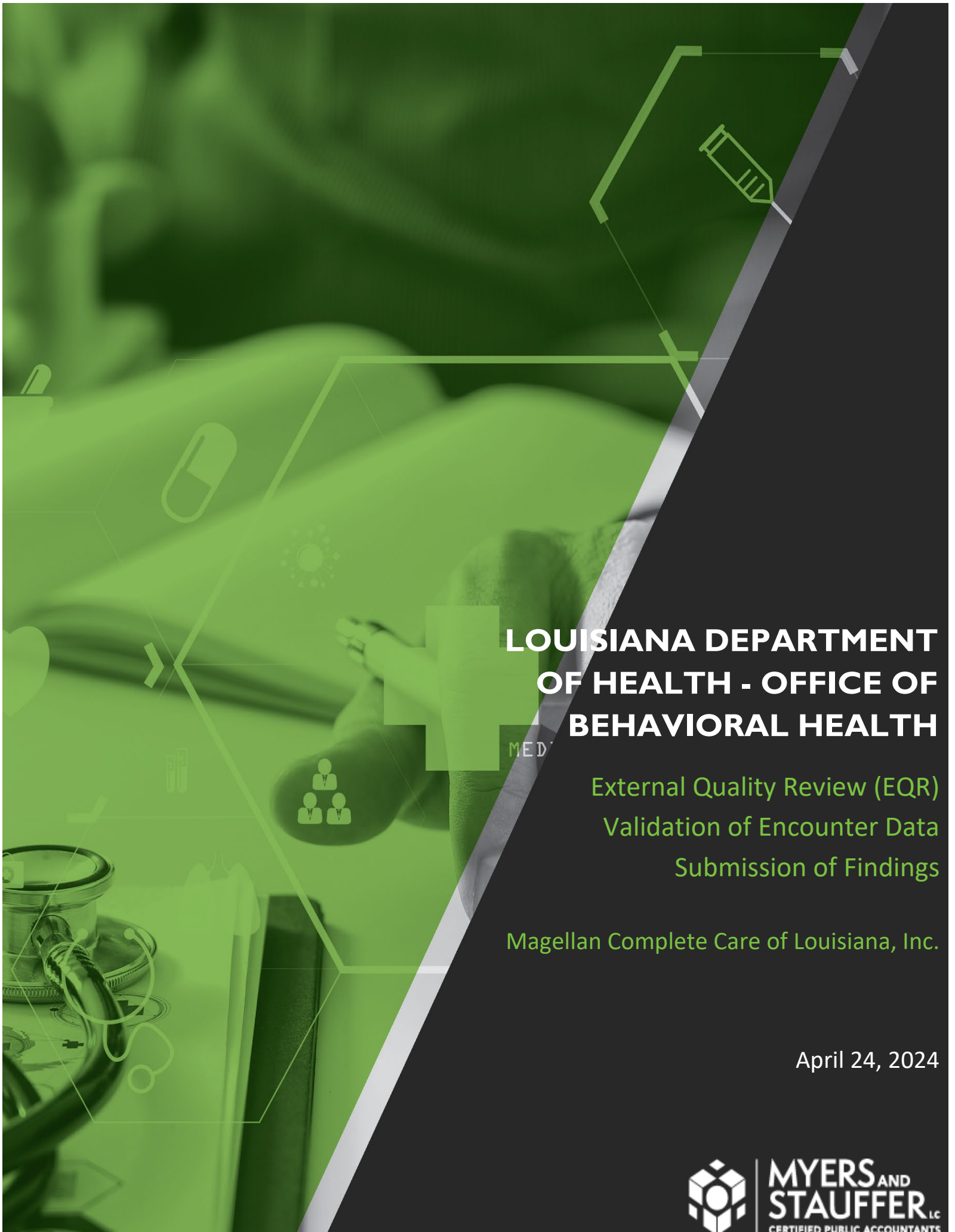


LOUISIANA DEPARTMENT OF HEALTH - OFFICE OF BEHAVIORAL HEALTH

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

Magellan Complete Care of Louisiana, Inc.

April 24, 2024

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

- Executive Summary 3
- Introduction 5
- Activity 1: Review State Requirements 7
- Activity 2: Review Health Plan Capability 8
- Activity 3: Analyze Electronic Encounter Data 9
  - Completeness 9
  - Accuracy 11
  - Findings and Recommendations 12
  - Statistics and Distributions 13
  - Findings and Recommendations 15
- Activity 4: Review of Medical Records 16
  - Validation 16
  - Findings and Recommendations 17
- Activity 5: Submission of Findings 18
- Glossary 20
- Appendices

Executive Summary

The Louisiana Department of Health - Office of Behavioral Health (LDH-OBH) engaged Myers and Stauffer to perform External Quality Review (EQR) Protocol 5 to evaluate the completeness and accuracy of the encounter data submitted by Magellan Complete Care of Louisiana, Inc. (Magellan or MHS) for members enrolled in the State's Coordinated System of Care (CSoC) program. MHS's calendar year (CY) 2022 encounters were reviewed to determine if the encounters met the State's contract requirements for completeness, accuracy, prompt payment and encounter submission timeliness.

The health plan-submitted data and encounters evaluated included the following:

- Monthly cash disbursement journals (CDJ), which include payment dates and amounts paid by the health plan to providers (i.e., the bi-monthly Encounter Data Validation Report).
- Sample claims data which included transactions with payment/adjudication dates within two selected sample months, March 2022 and September 2022.
- Encounter data provided by the fiscal agent contractor (FAC), on a monthly basis, in a standardized data extract and included encounters received and processed by the FAC and transmitted to Myers and Stauffer through January 30, 2024.
- Medical records were randomly sampled from encounters with dates of service during the measurement period. A sample size of 100 medical records was approved by LDH-OBH for review.

A 95 percent completeness, accuracy, and validity threshold was used for comparing the encounters to the CDJs, sample claims data and medical records submitted by the health plan.

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

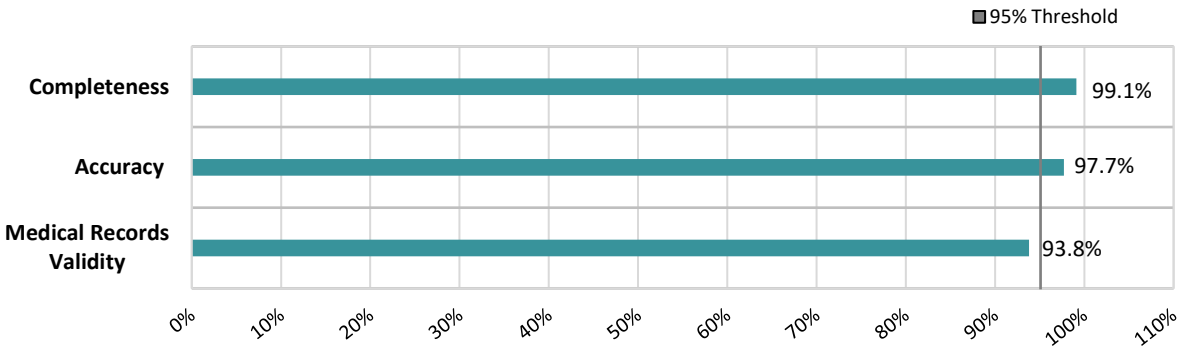
Findings

Observations and findings are based on the information provided and known at the time of the review. The findings and issues noted may reside with the health plan and/or the FAC. The health plan should work with LDH-OBH and the FAC to resolve issues noted with the encounter data.

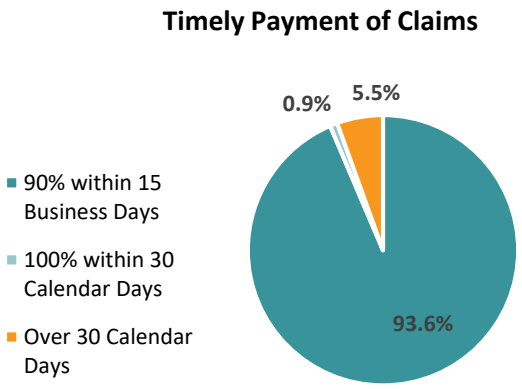
- **Completeness** Encounter completion percentages were above the 95 percent threshold for all twelve (12) months of the measurement period when compared to CDJ paid amounts, with an average CY 2022 completion percentage of 99.7 percent. When compared to sample claims paid

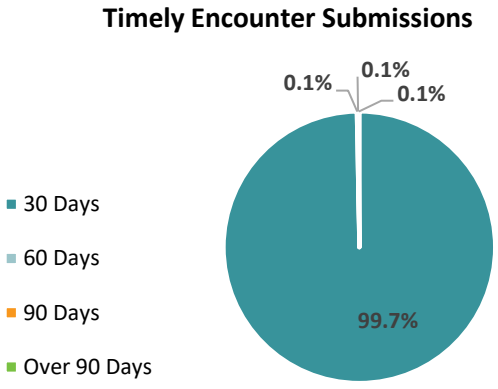
amount, encounter paid amounts were at or above the 95 percent threshold. When compared to sample claim counts, encounter counts for the March 2022 sample met the 95 percent threshold and was below the 95 percent threshold when compared to the September 2022 sample. The overall aggregate completion percentage was 99.1 percent.

- **Accuracy:** The overall accuracy percentage was above the 95 percent threshold (97.7 percent).
- **Medical Record Validation Rates:** The health plan submitted 82 of the 100 medical records requested (82.0 percent) for review. The validation rate for the 82 medical records tested was below the 95 percent threshold (93.8 percent).



- **Timeliness:** The health plan met the 90 percent, 15 business day required level of timeliness for the payment of claims and did not meet the 99 percent, 30 calendar day required level of timeliness. The health plan submitted 99.7 percent of all CY 2022 encounters within 30 days.





Introduction

The Louisiana Department of Health – Office of Behavioral Health (LDH-OBH) contracted with Magellan Complete Care of Louisiana, Inc. (Magellan) to manage, coordinate, and administer specialized behavioral health services for its CSoC waiver program. The program provides services to Medicaid children ages 5 through 20 that have mental health challenges or co-occurring disorders and are in or at-risk of out-of-home placement [1]. Magellan operates as a prepaid inpatient health plan (PIHP) responsible for the coordination and management of specialized Medicaid behavioral health benefits across multiple state agencies including LDH-OBH, the Department of Children and Family Services (DCFS), the Office of Juvenile Justice (OJJ) and the Department of Education (DOE).

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

CMS indicated that states could meet the independent audit requirement by conducting an encounter data validation study based on EQR Protocol 5[3]. Protocol 5 assesses the completeness and accuracy of the encounter data that has been adjudicated (i.e., paid or denied) by the health plan and submitted to the State's Fiscal Agent Contractor (FAC). Although Protocol 5 is a voluntary protocol, CMS strongly encourages states to contract with qualified entities to implement Protocol 5 to meet the audit requirement of the final rule. States may be at risk for loss of federal financial participation/reimbursement if the encounter data is incomplete and/or inaccurate.

Encounter data validation can assist states in reaching the goals of transparency and payment reform to support its efforts in quality measurement and improvement. The final Medicaid Managed Care Rule strengthens the requirements for state monitoring of managed care programs. Under the rule, each state Medicaid agency must have a monitoring system that addresses all aspects of the state's managed care program[4]. Additionally, states are required to provide accurate encounter data to the actuaries, as well as to CMS as part of the Transformed Medicaid Statistical Information System (T-MSIS) project. Protocol 5 enables states to meet these data validation and monitoring requirements. Protocol 5 evaluates state/department policies, as well as the policies, procedures, and systems of the health plan, assists states in gauging utilization, identifying potential gaps in services, evaluating program effectiveness, and identifying strengths and opportunities to enhance oversight.

[1] https://www.ldh.la.gov/page/for-familiesyouth
[2] https://www.cms.gov/newsroom/fact-sheets/medicaid-childrens-health-insurance-program-chip-managed-care-final-rule-cms-2408-f
[3] 81 Fed. Reg. 27,498, 27,603 (May 6, 2016).
[4] Electronic Code of Federal Regulations: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438

LDH-OBH engaged Myers and Stauffer LC (Myers and Stauffer) to perform EQR Protocol 5 to evaluate the completeness and accuracy of the encounter data submitted by Magellan Complete Care of Louisiana, Inc. for members enrolled in the State's CSoC program. EQR Protocol 5 validation analyses were performed on MHS's CY 2022 encounter data. CMS guidelines were followed and applied during the review.

On March 11, 2020, Louisiana's Governor, John Bel Edwards, declared a public health emergency (PHE)[5]. Federal and state responses to the PHE triggered social and economic disruptions, and periodically limited health care services to essential, emergency services. Temporary policies were put into place to protect the health and safety of the CSoC members. These temporary policies were in effect throughout the measurement period.

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

For each activity, a summary of results and observations are presented along with detailed analyses. Observations and findings are based on the information provided, interviews with subject matter experts, and known data limitations at the time of the review. The report is written specific to the health plan; however, the findings and issues noted may reside with the fiscal agent contractor (FAC). The recommendations and findings within this report provide an opportunity for the health plan to review its processes to ensure information and data submitted to the State and/or captured by the FAC is complete and accurate. The expectation is for the health plan to work with LDH-OBH and the FAC to resolve issues noted within the encounter data.

[5] https://www.nga.org/coronavirus-state-actions/louisiana/

Activity 1: Review State Requirements

The purpose of Activity 1 is to review information about the State's requirements for collecting and submitting encounter data. This review determines if additional or updated requirements are needed to ensure encounter data is complete and accurate. LDH-OBH provided Myers and Stauffer with the State-required items (as listed in Protocol 5), as well as acceptable error rates, and accuracy and completeness thresholds.

In addition to reviewing the State requirements, LDH-OBH's contract with the health plan was reviewed in detail. Myers and Stauffer also met with LDH-OBH and FAC representatives regularly. Monthly status meetings conducted with LDH-OBH and the FAC ensured that our understanding of policies, processes and systems were accurate.

Observations made from the reviews are summarized below along with recommendations for LDH-OBH and/or the FAC.

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

Activity 2: Review Health Plan Capability

The health plan's information systems and controls were evaluated to determine its ability to collect and submit complete and accurate encounter data. A survey was developed, requested documentation was reviewed, and interviews were conducted with health plan personnel to gain an understanding of the health plan's structure and processes. The survey and personnel interviews included questions related to claims processing, data submissions, enrollment, data systems, controls and mechanisms[6]. The requested documentation supported work flows, policies and procedures, and organizational structures.

Observations and findings related to the review and interviews are summarized below along with recommendations for LDH-OBH and the health plan.

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

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

Activity 3: Analyze Electronic Encounter Data

Activity 3 determines the validity of the encounter data submitted to the State and requires verifying its completeness and accuracy. Encounter data for the period January 1, 2022 through December 31, 2022 (i.e., CY 2022) was used for the analyses. The health plan-submitted CDJs and sample claims data were compared to the encounter data submitted to the FAC to determine the encounter data's integrity (i.e., completeness and accuracy). Statistics and distributions were also generated on the data for validation.

Completeness

Complete encounter data is dependent upon the timely submission of encounters. Encounters are a record of claims that have been adjudicated by the health plan to providers that have rendered services to members enrolled with the health plan. These encounters are submitted by the Medicaid managed care health plans to LDH-OBH via the FAC, Gainwell Technologies.

LDH-OBH's contract with the health plan requires the health plan to submit complete and accurate encounter data at least weekly. This includes encounters reflecting a zero dollar amount ($0.00) and encounters in which the health plan has a capitation arrangement with provider(s). Encounters are due in accordance with the encounter reconciliation schedule published by LDH-OBH or its contracted review organization (Appendix A). Encounter data completeness is measured by comparing the encounters to cash disbursements within a five (5) percent error threshold (i.e., at least 95 percent complete).[7]

Cash Disbursement Journals and Timely Encounter Submissions

Under a separate contract with LDH-OBH, Myers and Stauffer performs a bi-monthly reconciliation of the health-plan-submitted CDJs to the FAC encounter data to measure the encounter data completeness (i.e., Encounter Data Validation Report). On a monthly basis, Myers and Stauffer receives encounter data from the FAC in a standardized data extract, which includes both paid and denied encounters. The health plan's paid encounters are reviewed to determine if the paid encounters meet the State's contract minimum completeness requirement of 95 percent when compared to the CDJ files that are submitted monthly to Myers and Stauffer by the health plan. For this validation, the encounter extract included encounters received and accepted by the FAC and transmitted to Myers and Stauffer through January 30, 2024.

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. A 95 percent threshold was used for validation. Detailed results can be found in the March 2024 Encounter Data Validation Report, Appendix B.

[7] Contract Section 15.6.2.2, effective 11/1/2021 through 7/31/2022 and the contract effective 8/1/2022 through 12/31/2025.

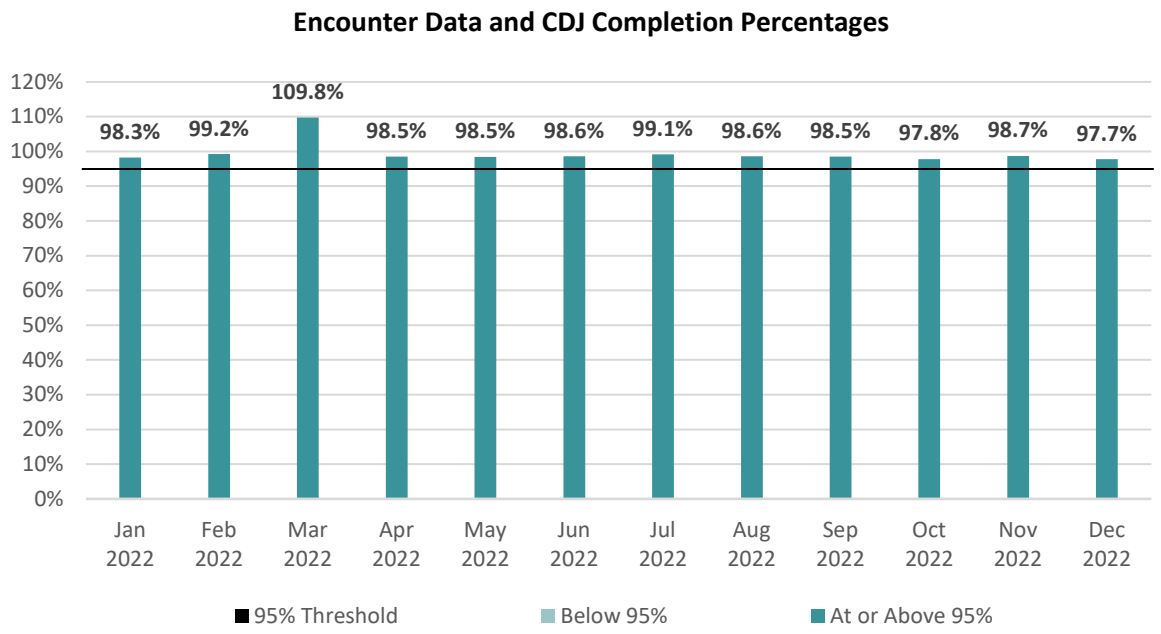


Figure 1 – Encounter Data and CDJ Completion Percentages: The paid amount from the CDJs for CY 2022 were used as the criteria for comparison. A 95 percent threshold was used for validation. The health plan's average completion percentage for CY 2022 was 99.7 percent.

The health plan's monthly completion percentages were above the 95 percent threshold for all twelve (12) months of the measurement period. The health plan's average completion percentage for CY 2022 was 99.7 percent.

Sample Claims

Sample Claims data submitted by the health plan for two sample months, March 2022 and September 2022, was also used to evaluate encounter data completeness. The comparison of the sample claims data to the encounter data sought to ensure that all claims were included in the sample claims and/or encounter data. The health plan-submitted sample claims data was traced to encounter data using data elements provided in the sample claims data. The encounters were evaluated against the sample claims data based on the following criteria:

- Sample Claims Count: The number of sample claims that were identified in the encounters.
- Sample Claims Paid Amount: Sample claims paid amounts compared to encounter paid amounts.

Figure 2 shows the completion percentages obtained after the identification of sample claims in the encounters and the comparison of the sample claim counts and paid amounts to encounter counts and paid amounts for each sample month. A 95 percent threshold was used for validation.

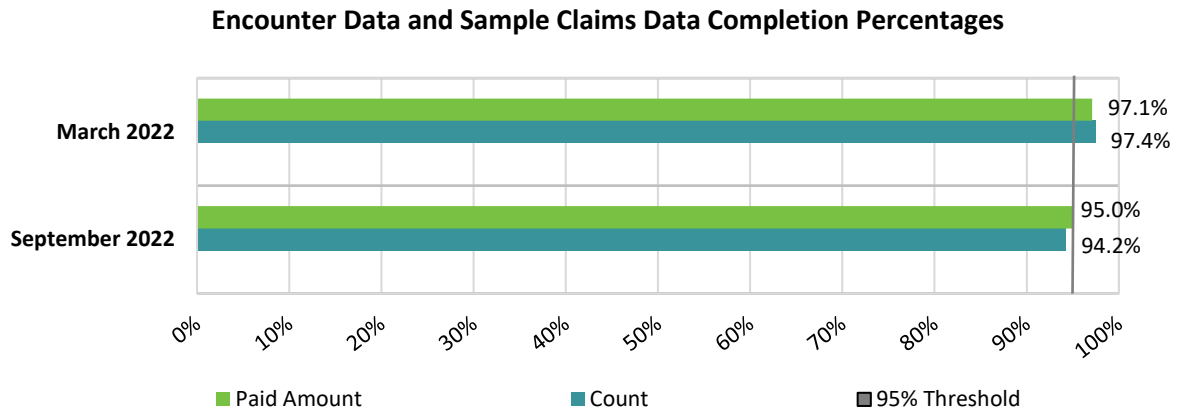


Figure 2: Encounter data and Sample Claims Data Completion Percentages. The counts and paid amounts from the sample claims data were used as the criteria for comparison. A 95 percent threshold was used for validation.

Encounter completion percentages were at or above the 95 percent threshold for both sample months when compared to sample claim paid amounts. For September 2022, sample claim counts were below the 95 percent threshold. Detailed results can be found in Appendix C and the overall completion percentage can be found in Appendix D.

Accuracy

For the purpose of validating encounter data accuracy, certain key data elements were selected for testing. The key data elements of the encounters traced to the sample claims data were compared to the corresponding key data elements on the sample claim. Consistency checks on blank or null data element values were also applied. The key data elements were evaluated based on the following criteria:

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

Individual key data element validity and accuracy rates were calculated based on the total number of records in the encounter dataset. The targeted error rate was expected to be below five percent per key data element (i.e., a 95 percent accuracy threshold). Accuracy percentages (i.e., valid values) are presented in **Table 1**, below. The key data elements evaluated and specific testing results are presented in Appendix E.

Key Data Elements Analysis			
Sample Month	**Valid Values**	**Missing Values**	**Erroneous Values**
March 2022	98.1%	0.0%	1.9%
September 2022	97.2%	0.0%	2.8%
Total Average	***97.7%***	***0.0%***	***2.3%***

Table 1: Key Data Elements Analysis. Validity rates were above the 95 percent threshold for both sample months.

Findings and Recommendations

The findings from the completeness and accuracy analyses of the encounter data are summarized below, including recommendations for LDH-OBH, the FAC and/or the health plan.

Findings and Recommendations		
	Findings	**Recommendations**
3-A	**Completion – Sample Claim Counts:** The encounter completion percentage, met the 95 percent threshold when compared to the March 2022 sample claim counts. The completion percentage was below the 95 percent threshold when compared to the September 2022 sample claim counts.	The health plan, in conjunction with the FAC, should investigate and identify the causes of encounters missing from the encounter data. Any issues noted during the investigation requiring encounter data revisions should be accurately addressed and incorporated into the FAC encounter data for use in future reporting or rate development.
3-B	**Accuracy – Admission Date** (Inpatient)**:** The encounter reflected a valid date value and the claim value was not populated for the March 2022 sample claims data.	The admission date should reflect the date the member was accepted as an inpatient into a facility for treatment. The health plan should ensure it is submitting the correct dates in the encounter data submissions.
3-C	**Accuracy – Billed Charges:** Both the sample claim and the encounter reflect valid values but do not agree.	The health plan should review its encounter submission procedures to ensure the health plan's paid dates and billed charges are submitted in accordance with encounter submission requirements and 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 health plan's adjudication date(s) and billed charges, as submitted by the health plan on all submitted encounters.
3-D	**Accuracy – Health Plan Paid Date:** Both the sample claim and the encounter reflect valid values but do not agree and/or the sample claims values were not populated.	
3-E	**Accuracy – Revenue Code:** The encounter reflects valid values and the sample claim values were not populated.	The health plan should ensure it is properly maintaining revenue codes used in its claims system and data warehouse and ensure the revenue code is being captured and included in the encounter submissions, as required/appropriate.

Statistics and Distributions

To further support the encounter data validation process, encounters with dates of service during the measurement period were analyzed for consistency among attributes such as member utilization and paid amounts, timeliness of payments, and encounter submissions timeliness. Encounters with CY 2022 dates of service were used to further evaluate the encounter data.

Members, Utilization and Paid Amounts

Enrollment data was used to evaluate utilization data on a per member basis. The total number of utilized services (i.e., units) and total paid amounts were divided by the average number of members for the measurement period to determine per member utilization. **Table 2** shows the resulting utilization and paid amounts per member.

Per Member Per Year (PMPY)[8] Utilization and Paid Amounts by Service Type				
Description	**CY 2022**			
Members				
Total Member Months	27,753			
Average Number of Members[9]	2,313			
Service Type	**Count**	**PMPY Count**	**Paid Amount**	**PMPY Paid Amount**
Behavioral Health	1,097	0.5	$71,398	$31
Family Support	143,514	62.0	$5,057,270	$2,186
Hospital Care	4,512	2.0	$3,432,631	$1,484
Mental Health	1,423	0.6	$93,865	$41
Physician	3,658	1.6	$113,172	$49
Psychology	31,228	13.5	$2,945,389	$1,273
Respite	36,641	15.8	$3,084,003	$1,333
Transition Care	4,133	1.8	$363,742	$157
Wraparound	202,296	87.5	$25,683,676	$11,104
Other Miscellaneous	1,606	0.7	$55,164	$24
Total Services	***430,108***	***186.0***	***$40,900,309***	***$17,683***

Table 2: Per Member Utilization and Paid Amount by Category. Per member counts and paid amounts are based on counts and paid amount, divided by the average number of members.

Eligible Medicaid members include children ages 5 through 20 that have mental health challenges or co-occurring disorders and are in or at-risk of out-of-home placement. The health plan coordinates and manages specialized behavioral health benefits for CSoC beneficiaries across multiple state agencies

[8] Counts and/or paid amount divided by the average number of members over a twelve (12) month period.
[9] The total of all member months during the measurement period, divided by the number of months in the measurement period.

including LDH-OBH, the Department of Children and Family Services (DCFS), the Office of Juvenile Justice (OJJ) and the Department of Education (DOE).

Timeliness

Timely Payment of Claims

This analysis measures the compliance of the health plan in paying or denying claims submitted by providers for payment. The contract between LDH-OBH and the health plan requires the health plan to perform an initial screening of the claim within five (5) business days of receipt of the claim, and either reject the claim or assign a unique control number and enter it into its system for processing and adjudication. The health plan must process and pay or deny at least 90 percent of all clean[10] claims within 15 business days of receipt, 99 percent within 30 calendar days of the date of receipt[11]. **Table 3** shows the results of the payment of claims analysis.

Timely Payment of Claims			
Number of Days – Percentage Requirement	Count	Percentage	
		Absolute	Cumulative
15 Business Days – 90%	453,825	93.6%	93.6%
30 Calendar Days – 99%	4,530	0.9%	94.5%
Over 30 Calendar Days – 100%	26,775	5.5%	100.0%

Table 3: Timely Payment of Claims measures the percentage of claims paid (adjudicated) by the health plan within the designated number of days. Percentages reflect encounters with CY 2022 dates of service.

The health plan's received dates and paid (adjudicated) dates from encounters with CY 2022 dates of service were used for the analysis. The number of days between these dates were used to determine the percentage of claims paid (adjudicated) by the health plan within the designated timeframes. The health plan met the 90 percent 15 business day required level of timeliness and did not meet the 99 percent 30 calendar day required level of timeliness for the payment of claims.

Timely Encounter Submissions

This analysis measures the percentage of encounters submitted by the health plan to the FAC after adjudicating (i.e., paying or denying) the claim. The health plan's contract with LDH-OBH requires the health plan to submit encounters weekly. As a result, encounters with CY 2022 dates of service were evaluated based on 30-day increments. The number of days between the health plan paid date and the Julian date (i.e., date the encounter was submitted to the FAC; digits one through four of the FAC assigned ICN number) from the encounters were used to determine the percentage of encounters

[10] A clean claim is one that can be processed without obtaining additional information from the healthcare provider or a third party. For purposes of this analysis, all claims were considered clean.
[11] Contract Section 8.6.2, effective 11/1/2021 through 7/31/2022 and the contract effective 8/1/2022 through 7/31/2025.

submitted within the indicated number of days. **Table 4** shows the results of the encounter submission analysis.

Timely Encounter Submissions			
		Percentage	
Number of Days	Count	Absolute	Cumulative
0 to 30 Days	483,975	99.7%	99.7%
31 to 60 Days	720	0.1%	99.8%
61 to 90 Days	446	0.1%	99.9%
Over 90 Days	388	0.1%	100.0%

Table 4: Timely Encounter Submissions measures the percentage of encounters submitted by the health plan to the FAC within the indicated number of days after adjudicating the claim. Percentages reflect encounters with CY 2022 dates of service.

The health plan submitted 99.7 percent of encounters within 30 days of adjudication. On average, the health plan submitted encounters within three (3) days.

Findings and Recommendations

The findings from the timeliness analysis are presented below, including recommendations for LDH-OBH, the FAC and/or the health plan.

Findings and Recommendations		
	Findings	Recommendations
3-F	The health plan met the 90 percent, 15 business day required level of timeliness and did not meet the 99 percent, 30 calendar day required level of timeliness for the payment of claims.	The health plan should regularly review and monitor its claims adjudication processes to ensure claims are processed promptly.

Activity 4: Review of Medical Records

Activity 4 attempts to confirm or provide supporting information for the findings detailed in the Activity 3 analysis of encounter data. This is done by tracing certain key data elements from the encounters to the provider medical record. Encounter data with dates of service during the measurement period was used as the population for the selection of records for review. A sample size of 100 medical records was specified by LDH-OBH for testing. A non-statistical[12], random sampling of records was selected from the encounter data for review.

The encounters selected for review were forwarded to the health plan on September 19, 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 October 23, 2023. The health plan brought up concerns regarding the documentation to be provided for the wraparound agencies and family support organizations, as these providers are paid a per diem rate. Based on correspondence with the health plan, it was determined that the health plan should have the documentation available to support the per diem billings. However, the due date for submitting the documentation supporting the medical records selected for review was extended to November 13, 2023. Medical records submitted after the extended due date, records with incorrect dates of service, and incomplete medical records were excluded from the validation.

Table 5, below, summarizes the number of records requested, received, and missing from the health plan, and the net number of medical records tested.

Medical Records Summary				
Description	**Requested**	**Missing**	**Replaced**	**Total Medical Records Received**
Medical Records	100	18	0	82
Percentage of Requested Records Received and Tested				***82.0%***

Table 5: Medical Records Summary. Eighty-two (82) of the 100 medical records requested were submitted for review.

Validation

The medical records submitted 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:

[12] 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

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

Table 6 reflects the validation rates from the medical record key data element review. A 95 percent threshold was used for validation. The supported validation rate for the 82 medical records reviewed was below the 95 percent threshold.

Medical Records Validation Rates		
Description	**Supported**	**Unsupported**
Total	***93.8%***	***6.2%***

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

Validation issues were primarily related to dates of birth missing from the medical records, and dates of service, procedure code modifiers and diagnosis codes not supported by the medical record documentation submitted.

Findings and Recommendations

The findings from the encounter data testing against medical records are presented below, including recommendations for LDH-OBH, the FAC and/or the health plan.

Findings and Recommendations		
	Findings	**Recommendations**
4-A	82 of the 100 medical records requested (82.0 percent) were submitted for testing. The health plan did not provide an explanation as to why it was not able obtain the remaining records requested.	The health plan should work with its providers to ensure that medical records are available upon request and ensure the data elements submitted on claims and encounter submissions are supported by the medical record(s).
4-B	The validation rate for the 82 medical records tested was below the 95 percent threshold, at 93.8 percent.	

Activity 5: Submission of Findings

Activity 5 summarizes the findings and recommendations identified in Activity 1 through Activity 4. The table below contains finding numbers corresponding to the activity and sequential finding within each section of the report.

Findings and Recommendations		
	Findings	**Recommendations**
Activity 1 – Review State Requirements		
There were no findings related to our review of the State's requirements.		
Activity 2 – Review Health Plan Capability		
There were no findings related to our review of the health plan's capabilities.		
Activity 3 – Analyze Electronic Encounter Data		
3-A	**Completion – Sample Claim Counts:** The encounter completion percentage, met the 95 percent threshold when compared to the March 2022 sample claim counts. The completion percentage was below the 95 percent threshold when compared to the September 2022 sample claim counts.	The health plan, in conjunction with the FAC, should investigate and identify the causes of encounters missing from the encounter data. Any issues noted during the investigation requiring encounter data revisions should be accurately addressed and incorporated into the FAC encounter data for use in future reporting or rate development.
3-B	**Accuracy – Admission Date** (Inpatient)**:** The encounter reflected a valid date value and the claim value was not populated for the March 2022 sample claims data.	The admission date should reflect the date the member was accepted as an inpatient into a facility for treatment. The health plan should ensure it is submitting the correct dates in the encounter data submissions.
3-C	**Accuracy – Billed Charges:** Both the sample claim and the encounter reflect valid values but do not agree.	The health plan should review its encounter submission procedures to ensure the health plan's paid dates and billed charges are submitted in accordance with encounter submission requirements and 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 health plan's adjudication date(s) and billed charges, as submitted by the health plan on all submitted encounters.
3-D	**Accuracy – Health Plan Paid Date:** Both the sample claim and the encounter reflect valid values but do not agree and/or the sample claims values were not populated.	
3-E	**Accuracy – Revenue Code:** The encounter reflects valid values and the sample claim values were not populated.	The health plan should ensure it is properly maintaining revenue codes used in its claims system and data warehouse and ensure the revenue code is being captured and included in the encounter submissions, as required/appropriate.

Findings and Recommendations		
	Findings	**Recommendations**
3-F	The health plan met the 90 percent, 15 business day required level of timeliness and did not meet the 99 percent, 30 calendar day required level of timeliness for the payment of claims.	The health plan should regularly review and monitor its claims adjudication processes to ensure claims are processed promptly.
Activity 4 – Review of Medical Records		
4-A	82 of the 100 medical records requested (82.0 percent) were submitted for testing. The health plan did not provide an explanation as to why it was not able obtain the remaining records requested.	The health plan should work with its providers to ensure that medical records are available upon request and ensure the data elements submitted on claims and encounter submissions are supported by the medical record(s).
4-B	The validation rate for the 82 medical records tested was below the 95 percent threshold, at 93.8 percent.	

Glossary

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

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

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

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

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

Capitation – A payment arrangement for health care services that pays a set amount for each enrolled member assigned to a provider and/or health plan.

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

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

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

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

CFR – Code of Federal Regulations.

Coordinated System of Care (CSoC) – A Medicaid waiver program for the State's coordinated network of services and supports for children and youth, ages 5 through 20, who have mental health challenges and/or co-occurring disorders and are in or at-risk of out-of-home placement.

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).

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

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

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

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

Family Support Organization (FSO) – Provides support, education, and advocacy for children/youth with significant emotional and behavioral challenges and their families at a time and place most convenient for the family.

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

Health Plan – A private organization that has entered into a contractual arrangement with LDH-OBH to manage the behavioral health care of children eligible for the CSoC. The health plan is reimbursed for expenses incurred in managing health care services for enrolled CSoC members only after the health plan has paid the expense. Also referred to as a prepaid inpatient health plan (PIHP).

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

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).

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).

Julian Date – A continuous count of days in a calendar year. For example, February 1 is 032.

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

Louisiana Department of Health (LDH) – The department within the state of Louisiana that oversees and administers Medicaid.

Magellan Complete Care of Louisiana, Inc. (Magellan) – A private health care organization that has entered into a contractual arrangement with LDH-OBH to manage the behavioral health care of children eligible for the CSoC program.

Medicaid Management Information System (MMIS) – The claims processing system used by the FAC to adjudicate Louisiana Medicaid claims. Health plan submitted encounters are loaded into this system and assigned a unique claim identifier.

Medicaid Waiver – A provision in Medicaid which allows the federal government to waive rules that usually apply to the Medicaid program. The intention is to allow individual states to accomplish certain goals, such as reducing costs, expanding coverage, or improving care for certain target groups. Waivers enable states to provide services to residents that typically would not be covered by Medicaid.

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

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

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.

Wraparound – A comprehensive, strengths-based, planning process for responding to serious mental health or behavioral challenges involving children within the CSoC needing such supports. It is a team-driven process that provides coordinated and individualized community-based services for children and their families to help them achieve positive outcomes.

Appendix A: Encounter Reconciliation Schedule

	CY 2022					
	January 2022 Reconciliation	**March 2022 Reconciliation**	**May 2022 Reconciliation**	**July 2022 Reconciliation**	**September 2022 Reconciliation**	**November 2022 Reconciliation**
Overall Encounter Submission Goal (cumulative)*	95%	95%	95%	95%	95%	95%
Submission Requirements for Subcontractor Encounters (for delegated vendors only)*	95%	0.95	95%	95%	95%	95%
Reconciliation Time Period	11/1/2019 - 10/31/2020	1/1/2020 - 12/31/2021	3/1/2020 - 2/28/2022	5/1/2020 - 04/30/2022	7/1/2020 - 06/30/2022	9/1/2020 - 08/31/2022
Magellan Encounter MMIS Submission Cut-off Date (by 12 noon CST/CDT)[1]	10/22/20 Encounters: September 2020 11/19/2020 Encounters: October 2020	12/24/2020 Encounters: November 2020 1/21/2022 Encounters: December 2020	2/18/2022 Encounters: January 2022 3/25/2022 Encounters: February 2022	4/22/2022 Encounters: March 2022 5/20/2022 Encounters: April 2022	6/24/2022 Encounters: May 2022 7/22/2022 Encounters: June 2022	8/26/2022 Encounters: July 2022 9/23/2020 Encounters: August 2022
Cash Disbursement Journal Files due to Myers and Stauffer	*expected: 10/15/2021, 11/15/2021*	*expected: 12/15/2021, 1/17/2022*	*expected: 2/15/2022, 3/15/2022*	*expected: 4/15/2022, 5/16/2022*	*expected: 6/15/2022, 7/15/2022*	*expected: 8/15/2022, 9/15/2022*
Draft Magellan Encounter Reconciliations Due to LDH	1/27/2022	3/31/2022	5/26/2022	7/28/2022	9/29/2022	11/30/2022
OBH to provide Magellan with Draft Encounter Reconciliation Report	1/28/2022	4/1/2022	5/27/2022	7/29/2022	9/30/2022	12/1/2022
Myers and Stauffer to Post Raw Encounter Data Files and Supplemental Duplicates / Calculated Voids Files	1/28/2022	4/1/2022	5/27/2022	7/29/2022	9/30/2022	12/1/2022
Due from Magellan to be Included in the Next Report: Feedback on (1) Duplicates / Voids File and (2) Encounter Reconciliation	2/4/2022	4/8/2022	6/3/2022	8/5/2022	10/7/2022	12/8/2022

* LDH and Myers and Stauffer will not round encounter submission results

[1] The MMIS submission cut-off-date is set by Gainwell Technologies, LLC and is subject to change per changes to the data extract frequency or data processes.

[2] For every day the encounter data from Gainwell Technologies, LLC is delayed, the Magellan Encounter Reconciliation report will be delayed by two days.

Appendix B

Louisiana Department of Health

Comparison of Health Plan Encounter Data to Cash Disbursements for Magellan Health Services, Inc. January 1, 2022 – December 31, 2023

March 28, 2024

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

- **Study Purpose** **3**
- **Summary** **4**
  - Entire Plan 4
  - Encounter Data Analysis 5
  - Summary Charts 6
  - Data Issues and Recommendations 7
- **Magellan Health Monthly Table** **8**
- **Appendix A: Definitions and Acronyms** **9**
- **Appendix B: Analysis** **11**
- **Appendix C: Data Analysis Assumptions** **12**

Study Purpose

The Louisiana Department of Health (LDH) – Office of Behavioral Health (LDH-OBH) engaged Myers and Stauffer LC to analyze behavioral health encounter data that has been submitted by the prepaid inpatient health plan (PIHP), Magellan Health Services, Inc. (Magellan Health), to Louisiana's fiscal agent contractor (FAC), Gainwell Technologies, and complete a comparison of the encounters to cash disbursement journals (CDJ) provided by the PIHP. For purposes of this analysis, "encounter data" are claims that have been paid by the PIHP to health care providers that have rendered behavioral health care services to members enrolled with the plan.

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

The results of our engagement and this report are intended only for the internal use of the LDH and should not be used for any other purpose.

Summary

Entire Plan

LDH-OBH requested that, for this study, we review the plan's paid encounters to determine if the paid encounters meet the state contract minimum completeness requirement of **95 percent** when compared to the cash disbursement journal (CDJ) files that are submitted by the PIHP. The encounters and CDJ file utilized in this study met the following criteria:

- Encounter and CDJ transactions were paid within the reporting period of **January 1, 2022 through December 31, 2023**.
- Encounters were received and accepted by the FAC and transmitted to Myers and Stauffer LC through **January 30, 2024**.

Table A — Magellan Health Cumulative Completion Totals and Percentages

Description	Entire Plan
Encounter Total (FAC reported)	**$91,840,076**
Total Encounter Adjustments ($)	($8,870,515)
Total Encounter Adjustments (%)	-9.65%
Net Encounter Total	**$82,969,562**
CDJ Total	**$85,727,811**
Variance	($2,758,250)
Completion (%)	**96.78%**
Contract Minimum Completeness Requirement (%)	**95.00%**
Non-Compliant (%)	**N/A**

Encounter Data Analysis

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

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

1. The payment amounts associated with denied encounters are identified as zero dollars in the encounter reconciliation analysis since they bear no impact on cash disbursements.
2. We identified potential duplicate encounters using our encounter review logic. Based on a comparison to the CDJ files, we noted some of these potential duplicates appear to be partial payments, some are actual duplicate submissions, and some are replacement encounters without a matching void. At the direction of LDH, we have attempted to adjust our totals to reflect the actual payment made and have removed duplicate payment amounts from our analysis.

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

Description	Encounter Count	Paid Amount	Paid Amount (% of Total*)
Total Encounter Amount (FAC Reported)	**1,603,696**	**$91,840,076**	**100.00%**
Adjustment Type			
State System Denied	(88,836)	($8,145,192)	-8.86%
Health Plan Denied	(386,251)	($723,154)	-0.78%
Calculated Void	(21)	($1,451)	0.00%
Duplicate	(2)	($717)	0.00%
Total Adjustments Made	(475,110)	($8,870,515)	-9.65%
Net Encounter Amounts	**1,128,586**	**$82,969,562**	**90.35%**

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

Summary Charts

Chart 1. PIHP CDJ and Encounter Totals by Paid Month

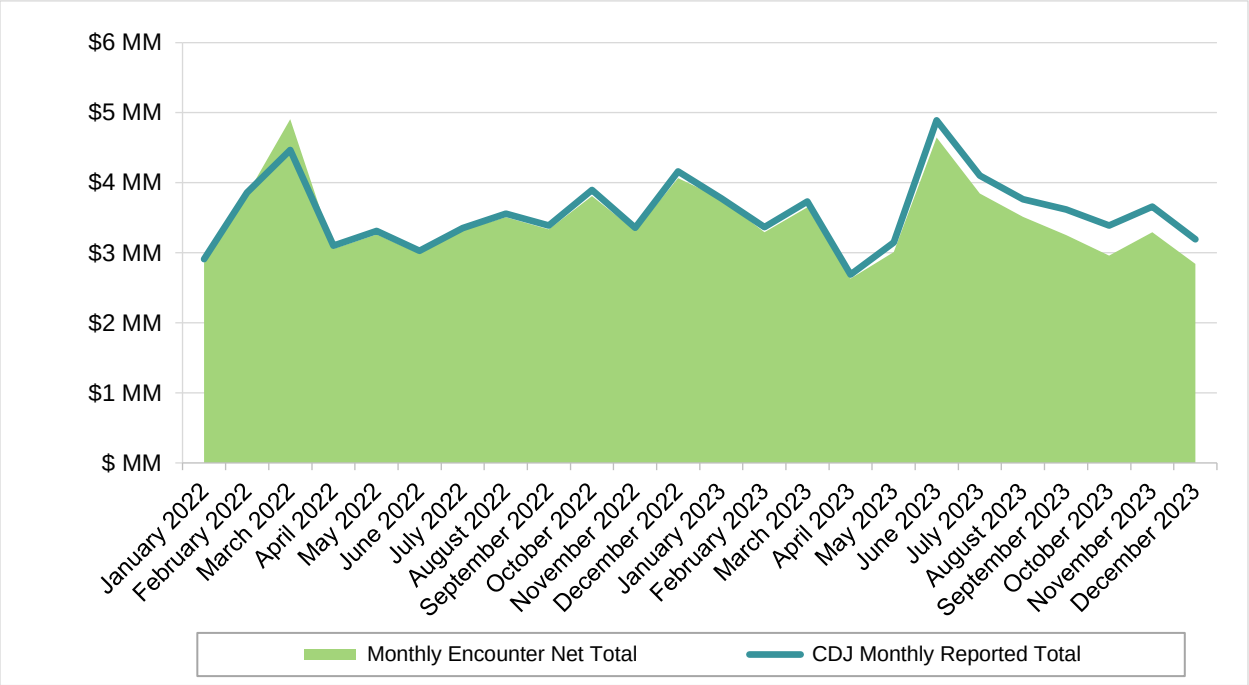
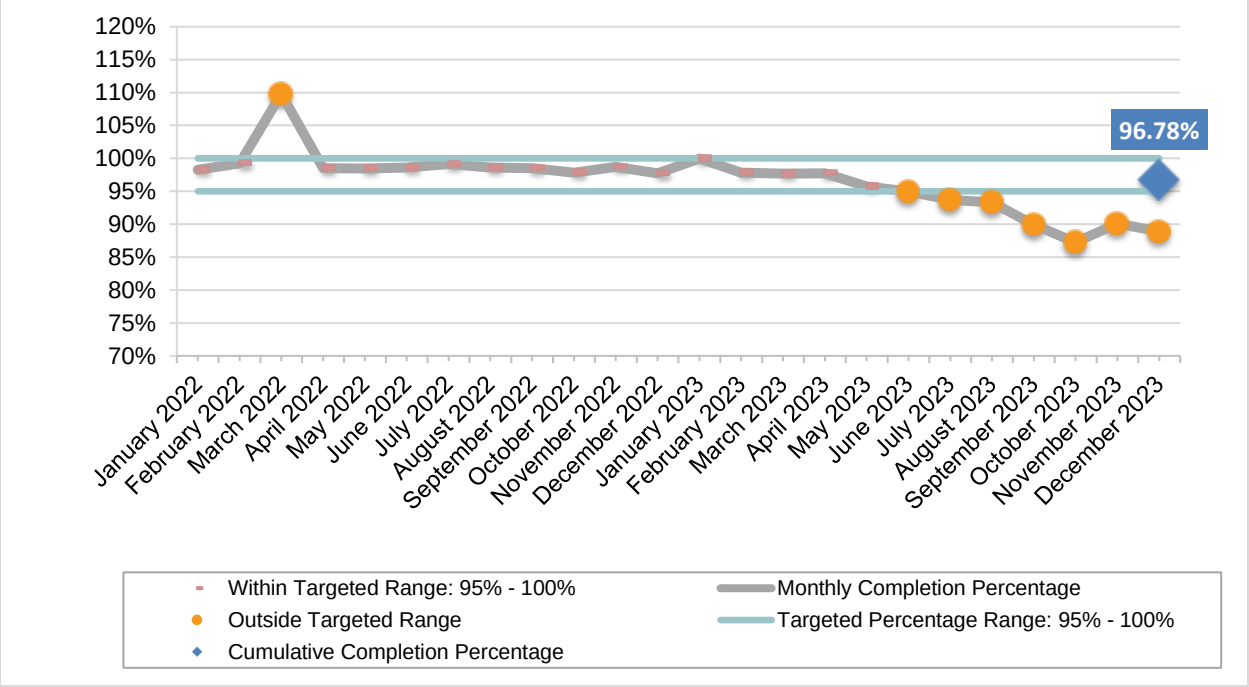


Chart 2. PIHP Completion Percentage by Paid Month



Data Issues and Recommendations

During this analysis, Myers and Stauffer identified potential data issues that may impact the completion percentages for MHS. Please reference Table C for MHS reconciliation period tables. These tables contain detailed reconciliation totals, completion percentages, and encounter analysis adjustments.

1. March 2022 has monthly completion percentage over 100 percent as follows:

    - March 2022 appears to be due to encounter transaction amounts not matching with the corresponding CDJ transaction amounts.

    We recommend Magellan Health work with Myers and Stauffer and Gainwell to identify and correct any CDJ file and/or encounter data submission issues.

2. June 2023 through December 2023 have monthly completion percentages below 95 percent as follows:

    - June 2023 through December 2023 low completion percentages appear to be due to state system denied encounters when compared to corresponding CDJ transactions.

    We recommend Magellan Health work with Myers and Stauffer and Gainwell to identify and correct any CDJ file and/or encounter data submission issues.

Magellan Health Monthly Table

Table C — Magellan 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
January 2022	$3,127,925	($268,660)	-8.58%	$2,859,265	$2,909,211	($49,946)	98.28%
February 2022	$3,930,304	($98,630)	-2.50%	$3,831,673	$3,861,308	($29,635)	99.23%
March 2022	$5,004,673	($97,377)	-1.94%	$4,907,296	$4,469,689	$437,607	109.79%
April 2022	$3,135,036	($78,622)	-2.50%	$3,056,414	$3,102,430	($46,016)	98.51%
May 2022	$3,347,176	($86,260)	-2.57%	$3,260,916	$3,311,893	($50,977)	98.46%
June 2022	$3,045,916	($59,952)	-1.96%	$2,985,964	$3,028,222	($42,258)	98.60%
July 2022	$3,401,902	($79,408)	-2.33%	$3,322,495	$3,350,981	($28,486)	99.14%
August 2022	$3,576,722	($66,498)	-1.85%	$3,510,225	$3,560,509	($50,284)	98.58%
September 2022	$3,434,984	($98,333)	-2.86%	$3,336,651	$3,387,099	($50,448)	98.51%
October 2022	$4,026,227	($216,250)	-5.37%	$3,809,976	$3,894,857	($84,881)	97.82%
November 2022	$3,468,746	($153,186)	-4.41%	$3,315,560	$3,359,420	($43,860)	98.69%
December 2022	$5,150,772	($1,084,512)	-21.05%	$4,066,260	$4,160,211	($93,951)	97.74%
January 2023	$3,867,920	($94,111)	-2.43%	$3,773,809	$3,775,407	($1,598)	99.95%
February 2023	$4,109,257	($815,520)	-19.84%	$3,293,737	$3,367,017	($73,280)	97.82%
March 2023	$4,513,582	($865,863)	-19.18%	$3,647,719	$3,733,511	($85,792)	97.70%
April 2023	$2,734,094	($105,190)	-3.84%	$2,628,904	$2,689,330	($60,426)	97.75%
May 2023	$3,276,898	($264,674)	-8.07%	$3,012,224	$3,145,507	($133,284)	95.76%
June 2023	$5,049,536	($403,950)	-7.99%	$4,645,585	$4,890,740	($245,154)	94.98%
July 2023	$4,287,702	($441,796)	-10.30%	$3,845,905	$4,104,069	($258,163)	93.70%
August 2023	$4,058,975	($547,679)	-13.49%	$3,511,296	$3,763,318	($252,022)	93.30%
September 2023	$4,197,321	($944,401)	-22.50%	$3,252,920	$3,618,882	($365,962)	89.88%
October 2023	$3,910,599	($951,566)	-24.33%	$2,959,033	$3,391,239	($432,206)	87.25%
November 2023	$3,914,712	($619,123)	-15.81%	$3,295,589	$3,657,839	($362,250)	90.09%
December 2023	$3,269,097	($428,952)	-13.12%	$2,840,146	$3,195,123	($354,978)	88.89%
Cumulative Totals	**$91,840,076**	**-$8,870,515**	**-9.65%**	**$82,969,562**	**$85,727,811**	**-$2,758,250**	**96.78%**
						Minimum Completeness (%)	95.00%
						Non-Compliant	**N/A**

Appendix A: Definitions and Acronyms

The following terms are used throughout this document:

- **Cash Disbursement Journal (CDJ) –** A record of payments from a PIHP to service providers for a given month as reported by the PIHP to the Louisiana Department of Health (LDH).
- **DXC Technology (DXC) –** State fiscal agent contractor prior to October 1, 2020. In 2020, DXC was sold to Veritas Capital and ultimately formed a new company, Gainwell Technologies.
- **Fiscal Agent Contractor (FAC) –** A contractor selected to design, develop and maintain the Medicaid Management Information System (MMIS); Gainwell is the current FAC.
- **Gainwell Technologies (Gainwell) –** Current State fiscal agent contractor. Formerly known as DXC Technology.
- **Louisiana Coordinated System of Care (CSoC)** – The current statewide behavioral health managed care program in Louisiana, which became effective as a risk-based program on November 1, 2018. The Louisiana Department of Health (LDH) has designated the Office of Behavioral Health (LDH-OBH) for the oversight of the CSoC.
- **Louisiana Department of Health (LDH) –** The agency in charge of overseeing the health services for the citizens of the state of Louisiana.
    - **Office of Behavioral Health (LDH-OBH**) – This office has the oversight of the Louisiana Coordinated System of Care (CSoC) program. Its mission in to promote recovery and resiliency in the community through services and supports that are preventive, accessible, comprehensive and dynamic.
- **Medicaid Management Information System (MMIS) –** The claims and encounter processing system used by the FAC. PIHP submitted encounters are loaded into this system and assigned a unique claim identifier.
- **Prepaid Inpatient Health Plan (PIHP)** – A private organization operating the Louisiana Coordinated System of Care (CSoC). Magellan Health Services, Inc. (MHS) is the current PIHP for CSoC.

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

- **CDJ Monthly Reported Total –** The sum of all payments from a PIHP to service providers for the reconciliation period reported in the Cash Disbursement Journal (CDJ).
- **Monthly Completion Percentage –** The "Monthly Encounter Net Total" divided by "CDJ Monthly Reported Total."
- **Monthly Encounter Net Total –** The difference between the "Monthly Encounter Total (FAC Reported)" and "Monthly Encounter Total (Adjustments)."
- **Monthly Encounter Total (Adjustments) –** Total paid amount of encounters identified as denied, calculated void or potential duplicate.
    - State System Denied Encounter – A submitted encounter that is paid by the plan but is denied by the Fiscal Agent Contractor (FAC) due to MMIS Claims Subsystem edits.
    - Health Plan Denied Encounter – A submitted encounter that is denied by the plan. This denied encounter is indicated by a value of 'D' in the second position of the PIHP ICN submitted by the plan.
    - Calculated Voids – A pair of paid encounters having the same base patient account number or plan internal control number (ICN) if applicable. One of the encounters may appear to be a replacement of the other without a corresponding void encounter transaction being present. In this case, an adjustment is made to account for the missing void transaction. The magnitude of this adjustment depends upon the plans' response to a listing of potential calculated void encounters.
    - Duplicate Encounters – A pair of paid encounters having identically-billed fields that appear to be duplicates of one another. One of these encounters may be excluded from the analysis depending upon the plans' response to a listing of potential duplicate encounters.
- **Monthly Encounter Total (FAC Reported) –** The sum of all paid amounts on encounters submitted to the MMIS.
- **Monthly Variance –** The difference between the "Monthly Encounter Net Total" and the "CDJ Monthly Reported Total."
- **Percentage of Encounters Adjusted –** The "Monthly Encounter Total (Adjustments)" divided by "Monthly Encounter Total (FAC Reported)."

Appendix B: Analysis

Encounters from behavioral health services were combined on like data fields. We analyzed the line reported information of each encounter to capture the amount paid on the entire claim. Encounter totals were calculated by summarizing the data by the PIHP paid date. Submitted cash disbursements were summarized by the PIHP transaction date to create a matching table. These data sources were then combined to produce the results.

Appendix C: Data Analysis Assumptions

1. This analysis is performed on encounter data that was submitted by the PIHP to the FAC and loaded into the FAC MMIS. Encounters submitted by any PIHP that were rejected by the FAC for errors in submission or other reasons are not transmitted to Myers and Stauffer LC.
2. For the purposes of this study, the payment amounts associated with denied encounters are identified as zero dollars in the encounter reconciliation analysis since they bear no impact on cash disbursements.
3. A voiding encounter has the same paid date as the original/voided encounter, which may differ from when the void or adjustment occurred. Therefore, the voiding encounters were coded to match the adjustment claim's paid date to allow for the proper matching of cash disbursements that occurred due to these void transactions. However, we were unable to reallocate the void encounters in which there was not an associated adjustment claim.
4. CDJ and encounter payments are analyzed to ensure that positive and negative payments correspond to the record's transaction type. For example, a void should have a negative amount. Additionally, the payment's amount on void and back-out encounters should match the amount on the encounter being adjusted. If detected, the payment is adjusted to the appropriate sign or amount.
5. We instructed the PIHP to exclude referral fees, management fees, and other non-encounter related fees from the CDJ data that is submitted to Myers and Stauffer LC. We reviewed the CDJs for these payments and removed them from the analysis when they were identified.
6. Separately itemized interest expenses are excluded from the CDJ and encounter totals when the interest amounts are included in the PIHP paid amounts on the encounters and/or CDJ transactions.
7. Due to rounding, the sum of the displayed percentages in this report may not add up to the total.
8. The short run-out period for encounter submissions may not allow sufficient time for the PIHP to resolve encounter submission issues noted in previous reconciliation reports. This may result in lower completion percentages when reconciling the encounters to CDJ totals.
9. Opportunities for improving the encounter reconciliation process have been identified during analysis of the encounter data and cash disbursement journals, as well as frequent interactions with the PIHP, LDH, and the FAC. While we have attempted to account for these situations, other potential issues within the data may exist that have not yet been identified which may require us to restate a report or modify reconciliation processes in the future.

Appendix C: Sample Claims Completeness

Description	March 2022		September 2022		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Claims Sample Data						
Claims Sample Total	114,218	$9,581,953	40,018	$3,954,093	154,236	$13,536,046
Reconciling Adjustment	(65,051)	($4,496,517)	(7,439)	($571,459)	(72,490)	($5,067,977)
Net Claims Sample Total	***49,167***	***$5,085,436***	***32,579***	***$3,382,634***	***81,746***	***$8,468,070***
Encounter Data						
Total Matched Encounters	47,885	$4,943,380	30,675	$3,256,843	78,560	$8,200,223
Less Surplus Encounters	0	$0	0	$0	0	$0
Payment Adjustments	0	($7,443)	0	($43,434)	0	($50,877)
Net Matched Encounters	***47,885***	***$4,935,937***	***30,675***	***$3,213,409***	***78,560***	***$8,149,346***
Encounter Completeness Percentage	***97.4%***	***97.1%***	***94.2%***	***95.0%***	***96.1%***	***96.2%***

Appendix D: Overall Completeness

	CDJs		Sample Claims		Total	
	Total Paid Amount	Total Count	Total Paid Amount	Total Count	Total Paid Amount	Overall Average[1]
Health Plan-Submitted Data						
Health Plan-Submitted Data	$42,395,830	154,236	$13,536,046	154,236	$55,931,876	56,086,112
Reconciling Adjustment	$0	(72,490)	($5,067,977)	(72,490)	($5,067,977)	(5,140,467)
Net Health Plan-Submitted Data	***$42,395,830***	***81,746***	***$8,468,070***	***81,746***	***$50,863,900***	***50,945,646***
Encounter Data						
Total Matched Encounters	$44,650,383	78,560	$8,200,223	78,560	$52,850,606	52,929,166
Adjustments	($2,387,688)	0	($50,877)	0	($2,438,565)	(2,438,565)
Net Matched Encounters	***$42,262,695***	***78,560***	***$8,149,346***	***78,560***	***$50,412,041***	***50,490,601***
Encounter Completeness Percentage	***99.7%***	***96.1%***	***96.2%***	***96.1%***	***99.1%***	***99.1%***

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

Appendix E: Key Data Element Matching

Key Data Element	March 2022							September 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	125	0	0.0%	0	0.0%	125	100.0%	133	133	100.0%	0	0.0%	0	0.0%	258	133	51.6%	0	0.0%	125	48.4%
Billed Charges	47,885	42,069	87.9%	0	0.0%	5,816	12.1%	30,675	26,158	85.3%	0	0.0%	4,517	14.7%	78,560	68,227	86.8%	0	0.0%	10,333	13.2%
Billing Provider NPI/Number	47,885	47,885	100.0%	0	0.0%	0	0.0%	30,675	30,675	100.0%	0	0.0%	0	0.0%	78,560	78,560	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	47,885	47,111	98.4%	0	0.0%	774	1.6%	30,675	29,862	97.3%	0	0.0%	813	2.7%	78,560	76,973	98.0%	0	0.0%	1,587	2.0%
Date of Service	47,885	47,885	100.0%	0	0.0%	0	0.0%	30,675	30,675	100.0%	0	0.0%	0	0.0%	78,560	78,560	100.0%	0	0.0%	0	0.0%
Former/Original Claim ICN	47,885	47,701	99.6%	0	0.0%	184	0.4%	30,675	30,618	99.8%	0	0.0%	57	0.2%	78,560	78,319	99.7%	0	0.0%	241	0.3%
Health Plan Paid Amount	47,885	47,883	100.0%	0	0.0%	2	0.0%	30,675	30,675	100.0%	0	0.0%	0	0.0%	78,560	78,558	100.0%	0	0.0%	2	0.0%
Health Plan Paid Date	47,885	42,339	88.4%	0	0.0%	5,546	11.6%	30,675	24,342	79.4%	0	0.0%	6,333	20.6%	78,560	66,681	84.9%	0	0.0%	11,879	15.1%
MMIS ICN	47,885	47,885	100.0%	0	0.0%	0	0.0%	30,675	30,675	100.0%	0	0.0%	0	0.0%	78,560	78,560	100.0%	0	0.0%	0	0.0%
Medicaid Member ID	47,885	47,848	99.9%	0	0.0%	37	0.1%	30,675	30,675	100.0%	0	0.0%	0	0.0%	78,560	78,523	100.0%	0	0.0%	37	0.0%
Place of Service	47,758	47,758	100.0%	0	0.0%	0	0.0%	30,536	30,536	100.0%	0	0.0%	0	0.0%	78,294	78,294	100.0%	0	0.0%	0	0.0%
Procedure Code	47,760	47,758	100.0%	0	0.0%	2	0.0%	30,542	30,540	100.0%	0	0.0%	2	0.0%	78,302	78,298	100.0%	0	0.0%	4	0.0%
Procedure Code Modifiers	47,760	47,760	100.0%	0	0.0%	0	0.0%	30,542	30,542	100.0%	0	0.0%	0	0.0%	78,302	78,302	100.0%	0	0.0%	0	0.0%
Revenue Code	127	0	0.0%	0	0.0%	127	100.0%	139	0	0.0%	0	0.0%	139	100.0%	266	0	0.0%	0	0.0%	266	100.0%
Service Provider NPI/Number	47,885	47,856	99.9%	0	0.0%	29	0.1%	30,675	30,674	100.0%	0	0.0%	1	0.0%	78,560	78,530	100.0%	0	0.0%	30	0.0%
Service Provider Specialty/Taxonomy	47,885	47,677	99.6%	0	0.0%	208	0.4%	30,675	30,537	99.6%	0	0.0%	138	0.4%	78,560	78,214	99.6%	0	0.0%	346	0.4%
Surgical Procedure Codes	125	122	97.6%	0	0.0%	3	2.4%	133	129	97.0%	0	0.0%	4	3.0%	258	251	97.3%	0	0.0%	7	2.7%
Total	***670,390***	***657,537***	***98.1%***	***0***	***0.0%***	***12,853***	***1.9%***	***429,450***	***417,446***	***97.2%***	***0***	***0.0%***	***12,004***	***2.8%***	***1,099,840***	***1,074,983***	***97.7%***	***0***	***0.0%***	***24,857***	***2.3%***

Appendix F: Medical Records Validity Rates

Key Data Element	Total Elements Sampled	Supported Elements		Unsupported Elements	
		Count	Percent	Count	Percent
Member Name	82	82	100.0%	0	0.0%
Member DOB	82	77	93.9%	5	6.1%
Admit Date	1	1	100.0%	0	0.0%
Date of Service	82	77	93.9%	5	6.1%
Billing Provider	82	77	93.9%	5	6.1%
Type of Bill Code	1	1	100.0%	0	0.0%
Revenue Code	1	1	100.0%	0	0.0%
Place of Service	81	79	97.5%	2	2.5%
Procedure Code	81	81	100.0%	0	0.0%
Procedure Modifiers	27	25	92.6%	2	7.4%
Diagnosis Codes	94	76	80.9%	18	19.1%
Servicing Provider	82	76	92.7%	6	7.3%
Total	***696***	***653***	***93.8%***	***43***	***6.2%***

Note: 82 of the 100 medical records requested (82 percent) were submitted and tested.

Health Plan Response

The health plan was provided an opportunity to submit a response to the draft report. The following is the health plan's response.

May 30, 2024

Magellan of Louisiana
8550 United Plaza Blvd, Suite 704
Baton Rouge, LA 70809

Dear Myers and Stauffer,

I am writing to provide a response to the EQR Protocol 5 draft report received by Magellan. The letter is in response to the Activity 5: Submission of Findings. The response also includes a detailed review of finding numbers corresponding to the activity and sequential finding within each section.

Activity 5: Submission of Findings

- **Activity 1- Review State Requirements: No Findings**
- **Activity 2- Review Health Plan Capability: No Findings**
- **Activity 3- Analyze Electronic Encounter Data:**
    - **3-A-3-F**
        - Magellan has identified the findings and recommendations in Activity 3. Since the sample periods, numerous changes have been made to systems and processes in order to move Magellan into completion, accuracy and timeliness compliance.
- **Activity 4-Review of Medical Records:**
    - **4-A-4-B**
        - Magellan submitted 100 responses to the request for records, and out of 100 responses, 82 records were reviewed by Myers and Stauffer that included documentation and records. The 18 missing records identified by Myers and Stauffer enclosed in Magellan's response spreadsheet included per diem claims. These per diem claims do not have corresponding service documentation, but there are other claims (that can be identified by modifiers) that correspond to actual service delivery. Magellan has

updated the reporting methodology for future reports that make it clear which claims require associated progress notes and which do not.

Comparison of Health Plan Encounter Data to Cash Disbursements report:

- Magellan met with Myers and Stauffer on April 17, 2024, to discuss the lower completion percentages.
- Magellan determined that there was an encounters configuration issue.
- Magellan is in the process of correcting the encounters configuration issue, with an estimated completion timeline of mid-June 2024.

Thank you for your kind consideration to this response and providing Magellan the opportunity to provide further clarity into the matter at hand.

Thank you,

Syralja Griffin
Vice President, General Manager
Louisiana Coordinated System of Care