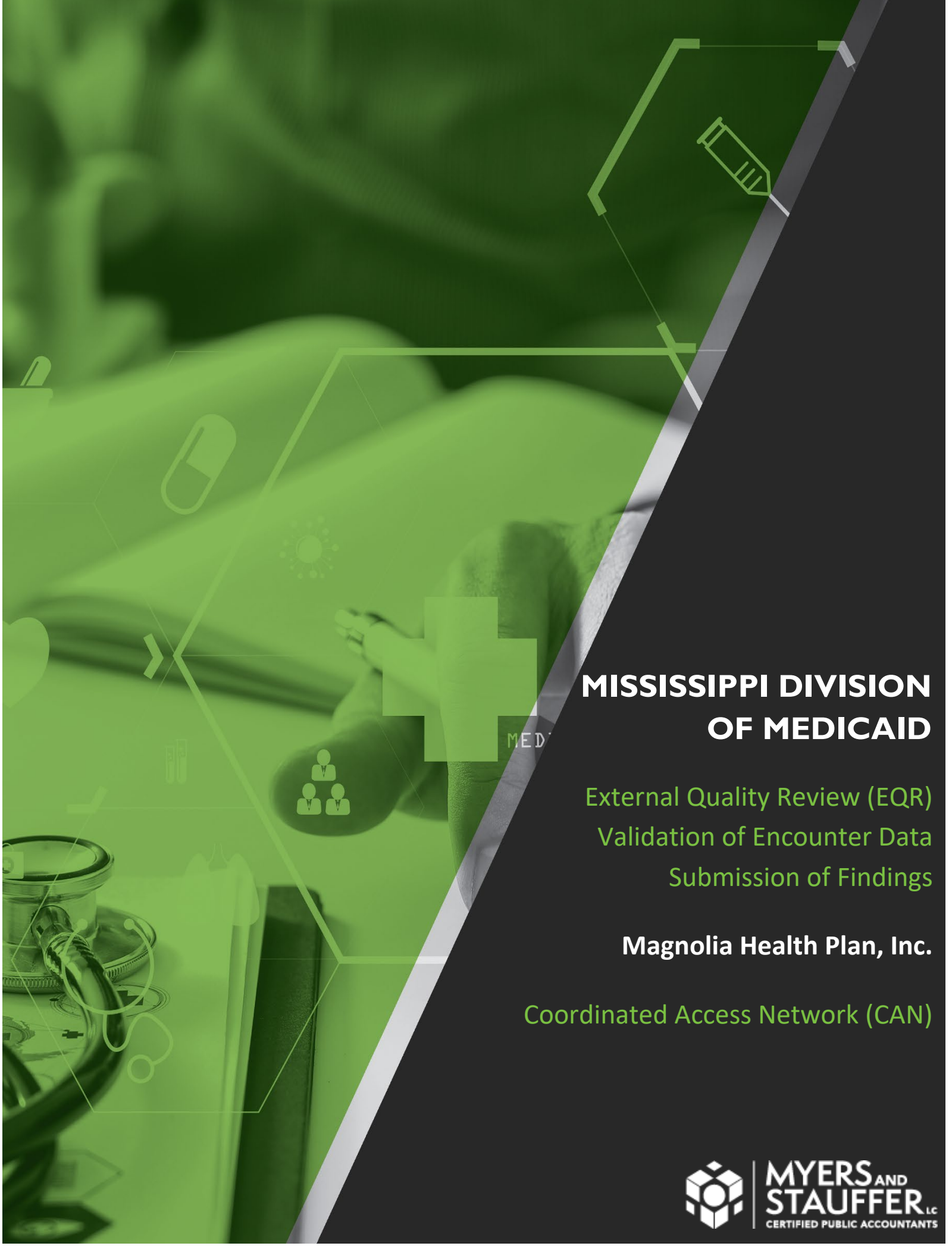


MISSISSIPPI DIVISION OF MEDICAID

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

Magnolia Health Plan, Inc.

Coordinated Access Network (CAN)

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

Executive Summary

Mr. Drew Snyder
Executive Director
Mississippi Division of Medicaid
Office of the Governor
550 High Street, Suite 1000
Jackson, MS 39201

Dear Mr. Snyder:

This report presents the results of our work conducted to satisfy the periodic independent audit requirements concerning the accuracy, truthfulness and completeness of the encounter data submitted by or on behalf of each Mississippi Coordinated Care Organization (CCO) as codified in the Medicaid Managed Care Final Rule at 42 Code of Federal Regulations § 438.602(e)[1]. We have completed the validation activities as prescribed by the *Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) Protocol 5 Validation of Encounter Data Reported by the Medicaid Managed Care Health Plan*[2] (EQR Protocol 5) for the Magnolia Health Plan, Inc. (MHP) Calendar Year (CY) 2022 encounter data.

This validation was conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS) for performance audits. These standards require we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In addition to GAGAS, this validation was conducted in accordance with Consulting Services Standards established by the American Institute of Certified Public Accountants (AICPA). This performance audit did not constitute an audit of financial statements or an attestation level report as defined under GAGAS and the AICPA standards for attestation engagements.

The audit objective(s) of our work were to perform an assessment and validation of the CY 2022 encounter data submitted by the CCOs to the Mississippi Division of Medicaid (DOM or state) managed care program, in accordance with EQR Protocol 5 guidelines, to assess the accuracy, truthfulness and completeness of this information; and to determine if the encounters met state and federal requirements.

[1] https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered
[2] https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf

Validation criteria were based on the five (5) activities outlined in EQR Protocol 5: (1) Review State Requirements, (2) Review the CCO's Capability, (3) Analyze Electronic Encounter Data, (4) Review Medical Records, and (5) Submission of Findings.

Our audit procedures assessed the CY 2022 encounter data submitted by the CCO to the fiscal agent contractor (FAC) for completeness and accuracy. The CCO submitted monthly cash disbursement journals (CDJs), which included payment dates and amounts paid by the CCO to providers (i.e., the bi-monthly Encounter Data Validation Report); and sample claims data which included transactions with payment/adjudication dates within two selected sample months of March 2022 and November 2022, during this assessment period. Encounter data was provided by the fiscal agent contractor (FAC) in a standardized monthly data extract, which included encounters received and processed by the FAC and transmitted to Myers and Stauffer through September 29, 2023. A 98 percent completeness and accuracy threshold was used for comparing the encounters to the CDJs and sample claims data submitted by the CCO.

In addition, medical records were reviewed to further endorse the findings from the analysis of encounters, but was not a medical necessity review. Medical records selected for review were randomly sampled from encounters with CY 2022 dates of service. A total of 120 medical records were selected for review. The CCO was responsible for retrieving the selected medical records from the providers and submitting the records to Myers and Stauffer for review.

As part of the EQR Protocol 5 validation, we assessed the effectiveness of the CCO's information systems and controls to determine its ability to collect and submit complete and accurate encounter data. In addition, the CCO's fraud risk management and activities were reviewed to evaluate the CCO's ability to mitigate potential fraud risks and vulnerabilities. We reviewed the System and Organization Control: Trust Services Criteria (SOC2®) report conducted on the CCO's internal controls. Based on the SOC2 report, no material issues relating to the CCO's systems used for member enrollment, claims processing or encounter submissions were noted. Additionally, no material concerns were noted with the CCO's fraud policies and procedures.

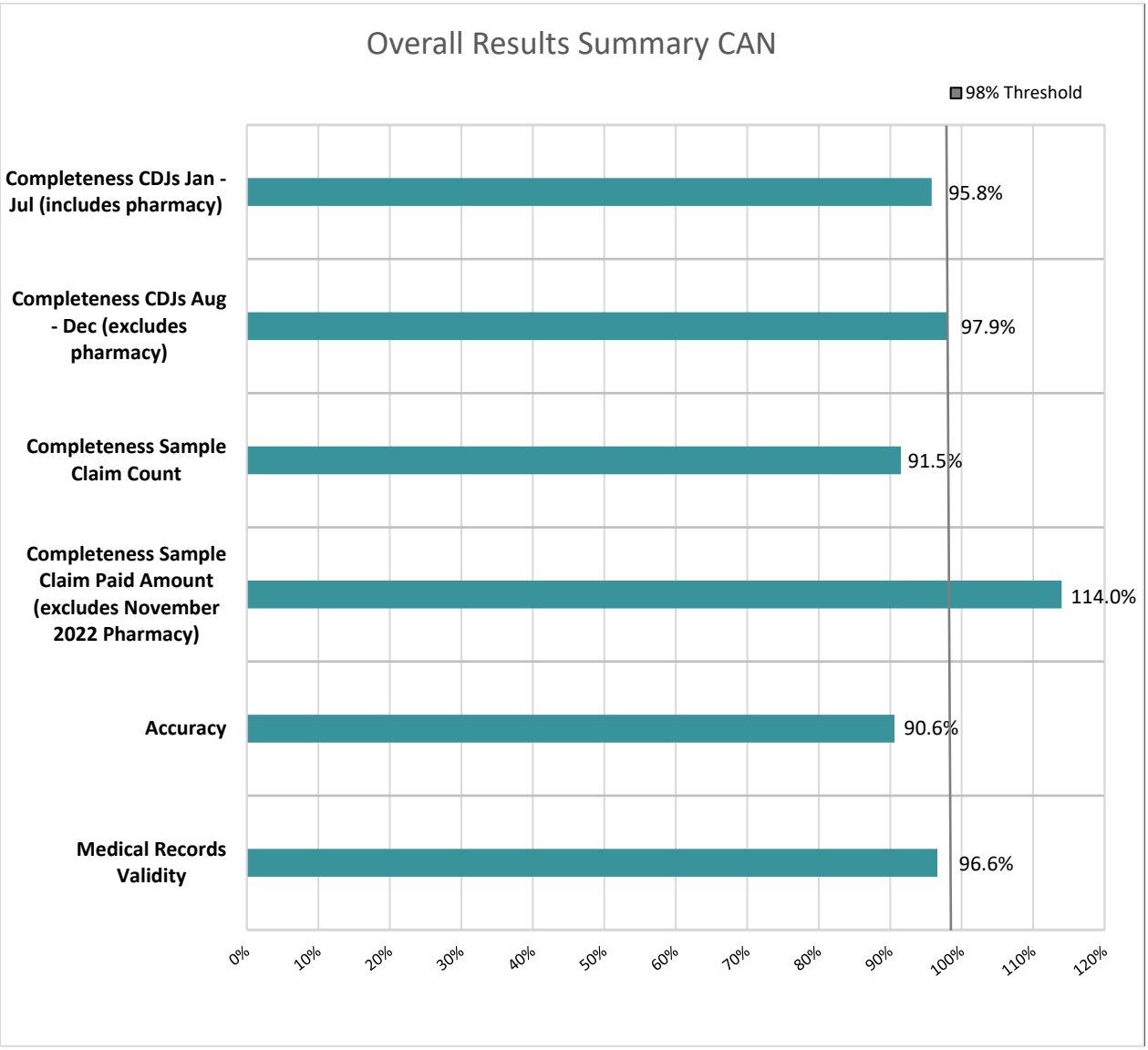
Our findings are summarized below and are based on the information provided and known at the time of the validation. The findings and weaknesses noted may reside with the CCO and/or the FAC. The CCO should work with DOM and the FAC to resolve deficiencies noted within the encounter data.

FINDINGS:

- **Completeness:** Encounter completion percentages were below the 98 percent threshold when compared to CDJ paid amounts, including pharmacy encounters, for January through July 2022 (95.8 percent). Issues with paid amounts submitted by the CCO's pharmacy vendor impeded the determination of pharmacy encounter completion percentages after July 2022. Completion percentages, based on CDJ paid amounts for August through December 2022, excluding pharmacy encounters, were at the 98 percent threshold (97.9 percent). When compared to

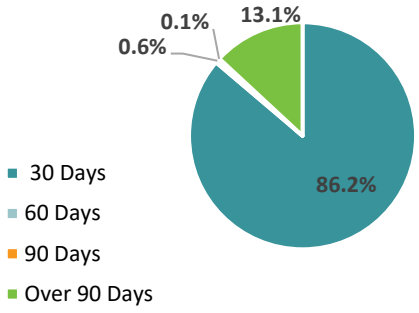
sample claim counts, completion percentages were below the 98 percent threshold (91.5 percent). Encounter paid amounts exceeded 100 percent (114.0 percent) when compared to sample claim paid amounts. The November 2022 pharmacy paid amounts were excluded from the calculation due to the encounter paid amount submission errors.

- **Accuracy:** The overall accuracy percentage was below the 98 percent threshold (90.3 percent). Encounter data accuracy issues were related to billing provider National Provider Identifier (NPI)/number, diagnosis related group (DRG), CCO paid date, Medicaid Management Information System (MMIS) Internal Control Number (ICN), and service/rendering/attending provider NPI and taxonomy.
- **Medical Record Validation Rates:** Of the 120 medical records requested, only 104 medical records (86.7 percent) were submitted and tested. The validation rate for the medical records tested was below the 98 percent threshold (96.8 percent).

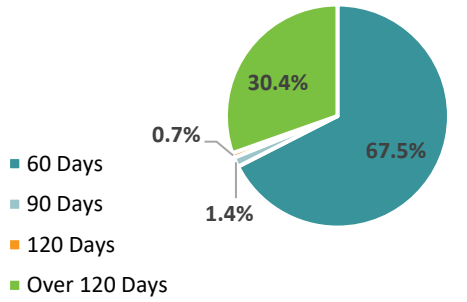


Timeliness: The CCO paid 86.2 percent of claims to providers within 30 days. The CCO did not meet the required level of timeliness for the submission of encounters. The CCO submitted 67.5 percent of encounters within the required 60 day timeframe.

Timely Payment of Claims



Timely Encounter Submissions



We have made recommendations within the report related to the findings and weaknesses identified within the CY 2022 encounter data. These recommendations are intended to improve the integrity of the encounter data. The report also includes appendices which provide the detailed analyses behind the counts, amounts and percentage values reflected in the report.

Sincerely,

Myers and Stauffer LC

Myers and Stauffer LC
Atlanta, Georgia
April 24, 2024

Background

Medicaid is a state and federal program created by the Social Security Amendments of 1965, Title XIX, to provide health coverage to eligible, low income populations. The Mississippi Division of Medicaid (DOM), in the Office of the Governor, is designated by state statute as the single state agency responsible for administering Medicaid in Mississippi. Medicaid health benefits encompass multiple programs administered by DOM: Medicaid fee-for-service, Medicaid managed care, and the Children's Health Insurance Program (CHIP).

Mississippi's Medicaid managed care program is known as Mississippi Coordinated Access Network (Mississippi CAN or CAN). Most Medicaid beneficiaries are required to enroll in a managed care plan for health care services. CHIP provides healthcare coverage to uninsured children up to 19 years of age who are not eligible for Medicaid. DOM contracts with three coordinated care organizations (CCOs) to provide healthcare services to CAN beneficiaries[3] and contracts with two CCOs to provide healthcare services to CHIP beneficiaries. MHP is contracted to arrange and manage healthcare services to CAN beneficiaries.

External Quality Review (EQR) Protocol 5

The Centers for Medicare & Medicaid Services (CMS) established requirements for states to improve the reliability of encounter data collected from managed care CCOs. In 2016, the Medicaid managed care final rule required states to conduct an independent audit of encounter data reported by each managed care CCO. Revisions to the Medicaid managed care regulations enhanced quality oversight criteria. Under the 2020 final rule, encounter data must include both the allowed and paid amounts and states must annually post on its website CCOs that are exempt from external quality review[4].

CMS indicated that states could meet the independent audit requirement by conducting an encounter data assessment based on EQR Protocol 5[5]. Protocol 5 evaluates the completeness and accuracy of the encounter data submitted to the State's fiscal agent contractor (FAC) by the CCOs contracted to provide healthcare services to CAN and CHIP beneficiaries. Although Protocol 5 is a voluntary protocol, CMS strongly encourages states to contract with qualified entities to implement Protocol 5 to meet the audit requirement of the final rule.

Additionally, states are required to provide accurate encounter data to actuaries, as well as CMS, as part of the Transformed Medicaid Statistical Information System (T-MSIS) project. Protocol 5, performed under GAGAS, enables states to meet these data validation and monitoring requirements. Protocol 5 evaluates state/department policies, as well as the policies, procedures, and systems of the CCO, assists states in gauging utilization, identifying potential gaps in services, evaluating program effectiveness, and identifying strengths and opportunities to enhance oversight.

[3] https://medicaid.ms.gov/programs/managed-care/
[4] https://www.cms.gov/newsroom/fact-sheets/medicaid-childrens-health-insurance-program-chip-managed-care-final-rule-cms-2408-f
[5] 81 Fed. Reg. 27,498, 27,603 (May 6, 2016).

Objective, Scope and Methodology

The objective for this performance audit was to:

- Perform the *Centers for Medicare and Medicaid Services (CMS) EQR Protocol 5 Encounter Data Validation* of the calendar year (CY) 2022 encounter data submitted by the CCO contracted to arrange and manage healthcare services to the State's CAN beneficiaries enrolled with MHP, to determine if the encounters met state and federal requirements.

The scope of the audit included the following, as outlined in Protocol 5 or required by GAGAS:

- Review State Requirements
- Review the CCO's Capability
  - Review the CCO's Information Systems Capability Assessment (ISCA)
  - Interview CCO Personnel
  - Review SOC 2 report findings completed on CCO to determine if there is an impact on the beneficiary enrollment, claims processing or submission of encounters.
  - Review the CCO's fraud procedures to determine adequacy.
- Analyze Electronic Encounter Data
  - Develop a Data Quality Test Plan Based on Data Element Validity Requirements
  - Verification of Encounter Data Integrity
  - Generate and Review Analytical Reports
  - Comparing findings to State-identified standards
- Review Medical Records

Methodologies and Results of Review

A summary of methodologies, findings and results for each audit scope are presented below along with detailed analyses. Findings are based on the information provided, interviews with subject matter experts, and known data limitations at the time of the review. The report is written specific to the CCO; however, the findings and issues noted may reside with the fiscal agent contractor (FAC). The findings and recommendations within this report provide an opportunity for the CCO to review its processes to ensure information and data submitted to the State and/or captured by the FAC is complete and accurate. The expectation is for the CCO to work with DOM and the FAC to resolve issues noted within the encounter data.

State Requirements

The State's contract with the CCO and system companion guides were reviewed to ensure a complete understanding of the State's requirements for the CCOs' encounter data and to determine if additional or updated requirements are needed to ensure the encounter data is complete and accurate. DOM provided Myers and Stauffer with acceptable error rates, accuracy and completeness thresholds, and documentation, which included the following information, as listed in Protocol 5:

- Specific requirements regarding the collection and submission of encounters
- Requirements regarding the types of encounters that must be validated
- Standards for the submitted data
- Standards for encounter data completeness and accuracy
- Data dictionary and companion guides
- Description of the information flow from the CCO to the State
- A list and description of automated edits or checks performed on the data
- The timeliness requirements for encounter data submissions
- Any EQR validation reports from previous years
- Any other information relevant to encounter data validation

Methodology

The State's requirements were evaluated to determine whether DOM's standards were consistent with the Final Medicaid Managed Care Rule and Protocol 5 criteria.

We reviewed the DOM-CCO contracts and system companion guides in effect for the period under review. DOM's standards were reviewed for completeness and accuracy, file transfer protocols, certification policies, collection and submission requirements, processes, claims, and encounter submission requirements. Myers and Stauffer also met with DOM representatives regularly. Monthly status meetings conducted with DOM ensured that our understanding of policies, processes and systems were accurate.

Medicaid Management Information System

During the measurement period, DOM replaced its Medicaid Management Information System (MMIS). The goal of this modernization was to enhance connections between health services systems and improve access to health information for Medicaid providers and members.[6] Along with this system replacement, DOM transitioned to a new fiscal agent contractor (FAC). Effective October 3, 2022,

[6] https://medicaid.ms.gov/the-mississippi-medicaid-mmis-replacement-project/

Gainwell Technologies, Inc. became the FAC. Prior to this transition, Conduent EDI Solutions, Inc. was DOM's FAC.

Findings and Recommendations

Findings from the state requirements review are summarized below, including recommendations for DOM, and/or the FAC.

Findings and Recommendations		
	Findings	**Recommendations**
1-A	The CCO's pharmacy paid amounts were submitted in the incorrect field/loop (i.e., Cost Paid field, 431-DV with a qualifier in field 342-HC of '07' instead of '02'). We have reviewed the pharmacy encounter data extracts received from the FAC to investigate if this field was included in one of the other amount fields (e.g., AMT_INGRED_COST_SUB), and were unable to identify pharmacy paid amount in any other amount field. DOM informed the CCO that it did not need to correct and resubmit the encounters. The pharmacy encounter data is known to be in error (from August 2022 through September 2023 which may potentially impact rate setting and other reporting and analyses for which the data may be used, as well as CMS' T-MSIS submission. Magnolia transitioned to a new PBM in October 2023 (Express Scripts) and the new vendor is now submitting the data in the correct field; however, data submitted by the prior vendor remains in the incorrect field for the period of August 2022 through September 2023.	We recommend that the CCO correct and resubmit the pharmacy encounter data in accordance with state and federal encounter data submission guidelines and requirements.

Review CCO Capability

The CCO's information systems and controls were evaluated to determine its ability to collect and submit complete and accurate encounter data.

Methodology

A survey was developed, documentation was requested, and interviews were conducted with CCO personnel to gain an understanding of the CCO's structure and processes.

The survey and personnel interviews requested information about the CCO, its parent company, and the local CCO environment. Questions related to claims processing, encounter data submissions, subcontractor/delegated vendor relationships, enrollment, data systems, controls and mechanisms[7] were addressed.

Requested documentation included the CCO's Information Systems Capability Assessment (ISCA)[8], work flows, policies and procedures for handling encounter data, subcontractor/delegated vendor information, key contacts, and organizational structures. The documentation was used to gain an understanding of the CCO's processes and to determine questions to ask during the interviews.

In addition, questions relating to the CCO's fraud risk management were solicited to evaluate the CCO's fraud mitigation controls and activities. Our questions were related to the following:

- Conducting comprehensive risk assessments to identify potential areas of vulnerability and/or to assess the effectiveness of the existing plan.
- Regular training and communication of policies (i.e., acceptable conduct, reporting mechanisms and consequences for fraudulent behavior).
- Internal controls including segregation of duties, access, controls and authorization mechanisms.
- Regular fraud awareness training for employees to recognize potential fraud indicators.
- Detection tools and analytics to monitor transactions, behavior patterns, and anomalies that may indicate potential fraudulent activity.
- Response plans for handling suspected fraud incidents, including protocols for investigations involving relevant internal and external parties, and compliance with legal and regulatory requirements.

A review of the results of the CCO's SOC2 report was also conducted. The results were evaluated to determine if any control issues were noted with the systems used for member enrollment, claims processing, and encounter submission. If findings were noted in these areas, the impact on encounter

[7] Questions found in Appendix V, Attachment B of the Validation of Encounter Data protocol were included in the survey. https://www.medicaid.gov/medicaid/quality-of-care/downloads/app5-attachb-isreview.pdf

[8] The key purpose of an ISCA is to determine the extent to which a CCO maintains the capacity to collect, manage, report and use valid and reliable data. ISCAs are performed by a third party to evaluate the systems within a CCO as part of the National committee for Quality Assurance (NCQA) accreditation process.

data completion and accuracy was evaluated and included in the finding and recommendations below.

Findings and Recommendations

Findings from the review and interviews are summarized below along with recommendations for DOM and the CCO.

Findings and Recommendations	
Findings	**Recommendations**
There were no findings related to our review of the CCO's capabilities.	

Analyze Electronic Encounter Data

Analyzing the encounter data is the core function for determining the validity of the encounter data. It is designed to assist the state in determining whether the data can be used for rate setting and other analyses and is comprised of the following steps:

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

Step 1: Developing a Data Quality Test Plan

CY 2022 encounter data and cash disbursement journal (CDJ) data were used in performing the encounter data testing and analysis. In addition, two distinct measurement sample periods of March 2022 and November 2022 were selected and approved by DOM for testing. These months were specifically selected to encompass testing of both the former FAC, Conduent EDI Solutions, Inc., and the current FAC Gainwell Technologies, Inc., that DOM transitioned to during October 2022. On a monthly basis, Myers and Stauffer received encounter data from the FAC in a standardized data extract, which included both paid and denied encounters. The CCO submitted sample claims data extracts, based on paid (adjudication) date, from its claims processing systems and from each subcontractor/delegated vendor's claims processing systems for the selected sample months. CDJs were submitted by the CCO and its subcontractor/delegated vendors and encounter data was provided by the FAC. The CDJ files were submitted monthly to Myers and Stauffer by the CCO and its subcontractor/delegated vendors.

The cumulative monthly totals from the CDJs and the encounter data were used to test the completeness of the encounter data. The sample claims were used to test the quality of the encounter data received from the FAC for completeness, accuracy and truthfulness. The sample claims testing was based on the expectation of the receipt of a full set of claims data from the CCO for the testing period to determine valid, missing, and erroneous encounters within the FAC encounter data by comparing the sample claims data 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 and accuracy of the encounter data. Validation analyses were performed on the CY 2022 CAN encounter data.

Completeness

DOM's contract with the CCO requires the CCO to submit 98 percent of all encounter data, including those of subcontractors and/or delegated vendors. The CCO must submit complete and accurate

encounter data at least weekly. This includes all claims paid, denied, adjusted, and voided by the CCO and its subcontracted/delegated vendors. Encounters are due no later than the sixtieth (60th) day after the date of adjudication.[9] Encounter data completeness is measured by comparing the encounters to CDJ and sample claim paid amounts within a two (2) percent error threshold.

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.

Cash Disbursement Journals

Under a contractual arrangement with DOM, Myers and Stauffer routinely performs a bi-monthly reconciliation of the CCO-submitted CDJs to the FAC encounter data to measure encounter data completeness (i.e., "*Comparison of Encounter Data to Cash Disbursements Report*"). The CCO's paid encounters are reviewed to determine if the paid encounters meet the State's contract minimum completeness requirement of 98 percent when compared to the CDJ files. For this validation, the encounter data extract included encounters received and accepted by the FAC and transmitted to Myers and Stauffer through September 29, 2023. These results were published within the bi-monthly report issued on October 31, 2023. Supplemental pharmacy data was subsequently provided to Myers and Stauffer by the FAC containing the pharmacy paid amounts, which was determined to have been submitted by the CCO in an incorrect data field/loop within the encounter data. This data field is not currently part of the extract file received by Myers and Stauffer. The results for the EQR Protocol 5 were not updated with this supplemental payment information, as these payment amounts remain uncorrected within the MMIS. Given the nature of the EQR Protocol 5 to report on the actual information contained within the system, it was determined that this report would utilize the pharmacy encounter data as presented in the MMIS. See findings and recommendations in Activity 1 (Finding 1-A).

[9] Contract between DOM and the CCO, Section 11 – Reporting Requirements, S. Member Encounter Data.

Figure 1, below, shows the monthly completion percentages obtained after the comparison of the CDJ paid amounts to the encounter paid amounts for CY 2022.

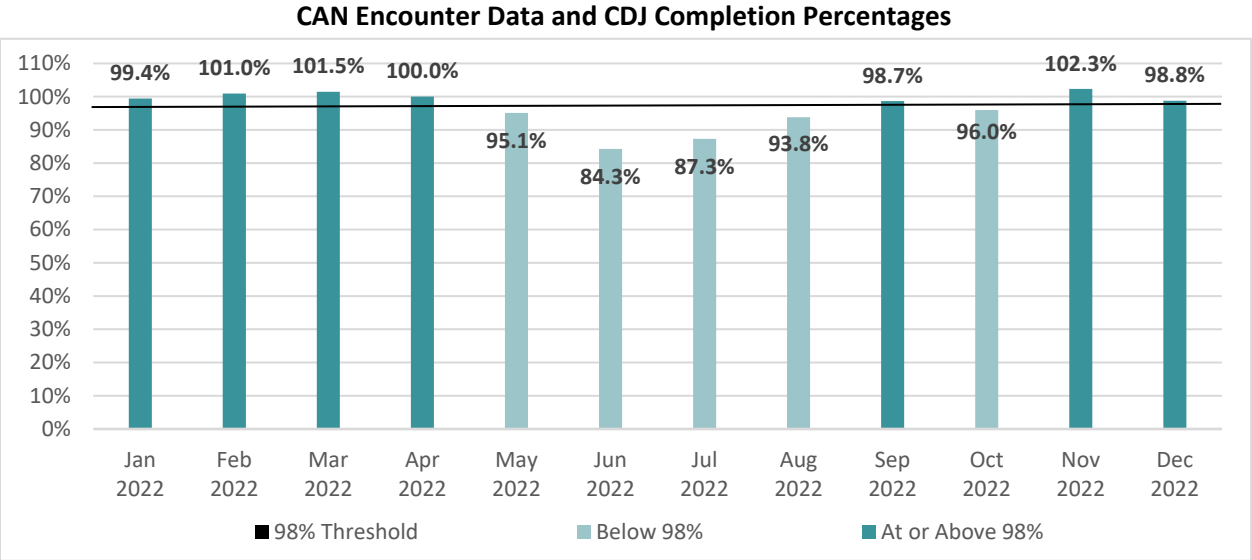


Figure 1 – CAN Encounter Data and CDJ Completion Percentages: The monthly completion percentages include delegated vendors, including pharmacy, through July 2022, with an average completion percentage of 95.8 percent; which is below the 98 percent contractual requirement. On or about July 2022, the CCO's pharmacy vendor began submitting encounter paid amounts in the incorrect field/loop. As a result, pharmacy completion percentages could not be determined. The completion percentages for August 2022 through December 2022, excluding pharmacy, were 97.9 percent. Detailed results can be found in the October 31, 2023 Encounter Data Validation Report, Appendix A. Since pharmacy amounts were included in the above analysis, the reported completion percentages for January 2022 through July 2022 above will vary from the October 31, 2023 report.

Sample Claims

The comparison of the March 2022 and November 2022 sample claims data to the encounter data for this same period sought to ensure that all CCO and delegated vendor adjudicated claims were properly transformed as encounters and present within the encounter data submitted to the FAC. The CCO-submitted sample claims data was traced to encounter data using data elements provided in the sample claims data. Completeness was evaluated on the following criteria:

- Sample Claim Count: The number of claims from the sample data that were identified as present within the encounters.
- Sample Claim Paid Amount: Sample claim paid amounts compared to encounter paid amounts.

Figure 2, below, shows the completion percentages obtained after the identification of sample claims present in the encounters and the comparison of the sample claim counts and paid amounts to encounter counts and paid amounts.

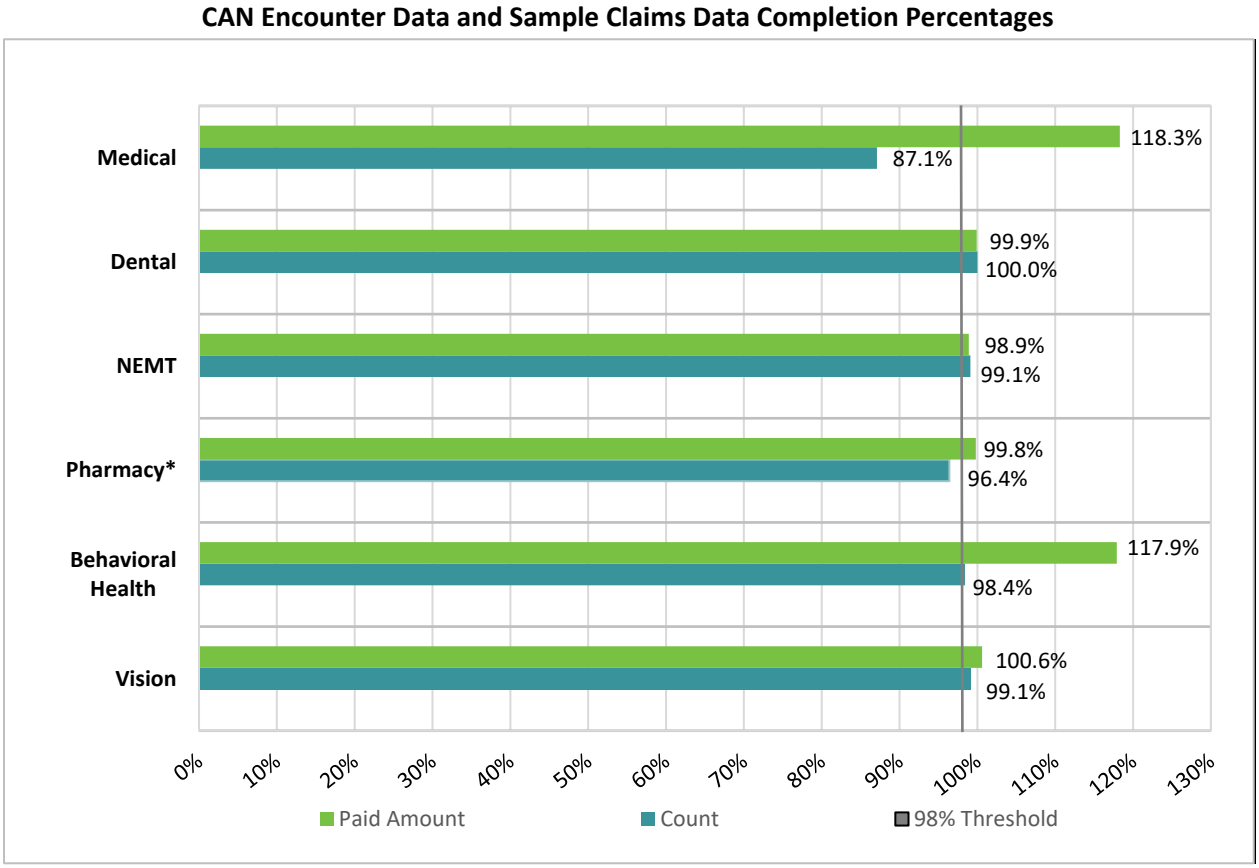


Figure 2 – CAN Encounter Data and Sample Claims Data Completion Percentages: Values reflect the two sample months of March 2022 and November 2022 combined, with the exception of pharmacy. *Pharmacy paid amount values reflected are for March 2022 only. On or about July 2022, the CCO's pharmacy vendor was submitting encounter paid amounts in the incorrect field/loop. This field was not included in the encounter data extracts received by Myers and Stauffer, and as a result, pharmacy completion percentages could not be determined for the November 2022 sample data. Detailed results can be found in Appendix B.

Completion percentages based upon our review of the sample claim counts were at or above the 98 percent threshold for dental, non-emergency medical transportation (NEMT), behavioral health and vision encounters. When compared to sample claim paid amounts, the medical, behavioral health and vision encounters exceeded the 100 percent completion level. While we were unable to determine the specific root cause of the completion percentages greater than 100 percent and/or below the 98 percent threshold, these unexpected percentages may be indicative of incomplete data, timing differences, potential duplicates, or claims, voids, replacements, adjustments and/or other transactions present or absent from the encounter data.

Accuracy

For the purpose of verifying the integrity of the encounter data, certain key data elements from the encounter data were compared with the sample claims data. The key data elements comparison analysis was limited to the encounters for which we were able to identify a corresponding matching adjudicated claim within the sample claims data provided. The key data elements were evaluated based on the following criteria:

- Valid Values: The encounter key data element value matched the sample claim key data element value. If the encounter key data element was blank (or NULL) and the data element in the sample claim was also blank (or NULL), it was considered valid.
- Missing Values: The encounter key data element was blank (or NULL) and the data element in the sample claim was populated (i.e., had a value).
- Erroneous Values: The encounter key data element had a value (i.e., was populated) and the sample claim key data element value was populated, but the values were not the same.

Consistency checks were performed, such as verifying that key data elements contained the expected value, were in the correct format and specificity, and were consistent across data elements. Individual key data element validity and accuracy rates were calculated based on the total number of records in the encounter dataset. The targeted error rate was expected to be below two percent per key data element (i.e., a 98 percent accuracy threshold). Accuracy percentages are presented in **Table 1**, below.

Key Data Elements Accuracy Percentages – Valid Values	
Encounter Type	**CAN**
Medical	92.3%
Dental	90.5%
NEMT	99.7%
Vision	93.9%
Behavioral Health	93.1%
Pharmacy	86.4%
Total Average	***90.6%***

Table 1 – Key Data Elements Accuracy Percentages – Valid Values: Values reflect the two sample months of March 2022 and November 2022 combined. The total average accuracy rate was below the established 98 percent threshold requirement. The key data elements evaluated and specific testing results are presented in Appendix C.

Encounter data accuracy issues were determined to be related to billing provider NPI/number, diagnosis related group (DRG), CCO paid date, MMIS ICN, and service/rendering/attending provider NPIs and taxonomy.

Findings and Recommendations

The findings from the completeness and accuracy analyses of the encounter data are summarized below, including recommendations for DOM, the FAC and/or the CCO.

Findings and Recommendations		
	Findings	**Recommendations**
3-A	**Completeness – CDJs:** The monthly completion percentages for January 2022 through July 2022 included all delegated vendors. The average completion percentage for this timeframe was below the 98 percent threshold (95.8 percent). On or about July 2022, the CCO's pharmacy vendor was submitting encounter paid amounts in an incorrect field/loop. This field was not included in the encounter data extracts provided to Myers and Stauffer, and as a result, pharmacy completion percentages could not be determined. The completion percentages for August 2022 through December 2022 excluded pharmacy and nearly met the 98 percent threshold (97.9 percent).	The CCO, in conjunction with the FAC, should investigate and identify the causes of any surplus and/or missing encounters present or absent in the encounter data. Any issues noted during the investigation requiring encounter data revisions should be accurately addressed and incorporated in the FAC encounter data. Additionally, the CCO should submit adjusted, void and denied claims and/or corrections/resubmissions to ensure all claims are accurately reflected within the encounter data. Additionally, the CCO should correct and resubmit the pharmacy encounter data in accordance with state and federal encounter data submission guidelines and requirements.
3-B	**Completeness – Sample Claim Count:** Dental, vision, NEMT and behavioral health encounter completion percentages, based on sample claim counts, were at or above the 98 percent threshold. Medical and pharmacy encounter counts were below the threshold.	
3-C	**Completeness – Sample Claim Paid Amount:** Dental and NEMT encounters, based on sample claim paid amounts, were at or above the 98 percent threshold**.** Medical, vision and behavioral health encounter completion percentages exceeded 100 percent. Pharmacy encounter paid amounts were above the threshold for March 2022, but could not be determined for the November 2022 sample month due to the paid amounts being submitted in the incorrect encounter field/loop.	
3-D	**Accuracy – Former/Original Claim ICN:** Medical – Both the sample claim data and the encounter data reflect valid values, but do not agree.	The CCO should ensure that appropriate audit trails are in place for all adjusted, replaced, and voided claims. The original ICN should be linked to the replacement, adjustment and/or voided claim and be available to trace the replacement or adjustment back to the original claim.

Findings and Recommendations		
	Findings	**Recommendations**
3-E	**Accuracy – MMIS ICN:** Medical, Dental, Behavioral Health, and Vision – Both the sample claim data and the encounter data reflect valid values, but do not agree. Pharmacy – Sample claim values were not populated.	The CCO/delegated vendors should ensure that appropriate audit trails are in place and it is properly capturing and storing all ICN(s) assigned by the FAC and returned to the CCO/delegated vendor on the FAC encounter (999 proprietary) response file.
3-F	**Accuracy – Diagnosis Related Group (DRG):** Medical (inpatient) – Both the sample claim data and the encounter data reflect valid values, but do not agree.	The CCO should ensure it is properly maintaining DRG information used for pricing a claim in its claims system and data warehouse and ensure the DRG is being captured and included in the encounter submissions, as required by the 837I Encounter Submission Guide.
3-G	**Accuracy – Health Plan Paid Date:** Medical, Vision and Pharmacy – Both the claim sample data and the encounter data reflect valid values, but do not agree.	The CCO and delegated vendor should review its encounter submission procedures to ensure CCO/delegated vendor paid dates are submitted in accordance with encounter submission requirements. Additionally, the CCO/delegated vendor should review its processes, claims system and data warehouse to ensure accurate adjudication dates (i.e., the date a determination was made to pay or deny a claim) are being reported on all encounter submissions. The FAC should also review its processes to ensure it is capturing the CCO's/delegated vendor's adjudication date(s), as submitted by the CCO/delegated vendor, on all submitted encounters. The CCO, delegated vendor and the FAC should work together to resolve this issue.
3-H	**Accuracy – Health Plan Paid Amount: Pharmacy -** Beginning on or about July 2022, the pharmacy paid amounts were submitted in the incorrect field/loop on the encounter data submissions (i.e., Cost Paid field, 431-DV with a qualifier in field 342-HC of '07' instead of '02'). DOM informed the CCO that it did not need to correct and resubmit the encounters. As a result, the paid amounts are not reported in accordance with the state submission guidance. We were unable to evaluate the November 2022 pharmacy encounter data health plan paid amount field.	The CCO should correct and resubmit the pharmacy encounter data in accordance with state and federal encounter data submission guidelines and requirements.

Findings and Recommendations		
	Findings	**Recommendations**
3-I	**Accuracy** **Billing Provider NPI/Number:** Dental and Vision **Service Provider NPI/ Number and Service Provider Taxonomy:** Medical, Behavioral Health, Dental, and Vision Both the sample claims data and the encounter data reflect valid values, but they do not agree and/or the values are inconsistently populated in the sample claims data and/or encounter data.	The CCO should ensure it is properly maintaining provider data within the claims system and data warehouse and be able to submit this information in the encounter submissions, as required by the 837 Encounter Submission Guidelines. Additionally, the FAC should review its processes to ensure it is capturing billing NPI/number, service provider NPI/number and taxonomy data as submitted by the health plan and ensure the data is provided in the encounter data extracts. The FAC and the CCO should work together to ensure the provider regulated values are properly submitted and captured in the encounter data.

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

To further support the encounter data validation process, encounters with dates of service during the measurement period were analyzed for consistency among other measurable attributes such as member utilization and paid amounts, timeliness of payments, and encounter submission timeliness. Encounters with CY 2022 dates of service were compared to Mississippi Medicaid managed care program data[10] to further evaluate the encounter data.

Members, Utilization and Paid Amounts

Member and/or capitation data was used to evaluate utilization data on a per member basis. The total number of utilized services and total paid amounts were divided by the average number of members to determine per member utilization.

[10] All CCOs contracted to provide healthcare services for Mississippi Medicaid managed care CAN beneficiaries were combined for comparative purposes.

Table 2 shows the resulting utilization and paid amounts per member.

CAN Per Member Per Year (PMPY)[11] Utilization and Paid Amounts by Service Type						
Service Type	**Mississippi CAN**		**MHP CAN**		**Variance**	
	Count	**Paid Amount**	**Count**	**Paid Amount**	**Count**	**Paid Amount**
Ancillary	5.7	$373	6.2	$403	8.8%	8.0%
Behavioral Health	3.0	$384	3.7	$541	23.3%	40.9%
Dental	4.4	$221	4.6	$231	4.5%	4.5%
Inpatient	3.0	$1,032	2.8	$945	-6.7%	-8.4%
Outpatient	11.0	$816	11.7	$855	6.4%	4.8%
Primary Care	13.6	$588	14.0	$599	2.9%	1.9%
Specialty Care	3.2	$170	2.9	$142	-9.4%	-16.5%
Vision	1.4	$50	1.7	$65	21.4%	30.0%
NEMT	0.5	$30	0.4	$38	-20.0%	26.7%
Pharmacy	14.4	$892	14.7	$580	2.1%	-35.0%
Telehealth	0.4	$32	0.5	$38	25.0%	18.8%
Total	***60.6***	***$4,588***	***63.2***	***$4,437***	***4.3%***	***-3.3%***

Table 2 - CAN Per Member Utilization and Paid Amount Statistics: The CCO's overall PMPY utilization was 4.3 percent higher than the Mississippi CAN overall PMPY utilization and the CCO's PMPY paid amount was 3.3 percent lower. Telehealth services include behavioral health telehealth visits. Detailed statistics are available in Appendix D.

Timeliness

Complete data takes into account the time necessary to adjudicate a submitted claim and the subsequent timely turnaround for the submission of the generated encounter. Inconsistent processing may indicate problems within the CCO's information systems. This analysis determines compliance with the timeliness requirements of the CCO's payment of provider claims and its submission of encounters to the FAC after adjudication (i.e., payment or denial).

Timely Payment of Claims

This analysis measures how quickly the CCO paid or denied (adjudicated) claims submitted by providers for payment. The received dates and paid (adjudication) dates from encounters with CY 2022 dates of service were used for the analysis. The number of days between these dates determined the percentage of claims paid (adjudicated) by the CCO within the designated timeframes.

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

Table 3 shows the results of the timely payment of claims analysis.

CAN Timely Payment of Claims				
Encounter Type	**30 Days**	**60 Days**	**90 Days**	**Average Days**
Medical	98.3%	99.1%	99.4%	10
Behavioral Health	99.0%	99.9%	99.9%	8
Dental	100.0%	100.0%	100.0%	5
NEMT	89.1%	96.3%	99.1%	17
Vision	100.0%	100.0%	100.0%	10
Pharmacy	73.1%	73.2%	73.3%	60
Overall Average	***86.2%***	***86.8%***	***86.9%***	***33***

Table 3 - CAN Timely Payment of Claims: The CCO paid 86.2 percent of claims within 30 days. Detailed results can be found in Appendix E.

Timely Encounter Submissions

This analysis determined how long it took the CCO to get encounters into the Medicaid management information system (MMIS). According to the CCO's contract with DOM, the CCO must submit [all][12] adjudicated clean claims as encounters no later than the sixtieth (60th) calendar day after the date the CCO adjudicated the claim.[13.]

The paid dates from encounters with CY 2022 dates of service and the date the FAC processed the encounter were used for the analysis. The number of days between these dates determined the percentage of encounters submitted by the CCO to the FAC within the designated timeframes.

Table 4 shows the results of the encounter submission timeliness analysis.

CAN Timely Encounter Submissions				
Encounter Type	**60 Days**	**90 Days**	**120 Days**	**Average Days**
Medical	95.5%	98.2%	99.5%	32
Behavioral Health	98.5%	98.5%	98.5%	19
Dental	83.0%	90.5%	93.2%	44
NEMT	51.7%	63.8%	73.9%	78
Vision	73.3%	73.4%	73.7%	71
Pharmacy	38.8%	38.8%	38.8%	141
Overall Average	***67.5%***	***68.9%***	***69.6%***	***46***

Table 4 – CAN Timely Encounter Submissions: The CCO submitted 67.5 percent of encounters within the required 60 day timeframe. Detailed results can be found in Appendix F.

[12] The word "all" is not included within the contract language. For purposes of this analysis, this requirement is assumed to contain a 100 percent threshold.
[13] Section 11, Reporting Requirements, S. Member Encounter Data.

Findings and Recommendations

The findings from the timeliness analyses are presented below, including recommendations for DOM, the FAC and/or the CCO.

Findings and Recommendations		
	Findings	**Recommendations**
3-J	**Timely Payment of Claims:** The CCO paid 86.2 percent of claims within 30 days. The Pharmacy claims, with a low 73.1 percent paid within 30 days, significantly impacted the overall claims average. Pharmacy claims were paid, on average, within 60 days.	The health plan should review and regularly monitor its claims adjudication practices and encounter submission procedures to ensure claims processing is timely and all encounter submissions are meeting contractual requirements.
3-K	**Timely Encounter Submissions:** Overall, the CCO did not meet the required level of timeliness for the submission of encounters. The CCO submitted 67.5 percent of all encounters within the 60 day timeframe. This percentage was significantly impacted by the NEMT and pharmacy encounter values with NEMT encounters submitted, on average, within 78 days and pharmacy encounters submitted, on average, within 141 days. The delay in the submission and/or acceptance of encounters may have been impacted by the replacement of the MMIS system during the measurement period and/or the transition to the new FAC during the fourth quarter of 2022.	

Review of Medical Records

A review of medical records confirms or provides supporting information for the findings from the analysis of encounters, but is not a medical necessity review. Certain key data elements from the encounters selected for review were traced to the corresponding provider medical records obtained, as the medical record is intended to represent the primary source of documentation for the service(s) provided. Encounter data with dates of service during the measurement period were used as the universe population for the selection of medical records. A sample size of 120 total medical records was specified by DOM for testing. One non-statistical[14], proportionate random sampling of records was drawn from the encounter data universe for review.

The encounters selected for review were forwarded to the CCO on June 26, 2023 for retrieval of the medical records from the billing provider. The notification included a guide outlining the specific types of documentation that may be submitted and stated that medical records were due to Myers and Stauffer by August 11, 2023. Medical records submitted after the due date, records with incorrect dates of service, and incomplete medical records were excluded from the validation process.

Table 5 below, summarizes the number of records requested, received, missing, and the net number of medical records submitted by the CCO for testing.

CCO Medical Records Summary						
Description	**Medical**	**Dental**	**Vision**	**Pharmacy**	**Behavioral Health**	**Total**
Total Records Requested	61	7	3	34	15	120
Records Missing	13	0	1	0	1	15
Records Submitted for the incorrect date of service	1	0	0	0	0	1
Medical Records Tested	47	7	2	34	14	104
Percentage of Requested Records Tested	***77.0%***	***100.0%***	***66.7%***	***100.0%***	***93.3%***	***86.7%***

Table 5 – CCO Medical Records Summary: CCO indicated that multiple attempts were made to obtain all of the medical records requested. The missing records were primarily a result of non-responsive providers.

The CCO submitted 105 of the 120 medical records requested. One (1) of the medical records submitted was for a date of service that was different from the date of service requested. The record was excluded from the validation, resulting in 104 (86.7 percent) of the 120 medical records requested being tested.

[14] Non-statistical sampling is the selection of a test group, such as sample size, that is based on the examiner's judgement, rather than a formal statistical method.
https://www.accountingtools.com/articles/non-statistical-sampling.html

Methodology

The medical records were reviewed and compared to the encounter data to validate that the tested key data elements were supported by the medical record documentation. Each key data element was independently evaluated against the medical record and deemed supported or unsupported (i.e., the medical record supported or did not support the encounter key data element value). The validation was segregated in the following manner:

- Supported: Encounters for which the medical records supported the key data element(s).
- Unsupported: Encounters for which the medical records reflected information that was different from the encounter key data element(s) and/or encounters for which the medical records did not include the information to support the encounter key data element(s).

Tables 6 reflects the validation rates from the medical record key data element review. A 98 percent threshold was utilized to evaluate the results of this validation. The supported validation rates for all claim types from this review fell below this 98 percent threshold.

Supported Medical Record Validation Rates	
Encounter Type	**CAN**
Medical	97.8%
Behavioral Health	95.9%
Dental	85.2%
Vision	88.9%
Pharmacy	97.9%
Total Average	***96.8%***

Table 6 – Supported Medical Record Validation Rates: The key data elements evaluated and specific testing results are presented in Appendix G.

Findings and Recommendations

The findings from the encounter data testing against medical records are presented below, including recommendations for DOM, the FAC and/or the CCO.

Findings and Recommendations		
	Findings	**Recommendations**
4-A	104 of the 120 (86.7 percent) medical records requested were submitted by the CCO. For the missing records, the CCO indicated that the providers were unresponsive to the CCO's requests.	The CCO should work with its providers to ensure medical records are available and that providers are contractually obligated to submit medical records upon request and within the specified time frame(s) and held accountable for non-compliance.
4-B	The validation rate for the 104 medical records tested was below the 98 percent threshold (96.8 percent).	The health plan should work with its providers to ensure appropriate data element values are submitted and captured in the claims and encounter submissions, and that the data elements submitted are supported by the medical record(s).

Submission of Findings

The table below summarizes the findings and recommendations identified during the scope of the audit. Finding numbers corresponding to the sequential finding for each audit scope within the report.

Findings and Recommendations		
	Findings	**Recommendations**
Review State Requirements		
1-A	The CCO's pharmacy paid amounts were submitted in the incorrect field/loop (i.e., Cost Paid field, 431-DV with a qualifier in field 342-HC of '07' instead of '02'). We have reviewed the pharmacy encounter data extracts received from the FAC to investigate if this field was included in one of the other amount fields (e.g., AMT_INGRED_COST_SUB), and were unable to identify pharmacy paid amount in any other amount field. DOM informed the CCO that it did not need to correct and resubmit the encounters. The pharmacy encounter data is known to be in error (from August 2022 through September 2023 present), which may potentially impact rate setting and other reporting and analyses for which the data may be used, as well as CMS' T-MSIS submission. Magnolia transitioned to a new PBM in October 2023 (Express Scripts) and the new vendor is now submitting the data in the correct field; however, data submitted by the prior vendor remains in the incorrect field for the period of August 2022 through September 2023.	We recommend that the CCO correct and resubmit the pharmacy encounter data in accordance with state and federal encounter data submission guidelines and requirements.
Review CCO Capability		
There were no findings related to our review of the CCO's capabilities.		

Findings and Recommendations		
	Findings	**Recommendations**
	Analyze Electronic Encounter Data	
3-A	**Completeness – CDJs:** The monthly completion percentages for January 2022 through July 2022 included all delegated vendors. The average completion percentage for this timeframe was below the 98 percent threshold (95.8 percent). On or about July 2022, the CCO's pharmacy vendor was submitting encounter paid amounts in an incorrect field/loop. This field was not included in the encounter data extracts provided to Myers and Stauffer, and as a result, pharmacy completion percentages could not be determined. The completion percentages for August 2022 through December 2022 excluded pharmacy and nearly met the 98 percent threshold (97.9 percent).	The CCO, in conjunction with the FAC, should investigate and identify the causes of any surplus and/or missing encounters present or absent in the encounter data. Any issues noted during the investigation requiring encounter data revisions should be accurately addressed and incorporated in the FAC encounter data. Additionally, the CCO should submit adjusted, void and denied claims and/or corrections/resubmissions to ensure all claims are accurately reflected within the encounter data. Additionally, the CCO should correct and resubmit the pharmacy encounter data in accordance with state and federal encounter data submission guidelines and requirements.
3-B	**Completeness – Sample Claim Count:** Dental, vision, NEMT and behavioral health encounter completion percentages, based on sample claim counts, were at or above the 98 percent threshold. Medical and pharmacy encounter counts were below the threshold.	
3-C	**Completeness – Sample Claim Paid Amount:** Dental and NEMT encounters, based on sample claim paid amounts, were at or above the 98 percent threshold**.** Medical, vision and behavioral health encounter completion percentages exceeded 100 percent. Pharmacy encounter paid amounts were above the threshold for March 2022, but could not be determined for the November 2022 sample month due to the paid amounts being submitted in the incorrect encounter field/loop.	
3-D	**Accuracy – Former/Original Claim ICN:** Medical – Both the sample claim data and the encounter data reflect valid values, but do not agree.	The CCO should ensure that appropriate audit trails are in place for all adjusted, replaced, and voided claims. The original ICN should be linked to the replacement, adjustment and/or voided claim and be available to trace the replacement or adjustment back to the original claim.

Findings and Recommendations		
	Findings	**Recommendations**
3-E	**Accuracy – MMIS ICN:** Medical, Dental, Behavioral Health, and Vision – Both the sample claim data and the encounter data reflect valid values, but do not agree. Pharmacy – Sample claim values were not populated.	The CCO/delegated vendors should ensure that appropriate audit trails are in place and it is properly capturing and storing all ICN(s) assigned by the FAC and returned to the CCO/delegated vendor on the FAC encounter (999 proprietary) response file.
3-F	**Accuracy – Diagnosis Related Group (DRG):** Medical (inpatient) – Both the sample claim data and the encounter data reflect valid values, but do not agree.	The CCO should ensure it is properly maintaining DRG information used for pricing a claim in its claims system and data warehouse and ensure the DRG is being captured and included in the encounter submissions, as required by the 837I Encounter Submission Guide.
3-G	**Accuracy – Health Plan Paid Date:** Medical, Vision and Pharmacy – Both the claim sample data and the encounter data reflect valid values, but do not agree.	The CCO and delegated vendor should review its encounter submission procedures to ensure CCO/delegated vendor paid dates are submitted in accordance with encounter submission requirements. Additionally, the CCO/delegated vendor should review its processes, claims system and data warehouse to ensure accurate adjudication dates (i.e., the date a determination was made to pay or deny a claim) are being reported on all encounter submissions. The FAC should also review its processes to ensure it is capturing the CCO's/delegated vendor's adjudication date(s), as submitted by the CCO/delegated vendor, on all submitted encounters. The CCO, delegated vendor and the FAC should work together to resolve this issue.
3-H	**Accuracy – Health Plan Paid Amount: Pharmacy -** Beginning on or about July 2022, the pharmacy paid amounts were submitted in the incorrect field/loop on the encounter data submissions (i.e., Cost Paid field, 431-DV with a qualifier in field 342-HC of '07' instead of '02'). DOM informed the CCO that it did not need to correct and resubmit the encounters. As a result, the paid amounts are not reported in accordance with the state submission guidance. We were unable to evaluate the November 2022 pharmacy encounter data health plan paid amount field.	The CCO should correct and resubmit the pharmacy encounter data in accordance with state and federal encounter data submission guidelines and requirements.

Findings and Recommendations		
	Findings	**Recommendations**
3-I	**Accuracy** **Billing Provider NPI/Number:** Dental and Vision **Service Provider NPI/ Number and Service Provider Taxonomy:** Medical, Behavioral Health, Dental, and Vision Both the sample claims data and the encounter data reflect valid values, but they do not agree and/or the values are inconsistently populated in the sample claims data and/or encounter data. NEMT (Service Provider NPI/Number and Taxonomy) –Sample claim values and encounter values were not populated.	The CCO should ensure it is properly maintaining provider data within the claims system and data warehouse and be able to submit this information in the encounter submissions, as required by the 837 Encounter Submission Guidelines. Additionally, the FAC should review its processes to ensure it is capturing billing NPI/number, service provider NPI/number and taxonomy data as submitted by the health plan and ensure the data is provided in the encounter data extracts. The FAC and the CCO should work together to ensure the provider regulated values are properly submitted and captured in the encounter data.
3-J	**Timely Payment of Claims:** The CCO paid 86.2 percent of claims within 30 days. The Pharmacy claims, with a low 73.1 percent paid within 30 days, significantly impacted the overall claims average. Pharmacy claims were paid, on average, within 60 days.	The health plan should review and regularly monitor its claims adjudication practices and encounter submission procedures to ensure claims processing is timely and all encounter submissions are meeting contractual requirements.
3-K	**Timely Encounter Submissions:** Overall, the CCO did not meet the required level of timeliness for the submission of encounters. The CCO submitted 67.5 percent of all encounters within the 60 day timeframe. This percentage was significantly impacted by the NEMT and pharmacy encounter values with NEMT encounters submitted, on average, within 78 days and pharmacy encounters submitted, on average, within 141 days. The delay in the submission and/or acceptance of encounters may have been impacted by the replacement of the MMIS system during the measurement period and/or the transition to the new FAC during the fourth quarter of 2022.	
Review of Medical Records		
4-A	104 of the 120 (86.7 percent) medical records requested were submitted by the CCO. For the missing records, the CCO indicated that the providers were unresponsive to the CCO's requests.	The CCO should work with its providers to ensure medical records are available and that providers are contractually obligated to submit medical records upon request and within the specified time frame(s) and held accountable for non-compliance.
4-B	The validation rate for the 104 medical records tested was below the 98 percent threshold (96.8 percent).	The health plan should work with its providers to ensure appropriate data element values are submitted and captured in the claims and encounter submissions, and that the data elements submitted are supported by the medical record(s).

Glossary

834 file – HIPAA-compliant benefit enrollment and maintenance documentation.

835 file – HIPAA-compliant health care claim payment/advice documentation.

837 file – The standard format used by institutional providers and health care professionals and suppliers to transmit health care claims electronically.

Adjudication – The process of determining whether a provider submitted claim should be paid or denied.

American Institute of Certified Public Accountants (AICPA) – The national professional organization of Certified Public Accountants.

Ancillary Services – Supplies and equipment, laboratory and diagnostic tests, therapies (i.e., physical, occupational and speech) and home health services requested by a health care provider as a supplement to fundamental services.

Capitation – A payment arrangement for health care services that pays a set amount (typically monthly or prorated portion) for each enrolled member assigned to a provider and/or CCO.

Cash Disbursement Journal (CDJ) – A journal used to record and track cash payments by the CCO or other entity.

Centers for Medicare & Medicaid Services (CMS) – The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

Centers for Medicare & Medicaid Services (CMS) Medicaid and the Children's Health Insurance Program (CHIP) Managed Care Final Rule – On April 25, 2016 CMS published the Medicaid and CHIP Managed Care Final Rule which modernizes the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The final rule aligns many of the rules governing Medicaid managed care with those of other major sources of coverage; implements statutory provisions; strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It also ensures appropriate beneficiary protections and enhances policies related to program integrity.

Certified Public Accountant (CPA) – A designation given by the AICPA to individuals that pass the uniform CPA examination and meet the education and experience requirements. The CPA designation helps enforce professional standards in the accounting industry.

CFR – Code of Federal Regulations.

Children's Health Insurance Program (CHIP) – Insurance program that provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid, but not enough to

buy private insurance.

Conduent EDI Solutions, Inc. – The state of Mississippi's fiscal agent contractor up until October 2022.

Coordinated Care Organization – A private organization that has entered into a contractual arrangement with DOM to obtain and finance certain health care services for enrolled Medicaid members. CCOs receive a capitation or per member per month (PMPM) payment from DOM for each enrolled member.

Data Warehouse (DW) – A central repository for storing, retrieving, and managing large amounts of current and historical electronic data. Data stored in the warehouse is uploaded from the operational systems and may pass through additional processing functions before it is stored in the warehouse. Also known as an enterprise data warehouse (EDW).

Dental Services – Dentistry is the evaluation, diagnosis, prevention, and/or treatment (i.e., non-surgical, surgical, or related procedures) of diseases, disorders, injuries, and malformations of the teeth, gums, jaws, and mouth. Dental services include the removal, correction, and replacement of decayed, damaged, or lost parts, including the filling and crowning of teeth, the straightening of teeth, and the construction of artificial dentures**.**

Diagnosis Related Group (DRG) – A patient classification scheme which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital for inpatient hospital stays.

Division of Medicaid (DOM) – The agency within the state of Mississippi that oversees and administers Medicaid.

Encounter – A health care service rendered to a member, by a unique provider, on a single date of service, whether paid or denied by a coordinated care organization. One patient encounter may result in multiple encounter records.

Encounter Data – Claims that have been adjudicated by the CCO or subcontracted vendor(s), if applicable, for providers that have rendered health care services to members enrolled with the CCO. These claims are submitted to DOM via the FAC for use in rate setting, federal reporting, program oversight and management, tracking, accountability, and other ad-hoc analyses.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review or other EQR-related activities as set forth in 42 CFR §438.358, or both.

External Quality Review (EQR) – The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that CCOs, or its contractors, furnish to Medicaid recipients.

Fiscal Agent Contractor (FAC) – A contractor selected to design, develop, and maintain the claims processing Medicaid Management Information System (MMIS). Gainwell Technologies is the current FAC for Mississippi. Also known as a fiscal intermediary (FI).

Gainwell Technologies, Inc. – The state of Mississippi's current fiscal agent contractor since October 2022.

Generally Accepted Government Auditing Standards (GAGAS) – Also known as the Yellow Book, are the

guidelines for audits created by the Comptroller General and the audit agency of the United States Congress, the Government Accountability Office.

GAGAS Performance Audit - Generally Accepted Government Auditing Standards (GAGAS) published by the federal Government Accountability Office (GAO), provide objective analysis, findings, and conclusions to assist management and those charged with governance and oversight with, among other things, improving program performance and operations, reducing costs, facilitating decision making by parties.

Health Insurance Portability and Accountability Act (HIPAA) – A set of federal regulations designed to protect the privacy and maintain security of protected health information (PHI).

Information Systems Capabilities Assessment (ISCA) – A tool for collecting facts about a CCO's information system to ensure that the CCO maintains an information system that can accurately and completely collect, analyze, integrate and report data on member and provider attributes, and services furnished to members. An ISCA is a required part of multiple mandatory External Quality Review protocols.

Internal Control Number (ICN) – A numerical mechanism used to track health care claims and encounters. Also referred to as Transaction Control Number (TCN) or a Document Control Number (DCN).

Inpatient Services – Care or treatment provided to members who are extremely ill, have severe trauma, unable to care for themselves or have physical illnesses whose condition requires admission for at least one overnight stay. Lengths of stay are generally short and patients are provided 24-hour care in a safe and secure facility.

Key Data Element – A fundamental unit of information that has a unique meaning and distinct units or values (i.e., numbers, characters, figures, symbols, a specific set of values, or range of values) defined for use in performing computerized processes.

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 (i.e. ICN).

Non-Emergency Medical Transportation (NEMT) – Transportation services provided to members who are not in an emergency situation but may need more assistance than a taxi service is able to provide. Service providers are specially equipped to transport riders in wheelchairs, stretchers or with other special needs to medical appointments or the pharmacy.

Outpatient Services – Care or treatment that can be provided in a few hours at a facility without an overnight stay. Patients continue working or attend school, interacting and living their lives while receiving treatment. Outpatient services include rehabilitation services such as counseling and/or substance abuse.

Per Member Per Month (PMPM) – The amount paid to a CCO each month for each person for whom the CCO is responsible for providing health care services under a capitation agreement.

Potential Duplicate (PDUP) – An encounter that Myers and Stauffer LC has identified as being a potential duplicate of another encounter in the FAC's data warehouse.

Primary Care Services – Medical providers in family and general practice, obstetrics and gynecology (for preventive and maternity care), pediatrics (without other sub specialties), and internal medicine (without other sub specialties) are generally considered primary care providers. Federally qualified health clinics and rural health clinics are included, as these clinics provide comprehensive primary and preventative care to underserved areas or populations. Primary care services provide a range of preventive and restorative care over a period of time and primary care providers, generally, coordinate all of the care that a member receives.

SOC 2 (System and Organization Control) Trust Services Criteria – is a voluntary compliance standard for service organizations, developed by the American Institute of CPAs (AICPA), which specifies how organizations should manage customer data. The standard is based on the following Trust Services Criteria: security, availability, processing integrity, confidentiality, privacy.

SOC 2 report – is tailored to the unique needs of each organization. Depending on its specific business practices, each organization can design controls that follow one or more principles of trust. These internal reports provide organizations and their regulators, business partners, and suppliers, with important information about how the organization manages and secures its data.

Specialty Care Services – Specialists are medical providers who devote attention to a particular branch of medicine (i.e., any type of medical provider who is not considered a primary care provider) in which they have extensive training and education. Specialty care includes services such as cardiology, diabetes and endocrinology, optometry, and behavioral health.

Sub-Capitated Provider – A health care provider that is paid on a capitated or per member per month (PMPM) basis that has contracted with a CCO and is 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 members. Also known as delegated vendor.

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.

Appendices

APPENDIX A: BI-MONTHLY ENCOUNTER DATA COMPARISON

JULY 1, 2021 THROUGH JUNE 30, 2023

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

OCTOBER 31, 2023

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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STUDY PURPOSE

The Mississippi Division of Medicaid (DOM) requires that each of the coordinated care organizations (CCOs) submit encounter data to the DOM's fiscal agent contractor (FAC), Gainwell Technologies. To ensure complete encounter data is being received, Myers and Stauffer provides bi-monthly encounter reconciliations. As part of this process, Myers and Stauffer analyzes Medicaid encounter data that has been submitted by the CCOs to the FAC 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 rendered 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 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 Rule, to provide program management and oversight, and for tracking, accounting, and other ad hoc analyses.

Section 11.S.6 of the contract between DOM and the CCO for the reporting period states,

> *"The Contractor shall submit at least ninety-eight percent (98%) of all Member Encounter Data in a valid format, which will be deemed valid by the Division, including those of Subcontractors or Delegated Vendors as provided for in this Section, both for the original and any adjustment or void. The Division or its Agent will validate Member Encounter Data submissions according to the Cash Disbursement Journal of the Contractor and any of its applicable Subcontractors. If the Contractor fails to submit complete Member Encounter Data, as measured by a comparison of encounters to cash disbursements, Contractor may be subject to liquidated damages as outlined in Section 16, Default and Termination, of this 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 5 (formerly 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 5, 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. DOM has recently engaged Myers and Stauffer to perform another Protocol 5 review. These results are expected to be issued in a separate report later this year.

Our work was performed in accordance with American Institute of Certified Public Accountants (AICPA) professional standards for consulting engagements. We were not engaged to, nor did we perform, an audit, examination, or review services; accordingly, we express no opinion or conclusion related to the procedures performed or the information and documentation we reviewed. In addition, our engagement was not specifically designed for, and should not be relied on, to disclose errors, fraud, or other illegal acts that may exist.

The results of our engagement and this report are intended only for the internal use of the Mississippi Division of Medicaid (DOM), and should not be used for any other purpose.

SUMMARY

DOM requested that, for this study, we review the CCO's entire plan, each delegated vendor, and fee-for-service (non-vendor) paid encounters to determine if the paid encounters meet the state contract minimum completeness requirement of **98 percent** when compared to the CDJ files. The encounters and CDJ files utilized in this study met the following criteria:

- Encounters were paid within the reporting period of July 1, 2021 through June 30, 2023;
- CDJ transactions had payment dates within the reporting period of July 1, 2021 through June 30, 2023;
- Encounters were received and processed by the FAC for transmission to Myers and Stauffer through September 29, 2023.

Table A — Magnolia Health CAN Cumulative Completion Totals and Percentages

			Delegated Vendor				
Description	**Entire Plan***	**Fee-for-Service (Non-Vendor)**	**Envolve Pharmacy Solutions (Pharmacy Benefits)**	**Envolve Dental (Dental Services)**	**Envolve Vision (Vision Services)**	**Magnolia Behavioral Health**	**MTM (NET)**
Encounter Total (FAC reported)	**$1,483,992,881**	**$1,148,459,095**	**$197,303,324**	**$82,213,848**	**$28,311,267**	**$211,355,081**	**$13,653,590**
Total Encounter Adjustments ($)	*($268,942,890)*	*($224,570,831)*	*($4,044,489)*	*($7,187,896)*	*($7,153,411)*	*($28,483,150)*	*($1,547,601)*
Total Encounter Adjustments (%)	*-18.12%*	*-19.55%*	*-2.04%*	*-8.74%*	*-25.26%*	*-13.47%*	*-11.33%*
Net Encounter Total	**$1,215,049,991**	**$923,888,264**	**$193,258,835**	**$75,025,952**	**$21,157,856**	**$182,871,931**	**$12,105,988**
CDJ Total	**$1,217,825,827**	**$923,992,630**	**$404,846,674**	**$75,215,548**	**$21,121,726**	**$185,420,879**	**$12,075,043**
Variance	*($2,775,836)*	*($104,366)*	*($211,587,839)*	*($189,596)*	*$36,129*	*($2,548,948)*	*$30,945*
Completion (%)	**99.77%**	**99.98%**	**47.73%**	**99.74%**	**100.17%**	**98.62%**	**100.25%**
100% Limited^ Completion (%)	***99.76%***				***100.00%***		***100.00%***
Contract Minimum Completeness Requirement (%)	**98.00%**						
Non-Compliant (%)			**-50.27%**				

** – The Envolve Pharmacy CDJ and encounter totals have been excluded from the entire plan results for this reporting period at the direction of DOM. DOM has deferred the 98 percent requirement for Magnolia Health pharmacy in this draft report due to paid amount issues with the encounter data extracts. This report will be finalized with the updated pharmacy totals once this issue has been resolved. Please reference data analysis assumption number 7 on page 19 for further explanation.*

^ – To avoid overstating the Entire Plan CAN results in situations where the CCO or an individual vendor's cumulative completion percentage exceeds 100 percent, we have decreased the encounter totals by the reporting period's variance in comparison with the CDJs. Please see data analysis assumption number 9 on page 19 for further explanation.

ENCOUNTER DATA ANALYSIS

For this study, Myers and Stauffer analyzes the encounter data that is submitted by the CCOs to the FAC, Gainwell Technologies, and loaded into the FAC Medicaid Management Information System (MMIS). Encounters submitted by any CCO that were rejected by the FAC for errors in submission or other reasons are not transmitted to Myers and Stauffer.

Furthermore, Myers and Stauffer analyzes the encounter data from the FAC MMIS and makes the following adjustments. Table B below outlines the impact of applying these encounter analysis adjustments to the encounter paid amounts, when compared to the raw data received.

1. Medical and institutional encounter voids with positive plan paid amounts and/or invalid former TCN values are excluded from the encounter totals. Additionally, pharmacy encounters being identified as denied in the MMIS are excluded from the encounter totals.

2. Myers and Stauffer identified potential duplicate encounters using our encounter review logic. Based on a comparison to the CDJ files, we noted some are actual duplicate submissions, and some are replacement encounter records without a matching void (i.e. calculated voids). Lists of these potential duplicates, noted in previous reports, were provided to Magnolia for examination. We have reviewed Magnolia Health's disputed duplicate response files submitted to us prior to August 26, 2023. The accepted responses have been incorporated into the analysis for this report. Responses requiring further explanation have not been added to this report and will be resubmitted to the CCO.

3. Our potential duplicate and calculated void processes attempt to identify and remove encounters that appear to be duplicated for some reason. Encounters paid by the CCO but denied by the FAC were included in both our potential duplicate and calculated void processes. It should be noted that the inclusion of denied encounters by either the FAC or the CCO can artificially inflate the percentages of encounter counts and paid amounts being removed. In the case of encounters denied by the FAC, some of these encounters may have already been identified and flagged by the FAC as being duplicates.

Table B — Myers and Stauffer LC's Adjustments to Magnolia Health CAN Encounters

Description	Encounter Count	Paid Amount	Paid Amount (% of Total*)
Total Encounter Amount (FAC Reported)	**7,686,359**	**$1,483,992,881**	**100.00%**
Adjustment Type			
Denied	*(490,518)*	*($6,599)*	*0.00%*
Calculated Void	*(1,599,535)*	*($259,726,616)*	*-17.50%*
Duplicate	*(25,668)*	*($9,209,676)*	*-0.62%*
Total Adjustments Made	*(2,115,721)*	*($268,942,890)*	*-18.12%*
Net Encounter Amounts	**5,570,638**	**$1,215,049,991**	**81.88%**

** - Percentage ratios are rounded down for each adjustment type and may not add up to the total percentage of adjustments made for this reporting period. Please see data analysis assumption number 9 on page 19 for further explanation*

Additionally, the Envolve Pharmacy CDJ and encounter totals have been excluded from the entire plan results in the draft report for this period at the direction of DOM. Please reference data analysis assumption number 7 on page 19 for further explanation.

DATA ISSUES AND RECOMMENDATIONS

During the course of this analysis, Myers and Stauffer identified potential data issues that may impact the completion percentages for specific delegated vendors and/or fee-for-service (non-vendor). **Section A** details payor specific issues related to completion percentages outside the targeted range, while **Section B** notes outstanding payor specific data issues that Magnolia Health may need to continue to work to identify and resolve. **Section C** notes data issues that may impact all payors to some extent (non-vendor and vendor).

Please reference Tables 1 through 7 starting on page 8 for Magnolia Health's CAN plan, delegated vendor, and fee-for-service (non-vendor) reconciliation period tables. These tables contain detailed reconciliation totals, completion percentages, and encounter analysis adjustments made by Myers and Stauffer.

SECTION A – Non-vendor and/or vendor data issues that may cause completion percentages outside the targeted range (below 98 percent or above 100 percent):

1. **Envolve Pharmacy Solutions (Table 3):** The Envolve Pharmacy CAN monthly completion percentages are low beginning in May 2022 due to potentially missing encounter records. We have received no original pharmacy encounter records with paid amounts greater than zero dollars for Magnolia since the FAC transition to Gainwell.

    - It appears that potentially missing or misallocated encounter sequences (including voids), may be contributing to some of the high monthly completion percentages for earlier months (e.g., February 2022 and September 2022).

    ➢ **The Magnolia pharmacy encounter records in our Gainwell data with zero dollar encounter paid amounts are being researched further. This draft report will be finalized to include the pharmacy encounter totals once this issue has been addressed.**

2. **Envolve Vision (Table 5):** The Envolve Vision CAN cumulative completion percentage appears to be above 100 percent mostly due to potentially missing and/or misallocated encounter void sequences when compared to the CDJ files.

    - Since the Envolve Vision encounters originally submitted to Gainwell were missing header paid dates, the claim received date was used as an approximate paid date for reconciliation purposes. This issue has been corrected going forward and Magnolia Health worked with Envolve Vision to submit many encounter corrections. However, instances where the claim received date and paid date are not in the same month and the original encounter has not been replaced by a corrected encounter are causing both high and low completion percentages fluctuations between November 2022 and December 2022 as well as April 2023, May 2023, and June 2023.

    ➢ **We recommend Magnolia work with Envolve Vision to submit any potentially missing encounter sequences, particularly voids.**

3. **MTM (Table 7):** The MTM CAN cumulative completion percentage appears to be slightly inflated primarily due to unmatched payment sequences, including potentially missing CDJ transactions, when the encounter data and CDJ files are compared.

    - We also noted instances of trip legs with different paid dates in the CDJ files having corresponding encounter submissions where the total paid amount is allocated to only the last paid date. MTM clarified the trip leg payments are rolled up into a single encounter record for a given member and date of service and assigned the latest paid date. This may be

contributing to monthly completion percentage variances when the CDJ paid dates occur in different months.

- **We recommend Magnolia Health continue to work with MTM to ensure all encounter and CDJ sequences are submitted.**

SECTION B – Additional non-vendor and/or vendor data issues and notes that currently may not impact compliance:

4. **Fee-for-Service (non-vendor) and Behavioral Health (Tables 2 and 6):** While the fee-for-service (FFS) and Behavioral Health CAN cumulative completion percentages are in compliance, the Behavioral Health monthly completion percentage appear to be below 98 percent for several months due to potentially missing encounter records. We noted potentially missing behavioral health encounter records with October 6, 2022 and June 22, 2023 paid dates appear to be causing the recent very low monthly completion percentages for those months.

    - Additionally, there are several FFS and behavioral health monthly completion percentages over 100 percent. We noted instances of Conduent/Truven encounter voids being allocated to their original paid dates, often prior to the reporting period, instead of the actual dates the encounter voids occurred. This previous FAC system issue appears to be overstating the CAN completion percentages for some months through June 2022. Potentially missing encounter voids appear to be causing the inflated November 2022 completion percentages for FFS and behavioral health and may be contributing to some of the other monthly completion percentages over 100 percent.

    - We noted instances of multiple payment sequences being submitted in the encounter data records related to each CDJ payment sequence. The final paid amounts for the encounters appear to mostly match the CDJ data totals with the use of potential duplicate identification logic. However, the payment amounts related to a specific sequence may be allocated to one month in the encounters and a different month in the CDJ transactions. This issue is causing the CAN encounter totals for some months (e.g., August 2022 for FFS) to be understated and the encounter totals for some earlier months (e.g., August 2021 for FFS) to be overstated.

    - **We recommend Magnolia Health identify and submit any potentially missing medical and behavioral health encounter records.**

5. **Envolve Dental (Table 4):** The Dental CAN cumulative completion percentage is in compliance, however, we noted some monthly completion percentages are above 100 percent. It appears that potentially missing or misallocated encounter sequences when compared to the CDJ files may be contributing to these inflated monthly completion percentages.

    - We noted instances of adjustments submitted as original encounters without voiding the replaced records. These encounters are being identified as potential duplicates and excluded from the reconciliation totals.

    - **We recommend Magnolia Health work with Envolve Dental to identify any potentially missing dental encounter sequences, particularly voids.**

SECTION C – General data issues that may be contributing to non-vendor and/or vendor variances:

6. **Calculated Voids and Potential Duplicates (Tables 1 through 7):** There appear to be an increased number of calculated voids and potential duplicates identified starting in August 2022 related to the FAC transition.

7. **Encounter Voids (Tables 1 through 7):** There appear to be instances of Gainwell voids where the CCO paid amount on the encounter is more than zero dollars. Since encounter voids are not expected to have any associated final CCO paid amounts, these encounter void amounts are being set to zero. However, we are working with Gainwell to examine the relationship between the frequency codes submitted by the MCOs and the transaction codes found on the encounter records.

MAGNOLIA HEALTH CAN ENTIRE PLAN MONTHLY TABLE

Table 1 — Magnolia Health CAN (Entire Plan)							
Paid Month	Monthly Encounter Total (FAC Reported)	Monthly Encounter Total (Adjustments)	Percentage of Encounters Adjusted	Monthly Encounter Net Total	CDJ Monthly Reported Total	Monthly Variance	Monthly Completion Percentage
July 2021	$67,629,375	($3,991,798)	-5.90%	$63,637,577	$62,020,192	$1,617,385	102.60%
August 2021	$57,513,395	($2,973,113)	-5.16%	$54,540,282	$52,928,412	$1,611,870	103.04%
September 2021	$64,900,780	($3,169,231)	-4.88%	$61,731,549	$61,451,831	$279,718	100.45%
October 2021	$48,414,915	($1,945,562)	-4.01%	$46,469,353	$46,485,738	($16,386)	99.96%
November 2021	$50,585,986	($1,644,234)	-3.25%	$48,941,752	$49,326,297	($384,545)	99.22%
December 2021	$56,001,295	($3,198,027)	-5.71%	$52,803,268	$52,724,912	$78,355	100.14%
January 2022	$46,810,540	($2,539,122)	-5.42%	$44,271,418	$44,612,661	($341,243)	99.23%
February 2022	$50,994,941	($1,430,072)	-2.80%	$49,564,868	$48,982,539	$582,329	101.18%
March 2022	$63,872,486	($2,430,980)	-3.80%	$61,441,506	$60,246,944	$1,194,562	101.98%
April 2022	$55,667,236	($11,618,658)	-20.87%	$44,048,578	$43,790,920	$257,658	100.58%
May 2022	$51,026,458	($5,965,270)	-11.69%	$45,061,187	$45,238,276	($177,089)	99.60%
June 2022	$60,802,277	($9,881,831)	-16.25%	$50,920,445	$48,958,500	$1,961,945	104.00%
July 2022	$48,213,606	($9,106,870)	-18.88%	$39,106,736	$39,371,284	($264,548)	99.32%
August 2022	$57,683,088	($16,251,504)	-28.17%	$41,431,584	$44,164,119	($2,732,535)	93.81%
September 2022	$105,142,967	($47,463,362)	-45.14%	$57,679,605	$58,463,527	($783,922)	98.65%
October 2022	$90,078,573	($40,105,576)	-44.52%	$49,972,997	$52,071,625	($2,098,628)	95.96%
November 2022	$72,021,093	($28,979,192)	-40.23%	$43,041,901	$42,072,021	$969,879	102.30%
December 2022	$65,724,889	($9,897,243)	-15.05%	$55,827,647	$56,512,177	($684,531)	98.78%
January 2023	$46,441,985	($5,887,016)	-12.67%	$40,554,969	$40,568,185	($13,216)	99.96%
February 2023	$56,753,668	($7,296,128)	-12.85%	$49,457,539	$49,963,252	($505,713)	98.98%
March 2023	$75,419,298	($10,314,522)	-13.67%	$65,104,776	$65,348,800	($244,024)	99.62%
April 2023	$58,893,472	($7,426,926)	-12.61%	$51,466,546	$51,986,743	($520,197)	98.99%
May 2023	$54,026,887	($9,142,230)	-16.92%	$44,884,656	$45,156,194	($271,538)	99.39%
June 2023	$79,373,673	($26,284,422)	-33.11%	$53,089,251	$55,380,675	($2,291,423)	95.86%
Cumulative Totals	**$1,483,992,881**	**($268,942,890)**	**-18.12%**	**$1,215,049,991**	**$1,217,825,827**	**($2,775,836)**	**99.77%**
100% Limited^ Cumulative Totals				**$1,214,982,916**	**$1,217,825,827**	**($2,842,910)**	**99.76%**
					State Contract Minimum Completeness Percentage Requirement		*98.00%*

** - The Envolve Pharmacy encounter and CDJ totals have been excluded from the entire plan results in the draft report for this period at the direction of DOM. Please reference data analysis assumption number 7 on page 19 for further explanation.*

^ - Since the CAN cumulative completion percentage for the CCO and/or delegated vendor(s) exceed 100 percent, we have decreased the Entire Plan CAN encounter totals by the total variance in comparison to the CDJs to avoid overstating the Entire Plan results. Please reference data analysis assumption number 9 on page 19 for further explanation.

MAGNOLIA HEALTH CAN
SUMMARY REPORTING CHARTS

Chart 1. Monthly CDJ totals and encounter submissions for Magnolia Health CAN's entire plan

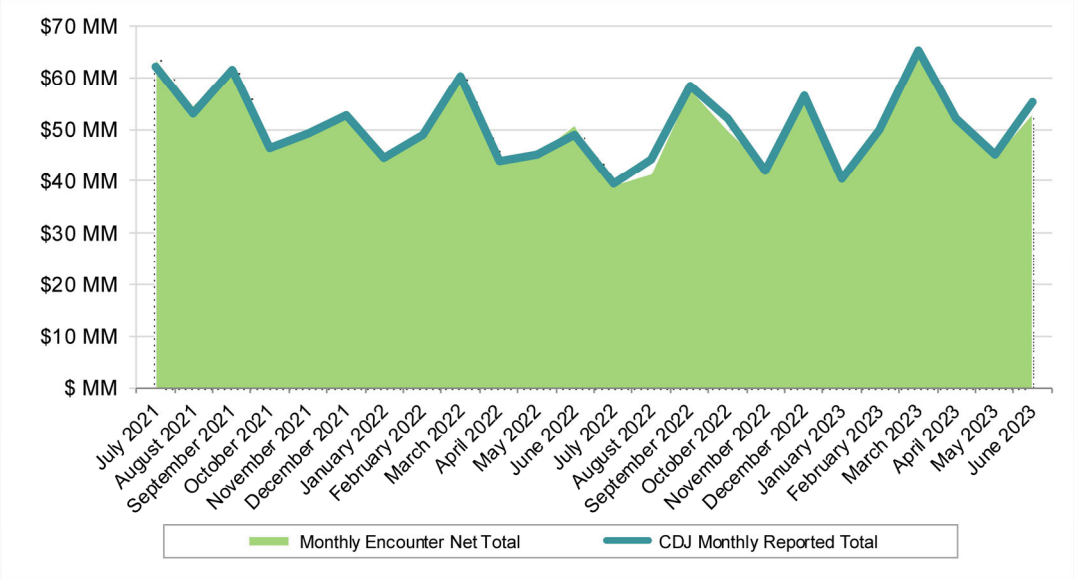

Chart 2. Magnolia Health CAN's monthly encounter submissions expressed as a percentage of payments submitted to the FAC to reported CCO CDJ payments for the entire plan

** - The Envolve Pharmacy encounter and CDJ totals have been excluded from the entire plan results in the draft report for this period at the direction of DOM. Please reference data analysis assumption number 7 on page 19 for further explanation*

^ - To avoid overstating the Entire Plan results in situations when the CCO or an individual vendor's cumulative completion percentage exceeds 100 percent, we decreased the CAN encounter totals by the reporting period's variance in comparison with the CDJs. Please see data analysis assumption number 9 on page 19 for further explanation.

MAGNOLIA HEALTH CAN FEE-FOR-SERVICE MONTHLY TABLE

Table 2 — Magnolia Health CAN Fee-for-Service (Non-Vendor)							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
July 2021	$51,017,084	($3,075,406)	-6.02%	$47,941,678	$47,325,352	$616,326	101.30%
August 2021	$45,061,555	($2,478,359)	-5.49%	$42,583,196	$40,933,675	$1,649,521	104.02%
September 2021	$50,417,865	($2,017,144)	-4.00%	$48,400,721	$48,355,453	$45,267	100.09%
October 2021	$36,093,127	($975,521)	-2.70%	$35,117,606	$35,157,552	($39,946)	99.88%
November 2021	$37,334,078	($1,008,918)	-2.70%	$36,325,159	$36,656,752	($331,592)	99.09%
December 2021	$39,776,814	($2,082,959)	-5.23%	$37,693,856	$37,609,937	$83,918	100.22%
January 2022	$36,510,306	($2,175,061)	-5.95%	$34,335,245	$34,750,427	($415,183)	98.80%
February 2022	$39,945,856	($1,156,419)	-2.89%	$38,789,437	$38,319,773	$469,664	101.22%
March 2022	$48,826,454	($1,322,008)	-2.70%	$47,504,446	$46,375,980	$1,128,466	102.43%
April 2022	$43,947,400	($11,375,952)	-25.88%	$32,571,448	$32,298,946	$272,502	100.84%
May 2022	$39,402,798	($5,713,741)	-14.50%	$33,689,057	$33,856,455	($167,398)	99.50%
June 2022	$47,270,771	($8,365,009)	-17.69%	$38,905,761	$36,920,606	$1,985,155	105.37%
July 2022	$37,979,161	($7,818,059)	-20.58%	$30,161,102	$30,406,051	($244,949)	99.19%
August 2022	$43,726,898	($13,972,489)	-31.95%	$29,754,408	$32,335,754	($2,581,346)	92.01%
September 2022	$84,260,708	($39,657,124)	-47.06%	$44,603,584	$45,129,751	($526,166)	98.83%
October 2022	$74,509,466	($35,079,783)	-47.08%	$39,429,683	$40,114,793	($685,109)	98.29%
November 2022	$54,359,623	($22,350,546)	-41.11%	$32,009,077	$31,144,507	$864,570	102.77%
December 2022	$49,383,052	($6,199,689)	-12.55%	$43,183,363	$43,883,118	($699,755)	98.40%
January 2023	$35,766,152	($4,728,242)	-13.21%	$31,037,910	$31,048,775	($10,866)	99.96%
February 2023	$43,260,338	($6,092,516)	-14.08%	$37,167,823	$37,517,043	($349,221)	99.06%
March 2023	$59,049,051	($8,713,668)	-14.75%	$50,335,383	$50,551,363	($215,980)	99.57%
April 2023	$44,752,572	($6,340,757)	-14.16%	$38,411,816	$39,083,517	($671,702)	98.28%
May 2023	$40,834,818	($8,092,208)	-19.81%	$32,742,611	$33,131,331	($388,721)	98.82%
June 2023	$64,973,148	($23,779,254)	-36.59%	$41,193,894	$41,085,717	$108,176	100.26%
Cumulative Totals	**$1,148,459,095**	**($224,570,831)**	**-19.55%**	**$923,888,264**	**$923,992,630**	**($104,366)**	**99.98%**
						State Contract Minimum Completeness Percentage Requirement	*98.00%*

MAGNOLIA HEALTH CAN ENVOLVE PHARMACY SOLUTIONS MONTHLY TABLE

Table 3 — Magnolia Health CAN Envolve Pharmacy Solutions (Pharmacy)							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
July 2021	$17,560,386	($59,223)	-0.33%	$17,501,162	$17,625,756	($124,593)	99.29%
August 2021	$18,255,221	($41,619)	-0.22%	$18,213,603	$18,215,531	($1,929)	99.98%
September 2021	$15,597,575	($22,907)	-0.14%	$15,574,668	$15,498,384	$76,284	100.49%
October 2021	$17,625,013	($75,040)	-0.42%	$17,549,973	$17,613,740	($63,766)	99.63%
November 2021	$16,890,102	($45,375)	-0.26%	$16,844,727	$16,854,934	($10,206)	99.93%
December 2021	$17,919,134	($106,353)	-0.59%	$17,812,781	$17,927,950	($115,169)	99.35%
January 2022	$17,167,416	($2,038,361)	-11.87%	$15,129,056	$15,133,114	($4,058)	99.97%
February 2022	$16,812,417	($1,450,109)	-8.62%	$15,362,308	$15,330,936	$31,373	100.20%
March 2022	$16,708,895	($62,098)	-0.37%	$16,646,797	$16,701,056	($54,259)	99.67%
April 2022	$17,291,594	($44,296)	-0.25%	$17,247,298	$17,500,745	($253,447)	98.55%
May 2022	$13,327,783	($26,865)	-0.20%	$13,300,917	$16,125,659	($2,824,742)	82.48%
June 2022	$2,669,031	($54,768)	-2.05%	$2,614,262	$14,560,405	($11,946,143)	17.95%
July 2022	$9,478,756	($17,475)	-0.18%	$9,461,281	$16,243,891	($6,782,610)	58.24%
August 2022	$0	$0		$0	$16,332,126	($16,332,126)	0.00%
September 2022	$0	$0		$0	$17,567,984	($17,567,984)	0.00%
October 2022	$0	$0		$0	$16,658,079	($16,658,079)	0.00%
November 2022	$0	$0		$0	$18,517,747	($18,517,747)	0.00%
December 2022	$0	$0		$0	$16,998,758	($16,998,758)	0.00%
January 2023	$0	$0		$0	$16,651,461	($16,651,461)	0.00%
February 2023	$0	$0		$0	$16,361,789	($16,361,789)	0.00%
March 2023	$0	$0		$0	$18,073,387	($18,073,387)	0.00%
April 2023	$0	$0		$0	$16,572,450	($16,572,450)	0.00%
May 2023	$0	$0		$0	$18,171,965	($18,171,965)	0.00%
June 2023	$0	$0		$0	$17,608,830	($17,608,830)	0.00%
Cumulative Totals	**$197,303,324**	**($4,044,489)**	**-2.04%**	**$193,258,835**	**$404,846,674**	**($211,587,839)**	**47.73%**
						State Contract Minimum Completeness Percentage Requirement	*98.00%*
						Non-Compliant	***-50.27%***

** - The Envolve Pharmacy encounter and CDJ totals have been excluded from the entire plan results in the draft report for this period at the direction of DOM. Please reference data analysis assumption number 7 on page 19 for further explanation.*

MAGNOLIA HEALTH CAN ENVOLVE DENTAL MONTHLY TABLE

Table 4 — Magnolia Health CAN Envolve Dental (Dental)							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
July 2021	$3,562,848	($182,130)	-5.11%	$3,380,718	$3,428,388	($47,670)	98.60%
August 2021	$4,125,712	($93,743)	-2.27%	$4,031,969	$4,026,614	$5,355	100.13%
September 2021	$3,492,826	($117,868)	-3.37%	$3,374,958	$3,374,559	$400	100.01%
October 2021	$3,448,175	($125,434)	-3.63%	$3,322,741	$3,328,586	($5,845)	99.82%
November 2021	$3,483,332	($165,243)	-4.74%	$3,318,090	$3,314,380	$3,710	100.11%
December 2021	$3,913,134	($201,197)	-5.14%	$3,711,937	$3,732,091	($20,154)	99.45%
January 2022	$2,914,465	($199,900)	-6.85%	$2,714,565	$2,724,306	($9,741)	99.64%
February 2022	$3,249,754	($218,992)	-6.73%	$3,030,763	$3,036,606	($5,843)	99.80%
March 2022	$4,334,728	($999,198)	-23.05%	$3,335,530	$3,353,131	($17,601)	99.47%
April 2022	$3,232,315	($23,463)	-0.72%	$3,208,852	$3,217,571	($8,720)	99.72%
May 2022	$2,700,048	($40,062)	-1.48%	$2,659,985	$2,666,855	($6,869)	99.74%
June 2022	$2,941,666	($37,886)	-1.28%	$2,903,780	$2,917,746	($13,966)	99.52%
July 2022	$1,982,410	($41,134)	-2.07%	$1,941,276	$1,948,116	($6,841)	99.64%
August 2022	$3,949,665	($22,349)	-0.56%	$3,927,316	$3,931,600	($4,284)	99.89%
September 2022	$4,559,530	($1,217,501)	-26.70%	$3,342,029	$3,366,156	($24,127)	99.28%
October 2022	$3,807,374	($946,881)	-24.86%	$2,860,494	$2,857,416	$3,078	100.10%
November 2022	$4,932,797	($2,109,883)	-42.77%	$2,822,914	$2,801,742	$21,173	100.75%
December 2022	$2,832,619	($23,468)	-0.82%	$2,809,151	$2,808,120	$1,032	100.03%
January 2023	$2,655,414	($34,452)	-1.29%	$2,620,962	$2,628,867	($7,905)	99.69%
February 2023	$2,949,329	($36,555)	-1.23%	$2,912,775	$2,913,098	($323)	99.98%
March 2023	$3,690,979	($44,917)	-1.21%	$3,646,062	$3,658,112	($12,050)	99.67%
April 2023	$2,949,580	($35,324)	-1.19%	$2,914,255	$2,923,549	($9,294)	99.68%
May 2023	$2,891,980	($47,489)	-1.64%	$2,844,491	$2,859,530	($15,039)	99.47%
June 2023	$3,613,166	($222,827)	-6.16%	$3,390,339	$3,398,411	($8,072)	99.76%
Cumulative Totals	**$82,213,848**	**($7,187,896)**	**-8.74%**	**$75,025,952**	**$75,215,548**	**($189,596)**	**99.74%**
						State Contract Minimum Completeness Percentage Requirement	*98.00%*

MAGNOLIA HEALTH CAN ENVOLVE VISION MONTHLY TABLE

Table 5 — Magnolia Health CAN Envolve Vision (Vision)							
Paid Month	Monthly Encounter Total (FAC Reported)	Monthly Encounter Total (Adjustments)	Percentage of Encounters Adjusted	Monthly Encounter Net Total	CDJ Monthly Reported Total	Monthly Variance	Monthly Completion Percentage
July 2021	$1,103,717	($19,557)	-1.77%	$1,084,159	$1,091,526	($7,367)	99.32%
August 2021	$1,231,287	($72,028)	-5.84%	$1,159,259	$1,162,812	($3,553)	99.69%
September 2021	$1,244,311	($136,998)	-11.00%	$1,107,313	$1,112,289	($4,976)	99.55%
October 2021	$1,021,324	($90,911)	-8.90%	$930,413	$934,496	($4,083)	99.56%
November 2021	$955,575	($84,652)	-8.85%	$870,924	$874,280	($3,357)	99.61%
December 2021	$1,036,973	($76,755)	-7.40%	$960,218	$962,771	($2,553)	99.73%
January 2022	$763,013	($50,261)	-6.58%	$712,753	$712,945	($193)	99.97%
February 2022	$890,573	($36,481)	-4.09%	$854,092	$858,502	($4,411)	99.48%
March 2022	$1,116,885	($33,603)	-3.00%	$1,083,282	$1,081,153	$2,130	100.19%
April 2022	$814,475	($10,709)	-1.31%	$803,766	$807,537	($3,770)	99.53%
May 2022	$732,337	($10,199)	-1.39%	$722,138	$725,758	($3,621)	99.50%
June 2022	$865,725	($4,954)	-0.57%	$860,771	$856,234	$4,537	100.52%
July 2022	$796,794	($5,583)	-0.70%	$791,212	$786,720	$4,492	100.57%
August 2022	$1,004,866	($17,750)	-1.76%	$987,116	$990,950	($3,834)	99.61%
September 2022	$1,168,378	($159,570)	-13.65%	$1,008,808	$1,004,640	$4,168	100.41%
October 2022	$1,529,568	($764,085)	-49.95%	$765,483	$758,466	$7,016	100.92%
November 2022	$1,576,320	($769,264)	-48.80%	$807,056	$732,810	$74,246	110.13%
December 2022	$1,637,270	($933,808)	-57.03%	$703,462	$755,348	($51,886)	93.13%
January 2023	$1,398,730	($746,749)	-53.38%	$651,981	$647,363	$4,618	100.71%
February 2023	$1,693,966	($892,935)	-52.71%	$801,031	$792,181	$8,850	101.11%
March 2023	$2,342,409	($1,260,062)	-53.79%	$1,082,346	$1,074,547	$7,799	100.72%
April 2023	$1,721,435	($737,588)	-42.84%	$983,847	$806,145	$177,702	122.04%
May 2023	$1,090,324	($232,397)	-21.31%	$857,927	$732,153	$125,774	117.17%
June 2023	$575,012	($6,512)	-1.13%	$568,501	$860,099	($291,599)	66.09%
Cumulative Totals	**$28,311,267**	**($7,153,411)**	**-25.26%**	**$21,157,856**	**$21,121,726**	**$36,129**	**100.17%**
100% Limited^ Cumulative Totals				**$21,121,726**	**$21,121,726**	**$0**	**100.00%**
					State Contract Minimum Completeness Percentage Requirement		*98.00%*

^ - The Envolve Vision CAN cumulative completion percentage was limited to a maximum of 100 percent by decreasing the encounter totals by the reporting period's variance in comparison to the CDJs. Please reference data analysis assumption number 9 on page 19 for further explanation.

MAGNOLIA HEALTH CAN BEHAVIORAL HEALTH MONTHLY TABLE

Table 6 — Magnolia Health CAN Behavioral Health							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
July 2021	$11,396,533	($714,138)	-6.26%	$10,682,395	$9,626,000	$1,056,395	110.97%
August 2021	$6,647,633	($327,572)	-4.92%	$6,320,062	$6,359,458	($39,396)	99.38%
September 2021	$9,204,137	($878,879)	-9.54%	$8,325,258	$8,089,811	$235,447	102.91%
October 2021	$6,961,198	($286,225)	-4.11%	$6,674,973	$6,641,493	$33,479	100.50%
November 2021	$8,362,269	($380,121)	-4.54%	$7,982,148	$8,035,188	($53,040)	99.33%
December 2021	$10,766,360	($837,116)	-7.77%	$9,929,244	$9,920,155	$9,089	100.09%
January 2022	$6,277,672	($113,900)	-1.81%	$6,163,772	$6,081,998	$81,774	101.34%
February 2022	$6,480,982	($18,180)	-0.28%	$6,462,802	$6,341,330	$121,472	101.91%
March 2022	$9,036,517	($76,171)	-0.84%	$8,960,345	$8,881,326	$79,020	100.88%
April 2022	$7,225,693	($208,513)	-2.88%	$7,017,180	$7,019,575	($2,395)	99.96%
May 2022	$7,753,060	($201,169)	-2.59%	$7,551,891	$7,551,092	$799	100.01%
June 2022	$8,617,789	($919,323)	-10.66%	$7,698,466	$7,712,210	($13,744)	99.82%
July 2022	$6,456,938	($743,736)	-11.51%	$5,713,201	$5,731,726	($18,525)	99.67%
August 2022	$8,523,806	($2,238,917)	-26.26%	$6,284,889	$6,420,396	($135,506)	97.88%
September 2022	$14,590,910	($6,429,167)	-44.06%	$8,161,743	$8,400,379	($238,636)	97.15%
October 2022	$9,755,105	($3,314,828)	-33.98%	$6,440,277	$7,862,598	($1,422,321)	81.91%
November 2022	$10,654,719	($3,749,499)	-35.19%	$6,905,220	$6,897,514	$7,706	100.11%
December 2022	$11,275,341	($2,740,262)	-24.30%	$8,535,079	$8,475,434	$59,645	100.70%
January 2023	$6,175,124	($377,573)	-6.11%	$5,797,551	$5,803,026	($5,475)	99.90%
February 2023	$8,337,686	($273,336)	-3.27%	$8,064,350	$8,240,503	($176,153)	97.86%
March 2023	$9,680,921	($295,874)	-3.05%	$9,385,047	$9,407,261	($22,214)	99.76%
April 2023	$8,934,516	($313,246)	-3.50%	$8,621,270	$8,637,774	($16,504)	99.80%
May 2023	$8,691,815	($770,137)	-8.86%	$7,921,678	$7,916,616	$5,062	100.06%
June 2023	$9,548,357	($2,275,267)	-23.82%	$7,273,090	$9,368,016	($2,094,926)	77.63%
Cumulative Totals	**$211,355,081**	**($28,483,150)**	**-13.47%**	**$182,871,931**	**$185,420,879**	**($2,548,948)**	**98.62%**
						State Contract Minimum Completeness Percentage Requirement	*98.00%*

MAGNOLIA HEALTH CAN MTM MONTHLY TABLE

Table 7 — Magnolia Health CAN MTM (NET)							
Paid Month	**Monthly Encounter Total (FAC Reported)**	**Monthly Encounter Total (Adjustments)**	**Percentage of Encounters Adjusted**	**Monthly Encounter Net Total**	**CDJ Monthly Reported Total**	**Monthly Variance**	**Monthly Completion Percentage**
July 2021	$549,193	($566)	-0.10%	$548,627	$548,925	($298)	99.94%
August 2021	$447,208	($1,411)	-0.31%	$445,796	$445,854	($58)	99.98%
September 2021	$541,641	($18,341)	-3.38%	$523,299	$519,719	$3,580	100.68%
October 2021	$891,091	($467,471)	-52.46%	$423,620	$423,611	$10	100.00%
November 2021	$450,732	($5,300)	-1.17%	$445,432	$445,697	($265)	99.94%
December 2021	$508,013	$0	0.00%	$508,013	$499,958	$8,056	101.61%
January 2022	$345,083	$0	0.00%	$345,083	$342,983	$2,100	100.61%
February 2022	$427,775	$0	0.00%	$427,775	$426,327	$1,447	100.33%
March 2022	$557,903	$0	0.00%	$557,903	$555,355	$2,548	100.45%
April 2022	$447,352	($21)	0.00%	$447,331	$447,291	$40	100.00%
May 2022	$438,216	($99)	-0.02%	$438,117	$438,117	$0	100.00%
June 2022	$1,106,326	($554,658)	-50.13%	$551,667	$551,704	($36)	99.99%
July 2022	$998,303	($498,358)	-49.92%	$499,945	$498,671	$1,275	100.25%
August 2022	$477,854	$0	0.00%	$477,854	$485,420	($7,566)	98.44%
September 2022	$563,441	$0	0.00%	$563,441	$562,602	$839	100.14%
October 2022	$477,060	$0	0.00%	$477,060	$478,352	($1,292)	99.72%
November 2022	$497,634	$0	0.00%	$497,634	$495,448	$2,186	100.44%
December 2022	$596,607	($16)	0.00%	$596,592	$590,158	$6,434	101.09%
January 2023	$446,566	$0	0.00%	$446,566	$440,154	$6,412	101.45%
February 2023	$512,348	($787)	-0.15%	$511,561	$500,428	$11,133	102.22%
March 2023	$655,938	$0	0.00%	$655,938	$657,518	($1,580)	99.75%
April 2023	$535,369	($11)	0.00%	$535,358	$535,758	($400)	99.92%
May 2023	$517,949	$0	0.00%	$517,949	$516,564	$1,386	100.26%
June 2023	$663,990	($562)	-0.08%	$663,428	$668,431	($5,003)	99.25%
Cumulative Totals	**$13,653,590**	**($1,547,601)**	**-11.33%**	**$12,105,988**	**$12,075,043**	**$30,945**	**100.25%**
100% Limited^ Cumulative Totals				**$12,075,043**	**$12,075,043**	**$0**	**100.00%**
					State Contract Minimum Completeness Percentage Requirement		98.00%

^ - The MTM CAN cumulative completion percentage was limited to a maximum of 100 percent by decreasing the encounter totals by the reporting period's variance in comparison to the CDJs. Please reference data analysis assumption number 9 on page 19 for further explanation.

APPENDIX A – 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.
- **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. On January 1, 2015, CHIP became a coordinated care program with UHC and Magnolia Health responsible for coordinating services until October 31, 2019. Beginning on November 1, 2019, Molina Healthcare and UHC became responsible for coordinating CHIP 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. Before October 1, 2018, two CCOs were operating in the state of Mississippi during the reconciliation period. They were Magnolia Health Plan (Magnolia Health) and UnitedHealthcare Community Plan (UHC). Effective October 1, 2018, Molina Healthcare joined the other two CCOs to provide services to enrolled members.
- **Conduent** – Previous state fiscal agent contractor, formerly known as Xerox Health Solutions. Conduent was replaced by Gainwell Technologies as the FAC for Mississippi effective October 3, 2022.
- **Fiscal Agent Contractor (FAC)** – A contractor selected to design, develop, and maintain the claims processing system, Medicaid Management Information System (MMIS); Gainwell Technologies became the FAC effective October 3, 2022.
- **Gainwell Technologies** – State fiscal agent contractor effective October 3, 2022, formerly known as DXC Technology (DXC).
- **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. There are three coordinated care organizations responsible for coordinating services for Mississippi Medicaid beneficiaries, effective October 1, 2018.
- **Mississippi Division of Medicaid (DOM)** – The division in the Office of the Governor that is responsible for administering Medicaid in Mississippi.
- **Monthly Completion Percentage** – The percentage of the monthly encounter total in relation to the CDJ monthly reported total.

- **Monthly Encounter Net Total** – The sum of the encounter submissions for a given month incorporating the Myers and Stauffer LC encounter data adjustments made to the encounter submissions stored in the FAC's encounter data warehouse.
- **Monthly Encounter Total (Adjustments)** – The sum of all Myers and Stauffer LC adjustments for a given month that were removed from the encounter submissions stored in the FAC's encounter data warehouse.
- **Monthly Encounter Total (FAC Reported)** – The sum of all encounter submissions for a given month stored in the FAC's encounter data warehouse.
- **Monthly Variance** – The difference between the monthly encounter 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 former fiscal agent contractor, Conduent, responsible for the encounter data warehouse.

APPENDIX B – ANALYSIS

Encounters from institutional, medical, and pharmacy service types were combined on like data fields. We analyzed the information reported on 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. Each cash disbursement submitted by the CCO were summarized by paid date, CCO program identifier, 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***
  - Truven submitter ID equal to '91473' or Gainwell submitter ID equal to 'TP000169'.
  - Truven MC Prov ID equal to '09253560' or Gainwell Encounter Prov ID equal to '009253560'.
  - Pay to Provider Number equal to '09253560' or first COB Payer ID equal to '09253560' for Truven pharmacy encounters only.
- ***Magnolia Health CHIP Encounters[1]***
  - Truven submitter ID equal to '93550' or Gainwell submitter ID equal to 'TP000170'
  - Truven MC Prov ID equal to '01935367' or Gainwell Encounter Prov ID equal to '001935367'.
  - Pay to Provider Number equal to '01935367' or first COB Payer ID equal to '01935367' for Truven pharmacy encounters only.
- ***Envolve Dental – Dental Services***
  - Plan TCN or Patient Account Number field contains "DH' in the first and second positions.
- ***Envolve Vision - Vision Services***
  - Plan TCN or Patient Account Number field contains 'OC' in the first and second positions.
- ***Magnolia Behavior Health– Behavioral Health Services***
  - Plan TCN field contains 'MK'.
- ***MTM – Non-emergency Transportation***
  - Plan TCN or Patient Account Number field contains 'MOM' or 'MIS' in the first through third positions
  - Plan TCN or Patient Account Number field contains 'Q0' in the first and second positions and the third position does not contain a number.
- ***Envolve Pharmacy Solutions - Pharmacy Benefit***
  - These encounters are contained in separate data warehouse tables as a result of pharmacy encounter submissions processing.
- ***Magnolia Fee-for-Service***
  - All other plan submitted encounters that do not meet the listed criteria.

1 – Magnolia's CHIP contract with the State ended on October 31, 2019, prior to the current reporting period. Any remaining CHIP encounter records have been excluded from this report.

APPENDIX C – DATA ANALYSIS ASSUMPTIONS

1. We assume that all data provided to Myers and Stauffer is complete and accurate.

2. Voided encounter records contained within the encounter submissions were coded to match the associated adjustment'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 encounter.

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

4. 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.

5. Magnolia Health CHIP contract with DOM ended on October 31, 2019, prior to the start of the current reporting period. Magnolia Health's CHIP completion percentage information will no longer be included in the reconciliation reports.

6. We noted instances of Magnolia Health encounters with missing header paid dates. The claim received dates were used to approximate the CCO paid dates when possible. However, these estimated paid dates may contribute to some monthly completion percentage variances.

7. The Envolve Pharmacy encounter and CDJ totals have been excluded from the entire plan results for this reporting period at the direction of DOM due to some paid amount issues in the encounter data extracts still being researched. This report will be finalized with updated pharmacy encounter data totals included in the entire plan results (Tables A, B, and 1; Charts 1 and 2).

8. Percentage ratios noted in this report are rounded down. The sum of the percentages may not add up to the percentage sum total (Tables A and B).

9. Cumulative completion percentages exceeding 100 percent were noted for Magnolia Health's Envolve Vision CAN and MTM CAN totals. So that the impacted amounts do not overstate the Entire Plan CAN results, we have decreased the encounter monthly reported totals by the variance between the encounter data and cash disbursement journals. Therefore, the cumulative completion percentages are decreased to a maximum of 100 percent (Tables A, 1, 5, and 7; Chart 2).

10. Opportunities for improving the encounter reconciliation process have been identified during the analysis of the encounter data and cash disbursement journals, as well as frequent interactions with the CCOs, their delegated vendors, DOM, and the FAC. While we have attempted to account for these situations, other potential data issues within the data may exist that have not yet been identified which may require use to restate prior reports or modify reconciliation processes in the future.

Appendix B: Sample Claims Completeness

Description	Medical						Dental					
	March 2022		November 2022		Total		March 2022		November 2022		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Claims Sample Data												
Claims Sample Total	740,904	$46,373,494	905,236	$31,148,861	1,646,140	$77,522,355	69,200	$3,378,667	56,487	$2,832,201	125,687	$6,210,868
Reconciling Adjustment	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
Net Claims Sample Total	***740,904***	***$46,373,494***	***905,236***	***$31,148,861***	***1,646,140***	***$77,522,355***	***69,200***	***$3,378,667***	***56,487***	***$2,832,201***	***125,687***	***$6,210,868***
Encounter Data												
Total Matched Encounters	709,487	$47,668,856	753,388	$51,482,287	1,462,875	$99,151,143	84,566	$4,122,859	58,579	$2,966,735	143,145	$7,089,594
Less Surplus Encounters	(7,114)	($65,339)	(22,124)	($2,506,605)	(29,238)	($2,571,943)	(15,427)	($747,540)	(2,092)	($122,938)	(17,519)	($870,478)
Payment Adjustments	0	($406,322)	0	($4,458,270)	0	($4,864,592)	0	$0	0	($11,596)	0	($11,596)
Net Matched Encounters	***702,373***	***$47,197,195***	***731,264***	***$44,517,413***	***1,433,637***	***$91,714,608***	***69,139***	***$3,375,319***	***56,487***	***$2,832,201***	***125,626***	***$6,207,520***
Encounter Completeness Percentage	***94.8%***	***101.8%***	***80.8%***	***142.9%***	***87.1%***	***118.3%***	***99.9%***	***99.9%***	***100.0%***	***100.0%***	***100.0%***	***99.9%***

Description	Vision						NEMT					
	March 2022		November 2022		Total		March 2022		November 2022		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Claims Sample Data												
Claims Sample Total	29,440	$1,084,846	19,286	$738,889	48,726	$1,823,735	9,909	$537,877	8,250	$451,382	18,159	$989,260
Reconciling Adjustment	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
Net Claims Sample Total	***29,440***	***$1,084,846***	***19,286***	***$738,889***	***48,726***	***$1,823,735***	***9,909***	***$537,877***	***8,250***	***$451,382***	***18,159***	***$989,260***
Encounter Data												
Total Matched Encounters	29,054	$1,097,119	19,255	$739,918	48,309	$1,837,036	9,890	$529,214	8,233	$453,410	18,123	$982,624
Less Surplus Encounters	0	$0	0	$0	0	$0	(58)	($2,814)	(70)	($3,209)	(128)	($6,023)
Payment Adjustments	0	($1,416)	0	($562)	0	($1,978)	0	$1,430	0	$0	0	$1,430
Net Matched Encounters	***29,054***	***$1,095,703***	***19,255***	***$739,355***	***48,309***	***$1,835,058***	***9,832***	***$527,830***	***8,163***	***$450,201***	***17,995***	***$978,031***
Encounter Completeness Percentage	***98.7%***	***101.0%***	***99.8%***	***100.1%***	***99.1%***	***100.6%***	***99.2%***	***98.1%***	***98.9%***	***99.7%***	***99.1%***	***98.9%***

Description	Behavioral Health						Pharmacy					
	March 2022		November 2022		Total		March 2022		November 2022		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount[1]	Count	Paid Amount
Claims Sample Data												
Claims Sample Total	102,893	$8,882,995	52,180	$6,899,439	155,073	$15,782,434	337,500	$27,261,845	1,589,704		1,927,204	$27,261,845
Reconciling Adjustment	0	$0	0	$0	0	$0	(174,790)	($8,766,380)	(817,953)	N/A	(992,743)	($8,766,380)
Net Claims Sample Total	***102,893***	***$8,882,995***	***52,180***	***$6,899,439***	***155,073***	***$15,782,434***	***162,710***	***$18,495,465***	***771,751***		***934,461***	***$18,495,465***
Encounter Data												
Total Matched Encounters	101,429	$9,037,319	51,206	$10,460,866	152,635	$19,498,185	162,096	$18,460,082	739,179		901,275	$18,460,082
Less Surplus Encounters	(35)	($42,415)	(50)	($16,636)	(85)	($59,051)	(85)	($3,345)	(524)		(609)	($3,345)
Payment Adjustments	0	($69,290)	0	($767,566)	0	($836,856)	0	$0	0	N/A	0	$0
Net Matched Encounters	***101,394***	***$8,925,614***	***51,156***	***$9,676,663***	***152,550***	***$18,602,277***	***162,011***	***$18,456,737***	***738,655***		***900,666***	***$18,456,737***
Encounter Completeness Percentage	***98.5%***	***100.5%***	***98.0%***	***140.3%***	***98.4%***	***117.9%***	***99.6%***	***99.8%***	***95.7%***		***96.4%***	***99.8%***

[1]Beginning on or about July 2022, the pharmacy paid amounts were submitted in the incorrect field/loop on the encounter data submissions (i.e., Cost Paid field, 431-DV with a qualifier in field 342-HC of '07' instead of '02'). We have reviewed the pharmacy encounter data extracts to see if this field was included in one of the other amount fields (e.g., AMT_INGRED_COST_SUB), and were unable to identify pharmacy paid amount in any other amount field. DOM informed the CCO that it did not need to correct and resubmit the encounters. As a result, we were unable to evaluate the November 2022 pharmacy encounter data health plan paid amount field.

Description	Total					
	March 2022		November 2022		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Claims Sample Data						
Claims Sample Total	1,289,846	$87,519,724	2,631,143	$42,070,772	3,920,989	$129,590,496
Reconciling Adjustment	(174,790)	($8,766,380)	(817,953)	$0	(992,743)	($8,766,380)
Net Claims Sample Total	***1,115,056***	***$78,753,344***	***1,813,190***	***$42,070,772***	***2,928,246***	***$120,824,116***
Encounter Data						
Total Matched Encounters	1,096,522	$80,915,449	1,629,840	$66,103,216	2,726,362	$147,018,665
Less Surplus Encounters	(22,719)	($861,453)	(24,860)	($2,649,388)	(47,579)	($3,510,841)
Payment Adjustments	0	($475,598)	0	($5,237,994)	0	($5,713,592)
Net Matched Encounters	***1,073,803***	***$79,578,398***	***1,604,980***	***$58,215,834***	***2,678,783***	***$137,794,232***
Encounter Completeness Percentage	***96.3%***	***101.0%***	***88.5%***	***138.4%***	***91.5%***	***114.0%***

Appendix C: Key Data Element Matching

Medical																					
Key Data Element	March 2022							November 2022							Total						
	Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
		Count	Percent	Count	Percent	Count	Percent		Count	Percent	Count	Percent	Count	Percent		Count	Percent	Count	Percent	Count	Percent
Admission Date	39,234	39,234	100.0%	0	0.0%	0	0.0%	23,052	23,052	100.0%	0	0.0%	0	0.0%	62,286	62,286	100.0%	0	0.0%	0	0.0%
Bill Type (digits 1 and 2)	259,119	259,119	100.0%	0	0.0%	0	0.0%	377,230	377,230	100.0%	0	0.0%	0	0.0%	636,349	636,349	100.0%	0	0.0%	0	0.0%
Billed Charges	709,487	699,479	98.6%	0	0.0%	10,008	1.4%	753,388	753,388	100.0%	0	0.0%	0	0.0%	1,462,875	1,452,867	99.3%	0	0.0%	10,008	0.7%
Billing Provider NPI/Number	709,487	709,487	100.0%	0	0.0%	0	0.0%	753,388	741,515	98.4%	7,047	0.9%	4,826	0.6%	1,462,875	1,451,002	99.2%	7,047	0.5%	4,826	0.3%
Date of Service	709,487	709,487	100.0%	0	0.0%	0	0.0%	753,388	753,388	100.0%	0	0.0%	0	0.0%	1,462,875	1,462,875	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	709,487	709,349	100.0%	0	0.0%	138	0.0%	753,388	753,388	100.0%	0	0.0%	0	0.0%	1,462,875	1,462,737	100.0%	0	0.0%	138	0.0%
Diagnosis Related Group (DRG)	39,234	30,994	79.0%	797	2.0%	7,443	19.0%	23,052	20,779	90.1%	641	2.8%	1,632	7.1%	62,286	51,773	83.1%	1,438	2.3%	9,075	14.6%
Former/Original Claim ICN	709,487	697,522	98.3%	0	0.0%	11,965	1.7%	753,388	727,994	96.6%	0	0.0%	25,394	3.4%	1,462,875	1,425,516	97.4%	0	0.0%	37,359	2.6%
Health Plan Paid Amount	709,487	699,276	98.6%	0	0.0%	10,211	1.4%	753,388	738,328	98.0%	0	0.0%	15,060	2.0%	1,462,875	1,437,604	98.3%	0	0.0%	25,271	1.7%
Health Plan Paid Date	709,487	694,459	97.9%	0	0.0%	15,028	2.1%	753,388	743,065	98.6%	84	0.0%	10,239	1.4%	1,462,875	1,437,524	98.3%	84	0.0%	25,267	1.7%
ICN	709,487	690,009	97.3%	0	0.0%	19,478	2.7%	753,388	504,675	67.0%	0	0.0%	248,713	33.0%	1,462,875	1,194,684	81.7%	0	0.0%	268,191	18.3%
Member ID (Medicaid)	709,487	708,683	99.9%	547	0.1%	257	0.0%	753,388	752,938	99.9%	0	0.0%	450	0.1%	1,462,875	1,461,621	99.9%	547	0.0%	707	0.0%
Place of Service	450,368	450,368	100.0%	0	0.0%	0	0.0%	376,158	376,158	100.0%	0	0.0%	0	0.0%	826,526	826,526	100.0%	0	0.0%	0	0.0%
Procedure Code	670,253	670,252	100.0%	0	0.0%	1	0.0%	730,336	730,336	100.0%	0	0.0%	0	0.0%	1,400,589	1,400,588	100.0%	0	0.0%	1	0.0%
Procedure Modifiers	670,253	670,253	100.0%	0	0.0%	0	0.0%	730,336	730,336	100.0%	0	0.0%	0	0.0%	1,400,589	1,400,589	100.0%	0	0.0%	0	0.0%
Revenue Code	259,119	259,115	100.0%	0	0.0%	4	0.0%	377,230	377,228	100.0%	0	0.0%	2	0.0%	636,349	636,343	100.0%	0	0.0%	6	0.0%
Service Provider NPI/Number	709,487	703,148	99.1%	19	0.0%	6,320	0.9%	753,388	284,358	37.7%	468,328	62.2%	702	0.1%	1,462,875	987,506	67.5%	468,347	32.0%	7,022	0.5%
Service Provider Specialty/Taxonomy	709,487	522,131	73.6%	101	0.0%	187,255	26.4%	753,388	184,221	24.5%	167,324	22.2%	401,843	53.3%	1,462,875	706,352	48.3%	167,425	11.4%	589,098	40.3%
Surgical Procedure Codes	39,234	39,173	99.8%	0	0.0%	61	0.2%	23,052	23,052	100.0%	0	0.0%	0	0.0%	62,286	62,225	99.9%	0	0.0%	61	0.1%
Total	***10,231,171***	***9,961,538***	***97.4%***	***1,464***	***0.0%***	***268,169***	***2.6%***	***10,947,714***	***9,595,429***	***87.6%***	***643,424***	***5.9%***	***708,861***	***6.5%***	***21,178,885***	***19,556,967***	***92.3%***	***644,888***	***3.0%***	***977,030***	***4.6%***

Dental																		
Key Data Element	March 2022						November 2022						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Billed Charges	84,566	100.0%	0	0.0%	0	0.0%	58,579	100.0%	0	0.0%	0	0.0%	143,145	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	82,833	98.0%	6	0.0%	1,727	2.0%	116	0.2%	16,850	28.8%	41,613	71.0%	82,949	57.9%	16,856	11.8%	43,340	30.3%
Date of Service	84,566	100.0%	0	0.0%	0	0.0%	58,579	100.0%	0	0.0%	0	0.0%	143,145	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	83,621	98.9%	N/A		945	1.1%	58,008	99.0%	N/A		571	1.0%	141,629	98.9%	N/A		1,516	1.1%
Health Plan Paid Amount	84,566	100.0%	0	0.0%	0	0.0%	58,579	100.0%	0	0.0%	0	0.0%	143,145	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	84,566	100.0%	0	0.0%	0	0.0%	58,579	100.0%	0	0.0%	0	0.0%	143,145	100.0%	0	0.0%	0	0.0%
ICN	80,372	95.0%	0	0.0%	4,194	5.0%	33,480	57.2%	0	0.0%	25,099	42.8%	113,852	79.5%	0	0.0%	29,293	20.5%
Member ID (Medicaid)	84,511	99.9%	0	0.0%	55	0.1%	58,578	100.0%	0	0.0%	1	0.0%	143,089	100.0%	0	0.0%	56	0.0%
Place of Service	84,566	100.0%	0	0.0%	0	0.0%	58,560	100.0%	0	0.0%	19	0.0%	143,126	100.0%	0	0.0%	19	0.0%
Procedure Code	84,566	100.0%	0	0.0%	0	0.0%	58,579	100.0%	0	0.0%	0	0.0%	143,145	100.0%	0	0.0%	0	0.0%
Service Provider NPI/Number	84,560	100.0%	6	0.0%	0	0.0%	41,613	71.0%	16,966	29.0%	0	0.0%	126,173	88.1%	16,972	11.9%	0	0.0%
Service Provider Specialty/Taxonomy	36,902	43.6%	4	0.0%	47,660	56.4%	23,577	40.2%	6,846	11.7%	28,156	48.1%	60,479	42.3%	6,850	4.8%	75,816	53.0%
Tooth Number	84,566	100.0%	N/A		0	0.0%	58,579	100.0%	N/A		0	0.0%	143,145	100.0%	N/A		0	0.0%
Tooth Surface	84,566	100.0%	N/A		0	0.0%	58,579	100.0%	N/A		0	0.0%	143,145	100.0%	N/A		0	0.0%
Total	***1,129,327***	***95.4%***	***16***	***0.0%***	***54,581***	***4.6%***	***683,985***	***83.4%***	***40,662***	***5.0%***	***95,459***	***11.6%***	***1,813,312***	***90.5%***	***40,678***	***2.0%***	***150,040***	***7.5%***
Total Records in the Encounter Dataset	84,566						58,579						143,145					
Number of Key Data Element Evaluated	14						14						14					
Maximum Count	1,183,924	100.0%					820,106	100.0%					2,004,030	100.0%				

Vision																		
Key Data Element	March 2022						November 2022						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Billed Charges	29,054	100.0%	0	0.0%	0	0.0%	19,255	100.0%	0	0.0%	0	0.0%	48,309	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	5,015	17.3%	0	0.0%	24,039	82.7%	19,021	98.8%	234	1.2%	0	0.0%	24,036	49.8%	234	0.5%	24,039	49.8%
Date of Service	29,054	100.0%	0	0.0%	0	0.0%	19,255	100.0%	0	0.0%	0	0.0%	48,309	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	29,041	100.0%	0	0.0%	13	0.0%	19,237	99.9%	0	0.0%	18	0.1%	48,278	99.9%	0	0.0%	31	0.1%
Former/Original Claim ICN	28,959	99.7%	N/A		95	0.3%	19,206	99.7%	N/A		49	0.3%	48,165	99.7%	N/A		144	0.3%
Health Plan Paid Amount	29,042	100.0%	0	0.0%	12	0.0%	19,247	100.0%	0	0.0%	8	0.0%	48,289	100.0%	0	0.0%	20	0.0%
Health Plan Paid Date	29,054	100.0%	0	0.0%	0	0.0%	17,625	91.5%	0	0.0%	1,630	8.5%	46,679	96.6%	0	0.0%	1,630	3.4%
ICN	28,121	96.8%	0	0.0%	933	3.2%	17,979	93.4%	0	0.0%	1,276	6.6%	46,100	95.4%	0	0.0%	2,209	4.6%
Member ID (Medicaid)	29,044	100.0%	0	0.0%	10	0.0%	19,245	99.9%	0	0.0%	10	0.1%	48,289	100.0%	0	0.0%	20	0.0%
Place of Service	29,041	100.0%	0	0.0%	13	0.0%	19,248	100.0%	0	0.0%	7	0.0%	48,289	100.0%	0	0.0%	20	0.0%
Procedure Code	29,054	100.0%	0	0.0%	0	0.0%	19,255	100.0%	0	0.0%	0	0.0%	48,309	100.0%	0	0.0%	0	0.0%
Procedure Modifiers	29,054	100.0%	N/A		0	0.0%	19,255	100.0%	N/A		0	0.0%	48,309	100.0%	N/A		0	0.0%
Service Provider NPI/Number	29,054	100.0%	0	0.0%	0	0.0%	13,331	69.2%	5,924	30.8%	0	0.0%	42,385	87.7%	5,924	12.3%	0	0.0%
Service Provider Specialty/Taxonomy	28,350	97.6%	0	0.0%	704	2.4%	13,244	68.8%	5,924	30.8%	87	0.5%	41,594	86.1%	5,924	12.3%	791	1.6%
Total	***380,937***	***93.7%***	***0***	***0.0%***	***25,819***	***6.3%***	***254,403***	***94.4%***	***12,082***	***4.5%***	***3,085***	***1.1%***	***635,340***	***93.9%***	***12,082***	***1.8%***	***28,904***	***4.3%***
Total Records in the Encounter Dataset	29,054						19,255						48,309					
Number of Key Data Element Evaluated	14						14						14					
Maximum Count	406,756	100.0%					269,570	100.0%					676,326	100.0%				

NEMT																		
Key Data Element	March 2022						November 2022						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Billed Charges	9,778	98.9%	0	0.0%	112	1.1%	8,119	98.6%	0	0.0%	114	1.4%	17,897	98.8%	0	0.0%	226	1.2%
Billing Provider NPI/Number	9,890	100.0%	0	0.0%	0	0.0%	8,233	100.0%	0	0.0%	0	0.0%	18,123	100.0%	0	0.0%	0	0.0%
Date of Service	9,890	100.0%	0	0.0%	0	0.0%	8,233	100.0%	0	0.0%	0	0.0%	18,123	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	9,890	100.0%	0	0.0%	0	0.0%	8,233	100.0%	0	0.0%	0	0.0%	18,123	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	9,874	99.8%	N/A		16	0.2%	8,232	100.0%	N/A		1	0.0%	18,106	99.9%	N/A		17	0.1%
Health Plan Paid Amount	9,766	98.7%	0	0.0%	124	1.3%	8,119	98.6%	0	0.0%	114	1.4%	17,885	98.7%	0	0.0%	238	1.3%
Health Plan Paid Date	9,853	99.6%	0	0.0%	37	0.4%	8,164	99.2%	0	0.0%	69	0.8%	18,017	99.4%	0	0.0%	106	0.6%
ICN	9,890	100.0%	0	0.0%	0	0.0%	8,233	100.0%	0	0.0%	0	0.0%	18,123	100.0%	0	0.0%	0	0.0%
Member ID (Medicaid)	9,890	100.0%	0	0.0%	0	0.0%	8,233	100.0%	0	0.0%	0	0.0%	18,123	100.0%	0	0.0%	0	0.0%
Place of Service	9,890	100.0%	0	0.0%	0	0.0%	8,233	100.0%	0	0.0%	0	0.0%	18,123	100.0%	0	0.0%	0	0.0%
Procedure Code	9,890	100.0%	0	0.0%	0	0.0%	8,233	100.0%	0	0.0%	0	0.0%	18,123	100.0%	0	0.0%	0	0.0%
Procedure Modifiers	9,890	100.0%	N/A		0	0.0%	8,233	100.0%	N/A		0	0.0%	18,123	100.0%	N/A		0	0.0%
Total	***118,391***	***99.8%***	***0***	***0.0%***	***289***	***0.2%***	***98,498***	***99.7%***	***0***	***0.0%***	***298***	***0.3%***	***216,889***	***99.7%***	***0***	***0.0%***	***587***	***0.3%***
Total Records in the Encounter Dataset	9,890						8,233						18,123					
Number of Key Data Element Evaluated	12						12						12					
Maximum Count	118,680	100.0%					98,796	100.0%					217,476	100.0%				

Behavioral Health																						
Key Data Element	March 2022							November 2022							Total							
	Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
		Count	Percent	Count	Percent	Count	Percent		Count	Percent	Count	Percent	Count	Percent		Count	Percent	Count	Percent	Count	Percent
Admission Date	1,875	1,875	100.0%	0	0.0%	0	0.0%	1,707	1,707	100.0%	0	0.0%	0	0.0%	3,582	3,582	100.0%	0	0.0%	0	0.0%
Bill Type (digits 1 and 2)	2,421	2,421	100.0%	0	0.0%	0	0.0%	2,054	2,054	100.0%	0	0.0%	0	0.0%	4,475	4,475	100.0%	0	0.0%	0	0.0%
Billed Charges	101,429	101,126	99.7%	0	0.0%	303	0.3%	51,206	51,206	100.0%	0	0.0%	0	0.0%	152,635	152,332	99.8%	0	0.0%	303	0.2%
Billing Provider NPI/Number	101,429	101,429	100.0%	0	0.0%	0	0.0%	51,206	50,713	99.0%	493	1.0%	0	0.0%	152,635	152,142	99.7%	493	0.3%	0	0.0%
Diagnosis Codes	101,429	101,429	100.0%	0	0.0%	0	0.0%	51,206	51,206	100.0%	0	0.0%	0	0.0%	152,635	152,635	100.0%	0	0.0%	0	0.0%
Date of Service	101,429	101,429	100.0%	0	0.0%	0	0.0%	51,206	51,206	100.0%	0	0.0%	0	0.0%	152,635	152,635	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	101,429	101,233	99.8%	N/A		196	0.2%	51,206	50,545	98.7%	N/A		661	1.3%	152,635	151,778	99.4%	N/A		857	0.6%
Health Plan Paid Amount	101,429	100,511	99.1%	0	0.0%	918	0.9%	51,206	50,883	99.4%	0	0.0%	323	0.6%	152,635	151,394	99.2%	0	0.0%	1,241	0.8%
Health Plan Paid Date	101,429	101,013	99.6%	0	0.0%	416	0.4%	51,206	51,114	99.8%	0	0.0%	92	0.2%	152,635	152,127	99.7%	0	0.0%	508	0.3%
ICN	101,429	100,695	99.3%	0	0.0%	734	0.7%	51,206	41,204	80.5%	0	0.0%	10,002	19.5%	152,635	141,899	93.0%	0	0.0%	10,736	7.0%
Member ID (Medicaid)	101,429	101,386	100.0%	4	0.0%	39	0.0%	51,206	51,161	99.9%	0	0.0%	45	0.1%	152,635	152,547	99.9%	4	0.0%	84	0.1%
Place of Service	99,008	99,008	100.0%	0	0.0%	0	0.0%	49,152	49,152	100.0%	0	0.0%	0	0.0%	148,160	148,160	100.0%	0	0.0%	0	0.0%
Procedure Code	99,554	99,554	100.0%	0	0.0%	0	0.0%	49,499	49,498	100.0%	0	0.0%	1	0.0%	149,053	149,052	100.0%	0	0.0%	1	0.0%
Procedure Modifiers	99,554	99,554	100.0%	N/A		0	0.0%	49,499	49,499	100.0%	N/A		0	0.0%	149,053	149,053	100.0%	N/A		0	0.0%
Revenue Code	2,421	2,421	100.0%	0	0.0%	0	0.0%	2,054	2,054	100.0%	0	0.0%	0	0.0%	4,475	4,475	100.0%	0	0.0%	0	0.0%
Service Provider NPI/Number	101,429	101,376	99.9%	1	0.0%	52	0.1%	51,206	7,197	14.1%	43,983	85.9%	26	0.1%	152,635	108,573	71.1%	43,984	28.8%	78	0.1%
Service Provider Specialty/Taxonomy	101,429	60,750	59.9%	1	0.0%	40,678	40.1%	51,206	3,343	6.5%	43,039	84.1%	4,824	9.4%	152,635	64,093	42.0%	43,040	28.2%	45,502	29.8%
Surgical Procedure Codes	1,875	1,875	100.0%	0	0.0%	0	0.0%	1,707	1,707	100.0%	0	0.0%	0	0.0%	3,582	3,582	100.0%	0	0.0%	0	0.0%
Total	***1,422,427***	***1,379,085***	***97.0%***	***6***	***0.0%***	***43,336***	***3.0%***	***718,938***	***615,449***	***85.6%***	***87,515***	***12.2%***	***15,974***	***2.2%***	***2,141,365***	***1,994,534***	***93.1%***	***87,521***	***4.1%***	***59,310***	***2.8%***

Pharmacy																				
Key Data Element	March 2022							November 2022							Total					
	Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
		Count	Percent	Count	Percent	Count	Percent		Count	Percent	Count	Percent	Count	Percent		Count	Percent	Count	Percent	Count	Percent
Billed Charges	162,096	162,096	100.0%	0	0.0%	0	0.0%	739,179	739,179	100.0%	0	0.0%	0	0.0%	901,275	901,275	100.0%	0	0.0%	0	0.0%
Date of Service	162,096	162,096	100.0%	0	0.0%	0	0.0%	739,179	739,179	100.0%	0	0.0%	0	0.0%	901,275	901,275	100.0%	0	0.0%	0	0.0%
Days Supply	162,096	162,096	100.0%	0	0.0%	0	0.0%	739,179	739,179	100.0%	0	0.0%	0	0.0%	901,275	901,275	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	162,096	161,000	99.3%	N/A		1,096	0.7%	739,179	739,179	100.0%	N/A		0	0.0%	901,275	900,179	99.9%	N/A		1,096	0.1%
Health Plan Paid Amount[1]	162,096	162,096	100.0%	0	0.0%	0	0.0%	N/A			N/A		N/A		162,096	162,096	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	162,096	162,096	100.0%	0	0.0%	0	0.0%	739,179	0	0.0%	0	0.0%	739,179	100.0%	901,275	162,096	18.0%	0	0.0%	739,179	82.0%
ICN	162,096	162,096	100.0%	0	0.0%	0	0.0%	739,179	0	0.0%	0	0.0%	739,179	100.0%	901,275	162,096	18.0%	0	0.0%	739,179	82.0%
Member ID (Medicaid)	162,096	162,005	99.9%	0	0.0%	91	0.1%	739,179	739,039	100.0%	0	0.0%	140	0.0%	901,275	901,044	100.0%	0	0.0%	231	0.0%
National Drug Code (NDC)	162,096	161,972	99.9%	0	0.0%	124	0.1%	739,179	738,393	99.9%	0	0.0%	786	0.1%	901,275	900,365	99.9%	0	0.0%	910	0.1%
Prescribing Provider NPI	162,096	162,096	100.0%	0	0.0%	0	0.0%	739,179	725,460	98.1%	0	0.0%	13,719	1.9%	901,275	887,556	98.5%	0	0.0%	13,719	1.5%
Prescription Number	162,096	162,027	100.0%	0	0.0%	69	0.0%	739,179	739,085	100.0%	0	0.0%	94	0.0%	901,275	901,112	100.0%	0	0.0%	163	0.0%
Quantity Dispensed	162,096	160,944	99.3%	1,142	0.7%	10	0.0%	739,179	739,114	100.0%	0	0.0%	65	0.0%	901,275	900,058	99.9%	1,142	0.1%	75	0.0%
Refill Number	162,096	162,096	100.0%	0	0.0%	0	0.0%	739,179	739,179	100.0%	0	0.0%	0	0.0%	901,275	901,275	100.0%	0	0.0%	0	0.0%
Total	***2,107,248***	***2,104,716***	***99.9%***	***1,142***	***0.1%***	***1,390***	***0.1%***	***8,870,148***	***7,376,986***	***83.2%***	***0***	***0.0%***	***1,493,162***	***16.8%***	***10,977,396***	***9,481,702***	***86.4%***	***1,142***	***0.0%***	***1,494,552***	***13.6%***

[1]Beginning on or about July 2022, the pharmacy paid amounts were submitted in the incorrect field/loop on the encounter data submissions (i.e., Cost Paid field, 431-DV with a qualifier in field 342-HC of '07' instead of '02'). We have reviewed the pharmacy encounter data extracts to see if this field was included in one of the other amount fields (e.g., AMT_INGRED_COST_SUB), and were unable to identify pharmacy paid amount in any other amount field. DOM informed the CCO that it did not need to correct and resubmit the encounters. As a result, we were unable to evaluate the November 2022 pharmacy encounter data health plan paid amount field.

Total																					
Key Data Element	March 2022							November 2022							Total						
	Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Encounters Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
		Count	Percent	Count	Percent	Count	Percent		Count	Percent	Count	Percent	Count	Percent		Count	Percent	Count	Percent	Count	Percent
Admission Date	41,109	41,109	100.0%	0	0.0%	0	0.0%	24,759	24,759	100.0%	0	0.0%	0	0.0%	65,868	65,868	100.0%	0	0.0%	0	0.0%
Bill Type (digits 1 and 2)	261,540	261,540	100.0%	0	0.0%	0	0.0%	379,284	379,284	100.0%	0	0.0%	0	0.0%	640,824	640,824	100.0%	0	0.0%	0	0.0%
Billed Charges	1,096,522	1,086,099	99.0%	0	0.0%	10,423	1.0%	1,629,840	1,629,726	100.0%	0	0.0%	114	0.0%	2,726,362	2,715,825	99.6%	0	0.0%	10,537	0.4%
Billing Provider NPI/Number	934,426	908,654	97.2%	6	0.0%	25,766	2.8%	890,661	819,598	92.0%	24,624	2.8%	46,439	5.2%	1,825,087	1,728,252	94.7%	24,630	1.3%	72,205	4.0%
Date of Service	1,096,522	1,096,522	100.0%	0	0.0%	0	0.0%	1,629,840	1,629,840	100.0%	0	0.0%	0	0.0%	2,726,362	2,726,362	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	849,860	849,709	100.0%	0	0.0%	151	0.0%	832,082	832,064	100.0%	0	0.0%	18	0.0%	1,681,942	1,681,773	100.0%	0	0.0%	169	0.0%
Diagnosis Related Group (DRG)	39,234	30,994	79.0%	797	2.0%	7,443	19.0%	23,052	20,779	90.1%	641	2.8%	1,632	7.1%	62,286	51,773	83.1%	1,438	2.3%	9,075	14.6%
Former/Original Claim ICN	1,096,522	1,082,209	98.7%	0	0.0%	14,313	1.3%	1,629,840	1,603,164	98.4%	0	0.0%	26,676	1.6%	2,726,362	2,685,373	98.5%	0	0.0%	40,989	1.5%
Health Plan Paid Amount	1,096,522	1,085,257	99.0%	0	0.0%	11,265	1.0%	890,661	875,156	98.3%	0	0.0%	15,505	1.7%	1,987,183	1,960,413	98.7%	0	0.0%	26,770	1.3%
Health Plan Paid Date	1,096,522	1,081,041	98.6%	0	0.0%	15,481	1.4%	1,629,840	878,547	53.9%	84	0.0%	751,209	46.1%	2,726,362	1,959,588	71.9%	84	0.0%	766,690	28.1%
ICN	1,096,522	1,071,183	97.7%	0	0.0%	25,339	2.3%	1,629,840	605,571	37.2%	0	0.0%	1,024,269	62.8%	2,726,362	1,676,754	61.5%	0	0.0%	1,049,608	38.5%
Member ID (Medicaid)	1,096,522	1,095,519	99.9%	551	0.1%	452	0.0%	1,629,840	1,629,194	100.0%	0	0.0%	646	0.0%	2,726,362	2,724,713	99.9%	551	0.0%	1,098	0.0%
Place of Service	672,886	672,873	100.0%	0	0.0%	13	0.0%	511,377	511,351	100.0%	0	0.0%	26	0.0%	1,184,263	1,184,224	100.0%	0	0.0%	39	0.0%
Procedure Code	893,317	893,316	100.0%	0	0.0%	1	0.0%	865,902	865,901	100.0%	0	0.0%	1	0.0%	1,759,219	1,759,217	100.0%	0	0.0%	2	0.0%
Procedure Modifiers	808,751	808,751	100.0%	0	0.0%	0	0.0%	807,323	807,323	100.0%	0	0.0%	0	0.0%	1,616,074	1,616,074	100.0%	0	0.0%	0	0.0%
Revenue Code	261,540	261,536	100.0%	0	0.0%	4	0.0%	379,284	379,282	100.0%	0	0.0%	2	0.0%	640,824	640,818	100.0%	0	0.0%	6	0.0%
Service Provider NPI/Number	924,536	918,138	99.3%	26	0.0%	6,372	0.7%	882,428	346,499	39.3%	535,201	60.7%	728	0.1%	1,806,964	1,264,637	70.0%	535,227	29.6%	16,990	0.9%
Service Provider Specialty/Taxonomy	924,536	648,133	70.1%	106	0.0%	276,297	29.9%	882,428	224,385	25.4%	223,133	25.3%	434,910	49.3%	1,806,964	872,518	48.3%	223,239	12.4%	721,097	39.9%
Surgical Procedure Codes	41,109	41,048	99.9%	0	0.0%	61	0.1%	24,759	24,759	100.0%	0	0.0%	0	0.0%	65,868	65,807	99.9%	0	0.0%	61	0.1%
Tooth Number	84,566	84,566	100.0%	0	0.0%	0	0.0%	58,579	58,579	100.0%	0	0.0%	0	0.0%	143,145	143,145	100.0%	0	0.0%	0	0.0%
Tooth Surface	84,566	84,566	100.0%	0	0.0%	0	0.0%	58,579	58,579	100.0%	0	0.0%	0	0.0%	143,145	143,145	100.0%	0	0.0%	0	0.0%
Days Supply	162,096	162,096	100.0%	0	0.0%	0	0.0%	739,179	739,179	100.0%	0	0.0%	0	0.0%	901,275	901,275	100.0%	0	0.0%	0	0.0%
National Drug Code (NDC)	162,096	161,972	99.9%	0	0.0%	124	0.1%	739,179	738,393	99.9%	0	0.0%	786	0.1%	901,275	900,365	99.9%	0	0.0%	910	0.1%
Prescribing Provider NPI	162,096	162,096	100.0%	0	0.0%	0	0.0%	739,179	725,460	98.1%	0	0.0%	13,719	1.9%	901,275	887,556	98.5%	0	0.0%	13,719	1.5%
Prescription Number	162,096	162,027	100.0%	0	0.0%	69	0.0%	739,179	739,085	100.0%	0	0.0%	94	0.0%	901,275	901,112	100.0%	0	0.0%	163	0.0%
Quantity Dispensed	162,096	160,944	99.3%	1,142	0.7%	10	0.0%	739,179	739,114	100.0%	0	0.0%	65	0.0%	901,275	900,058	99.9%	1,142	0.1%	75	0.0%
Refill Number	162,096	162,096	100.0%	0	0.0%	0	0.0%	739,179	739,179	100.0%	0	0.0%	0	0.0%	901,275	901,275	100.0%	0	0.0%	0	0.0%
Total	***15,470,206***	***15,073,994***	***97.4%***	***2,628***	***0.0%***	***393,584***	***2.5%***	***21,725,272***	***18,624,750***	***85.7%***	***783,683***	***3.6%***	***2,316,839***	***10.7%***	***37,195,478***	***33,698,744***	***90.6%***	***786,311***	***2.1%***	***2,730,203***	***7.3%***

Appendix D: Per Member Utilization and Paid Amounts

CY 2022										
Description	**Mississippi CAN**				**MHP CAN**				**Percentage of Mississippi CAN**	
Members										
Total member Months	4,526,034				1,846,852				40.8%	
Average Number of Members[1]	377,170				153,904					
		PMPY [2]	***Paid***	***PMPY*** [2]		***PMPY*** [2]	***Paid***	***PMPY*** [2]	**Percentage Variance**	
Service Type	***Count***	**Count**	***Amount***	**Amount**	***Count***	**Count**	***Amount***	**Amount**	**Count**	**Amount**
Ancillary	2,141,445	5.7	$140,534,243	$373	957,177	6.2	$62,063,501	$403	8.8%	8.0%
Behavioral Health	1,115,089	3.0	$145,009,170	$384	569,340	3.7	$83,236,012	$541	23.3%	40.9%
Dental	1,660,698	4.4	$83,341,349	$221	701,407	4.6	$35,575,648	$231	4.5%	4.5%
Inpatient	1,144,643	3.0	$389,184,722	$1,032	427,166	2.8	$145,487,860	$945	-6.7%	-8.4%
Outpatient	4,160,524	11.0	$307,926,742	$816	1,800,687	11.7	$131,574,432	$855	6.4%	4.8%
Primary Care	5,137,258	13.6	$221,931,374	$588	2,161,942	14.0	$92,193,088	$599	2.9%	1.9%
Specialty	1,198,150	3.2	$63,935,069	$170	441,454	2.9	$21,855,781	$142	-9.4%	-16.5%
Vision	545,910	1.4	$18,791,282	$50	256,844	1.7	$10,055,348	$65	21.4%	30.0%
NEMT	171,335	0.5	$11,365,783	$30	56,610	0.4	$5,901,141	$38	-20.0%	26.7%
Pharmacy	5,437,589	14.4	$336,277,580	$892	2,266,569	14.7	$89,228,024	$580	2.1%	-35.0%
Telehealth[3]	154,448	0.4	$11,987,925	$32	75,051	0.5	$5,780,402	$38	25.0%	18.8%
Total Services [4]	***22,867,089***	***60.6***	***$1,730,285,238***	***$4,588***	***9,714,247***	***63.2***	***$682,951,237***	***$4,437***	***4.3%***	***-3.3%***

[1] Total member months divided by the number of months in the measurement period.

[2] Per member per year counts and/or paid amount divided by the average number of members.

[3] Includes behavioral health telehealth visits.

[4] Differences are due to rounding.

Appendix E: Timely Payment of Claims

CAN CY 2022													
Encounter Type	30 Days		60 Days			90 Days			Over 90 Days			Total Count	Average Days
		Percentage		Percentage			Percentage			Percentage			
	Count	Absolute	Count	Absolute	Cumulative	Count	Absolute	Cumulative	Count	Absolute	Cumulative		
Medical	2,126,923	98.3%	19,280	0.9%	99.1%	5,306	0.2%	99.4%	13,178	0.6%	100.0%	2,164,687	10
Behavioral Health	463,729	99.0%	4,056	0.9%	99.9%	142	0.0%	99.9%	393	0.1%	100.0%	468,320	8
Dental	117,687	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	117,687	5
NEMT	50,504	89.1%	4,117	7.3%	96.3%	1,606	2.8%	99.1%	486	0.9%	100.0%	56,713	17
Vision	72,986	100.0%	10	0.0%	100.0%	1	0.0%	100.0%	0	0.0%	100.0%	72,997	10
Pharmacy	1,944,931	73.1%	3,547	0.1%	73.2%	939	0.0%	73.3%	711,484	26.7%	100.0%	2,660,901	60
Total	***4,776,760***	***86.2%***	***31,010***	***0.6%***	***86.8%***	***7,994***	***0.1%***	***86.9%***	***725,541***	***13.1%***	***100.0%***	***5,541,305***	***33***

Appendix F: Timely Encounter Submissions

CAN CY 2022																
Encounter Type	30 Days		60 Days			90 Days			120 Days			Over 120 Days			Total Count	Average Days
		Percentage		Percentage			Percentage			Percentage			Percentage			
	Count	Absolute	Count	Absolute	Cumulative	Count	Absolute	Cumulative	Count	Absolute	Cumulative	Count	Absolute	Cumulative		
Medical	1,958,146	90.5%	108,670	5.0%	95.5%	59,491	2.7%	98.2%	28,534	1.3%	99.5%	9,846	0.5%	100.0%	2,164,687	32
Behavioral Health	423,336	90.4%	38,067	8.1%	98.5%	54	0.0%	98.5%	11	0.0%	98.5%	6,852	1.5%	100.0%	468,320	19
Dental	66,356	56.4%	31,349	26.6%	83.0%	8,758	7.4%	90.5%	3,177	2.7%	93.2%	8,047	6.8%	100.0%	117,687	44
NEMT	15,366	27.1%	13,953	24.6%	51.7%	6,848	12.1%	63.8%	5,757	10.2%	73.9%	14,789	26.1%	100.0%	56,713	78
Vision	53,526	73.3%	6	0.0%	73.3%	44	0.1%	73.4%	251	0.3%	73.7%	19,170	26.3%	100.0%	72,997	71
Pharmacy	774,684	29.1%	257,135	9.7%	38.8%	256	0.0%	38.8%	643	0.0%	38.8%	1,628,183	61.2%	100.0%	2,660,901	141
Total	***3,291,414***	***59.4%***	***449,180***	***8.1%***	***67.5%***	***75,451***	***1.4%***	***68.9%***	***38,373***	***0.7%***	***69.6%***	***1,686,887***	***30.4%***	***100.0%***	***5,541,305***	***46***

Appendix G: Medical Records Validity Rate

	Medical					Dental					Vision				
		Supported Elements		Unsupported Elements			Supported Elements		Unsupported Elements			Supported Elements		Unsupported Elements	
Key Data Element	Total Elements Sampled	Count	Percent	Count	Percent	Total Elements Sampled	Count	Percent	Count	Percent	Total Elements Sampled	Count	Percent	Count	Percent
Member Name	47	47	100.0%	0	0.0%	7	7	100.0%	0	0.0%	2	2	100.0%	0	0.0%
Member DOB	47	45	95.7%	2	4.3%	7	1	14.3%	6	85.7%	2	2	100.0%	0	0.0%
Admit Date	0	0	0.0%	0	0.0%	N/A					N/A				
Date of Service	47	46	97.9%	1	2.1%	7	7	100.0%	0	0.0%	2	2	100.0%	0	0.0%
Billing Provider	47	47	100.0%	0	0.0%	7	5	71.4%	2	28.6%	2	2	100.0%	0	0.0%
Type of Bill Code	7	7	100.0%	0	0.0%	N/A					N/A				
Revenue Code	33	33	100.0%	0	0.0%	N/A					N/A				
Procedure Code	114	111	97.4%	3	2.6%	26	26	100.0%	0	0.0%	6	4	66.7%	2	33.3%
Procedure Modifiers	41	39	95.1%	2	4.9%	N/A					0	0	0.0%	0	0.0%
Tooth Number	N/A					0	0	0.0%	0	0.0%	N/A				
Tooth Surface	N/A					0	0	0.0%	0	0.0%	N/A				
Diagnosis Codes	122	119	97.5%	3	2.5%	N/A					2	2	100.0%	0	0.0%
Servicing Provider	41	40	97.6%	1	2.4%	7	6	85.7%	1	14.3%	2	2	100.0%	0	0.0%
Surgical Procedure Codes	0	0	0.0%	0	0.0%	N/A					N/A				
Total	***546***	***534***	***97.8%***	***12***	***2.2%***	***61***	***52***	***85.2%***	***9***	***14.8%***	***18***	***16***	***88.9%***	***2***	***11.1%***

Note: 104 of the 120 medical records requested were tested.

	Pharmacy					Behavioral Health					Total				
		Supported Elements		Unsupported Elements			Supported Elements		Unsupported Elements			Supported Elements		Unsupported Elements	
Key Data Element	Total Elements Sampled	Count	Percent	Count	Percent	Total Elements Sampled	Count	Percent	Count	Percent	Total Elements Sampled	Count	Percent	Count	Percent
Member Name	34	34	100.0%	0	0.0%	14	14	100.0%	0	0.0%	104	104	100.0%	0	0.0%
Member DOB	34	34	100.0%	0	0.0%	14	13	92.9%	1	7.1%	104	95	91.3%	9	8.7%
Admit Date			N/A					N/A			0	0	0.0%	0	0.0%
Date of Service	34	34	100.0%	0	0.0%	14	14	100.0%	0	0.0%	104	103	99.0%	1	1.0%
Billing Provider	34	34	100.0%	0	0.0%	14	14	100.0%	0	0.0%	104	102	98.1%	2	1.9%
Type of Bill Code			N/A					N/A			7	7	100.0%	0	0.0%
Revenue Code			N/A					N/A			33	33	100.0%	0	0.0%
Procedure Code			N/A			14	14	100.0%	0	0.0%	160	155	96.9%	5	3.1%
Procedure Modifiers			N/A			23	21	91.3%	2	8.7%	64	60	93.8%	4	6.3%
Tooth Number			N/A					N/A			0	0	0.0%	0	0.0%
Tooth Surface			N/A					N/A			0	0	0.0%	0	0.0%
Diagnosis Codes			N/A			21	19	90.5%	2	9.5%	145	140	96.6%	5	3.4%
Servicing Provider			N/A			8	8	100.0%	0	0.0%	58	56	96.6%	2	3.4%
Surgical Procedure Codes			N/A					N/A			0	0	0.0%	0	0.0%
Date Prescribed	34	33	97.1%	1	2.9%			N/A			34	33	97.1%	1	2.9%
Prescription Number	34	34	100.0%	0	0.0%			N/A			34	34	100.0%	0	0.0%
National Drug Code (NDC)	34	33	97.1%	1	2.9%			N/A			34	33	97.1%	1	2.9%
Quantity Dispensed	34	32	94.1%	2	5.9%			N/A			34	32	94.1%	2	5.9%
Days Supply	34	32	94.1%	2	5.9%			N/A			34	32	94.1%	2	5.9%
Prescribing Provider	34	33	97.1%	1	2.9%			N/A			34	33	97.1%	1	2.9%
Total	***340***	***333***	***97.9%***	***7***	***2.1%***	***122***	***117***	***95.9%***	***5***	***4.1%***	***1,087***	***1,052***	***96.8%***	***35***	***3.2%***

Note: 104 of the 120 medical records requested were tested.

Appendix H: CCO's Responses to Report Findings

1020 Highland Colony Parkway
Suite 502
Ridgeland, MS 39157

April 5, 2024

Dear Mr. Buchser:

Please see below a summary of answers related to the MS External Quality Review (EQR) Validation of Encounter Data Submission of Findings report.

List of Findings with answers provided:

- ***1-A*** *Pharmacy paid amounts submitted in incorrect field.*
  - **Pharmacy:** DOM instructed Magnolia not to resubmit these encounters to correct this issue. DOM's email with this directive is provided. In light of this directive, Magnolia requests that this finding be removed.

- ***3-A Completeness – CDJs- Pharmacy***
  - **Pharmacy:** Based on review the discrepancies for May through July 2022 appears related to how adjustments are reported in the EQR study. In the EQR report, the voids related to adjustments are reported in the month the void occurred, whereas in the Bi-monthly M&S reconciliation report the void is reported in the month of the original payment. There was a large adjustment project completed in October/November 2022 which impacted reporting for previous months due to this discrepancy in how voids are allocated in the reports.

- ***3-B Completeness - Sample Claim Count****. Count of claims from claims report exceeds count of encounters processed. Medical (87.1%) and Pharmacy (96.4%) "Counts" below threshold.*
  - **Medical:** Internal analysis could not replicate the low percentage based on claim count. Based on internal review we matched 98.59% of encounters to a submission file for Medical. This data can be provided for further review if needed.
  - **Pharmacy** -The discrepancy for November 2022 is related to the Adjustment project referenced above. There were a large number of rejects related to that adjustment project due to changes in encounter format and updated member information between the time when the original encounter was submitted & accepted and when the adjusted encounter was submitted.

- ***3-C Completeness - Sample Claim Paid Amount****. Dollars submitted in encounters exceed dollars submitted in claim report. Medical, vision and CBH completion percentages exceeded 100%*
  - **Medical/CBH:** Based on internal review completeness was near 100% and Magnolia could not replicate the 117%/118% on page 17. Based on review of table on page 20, November 2022 appears to be the outlier month but there appears to be a discrepancy compared to table on page 10 for the same month showing near 100% instead of the 117/118%. Based on explanation from M&S provided on 3/29 the increased

percentage is based on timing of the pull, encounter voids/adjustments at a later are suspected to correct the issue based on current data.

- ***3-D Accuracy - Former/Original Claim ICN- Medical - sample claim data and encounter data mismatch.***

  - **All:** Based on internal review the issue could be related to the FI transfer from Conduent to Gainwell where the last two digits of the ICN were converted to 0's. This was a known issue during the FI conversion.

- ***3-E Accuracy - MMIS ICN.***

  - **Medical, Dental, CBH, Pharmacy, and Vision:** Based on internal review the issue could be related to the FI transfer from Conduent to Gainwell where the last two digits of the ICN were converted to 0's. This was a known issue during the FI conversion.

- ***3-F Accuracy - DRG***

  - Based on review the encounter data for DRG is accurate, the extract for the audit had some difference due to source table internally. For future claim extracts the claim extract source will be updated to match encounter source.

- ***3-G Accuracy - Paid Date***

  - **Vision**: There was a known issue with vision encounter sent with received date in paid date loop on encounter. This issue was fixed in 2023.

  - **Pharmacy:** PBM is not able to identify the cause of the discrepancy for the Paid Date and ICN. We have confirmed that both of those values are submitted by RxA in fields 443-E8 (Date CCO paid claim) and 993-A7 (MCO ICN)

- ***3-H Accuracy - Paid Amount***

  - **Pharmacy:** Based on latest discussions with DOM the current suggestion is to not resubmit these encounters to correct this issue.

- **3-I Accuracy - Billing NPI**

  - **Dental/Vision** -Magnolia compared extract examples to 837 encounter files and the billing NPI's are matching. Based on explanation provided by M&S on 3/29 *"dental NPI finding, we did not include any examples in the file because all of the November 2022 Billing Provider NPI fields are null (blank)."* Their recommendation is to work with Gainwell.

- **3-I Accuracy - Service Provider NPI/Taxonomy**

- **Medical, CBH** -Specific Examples provided by M&S on 3/29 indicate that the encounter submission is accurate, and the data extract was including the Billing NPI as the rendering NPI when it was blank. This logic can be removed for future claim data extracts to ensure matches.

- **3-J Timely Payment of Claims**

- **Pharmacy:** Based on review this is related to the large claims reprocessing in October/November 2022 regarding to the pricing freeze.

- **3-K Timely Encounter Submissions**

  Pharmacy: Due to previous upfront submission file failures it was agreed upon by DOM, Gainwell, and Magnolia to perform a bulk submission of any outstanding encounter records.
- **Vision:** There was a known issue with vision encounters submitted with received date in paid date loop on the 837 encounters. This issue was fixed in 2023.
- **NEMT:** Based on review the Conduent to Gainwell transition adversely affected our NEMT encounters submissions for a longer period effecting a greater volume of encounters related to timeliness.

Appendix I: Myers and Stauffer Response to CCO's Responses in Appendix H

Below is Myers and Stauffer's response to comments from the CCO on the findings in the MS External Quality Review (EQR) Validation of Encounter Data Submission of Findings report.

List of Findings with Myers and Stauffer's follow-up response to the CCO's response:

1-A Pharmacy paid amounts submitted in incorrect field.

The CCO is requesting this finding be removed because DOM instructed Magnolia not to resubmit these encounters; however, the EQR protocol five validation procedures includes not only the review of the CCO's processes, but also looks at state requirements and direction provided. Therefore, we concede that Magnolia was following DOM's directions, but will leave this as a finding in the report, as DOM may wish to consider the impact of not resubmitting the encounters and decide to update their directive at a later date.

3-A Completeness – CDJs- Pharmacy

There is no difference between the methodology of the CDJ analysis in the EQR protocol five and the bi-monthly encounter study as indicated in the CCO's response, as we utilized the results of the bi-monthly report in the Protocol five CDJ results. The CDJ results included in the EQR protocol five analysis were taken from the bi-monthly encounter study included in Appendix A. This was the October reconciliation report which included encounter data received and processed by the FAC and transmitted to Myers and Stauffer through September 29, 2023. We used this version of bi-monthly report as it aligned with the data set used throughout the EQR protocol five analysis. However, we acknowledge that there was a subsequent updated bi-monthly report issued that corrected an issue noted during the transition to Gainwell and the completeness percentage was re-evaluated in this revised bi-monthly report that utilized more current encounter data. Due to the time required to complete the Protocol five analysis, it is completed as of a specific point in time, while the ongoing bi-monthly analysis is to be utilized as a continuous method to monitor the completion of the encounters.

3-B Completeness – Sample Claim Count

Medical-We reviewed the CCO's response and the additional documentation provided by the CCO. We noted one main difference and two smaller ones in the calculation methodology utilized for this analysis, thereby causing the discrepancies between the CCO's calculation and our results, as reported. The main difference is the CCO's calculation was completed at the claims level, while our analysis was completed at the claim detail or line level. Therefore, the CCO is showing claims as received by the FAC regardless of whether all of the lines are present in the encounters. This results in the lower completion percentage included in the report, as there are claims where some lines were not accepted. The first of the two smaller differences is related to the CCO's inclusion of behavioral health claims within their calculation, while we separately reported the behavioral health claims, which had a higher completion percentage. The second smaller difference was attributable to claims within the sample claims data that

the CCO shows as accepted, while the encounter data utilized was received prior to the sample months' claims data. No adjustment is necessary to the reported completion percentages based on our review of the CCO's response and additional documentation.

Pharmacy - The claims count method for assessing completeness takes into account whether denied and paid claims are being submitted to the FAC, while the CDJ analysis primarily focuses on the amounts paid per the submitted encounters. The claims count EQR protocol 5 analysis is performed to determine whether the FAC has a complete denied and paid encounter population (inclusive of all encounter submission iterations). Since these two completion analyses are independent of one another, non-submitted denied claims can materially impact the claims count completion percentages, while these missing denied (zero dollar paid) claims would have no impact on the CDJ payment completion analysis.

3-C Completeness – Sample Claim Paid Amount

Based on the data that was submitted at the time of the request, the completeness percentages are reported accurately within the report.

3-D Accuracy – Former/Original Claim ICN- Medical

The CCO indicated the root cause of the issue in the response. We would recommend the CCO continue to work with the FI and DOM to resolve the issue moving forward.

3-E Accuracy – MMIS ICN

The CCO indicated the root cause of the issue in the response. We would recommend the CCO continue to work with the FI and DOM to resolve the issue moving forward.

3-F Accuracy – DRG

We acknowledge the CCO's response and agree with the CCO's approach moving forward.

3-G Accuracy – Paid Date

- **Vision-** We acknowledge the CCO's response and believe the finding is accurate based on the data that was submitted at the time of the request
- **Pharmacy**- We acknowledge the CCO's response. There is no update necessary based on the response provided.

3-H Accuracy – Paid Amount

We acknowledge the CCO's response. There is no update necessary based on the response provided.

3-I Accuracy – Billing NPI

We acknowledge the CCO's response. The root cause of the issue is currently unknown. It may be that data being submitted by the CCO in the 837 encounter file for the billing NPI value on their dental and vision encounters is not being successfully ingested into the MMIS or being stored by the FAC. The issue may also lie with the outbound files produced by the FAC and provided to us. We recommend that the

CCO work with the FAC to ensure the billing provider information is properly represented within the MMIS.

3-I Accuracy – Service Provider NPI/Taxonomy

We agree with the CCO's suggested correction for future claim data extracts to remove the logic of including the billing provider as the rendering provider when the rendering provider is null.

3-J Timeliness – Claims Payment

We acknowledge the CCO's response as to the root cause of the errors.

3-K **Timeliness – Encounter Submissions**

We acknowledge the CCO's response as to the root cause of the errors for Pharmacy, Vison, and NEMT encounters.