Commonwealth of Virginia
Department of
Medical Assistance Services

2020–2021 Commonwealth Coordinated Care Plus Encounter Data Validation Aggregate Report

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1. Executive Summary

Introduction

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, the Virginia Department of Medical Assistance Services (DMAS) requires its Commonwealth Coordinated Care (CCC) Plus contracted managed care organizations (MCOs) to submit high-quality encounter data. During state fiscal year (SFY) 2020–2021, DMAS contracted Health Services Advisory Group, Inc. (HSAG) to conduct an encounter data validation (EDV) study.

Methods

In alignment with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 5, Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019,[1-1] HSAG conducted the following two core evaluation activities for all six MCOs:

- Information systems (IS) review—assessment of DMAS' and the MCOs' information systems and processes. The goal of this activity is to examine the extent to which DMAS' and the MCOs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5.
- Administrative profile—analysis of DMAS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity is to evaluate the extent to which the encounter data in DMAS' Encounters Processing Solution (EPS) database are complete, accurate, and submitted by the MCOs in a timely manner for encounters with dates of service in calendar year (CY) 2020. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

Findings, Conclusions, and Recommendations

Information Systems Review

This information systems review provides self-reported, qualitative information from all six MCOs regarding the encounter data process: collection, processing, and transmission of encounter data to DMAS. The modular structure of the encounter data processing system ensures:

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 19, 2021,

- MCOs can submit data and receive feedback about timeliness, accuracy, and completeness.
- Electronic Data Interchange (EDI) file compliance and validation checks (files are in valid formats, data are checked for Health Insurance Portability and Accountability Act [HIPAA] compliance and prepared for business rules processing) are performed on encounter data.
- Data are validated against State (Commonwealth, also referred to as the "State") business rules (business rules engine).
- Data analyses for program management and decision support are run.

All MCOs describe their ability to develop adaptable data review processes, as well as personnel, departments, software systems, and/or external subcontractors, that can promptly respond to quality issues. MCOs also describe the systems/subcontractor oversight and data remediation activities in place to ensure the completeness and accuracy of data submitted to them or processed on their behalf.

General Recommendations

To improve the quality of encounter data submissions from MCOs, HSAG offers the following recommendations to assist DMAS and MCOs in addressing opportunities for improvement:

- DMAS should consider conducting validation activities that align with the Transformed Medicaid Statistical Information System (T-MSIS) Priority Items (TPI), to forestall potential data quality issues in T-MSIS data extracts routinely submitted to CMS.
- DMAS should consider reviewing the process involved in the identification and handling of duplicate encounters. Duplicate encounters appear to be identified at the header level and may undercount duplicate services reported at the detail level. Additionally, although total charges are incorporated in the de-duplication logic, the specific service or procedure code does not appear to be included.
- Questionnaire responses from some MCOs suggest that they have experienced challenges while using the currently agreed-upon virtual meeting application during communications with DMAS (Google Meets) and recommended a different platform such as WebEx or Zoom.
- HSAG identified there was a lack of standardized monitoring by the MCOs to ensure accuracy and completeness of encounter data, and the monitoring ranged in terms of scope and depth. As such, DMAS may consider the following recommendations:
  - Consider requiring all MCOs to add standardized metrics to actively monitor encounter data completeness and accuracy. Some examples include review encounter volume by month, high dollar claims, and establish trends.
  - Require the MCOs' monitoring results to be submitted to DMAS for use in its ongoing data monitoring.
- Some MCOs report that environmental claims/claims paid to a member are currently not submitted to DMAS because the service provider does not have a national provider identifier (NPI). DMAS may wish to consider reviewing the handling of environmental claims and/or claims resulting from services rendered by other providers of non-health-related services who are not eligible for an NPI.

Administrative Profile

Overall, DMAS' encounter data should continue to support analyses utilizing encounter data such as Healthcare Effectiveness Data and Information Set (HEDIS®)[1-2] performance measure calculation. Data were largely **complete**, **valid**, and **reliable**. While some gaps and data concerns were identified, this should not preclude DMAS from conducting further analysis given adequate assessment of encounters prior to analysis. Notable gaps include:

- The majority of United pharmacy encounters had submission dates to DMAS before the MCO payment date. Encounters with January 2020 payment dates had submission dates to DMAS after payment, as expected, but encounters throughout the remainder of the year generally had submission dates to DMAS before the MCO payment dates.[1-3]
  - **Impact**: Discrepancies in submission date to DMAS in relation to MCO payment date may skew timeliness of submission metrics.
  - **Recommendation**: DMAS should collaborate with United to determine the root cause and appropriate submission dates to DMAS for pharmacy encounters.
- For each encounter type, two MCOs did not meet the submission standards within 30 days of payment.
  - **Impact**: DMAS requires MCOs to submit 96 percent of professional and institutional encounters within 30 days. Aetna and Molina did not meet the standard for professional encounters while Aetna and VA Premier did not meet the standard for institutional encounters. United and VA Premier did not meet a 99 percent submission rate within 30 days of payment for pharmacy encounters.
  - **Recommendation**: DMAS should continue monitoring timeliness of MCO submission of all encounters and collaborate with MCOs to determine any barriers in timely submission.
- **Header Third-party liability (TPL) paid amounts** may be incomplete for **Molina** during at least the first half of 2020 for institutional encounters.
  - **Impact**: Financial analysis incorporating TPL paid amounts for 2020 will result in artificially low values, particularly for Molina, if stratified by MCO.
  - **Recommendation**: DMAS should monitor TPL completeness by MCOs to ensure the field is populated as expected and collaborate with Molina to determine a root cause.
- **Servicing Provider Taxonomy Code** was populated for 55.6 percent of institutional encounters.
  - **Impact**: While this field is not typically used in most performance measure calculation, other queries or analyses relying on this field will yield incomplete results. Moreover, there is substantial variation in field completeness across MCOs (i.e., 0.0 percent for Optima and 99.2 percent for VA Premier).
  - **Recommendation**: DMAS should work with its MCOs, particularly Optima, to submit codes for this field.
- **Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS) codes requiring National Drug Codes (NDCs)** did not have NDC codes consistently populated or

[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-3] Additional details can be found in Appendix Table H-14.

were populated with inappropriate NDCs for professional encounters, as well as institutional encounters with a type of bill code starting with "13" or "83."

- **Impact**: While there is an edit currently applied in DMAS' encounter processing system (EPS) based on a proprietary crosswalk file from the DMAS pharmacy team, HSAG used a publicly available crosswalk from CMS. If the crosswalk files are similar and produce similar results, MCOs may need additional time and collaboration with DMAS to ensure encounters meet DMAS' expectations.
- **Recommendation**: Collaborate with MCOs to ensure NDCs are submitted and are appropriate for qualifying HCPCS codes.

General Recommendations

- Build on current reporting dashboards and tools to include additional metrics related to data quality and completeness. Metrics may include those covered in this EDV study, the Data Quality Scorecard, or Transformed Medicaid Statistical Information System (T-MSIS) Priority Items (TPI) not already covered.
- Leverage data quality reporting tools from CMS (such as DQ Atlas and/or Imersis) to align internal encounter data quality monitoring with T-MSIS extracts sent to CMS. Internal data monitoring may be used to quickly identify the root cause of potential problem areas identified from CMS tools.

2. Overview and Methodology

Overview

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, DMAS requires its CCC Plus contracted MCOs to submit high-quality encounter data. DMAS relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During SFY 2020–2021, DMAS contracted HSAG to conduct an EDV study. In alignment with the CMS EQR Protocol 5, HSAG conducted the following two core evaluation activities for the EDV study:

- Information systems review—assessment of DMAS' and the MCOs' information systems and processes. The goal of this activity is to examine the extent to which DMAS' and the MCOs' information systems infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5.
- Administrative profile—analysis of DMAS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity is to evaluate the extent to which the encounter data in DMAS' EPS database are complete, accurate, and submitted by the MCOs in a timely manner for encounters with dates of service in CY 2020. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

HSAG conducted the EDV study for the following six CCC Plus MCOs:

- Aetna Better Health of Virginia (Aetna)
- HealthKeepers, Inc. (HealthKeepers)
- Molina Complete Care (Molina) [2-1]
- Optima Health (Optima)
- UnitedHealthcare of the Mid-Atlantic, Inc. (United)
- Virginia Premier Health Plan, Inc. (VA Premier)

In addition, because the MCOs terminated their contracts with DentaQuest on July 1, 2021, DMAS excluded the dental encounters from the study.

[2-1] Formerly Magellan Complete Care of Virginia.

Methodology

Information Systems Review

The information systems review seeks to define how each participant in the encounter data process collects and processes encounter data such that the data flow from the MCOs to DMAS is understood. The information systems review is key to understanding whether the information systems infrastructures are likely to produce complete and accurate encounter data. To ensure the collection of critical information, HSAG employed a three-stage review process that includes a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

Stage 1—Document Review

HSAG initiated the information systems review with a thorough desk review of existing documents related to encounter data initiatives/validation activities currently put forth by DMAS. Documents included data dictionaries, encounter system edits, DMAS' current encounter data submission requirements, monitoring reports, and documents to track issues, among others. The information obtained from this review was important for developing a targeted questionnaire to address important topics of interest to DMAS.

Stage 2—Development and Fielding of Customized Encounter Data Assessment

To conduct a customized encounter data assessment, HSAG developed an MCO questionnaire customized in collaboration with DMAS to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. The questionnaire also included a review of supplemental documentation regarding other data systems, including enrollment and provider data. Lastly, the questionnaire included specific topics of interest to DMAS.

The questionnaire for DMAS had similar domains as the questionnaire developed for the MCOs; however, it focused on DMAS' data exchange with the MCOs.

Since the encounter data submission requirements and processes for the CCC Plus and Medallion 4.0 are similar, HSAG sent one questionnaire to each MCO to collect information for both programs. If there were questions for the CCC Plus program only, HSAG clearly labelled them in the questionnaire. This approach helped prevent duplication.

Stage 3—Key Informant Interviews

After reviewing responses to the questionnaires, HSAG followed up with key DMAS and MCO information technology (IT) personnel to clarify any questions from the questionnaire responses.

Overall, the information systems reviews allowed HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data. From this analysis, HSAG was able to provide actionable recommendations to the existing encounter data systems on areas for improvement or enhancement.

Administrative Profile

An administrative profile, or analysis, of a state's encounter data is essential to gauging the general completeness, accuracy, and timeliness of encounter data, as well as whether encounter data are sufficiently robust for other uses such as performance measure calculation. The degree of data file completeness across the MCOs provides insight into the quality of DMAS' overall encounter data system and represents the basis for establishing confidence in subsequent analytical and rate setting activities.

HSAG assessed the final adjudicated encounters with service dates between January 1, 2020, and December 31, 2020, and extracted from the EPS database on or before July 8, 2021. In addition, the EDV study used member demographic/eligibility/enrollment data and provider data to evaluate the validity of key data elements in the encounter data. HSAG submitted a data submission requirements document to notify DMAS of the required data needed for the study. The data submission requirements document was based on the study objectives and data elements evaluated in this study. It included a brief description of the study, criteria for data extraction, required data elements, and information regarding the submission of the requested files. In addition, to assist DMAS in preparing the requested data files, HSAG followed the following two actions:

- Since this was the first time HSAG was to request encounter data from DMAS' EPS database, HSAG initially requested a set of test files from DMAS before DMAS extracted the complete set of data. The test data were smaller in size (e.g., encounters for one month) and allowed HSAG to detect any data extraction issues before the full data extract was submitted. In addition, the test data helped HSAG prepare the analyses in advance while waiting for the claim lag run-out to receive the complete data.
- After submitting the draft data submission requirements document to DMAS, HSAG scheduled a conference call with DMAS to review the document to ensure that all questions related to data preparation and extraction were addressed. Afterwards, HSAG submitted the final version of the data submission requirements document to DMAS for review/approval.

Once HSAG received the data files from DMAS, HSAG conducted a preliminary file review to ensure that the submitted data were adequate to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Extracted based on the data requirements document.
- Percentage present—Required data fields were present on the file and have values in those fields.
- Percentage of valid values—The values were as expected (e.g., valid International Classification of Diseases, Tenth Revision [ICD-10] codes in the diagnosis field).

Based on the preliminary file review results, HSAG followed up with DMAS to resubmit data, as needed.

Once the final data had been received and processed, HSAG conducted a series of analyses for metrics listed in the sections below. In general, HSAG calculated rates for each metric by MCO and encounter type (i.e., 837 Professional [837P], 837 Institutional [837I], and National Council for Prescription Drug Programs [NCPDP]). However, when the results indicated a data quality issue(s), HSAG conducted additional investigation to determine whether the issue was for a specific category of

service (e.g., nursing facilities, hospice); provider type (e.g., vision subcontractor, nonemergency transportation subcontractor); or sub-population. HSAG documented all noteworthy findings in the aggregate report.

Encounter Data Completeness

HSAG evaluated the encounter data completeness through the following metrics:

- Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occur): If the number of members remain stable and there are no major changes to members' medical needs, the monthly visit/service counts should have minimal variation. A low count for any month indicates incomplete data. Of note, instead of the claim number, HSAG evaluated the encounter volume based on a unique visit key. For example, for an office visit, the visit key is based on the member ID, rendering provider NPI, and date of service.
- Monthly encounter volume (i.e., visits) per 1,000 member months (MM) by service month: Compared to the metric above, this metric normalized the visit/service counts by the member counts. Of note, HSAG calculated the member counts by month for each MCO based on the member enrollment data extracted by DMAS.
- Paid amount per member per month (PMPM) by service month: This metric will allow DMAS to determine whether the encounter data were complete from a payment perspective. Of note, HSAG used the header paid amount to calculate this metric.
- TPL amount PMPM by service month: This metric will allow DMAS to determine whether the TPL amounts were complete and accurate.
- Percentage of duplicate encounters: This metric will allow DMAS to assess the number of potential duplicate encounters in DMAS' EPS database.

Encounter Data Timeliness

HSAG evaluated the encounter data timeliness through the following metrics:

- Percentage of encounters received by DMAS (as identified through the submission date to DMAS) within 30 days, 60 days, 90 days, etc., from the MCO payment date. The MCO contract states that the MCOs should "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) business days of the Contractor's payment date." This metric will allow DMAS to evaluate the extent to which the MCOs met the standard.
- Claims lag triangle to illustrate the percentage of encounters received by DMAS within two calendar months, three months, etc., from the service month (as identified through the last date of service). This metric will allow DMAS to evaluate how soon it may use the encounter data in the EPS database for activities such as performance measure calculation and utilization statistics.

Field-Level Completeness and Accuracy

HSAG evaluated whether the data elements in the final paid encounters are complete and accurate through the two study indicators described in Table 2-1 for the key data elements listed in Table 2-2. In addition, Table 2-2 shows the criteria HSAG used to evaluate the validity for each data element. These criteria are based on standard reference code sets or referential integrity checks against member or provider data.

Table 2-1—Study Indicators for Percent Present and Percent Valid

Study Indicator	Denominator	Numerator
Percent Present: Percentage of records with values present for a specific key data element.	Total number of final paid encounter records based on the level of evaluation noted in Table 2-2 (i.e., at either the header or detail line level) with dates of service in the study period.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 2-2.
Percent Valid: Percentage of records with values valid for a specific key data element.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 2-2. Note: Since not all HCPCS/CPT codes have Medically Unlikely Edits (MUEs), only service units for procedure codes with an MUE were included in the denominator when calculating this indicator for the data element Service Units.	Number of records with values valid for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 2-2. The criteria for validity are listed in Table 2-2.

Table 2-2—Key Data Elements for Percent Present and Percent Valid

Key Data Elements	837P Encounters	837I Encounters	NCPDP Encounters	Criteria for Validity
Member ID [H]	✓	✓	✓	• In member file • Enrolled in a specific MCO on the date of service • Member Date of Birth is on or before detail date of service
Header Service From Date [H]	✓	✓		• Header Service From Date ≤ Header Service To Date • Header Service From Date ≤ Paid Date
Header Service To Date [H]	✓	✓		• Header Service To Date ≥ Header Service From Date • Header Service To Date ≤ Paid Date

Key Data Elements	837P Encounters	837I Encounters	NCPDP Encounters	Criteria for Validity
Detail Service From Date [D]	✓	✓	✓	• Detail Service From Date ≤ Detail Service To Date • Detail Service From Date ≤ Paid Date
Detail Service To Date [D]	✓	✓	✓	• Detail Service To Date ≥ Detail Service From Date • Detail Service To Date ≤ Paid Date
Billing Provider NPI [H]	✓	✓	✓	In provider data when service occurred
Rendering Provider NPI [H]	✓			In provider data when service occurred
Attending Provider NPI [H]		✓		In provider data when service occurred
Servicing Provider Taxonomy Code [D]	✓	✓		• In standard taxonomy code set • Match with the value in provider data
Referring Provider NPI [H]	✓	✓		In provider data when service occurred
Prescribing Provider NPI			✓	In provider data when service occurred
Primary Diagnosis Codes [H]	✓	✓		In national ICD-10-Clinical Modification (CM) diagnosis code sets for the correct code year (e.g., in 2020 code set for services that occurred between October 1, 2019, and September 30, 2020)
Secondary Diagnosis Codes [H]	✓	✓		In national ICD-10-CM diagnosis code sets for the correct code year

Key Data Elements	837P Encounters	837I Encounters	NCPDP Encounters	Criteria for Validity
CPT/HCPCS Codes [D]	✓			In national CPT and HCPCS code sets for the correct code year (e.g., in 2020 code set for services that occurred in 2020) AND satisfies CMS' Procedure to Procedure Edits[2-2]
Service Units [D]	✓	✓		Positive and below the maximum units of service according to CMS' MUE[2-3]
Primary Surgical Procedure Codes [H]		✓		In national ICD-10-CM surgical procedure code sets for the correct code year
Secondary Surgical Procedure Codes [H]		✓		In national ICD-10-CM surgical procedure code sets for the correct code year
Revenue Codes [D]		✓		In national standard revenue code sets for the correct code year
Diagnosis-Related Groups (DRG) Codes [H]		✓		In the list of all patients refined (APR) DRGs from DMAS [2-4]
Type of Bill Codes [H]		✓		In national standard type of code set
National Drug Codes (NDCs) [D]	✓	✓	✓	In national NDC code sets
HCPCS/NDC Combination [D]	✓	✓ (for type of bill codes starting with "13" or "83")		Met the criteria listed in 2020 Average Sales Price Drug Pricing files[2-5]

[2-2] Centers for Medicare & Medicaid Services. PTP Coding Edits. Available at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits. Accessed on: Oct 19, 2021. Currently, DMAS does not apply the Procedure to Procedure Edits in EPS, and HSAG will note this in the final aggregate report.

[2-3] Centers for Medicare & Medicaid Services. Medically Unlikely Edits. Available at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE. Accessed on: Oct 19, 2021. Currently, DMAS does not apply the MUE edits in EPS, and HSAG will note this in the final aggregate report.

[2-4] Virginia Medicaid Department of Medical Assistance Services. Hospital Rates. Available at: https://www.dmas.virginia.gov/for-providers/rate-setting/hospital-rates/. Accessed on: Oct 15, 2021.

[2-5] Centers for Medicare & Medicaid Services. 2020 ASP Drug Pricing Files. Available at: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/2020-asp-drug-pricing-files. Accessed on: Oct 19, 2021. HSAG used this crosswalk to conduct the analysis. Currently, DMAS has a similar edit in EPS. However, it is based on a proprietary crosswalk from DMAS' pharmacy team.

Key Data Elements	837P Encounters	837I Encounters	NCPDP Encounters	Criteria for Validity
MCO Received Date (i.e., the date when the MCOs received claims from providers)	✓	✓	✓	MCO Paid Date ≥ MCO Received Date ≥ Detail Service To Date
MCO Paid Date [D]	✓	✓	✓	MCO Submission Date (i.e., the date when MCOs submit encounters to DMAS) ≥ MCO Paid Date ≥ MCO Received Date
Header Paid Amount [H]	✓	✓		Header Paid Amount equal to sum of the Detail Paid Amount
Header TPL Paid Amount [H]	✓	✓		Header TPL Paid Amount equal to sum of the Detail TPL Paid Amount
Detail Paid Amount [D]	✓	✓	✓	Zero or positive
Detail TPL Paid Amount [D]	✓	✓	✓	Zero or positive based on the TPL flag from the encounter data

[H] Conducted evaluation at the header level.

[D] Conducted evaluation at the detail level.

3. Information Systems Review

Representatives from all six MCOs completed DMAS-approved questionnaires supplied by HSAG. HSAG identified follow-up questions based on the MCOs' original questionnaire responses, and the MCOs responded to these MCO-specific questions. To support their questionnaire responses, the MCOs submitted a wide range of documents with varying formats and levels of detail. DMAS also completed its questionnaire. Although the MCOs reported on dental services, they were out of the scope of this study and hence were excluded from this report.

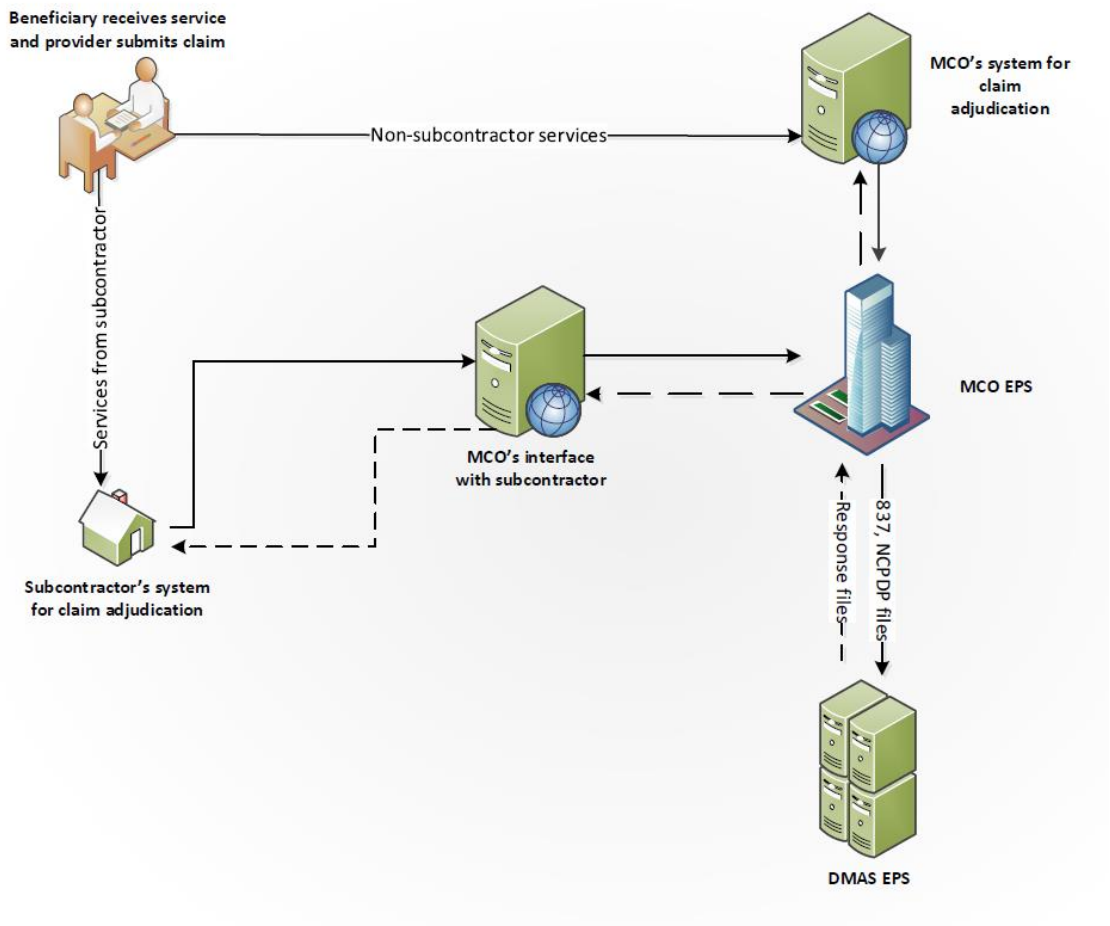
Encounter Data Sources and Systems

This section of the report summarizes data sources used in the claims data to encounter data cycle, the systems in place to process the data, the systematic formatting that occurs prior to submission (if completed by a third-party), and how data are verified from provider and beneficiary information.

Claims/Encounter Data Flow

Figure 3-1 shows a high-level process, which outlines the path followed by an MCO's encounter data from the time a member receives a service(s) until the encounter is processed by DMAS. The solid lines represent the primary transaction paths between each process agent; the dotted lines represent data transfer feedback loops. As shown in the figure, the claims/encounter process begins when a member receives a health care service from a provider. The providers then submit claims electronically or via paper to a clearinghouse responsible for aggregating and formatting claims for submission to the claim processor, although they may also submit the claims directly to the MCO for claims processing. Next, the claim is processed, and the data are submitted to the MCO's encounter data system (MCO EPS). If the claim was processed by a third-party, that subcontractor submits the claim information to the MCO through its encounter data system (MCO EPS). The MCO or its subcontractor is responsible for ensuring that encounter data are accurate, complete, and formatted correctly for timely submission to DMAS using 837P, 837I, or NCPDP D.0 files.

Figure 3-1—Claims/Encounter Data Path From Origin Through Submission to DMAS



Information System Infrastructure

DMAS receives 837P, 837I, and NCPDP files directly from the MCOs. Table 3-1 shows the source, format, and frequency of data submission to DMAS for all six MCOs. HealthKeepers, Optima, and VA Premier reported a small percentage of claims submitted by capitated providers. HealthKeepers reported 2 percent for medical (837P) claims, with approximately 1.8 percent of claims received for capitated providers via the paper claim process. Optima reported that less than 5 percent for medical (837P) claims were paid through capitated arrangements. Although Optima's subcontractor for vision and nonemergency transportation is capitated, providers are paid using a fee-for-service (FFS) model. VA Premier reported 100 percent for all claims, except medical 837P and 837I claims (0 percent), as the approximate percentage of claims submitted by capitated providers.

Table 3-1—Format and Submission Frequency of Encounters to DMAS for Both CCC Plus and Medallion 4.0 Programs

Data Source	Format (All MCOs)	Frequency
Institutional	X12 837I	Weekly
Professional	X12 837P	Weekly
Pharmacy	NCPDP D.0	Weekly for all, except HealthKeepers which is biweekly
Vision	X12 837P	Biweekly for all. Also, weekly for HealthKeepers
Non-Emergency Transportation	X12 837P	Weekly for all. Also, biweekly for HealthKeepers
Consumer Directed Personal Care Services	X12 837P	Weekly/Biweekly for all, except Aetna and HealthKeepers which are biweekly only

Aetna, HealthKeepers, and Molina use the Edifecs system for EDV as well as for preparing/generating outbound encounters for submission to DMAS for the majority of their encounter data file types. Other software used either for data validation or preparation for submission include:

- RxClaim; data validation (HealthKeepers, Optima)
- Facets, First Rx, ProClaim, 1EDI Source Tool, WindWard, and Verifier; data validation (Molina)
- First Rx, Seeburger Business Integration, 1 EDI Source Tool, Informatica, and Annkissam EDI; data preparation for submission (Molina)
- CSC/Wintegrate; data validation and preparation for submission (Optima)
- Web-based application that works in conjunction with RxClaim; data preparation for submission (Optima)
- Optum Transaction Validation Manager and NEMIS Validation and Adjustment Engines; data validation (United)
- NEMIS Extract/Generate; data preparation for submission (United)
- An encounter data manager (EDM) tool; data validation and preparation for submission and Facets; data validation of paper claims (VA Premier)

All plans reported software used for EDI compliance checks carried out on encounters submitted to DMAS through 837P and 837I formats, as well as Workgroup for Electronic Data Interchange Strategic National Implementation Process (WEDI SNIP) levels used for the checks.

Table 3-2 outlines modifications, reformatting, or changes made to claims/encounter data to accommodate DMAS' encounter data submission standards, as well as brief descriptions of how MCOs prepare/enrich data elements not on the claims received from providers but required by DMAS.

Table 3-2—Modification Made to Encounter Data to Accommodate DMAS Submission Standards and Creation Process for Data Elements not on Claims From Providers but Required by DMAS

Type	Field Description	Modification Details/Source Data and Creation Process
Aetna		
837P and I	N/A	None. If required data are missing, the claim is rejected or voided and sent to the provider for correction.
HealthKeepers		
Encounters	DRG	The last digit of the DRG is removed because DMAS only accepts a three-digit code. If a claim was not paid under the DRG, the DRG will not be submitted.
	Taxonomy	Taxonomy is added to encounters when it is missing on the claim. The NPI submitted on the claim is matched against the internal provider network data or using the National Plan and Provider Enumeration System (NPPES) NPI registry site.
Pharmacy	Cardholder field	Sourced from member eligibility record.
Molina		
Medical in 837I and P	Payment indicator	Determined based on Facets configuration criteria.
	Resubmission date	Date calculated, by when the corrected encounter data are loaded into Edifecs Encounter Management.
	Other payer information	Other Payer ID.
	Enhanced benefit indicator	Determined based on both Facets configuration criteria and procedure codes.
	Service line	None.
Vision (VSP)	Taxonomy code	Created using data from NPPES.
	Enhanced benefit indicator in 837P	Use CPT codes, member, and product data.
	Claim number	The last digit of the claim number is modified to avoid a rejection as a duplicate. The original claim number is maintained in a separate field.
Non-emergency transportation (Veyo) 837P	Enhanced benefit indicator	None.
CD/FEA(Aces$)	Ambulance pick-up and drop-off	Location data for each service mapped to ambulance fields in the 837.
	Electronic visit verification (EVV) time	EVV time maps to service description location.

Type	Field Description	Modification Details/Source Data and Creation Process
	Attendant info	Attendant information mapped to supervising provider fields.
	Date paid	Derived from check date.
	Enhanced benefit indicator in 837P	Use CPT codes, member, and product data.
	File names in 837P	Naming convention of file generated changed to accommodate DMAS requirements
Optima		
837I claims	Bill type	Some replacement claims update the last digit on the claim number to be accepted at DMAS.
837P and I claims	Taxonomy code	Linked to crosswalk table by NPI.
	Member ZIP Code	Populates 0000 if last four digits are missing.
	Payment reduction amount	Identifies when a payment reduction occurs due to emergency room payment reductions or hospital readmission reductions.
United		
837P claims	Member ZIP Code	Populates 0000 if last four digits are missing.
837P and I claims	Taxonomy code	Linked to crosswalk table by NPI.
	Payment reduction amount	Contains a concatenated value of a label, a hyphen, and an associated dollar amount.
VA Premier		
Subcontractor ID	Interchange sender ID and application sender's code	Hard-coded values provided by DMAS are included as instructed.
837P and I claims	Payment reduction amount	Identifies when a payment reduction has occurred due to emergency room payment reductions or hospital readmission reductions.
All claims	ZIP Code	Populates 0000 if last four digits are missing.
	Date received, date paid, date adjudicated, date resubmitted, payment status	Added by EDM tool.
All claims	Member demographic	Added from data warehouse using insured ID number. Process: If claim is received with insured ID number, the member demographic information is pulled/leveraged from the data warehouse and populated on the claim form.

Validation Performed on Claims

HealthKeepers' quality assurance area conducted a random statistically valid monthly audit to evaluate the financial, payment, and statistical accuracy of claims processing. Optima and VA Premier reviewed a 1 percent random stratified sample weekly. United conducted an audit of a stratified random sample of encounters for financial and procedural accuracy, which comprised 0.03 percent of encounters.

Duplicate, Denied, and Adjusted Claims

All MCOs provided a description of the process to identify duplicate claims, details on the fields used to identify duplicates, the point in the process the duplicates are identified, and how they are handled. Descriptions of some common fields examined for duplication across plans are member ID, provider ID, procedure code, and date of service. Table 3-3 shows descriptions of common fields examined for duplication and similarities across plans.

Table 3-3—Some Common Field Used by MCOs to Examine Claims for Duplication

Plan	Field Description
Aetna	Member ID, provider ID, service code, and date of service
HealthKeepers	Member ID, provider ID, procedure code, revenue code, exact charges, date of service, pharmacy ID, Rx#, fill date, refill number
Molina	Billing provider identifier, application sender's code, member ID, date of service, trip ID, prescription number, NDC, service code, date of service
Optima	Member number, subcontractor number, date of service, procedure code, total charges of current claim
United	Date of service, type of service, procedure code, modifier, diagnosis code, units billed, revenue code, place of service, charge, provider, and bill type
VA Premier	Member ID, date of service, service code, modifier, rendering physician, pay to provider

All MCOs reported submitting all types of claims/encounters (paid, denied, voided, or adjusted claims) to DMAS, except environmental claims (Optima and VA Premier). Environmental claims are typically not submitted because the company rendering the service does not have an NPI number.

All MCOs report taking measures to ensure denied claims/encounters do not include paid service lines. For example, United described that the claim level payment status is sent as paid if any line on the claim was paid, and sent as denied if all lines on the claim were denied.

The process to submit adjustments that have previously been submitted to DMAS is similar across MCOs. Adjustments may be submitted to DMAS with a frequency code referencing the original claim (Aetna) or handled as any other claim (Optima, VA Premier). For encounters that need adjustment, it can take up to 90 days (United) or as little as seven days (HealthKeepers) from identification to adjustment resubmission. VA Premier and Optima did not provide typical time frames for completing adjustments. Overall, the duration of this process varies across plans and depends on the adjustment need on the claim.

Collection, Use, and Submission of Provider and Enrollment Data

Aetna, HealthKeepers, United, and VA Premier collected and maintained provider data sent regularly by their respective subcontractor(s). Molina and Optima's data were collected and maintained by a subcontractor with responsibilities including claims processing and encounter submission/response.

Data Exchange Policies and Procedures

The encounter data submission process begins with reviewing contractual requirements and data submission requirements, such as companion guides and technical manuals. MCOs prepare their file submissions based on DMAS' guidelines, DMAS EDI companion guides, and technical manuals retrieved from https://eps.dmas.virginia.gov/epsportal/#/guides. Policy and procedure documents were submitted by each MCO to HSAG as supporting documentation for the completed questionnaires. These documents show that the MCOs employ encounter file generation and review processes that have been tailored to meet DMAS' encounter submission contractual requirements and specifications.

Payment Structures of Encounter Data

This section focuses primarily on the MCOs' collection of payment-related data and how claims are paid. Table 3-4 shows the MCOs' pricing methodology for inpatient, outpatient, pharmacy, and long-term care encounters. Some variation in pricing methodology exists among the MCOs.

Table 3-4—Pricing Methodology by MCO, Claim Type, and Payment Arrangement

MCO	Inpatient	Outpatient	Pharmacy	Long-Term Care
Aetna	• Line-by-Line • Per Diem • DRG	• Percent of Billed • Line-by-Line • Per Diem • Negotiated (Flat) Rate • Other (Ambulatory Surgery) • Other (Per Unit)	• Line-by-Line • Other (Ambulatory Surgery) • Other (Per Unit)	• Percent of Billed • Line-by-Line • Per Diem
HealthKeepers	• Percent of Billed • Line-by-Line • Per Diem • DRG • Negotiated (Flat) Rate • Other	• Percent of Billed • Line-by-Line • Per Diem • Capitation • Negotiated (Flat) Rate • Other	Ingredient cost	• Percent of Billed • Line-by-Line • Per Diem • DRG • Negotiated (Flat) Rate • Other

MCO	Inpatient	Outpatient	Pharmacy	Long-Term Care
Molina	• Line-by-Line • Per Diem • DRG	• Percent of Billed • Line-by-Line	Pharmacy average wholesale price (AWP)	• Percent of Billed • Line-by-Line • Per Diem • Negotiated (Flat) Rate
Optima	• Percent of Billed • Line-by-Line • Per Diem • DRG • Other	• Percent of Billed • Line-by-Line • Per Diem • Other	Line-by-Line	• Per Diem • Other
United	• Percent of Billed • Per Diem • DRG • Other	• Percent of Billed • Per Diem • Other	100% Claims for Covered Prescription services are paid at the lesser of the contracted network AWP discount, Medicare Administrative Contractors (MAC), or Usual and Customary (U&C), plus a dispensing fee.	• Percent of Billed • Per Diem • DRG • Other
VA Premier	• Per Diem • DRG • Negotiated (Flat) Rate	• Line-by-Line • Per Diem • Other	• Line-by-Line • Negotiated (Flat) Rate	• Line-by-Line • Per Diem • DRG • Negotiated (Flat) Rate • Other

Bundle Payment Structures

Aetna, HealthKeepers, and Molina reported they did not cover any services under bundle-payment structures. However, Optima and VA Premier reported that they adopted the DMAS bundled payment methodology for reimbursement of obstetrical services (OB), which provides a flat fee post-delivery, for various services rendered through postpartum. Similarly, United has a reimbursement policy for maternity/prenatal claims that pay as a bundle, even though there are no bundled payments.

Third-Party Liability (TPL) Data

All MCOs denied a claim if the MCO identified the member had other insurance, and the claim was received with no explanation of benefits (EOB). MCOs handled TPL in a similar manner. All plans collected and verified insurance coverage information from a variety of sources including internal departments, member communication, and other leads. Plans used internal validation and audit procedures to verify payment information and contracted with subcontractors to identify and recover overpayments.

Zero-Paid Claims

Not all plans report zero-paid claims the same way. Although all plans send these claims with a payment amount of $0.00, United indicated zero-paid claims are sent with a payment status of denied. All other plans indicated they treat zero-paid claims as approved/paid claims.

Scenarios in which zero-paid claims are created vary slightly across plans. Aetna, Optima, and United report zero-paid claims if the primary payer has paid more than the Medicaid allowable amount. Optima also reports capitated services as zero-paid claims. Molina reports zero-paid claims under special circumstances such as when a crossover or commercial claim does not require Medicaid payment.

Encounter Data Quality Monitoring and Reporting

All plans routinely monitored completeness, accuracy, and timeliness of claims. Plans that provided a description of these monitoring reports described assessing data quality through dashboards in Tableau or similar software (Aetna, HealthKeepers). Optima, United, and VA Premier described other reporting to monitor claim completeness and/or timeliness, while Molina did not provide details regarding monitoring/reporting activities.

Most plans reported that overall, up to 5.33 percent of encounters submitted to DMAS are rejected by DMAS' EDI translator. Similarly, a small percentage of encounters (up to 4 percent) were reported to have failed the EPS business rules, once passing DMAS' EDI translator.

Internal and External Challenges

Molina

- Internal: The 834 does not include a carrier code for TPL, making matching difficult and requiring manual documentation and monitoring for the current override process. [3-1]
- External: Repository of the EDI translator rules (compliance check) and reporting on informational edits when applicable.

[3-1] As of November 2021, DMAS has a project scheduled for 2022 that will address the issue noted in the bullet and improve the quality of the TPL information being shared with the MCOs.

Optima

- Internal: Turnaround time of IT implementing necessary changes to comply with DMAS changes or updates.
- External: Limiting files to 4999 claims or less, EPS not allowing the submission of adjustment or void claims if the original failed in EPS,[3-2] DMAS scorecard not having enough granular information into how some of the metrics are calculated, and the timing of the NDC update process by DMAS.

Changing the monthly meeting platform—Optima cited issues with Google Meets and recommended WebEx or Zoom.

VA Premier

- Internal: Turnaround time of EDM developers implementing necessary changes to comply with DMAS' changes or updates, during submission of encounter data to DMAS.
- External: DMAS' delay in getting NDCs loaded into its system; inability in DMAS' system to allow replacement claims to correct a previously submitted claim that may have failed for any number of reasons.[3-3] Also expressed a preference for prompt receipt of the encounter data quality scorecard.

[3-2] As of November 2021, DMAS is in the process of solving this issue.
[3-3] As of November 2021, DMAS is in the process of solving this issue.

4. Administrative Profile

This section shows results from the administrative profile, which evaluated the extent to which the encounter data in DMAS' EPS database are complete, accurate, and submitted by the MCOs in a timely manner for encounters with dates of service in CY 2020. HSAG conducted the analyses for the following three domains:

- Encounter data completeness
- Encounter data timeliness
- Field-level completeness and accuracy

Encounter Data Completeness

The following subsections will provide results by claim type for encounter data completeness. The figures will include results for the following:

- Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occur)
- Monthly encounter volume per 1,000 MM by service month
- Paid amount PMPM by service month
- TPL paid amount PMPM by service month
- Percentage of duplicate encounters

Monthly Encounter Volume

Figure 4-1 provides the monthly encounter volume for professional encounters. Although all plans exhibited a decline in April 2020 as a result of the coronavirus disease 2019 (COVID-19) public health emergency (PHE), Molina and United had the lowest volume and only a slight decline with a steady volume of encounters throughout the year.

Figure 4-1—Monthly Encounter Volume—Professional Encounters

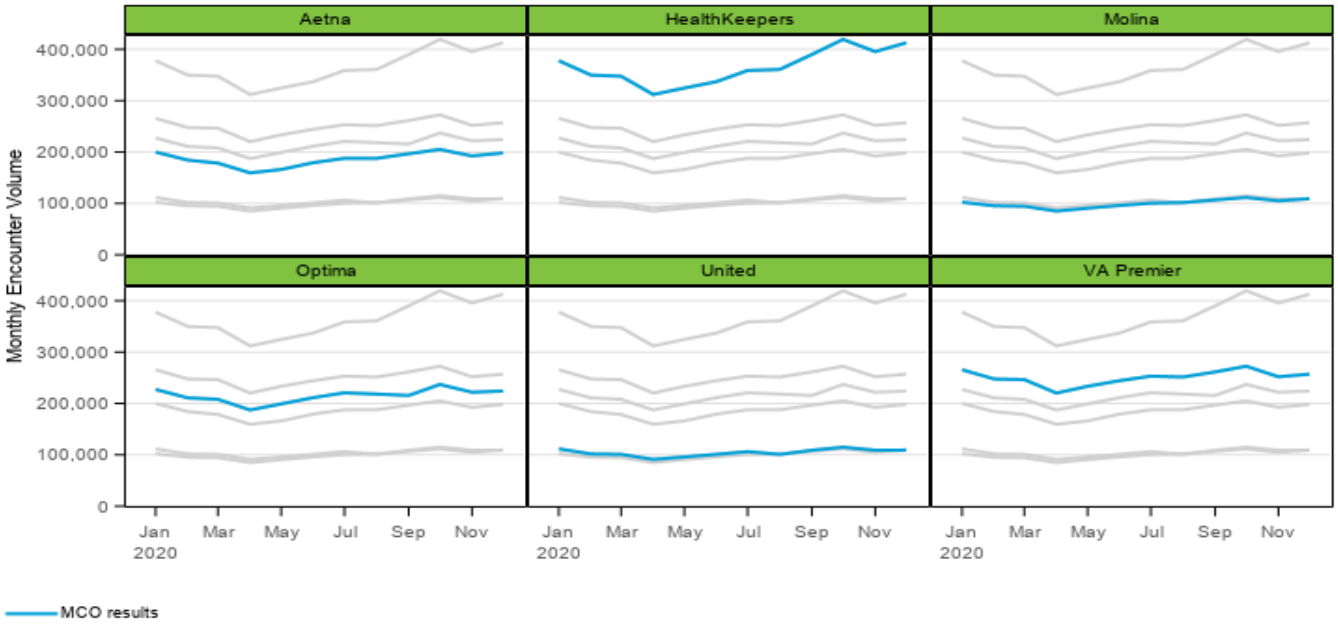


Figure 4-2 provides the monthly encounter volume for institutional encounters. The volume of institutional encounters declined substantially in the first four months of 2020, primarily due to the PHE, and recovered to near pre-pandemic levels by October 2020. Molina and United exhibited the lowest claim volume and the lowest impact from the PHE, with a decline of about 32 and 37 percent, respectively, between January and April 2020. Meanwhile, claim volume for HealthKeepers declined by 45 percent between January and April 2020.

Figure 4-2—Monthly Encounter Volume—Institutional Encounters

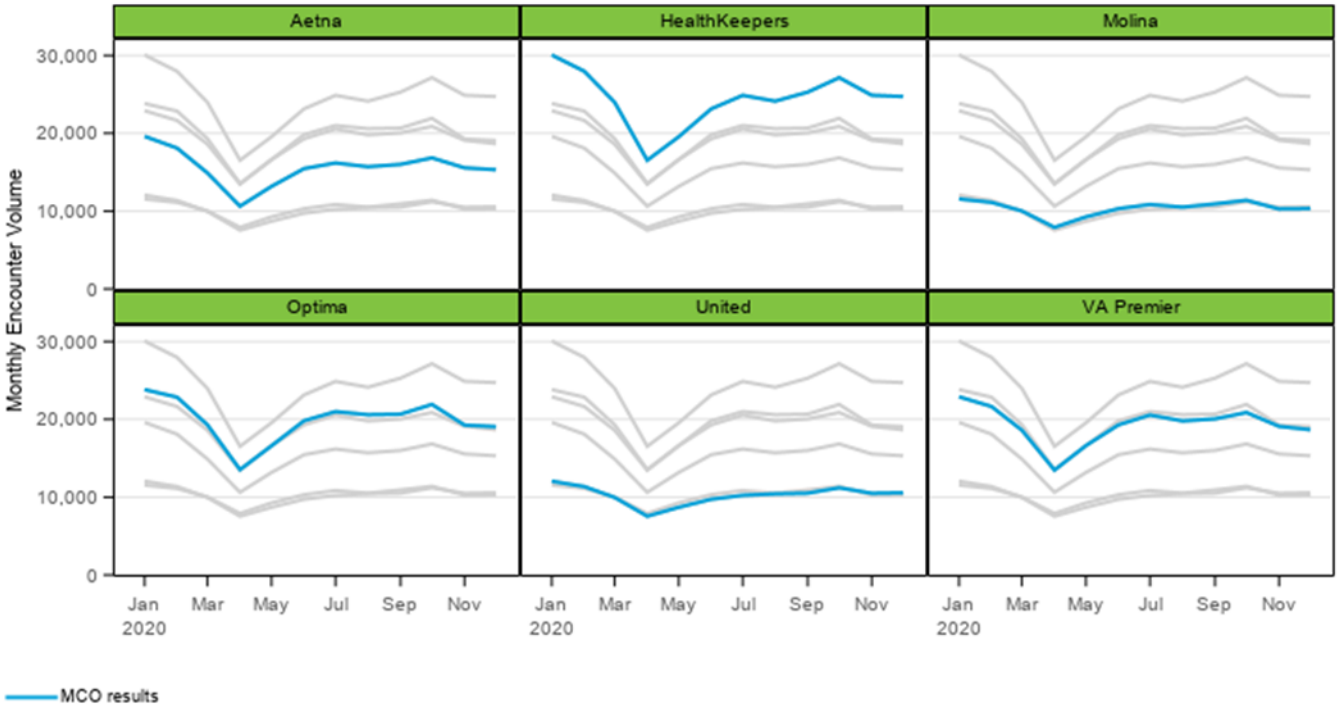
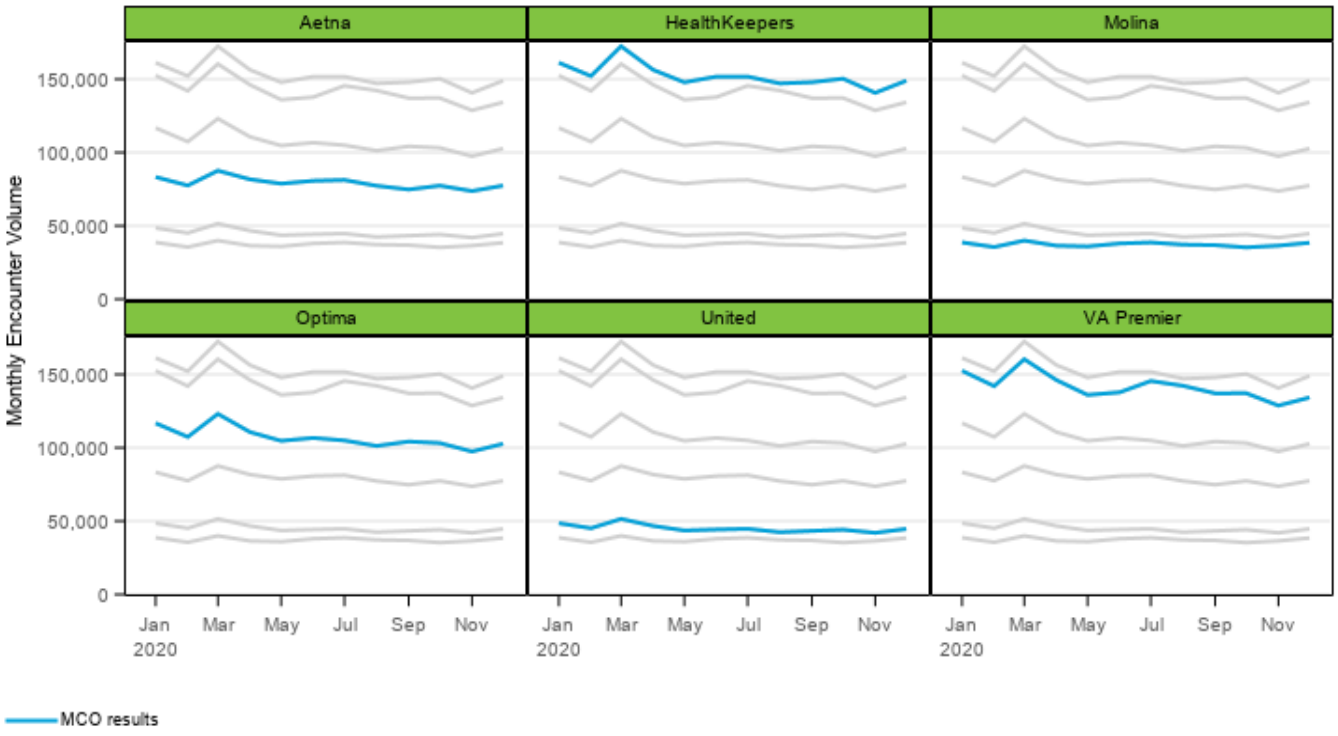


Figure 4-3 provides the monthly encounter volume for pharmacy encounters. Pharmacy encounters remained relatively steady throughout 2020 for all plans, each exhibiting an uptick in March 2020. There was substantive variation across plans, with Molina and United submitting fewer than 50,000 encounters per month and HealthKeepers averaging over 150,000.

Figure 4-3—Monthly Encounter Volume—Pharmacy Encounters



Monthly Encounter Volume per 1,000 MM

Figure 4-4 provides the monthly encounter volume per 1,000 MM for professional encounters. Controlling for MCO membership size, United and Molina still had fewer professional encounters submitted than other plans, at approximately 3,500 and 4,000 per 1,000 member months, respectively.

Figure 4-4—Monthly Encounter Volume per 1,000 MM—Professional Encounters

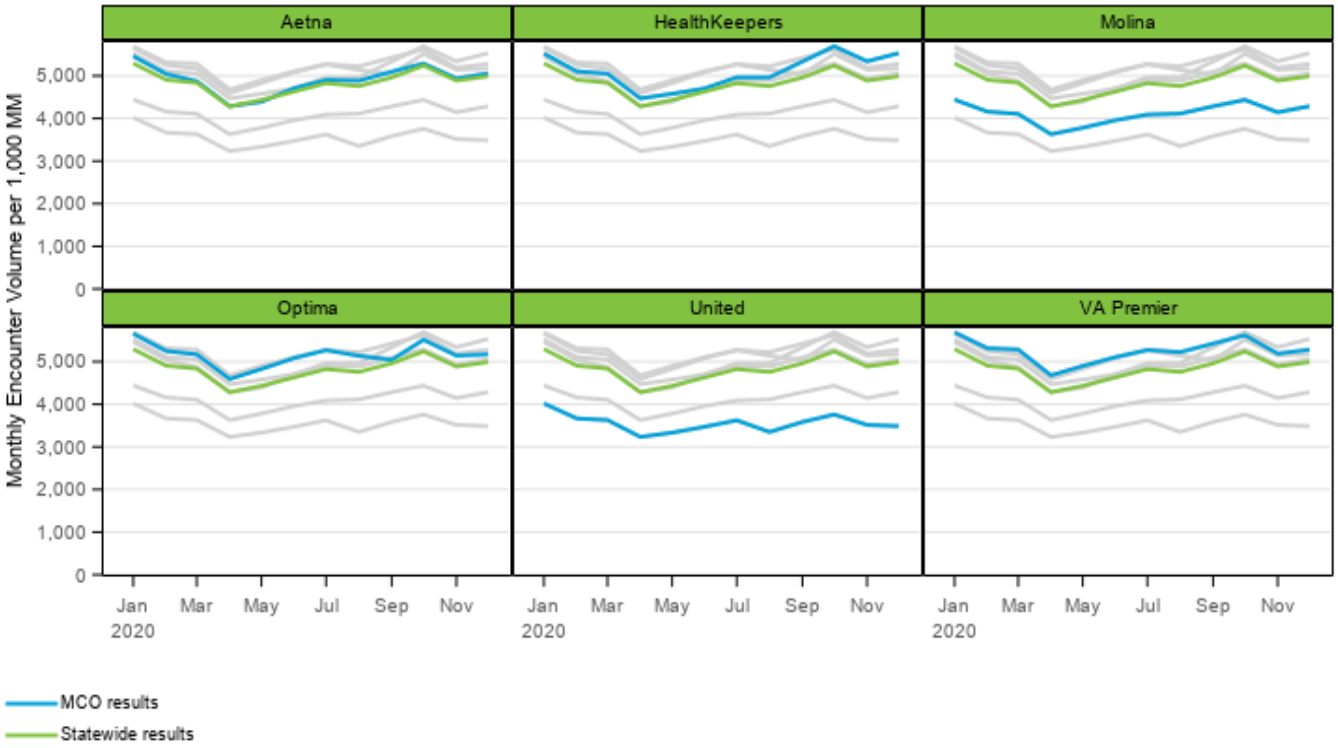


Figure 4-5 provides the monthly encounter volume per 1,000 MM for institutional encounters. Plan variation among institutional encounters was relatively lower compared to professional and pharmacy encounters, with most plans near the statewide average. Encounter volume among HealthKeepers members was generally about 15 percent lower than statewide, and Optima was about 20 percent higher. Statewide, encounter volume fell from 494 to 282 per 1,000 MM (a decline of 43 percent) between January and April 2020 before recovering and holding steady at approximately 400 per 1,000 member months for the second half of the year.

Figure 4-5—Monthly Encounter Volume per 1,000 MM—Institutional Encounters

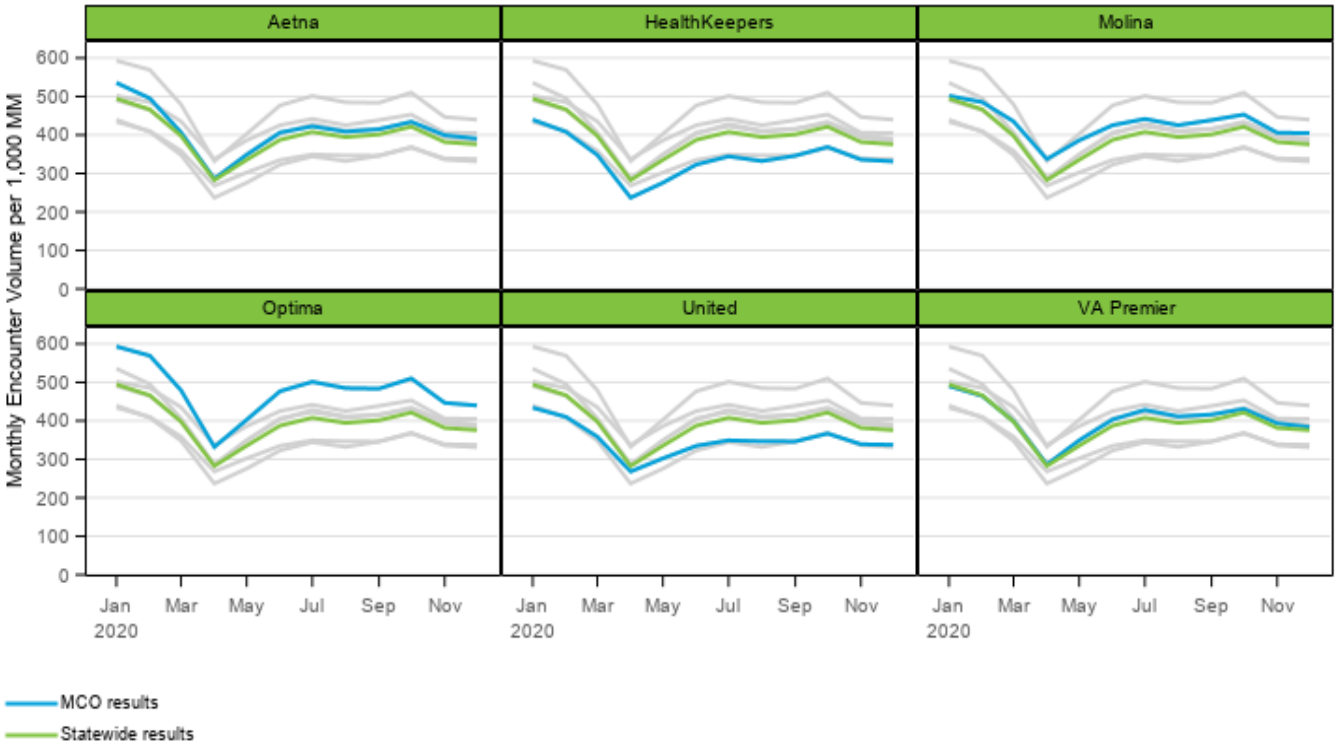
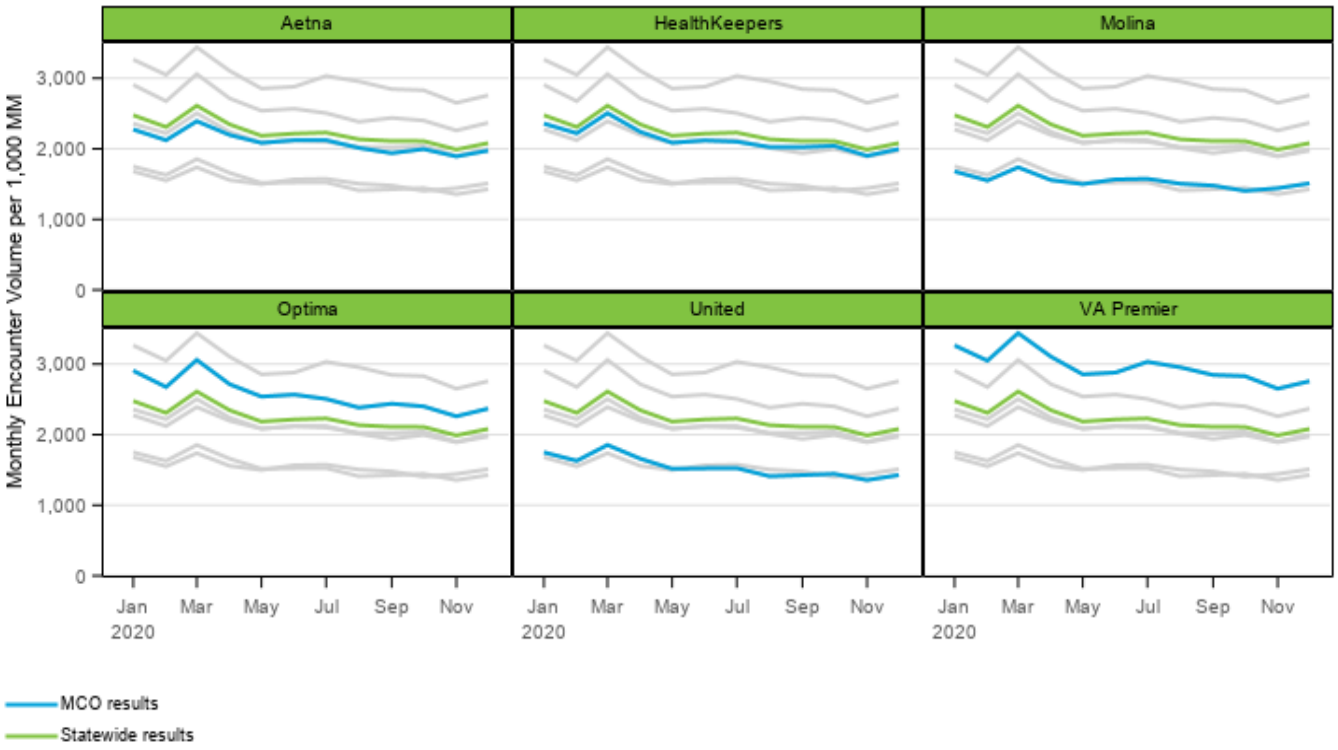


Figure 4-6 provides the monthly encounter volume per 1,000 MM for pharmacy encounters. While pharmacy encounters declined slightly throughout 2020, there was substantive variation across most plans. Encounter volume for United and Molina averaged approximately 1,500 per 1,000 MM while VA Premier averaged nearly 3,000 per 1,000 MM. Statewide encounter volume declined from a peak of 2,612 encounters per 1,000 MM in March 2020 to 1,989 in November 2020.

Figure 4-6—Monthly Encounter Volume per 1,000 MM—Pharmacy Encounters



Paid Amount PMPM

Figure 4-7 provides the PMPM paid amount for professional encounters. Statewide, professional encounters averaged $663, with a slight decline across all plans in March 2020. Similar to encounter volume, United and Molina had the lowest PMPM paid amounts, with United averaging $490. HealthKeepers and Optima had the highest PMPM paid amounts, with HealthKeepers averaging $774 and Optima averaging $746.

Figure 4-7—Paid Amount PMPM—Professional Encounters

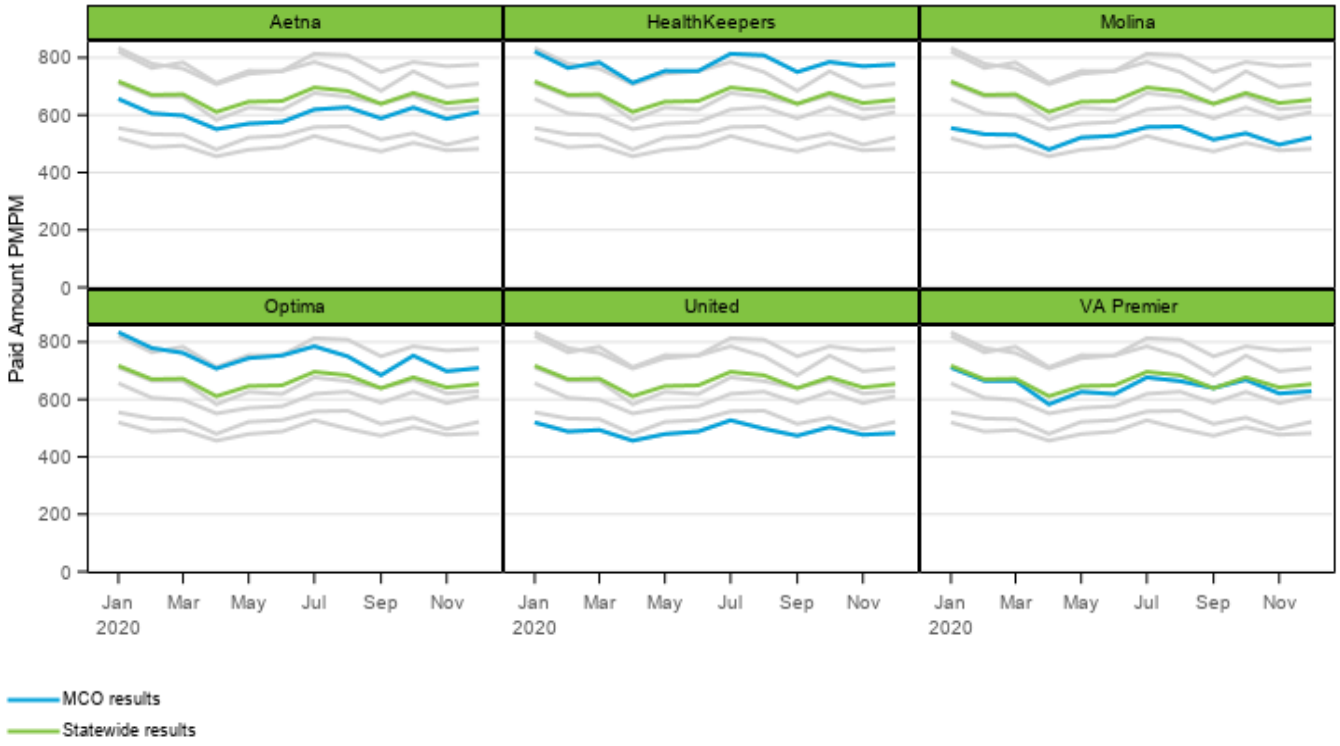


Figure 4-8 provides the paid amount PMPM for institutional encounters. While most plans exhibited a decline in institutional PMPM paid amounts in April 2020, this decline in costs was not nearly as substantive as the decline in encounter volume. This implies the average cost per claim increased during this time ostensibly as a result of the PHE. Statewide, average PMPM paid amounts for institutional encounters fell from $690 to $548, a 21 percent decline, compared to a 43 percent decline in encounter volume per 1,000 MM (Figure 4-5).

Figure 4-8—Paid Amount PMPM—Institutional Encounters

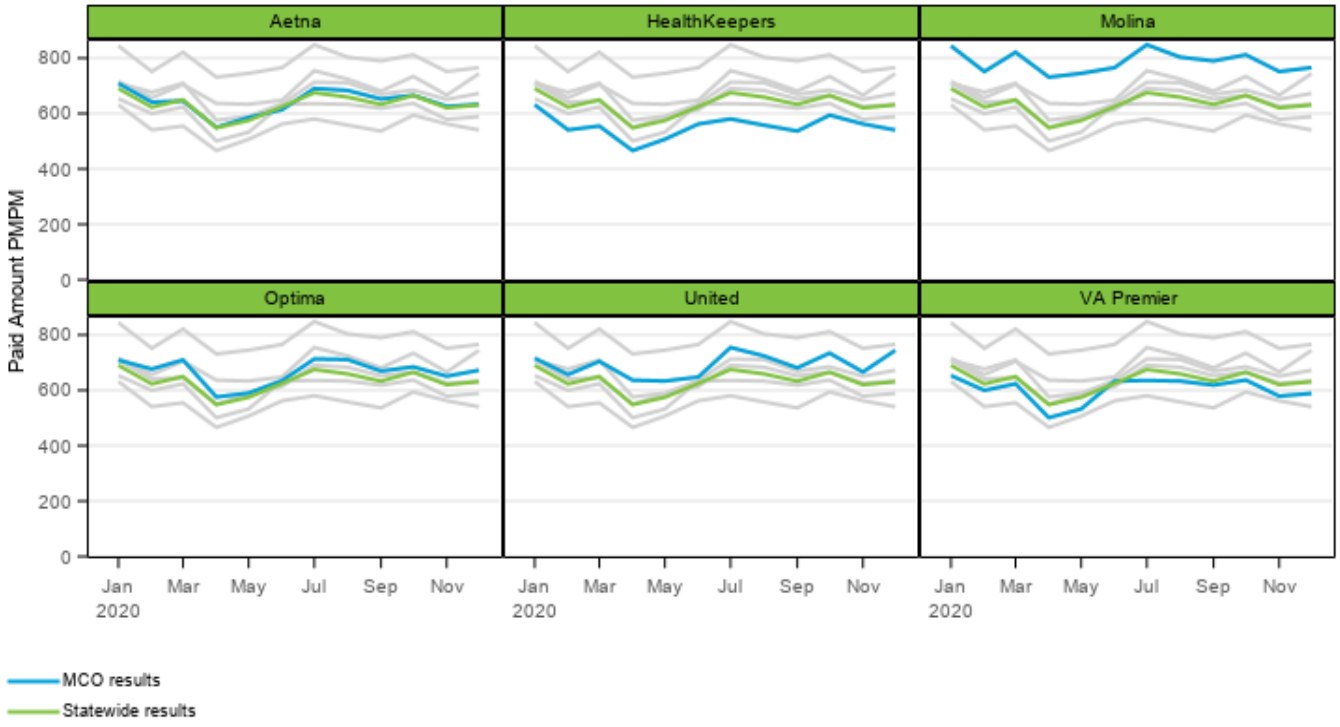
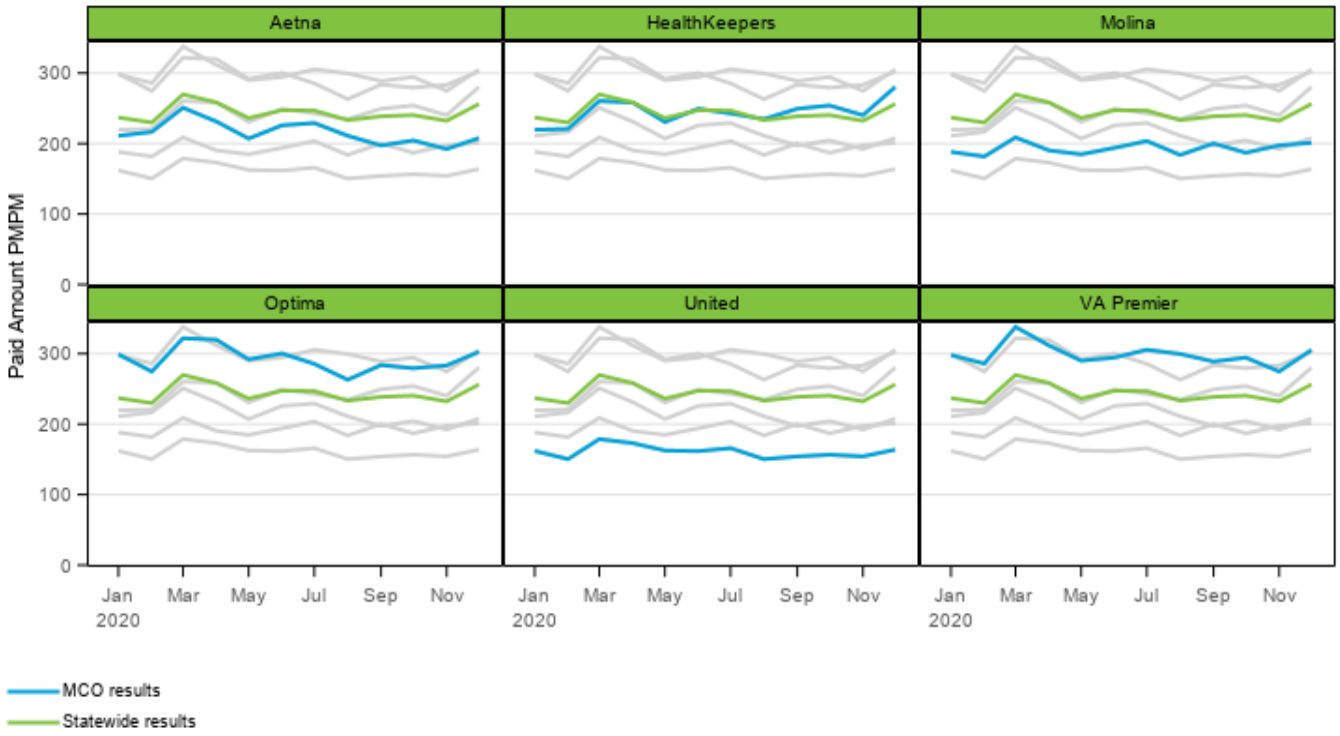


Figure 4-9 provides the paid amount PMPM for pharmacy encounters. Statewide, pharmacy encounters averaged $244, ranging from United at $161 to Optima and VA Premier averaging $292 and $299, respectively. Similar to pharmacy encounter volume, there was no discernable decline in April 2020 as there was for professional and institutional encounters.

Figure 4-9—Paid Amount PMPM—Pharmacy Encounters



TPL Paid Amount PMPM

Figure 4-10 provides the TPL paid amount PMPM for professional encounters. All plans reported TPL paid amounts on professional encounters throughout the study year, averaging $70 PMPM. Molina had the highest TPL paid amount at $100 but had the second lowest total PMPM paid amount shown in Figure 4-7.

Figure 4-10—TPL Paid Amount PMPM—Professional Encounters

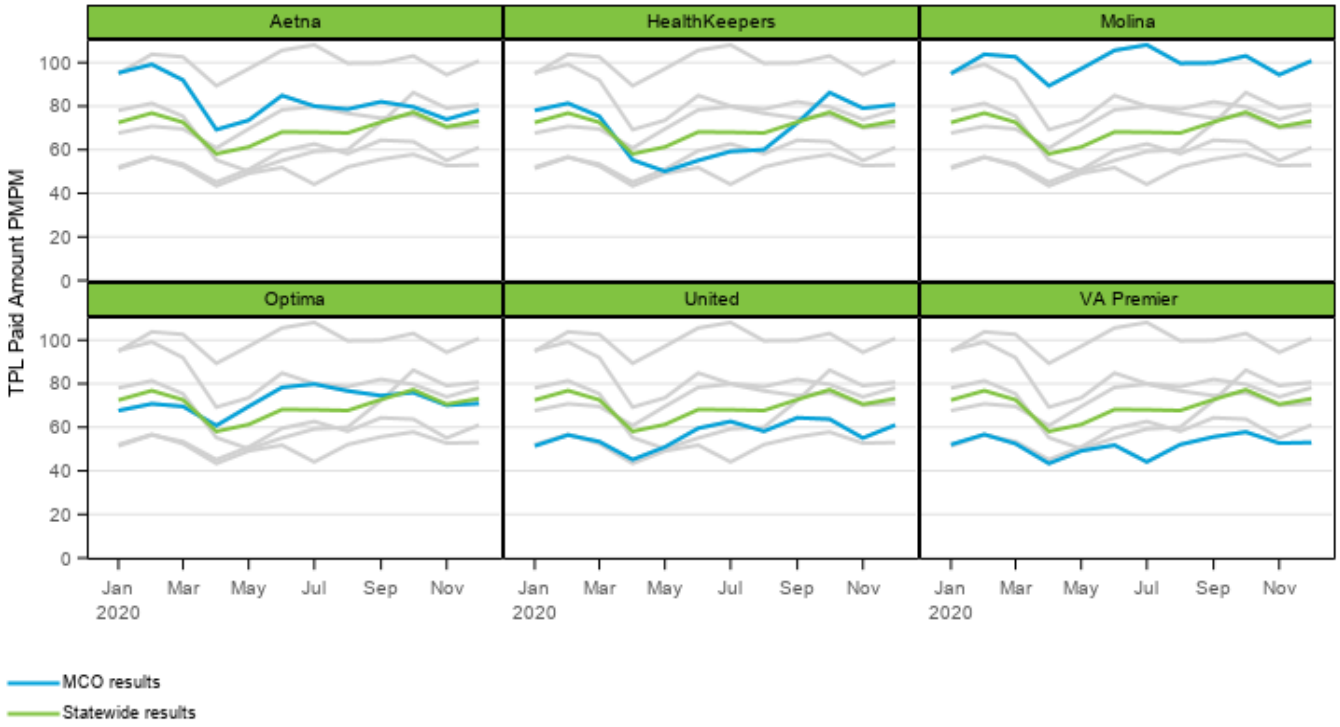


Figure 4-11 provides the TPL paid amount PMPM for institutional encounters. Prevalence of TPL paid amounts varied substantially across plans for institutional encounters. Molina, which had the highest TPL paid amounts for professional encounters, had virtually no TPL paid amounts for the first half of 2020, remaining low the rest of the year. Similarly, VA Premier had stable but low TPL paid amounts throughout the year, increasing steadily from $39 in January to $81 by December.

Figure 4-11—TPL Paid Amount PMPM—Institutional Encounters

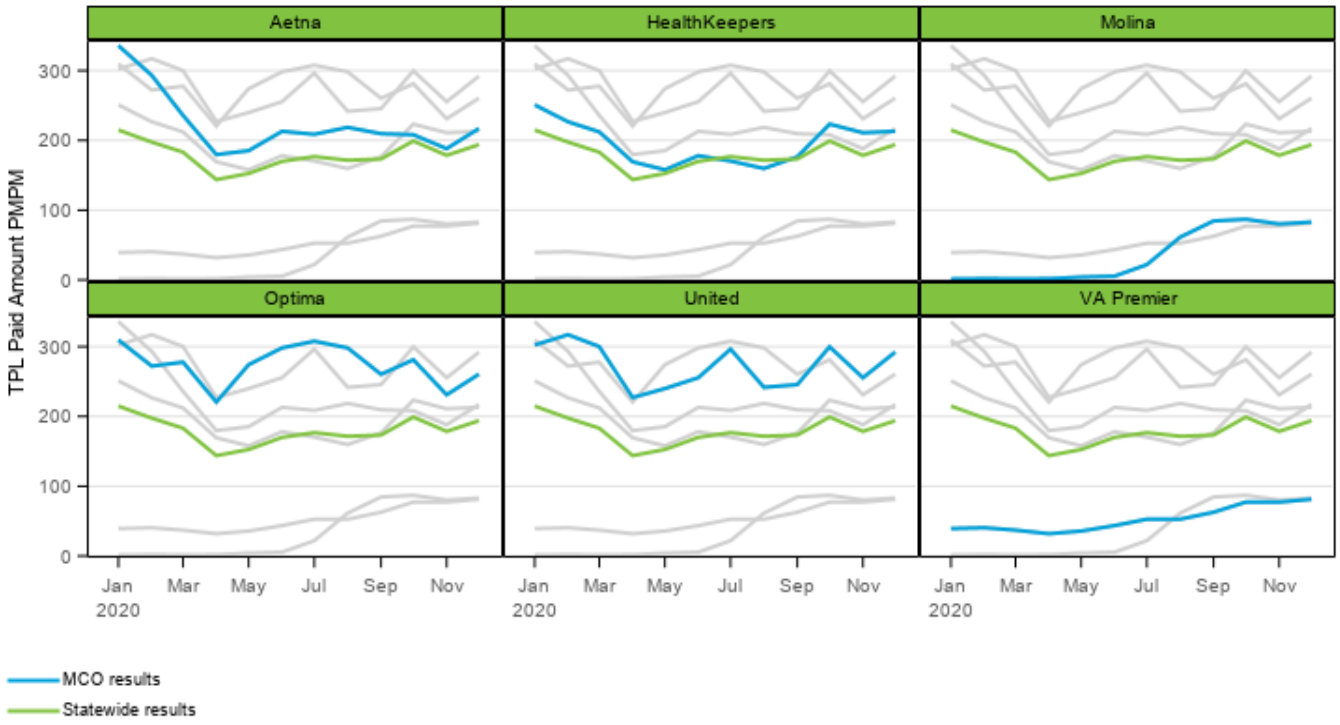
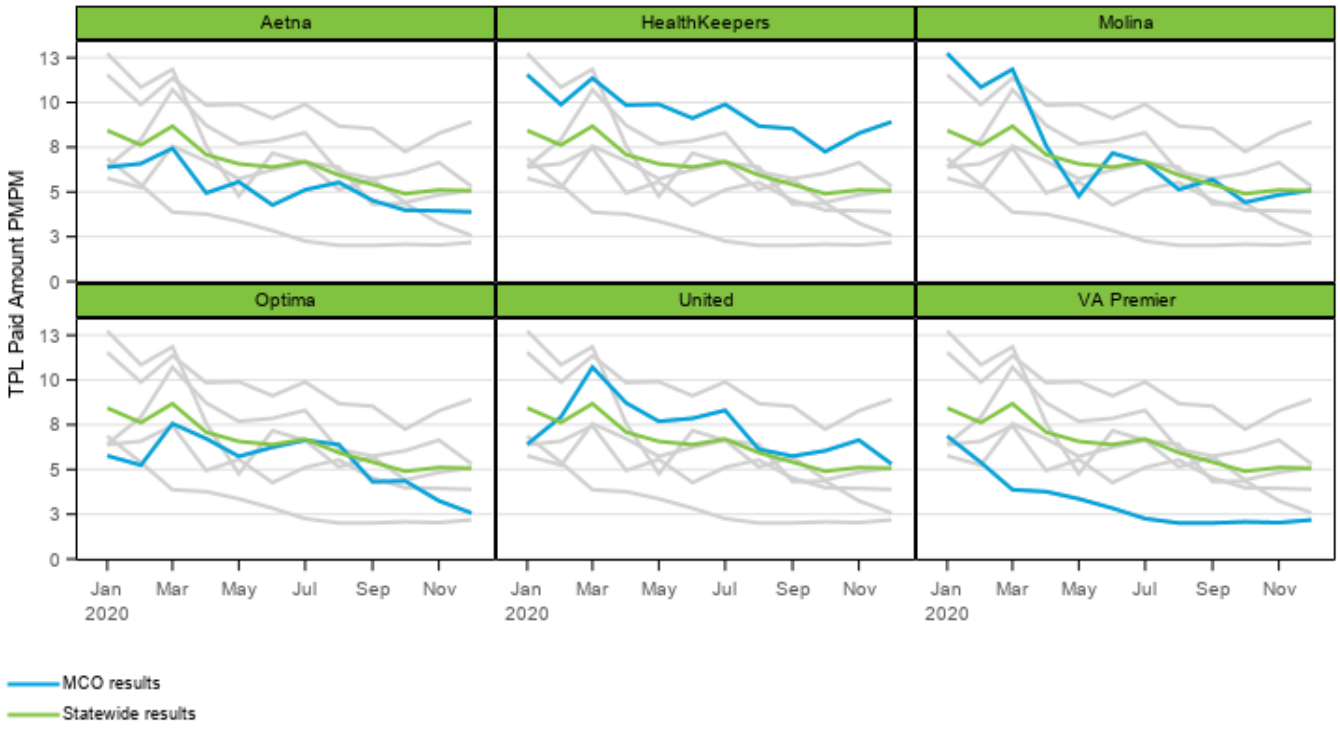


Figure 4-12 provides the TPL paid amount PMPM for pharmacy encounters. TPL paid amount for pharmacy claims was low and declined for all plans throughout the study year. Statewide, pharmacy TPL paid amount PMPM declined from $8.43 in January to $5.06 in December. All plans, however, appeared to submit encounters with non-zero TPL paid amounts throughout the year.

Figure 4-12—TPL Paid Amount PMPM—Pharmacy Encounters



Percentage of Duplicate Encounters

Duplicate encounters may enter the system for a variety of reasons, such as encounters submitted multiple times to rectify an issue for payment. While most performance metrics used by the State, its MCOs, and its EQRO are robust to the presence of duplicate claims,[4-1] identification and appropriate handling of duplicate encounters is crucial for accurate financial and actuarial calculations. HSAG assessed the percentage of records that were identified as duplicates across the following fields:

Table 4-1—Fields Used to Identify Duplicate Encounters

Field/Description	Professional	Facility	Pharmacy
Member ID	✓	✓	✓
Detail line number	✓	✓	✓
Claim Type		✓	
Revenue Code		✓	
CPT/HCPCS	✓	✓	
CPT Modifier 1	✓	✓	
CPT Modifier 2	✓	✓	
CPT Modifier 3	✓	✓	
CPT Modifier 4			
Billing Provider ID	✓	✓	
Rendering Provider ID	✓		✓
First date of service	✓	✓	✓
Last date of service	✓	✓	
NDC			✓
RX Number			✓

The original claim in a series of duplicates was not counted as a duplicate. For example, if three encounters were identified as duplicates (i.e., the values of all fields in Table 4-1 matched), then the number of duplicates counted is two: as one is counted for the original claim leaving two duplicates remaining.

Table 4-2 provides the percentage of duplicate records for all three encounter types. Professional encounters had the highest prevalence of duplicates at 1.6 percent, ranging between 0.2 percent for United and 5.3 percent for Molina. There were few duplicate pharmacy records at less than 0.1 percent

[4-1] For example, many HEDIS performance measures count whether or not members had a particular service rather than the number of services. Utilization measures that *do* count the number of services typically count multiple claims for the same service on the same day as a single service, thereby effectively removing duplicate claims.

for all MCOs, and 0.7 percent of institutional encounter records were duplicates, ranging from 0.1 percent for Molina to 2.0 percent for VA Premier.

Table 4-2—Percentage of Duplicate Encounters

Field	Percent Duplicate		
	Professional Encounters	Institutional Encounters	Pharmacy Encounters
Statewide	**1.6%**	**0.7%**	**<0.1%**
Aetna	0.9%	0.5%	<0.1%
HealthKeepers	0.9%	0.3%	<0.1%
Molina	5.3%	0.1%	0.0%
Optima	1.3%	0.3%	<0.1%
United	0.2%	0.7%	<0.1%
VA Premier	2.5%	2.0%	<0.1%

Encounter Data Timeliness

The following subsections will provide results by claim type for encounter data timeliness. The figures will include results for the following:

- Percentage of encounters received by DMAS within 30 days, 60 days, 90 days, etc., from the MCO payment date. During the study period, DMAS required MCOs to submit 96 percent of professional and institutional encounters and 99 percent of pharmacy encounters to DMAS within 30 days from the MCO payment date.
- Claims lag triangle to illustrate the percentage of encounters received by DMAS within two months, three months, etc., from the service month

Lag Between MCO Payment Date and Submission Date to DMAS

The MCO contract states that the MCOs should "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) calendar days of the Contractor's payment date." Figure 4-13 and Table 4-3 provide the cumulative percentage of encounters received by DMAS every 30 days through 360 days since the MCO payment date for **professional** encounters. Statewide, plans submitted 95.0 percent of professional encounters within 30 days of the payment date; however, this percentage ranged as low as 81.0 percent (Aetna) to 99.4 percent (Optima). Aetna generally lagged behind other plans in meeting a high submission rate of 96 percent, taking approximately 90 to 120 days, while Molina met this rate within 60 days and the remaining plans met this rate within the first 30 days.

Figure 4-13—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Professional Encounters

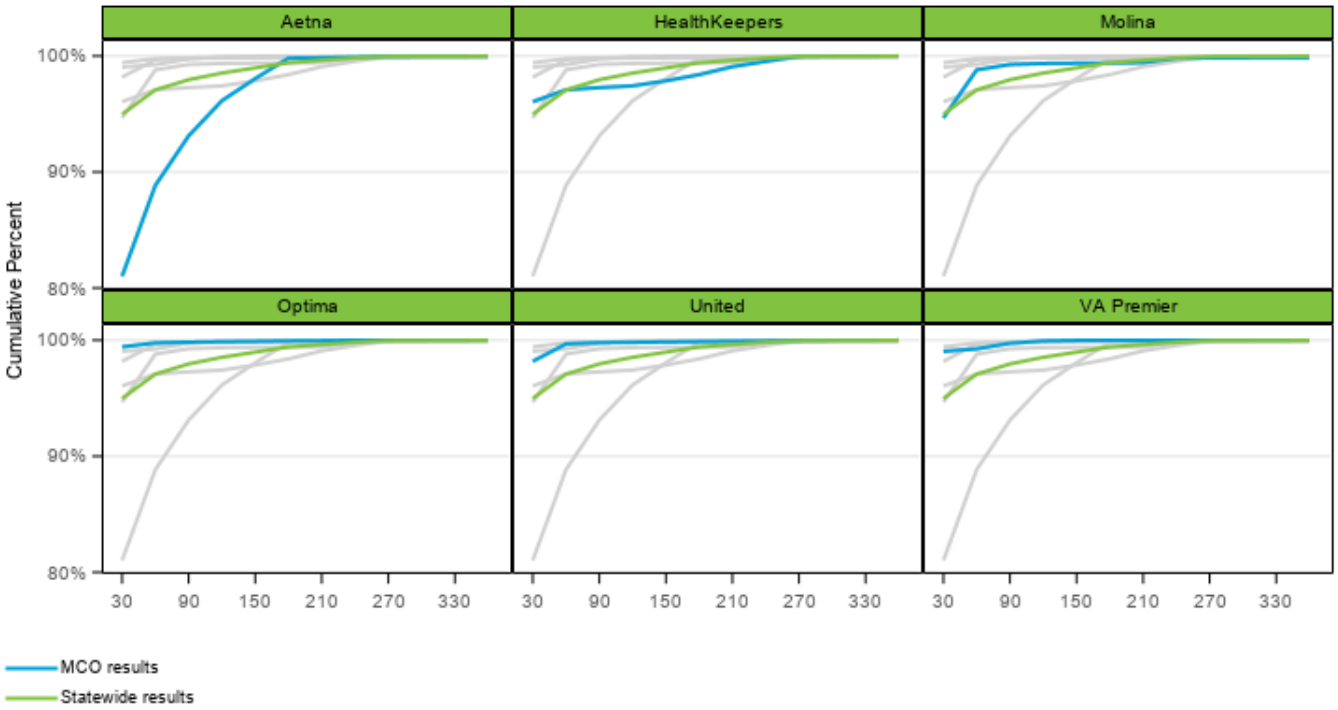


Table 4-3—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Professional Encounters

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 30 days	95.0%	81.0%	96.1%	94.7%	99.4%	98.2%	99.0%
Submitted within 60 days	97.1%	88.8%	97.1%	98.8%	99.8%	99.7%	99.2%
Submitted within 90 days	98.0%	93.1%	97.3%	99.3%	99.8%	99.8%	99.7%
Submitted within 120 days	98.5%	96.1%	97.4%	99.4%	99.9%	99.8%	99.9%
Submitted within 150 days	99.0%	98.0%	97.9%	99.4%	99.9%	99.8%	100.0%
Submitted within 180 days	99.4%	99.8%	98.4%	99.4%	99.9%	99.9%	100.0%
Submitted within 210 days	99.6%	99.8%	99.1%	99.4%	100.0%	99.9%	100.0%
Submitted within 240 days	99.8%	99.9%	99.5%	99.8%	100.0%	99.9%	100.0%
Submitted within 270 days	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%
Submitted within 300 days	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%
Submitted within 330 days	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%
Submitted within 360 days	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%
Submitted after 360 days	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
Submitted Prior to Paid Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Figure 4-14 and Table 4-4 show that all plans had at least a 90 percent submission rate within 30 days of payment for **institutional** encounters; however, Aetna and VA Premier lagged behind other plans, submitting approximately 92 percent of claims within 30 days and meeting a high submission rate of 96 percent by 120 to 180 days after payment. In contrast, Molina and Optima submitted over 99 percent of claims within 30 days.

Figure 4-14—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Institutional Encounters

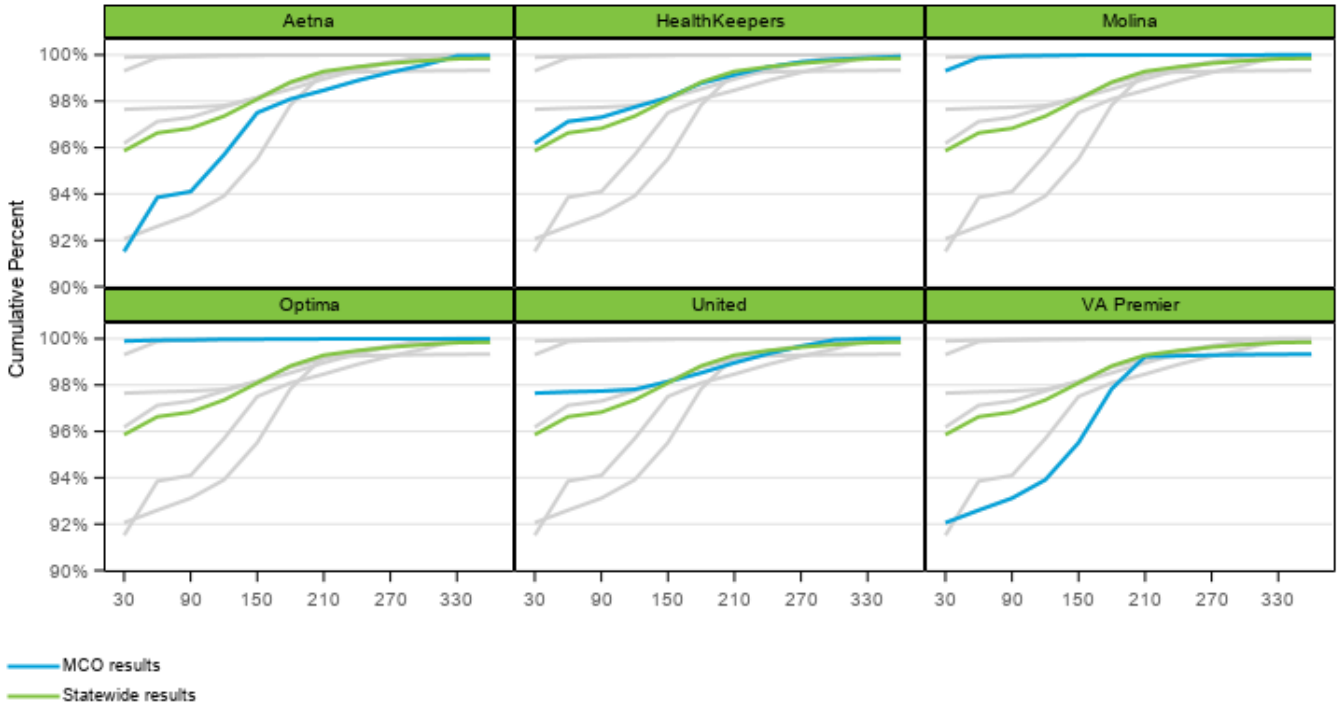


Table 4-4—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Institutional Encounters

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 30 days	95.9%	91.5%	96.2%	99.3%	99.9%	97.6%	92.1%
Submitted within 60 days	96.6%	93.8%	97.1%	99.9%	99.9%	97.7%	92.6%
Submitted within 90 days	96.8%	94.1%	97.3%	100.0%	99.9%	97.7%	93.1%
Submitted within 120 days	97.4%	95.7%	97.7%	100.0%	100.0%	97.8%	93.9%
Submitted within 150 days	98.1%	97.5%	98.2%	100.0%	100.0%	98.1%	95.5%
Submitted within 180 days	98.8%	98.1%	98.8%	100.0%	100.0%	98.5%	97.8%
Submitted within 210 days	99.3%	98.5%	99.1%	100.0%	100.0%	99.0%	99.2%
Submitted within 240 days	99.5%	98.9%	99.5%	100.0%	100.0%	99.3%	99.3%
Submitted within 270 days	99.6%	99.2%	99.7%	100.0%	100.0%	99.7%	99.3%
Submitted within 300 days	99.7%	99.6%	99.8%	100.0%	100.0%	99.9%	99.3%

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 330 days	99.8%	100.0%	99.9%	100.0%	100.0%	100.0%	99.3%
Submitted within 360 days	99.8%	100.0%	99.9%	100.0%	100.0%	100.0%	99.3%
Submitted after 360 days	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%
Submitted Prior to Paid Date	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%

Figure 4-15 and Table 4-5 show that all plans aside from United and VA Premier had a near 100 percent submission rate of **pharmacy** encounters within 30 days, and VA Premier reaching nearly 100 percent within 60 days. Most of the pharmacy encounters for United reported a submission date to DMAS before the payment date.

Figure 4-15—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Pharmacy Encounters

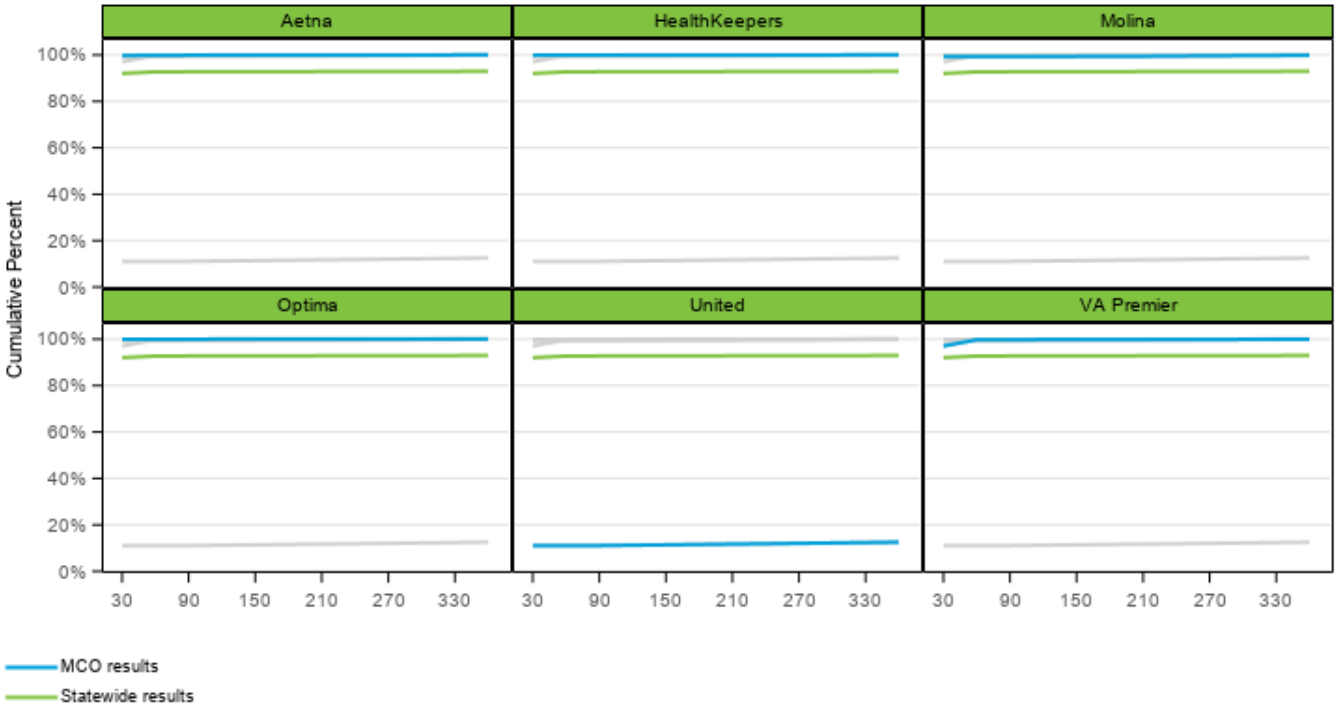


Table 4-5—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Pharmacy Encounters

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 30 days	92.0%	99.8%	99.9%	99.3%	100.0%	11.0%	97.1%
Submitted within 60 days	92.7%	99.8%	100.0%	99.3%	100.0%	11.0%	99.7%
Submitted within 90 days	92.7%	99.9%	100.0%	99.3%	100.0%	11.0%	99.7%
Submitted within 120 days	92.8%	100.0%	100.0%	99.4%	100.0%	11.2%	99.8%
Submitted within 150 days	92.8%	100.0%	100.0%	99.4%	100.0%	11.3%	99.8%

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 180 days	92.8%	100.0%	100.0%	99.4%	100.0%	11.5%	99.8%
Submitted within 210 days	92.8%	100.0%	100.0%	99.5%	100.0%	11.7%	99.9%
Submitted within 240 days	92.9%	100.0%	100.0%	99.6%	100.0%	11.8%	99.9%
Submitted within 270 days	92.9%	100.0%	100.0%	99.7%	100.0%	12.0%	99.9%
Submitted within 300 days	92.9%	100.0%	100.0%	99.7%	100.0%	12.2%	99.9%
Submitted within 330 days	92.9%	100.0%	100.0%	99.8%	100.0%	12.3%	99.9%
Submitted within 360 days	93.0%	100.0%	100.0%	99.8%	100.0%	12.5%	99.9%
Submitted after 360 days	0.0%	0.0%	0.0%	0.2%	0.0%	0.6%	0.1%
Submitted Prior to Paid Date	7.0%	0.0%	0.0%	0.0%	0.0%	86.9%	0.0%

Lag Between Service Month and Submission Month to DMAS

This section assesses the lag between service month and submission month to DMAS. Timely submission of encounters following their date of service is critical for conducting accurate analyses both for DMAS and its subcontractors such as actuaries, its EQRO, and independent evaluators for Section 1115 demonstrations.[4-2] Lags in data submission could result in delayed analysis or incomplete or biased results. Figure 4-16 and Table 4-6 show that statewide, 92.6 percent of **professional** encounters were submitted within three months from the last date of service. Aetna lagged behind other plans, submitting only 85.6 percent of claims within three months, but by six months completion was similar to that of other plans at 97.3 percent. Given a typical run-out of six months, 97.7 percent of encounters were submitted statewide, which represents a sufficient completeness rate for most analyses.

[4-2] For example, DMAS currently has one active and approved Section 1115 waiver in which CMS expects states to provide an interim evaluation report one year prior to the end of the demonstration. CMS expects this report to consist of current findings in order to inform the decision on demonstration renewal.

Figure 4-16—Cumulative Percentage of Encounters Submitted to DMAS Since Service Month—Professional Encounters

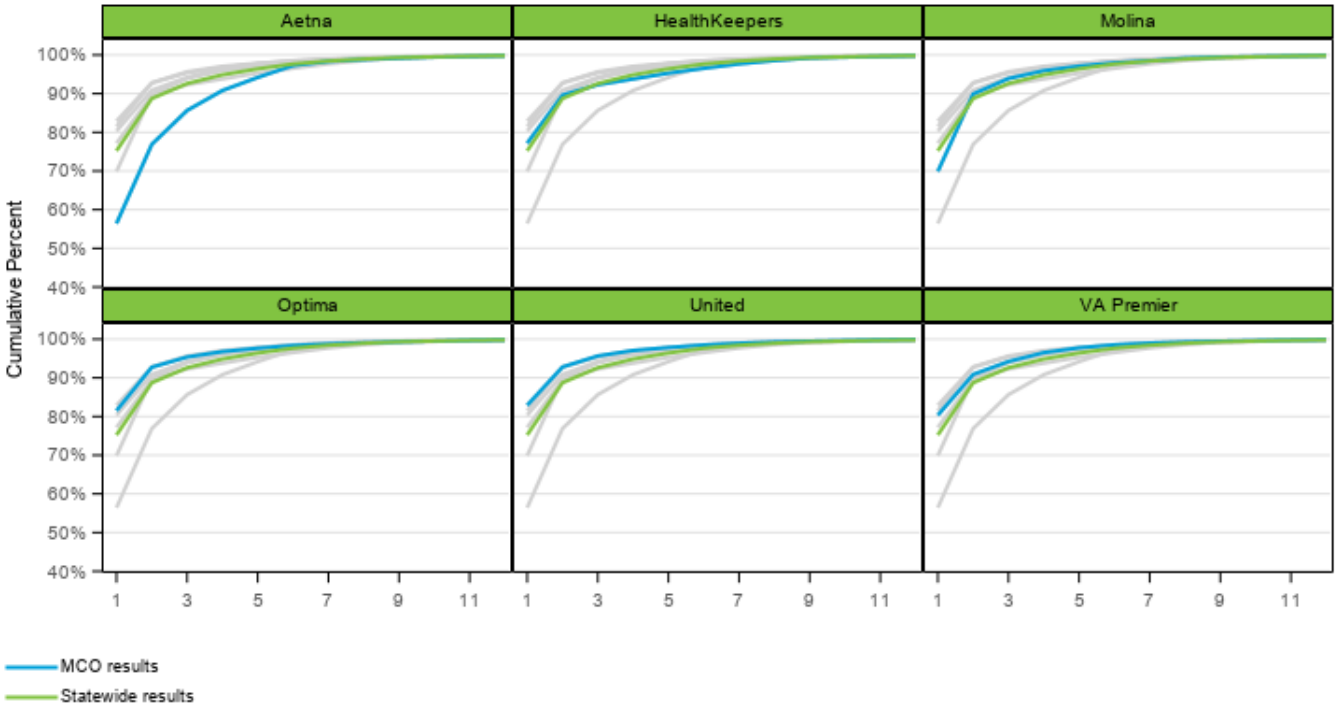


Table 4-6—Cumulative Percentage of Encounters Submitted to DMAS Since Service Month—Professional Encounters

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 1 month	75.2%	56.4%	77.2%	69.9%	81.5%	82.9%	80.3%
Submitted within 2 months	88.7%	76.9%	89.6%	89.9%	92.8%	92.8%	90.9%
Submitted within 3 months	92.6%	85.6%	92.3%	93.9%	95.4%	95.7%	94.2%
Submitted within 4 months	94.9%	90.8%	93.8%	95.9%	96.8%	97.1%	96.5%
Submitted within 5 months	96.4%	94.2%	95.3%	97.1%	97.7%	97.8%	97.8%
Submitted within 6 months	97.7%	97.3%	96.5%	98.0%	98.4%	98.5%	98.5%
Submitted within 7 months	98.4%	98.3%	97.7%	98.5%	98.8%	99.0%	99.0%
Submitted within 8 months	98.9%	98.8%	98.5%	99.2%	99.1%	99.3%	99.3%
Submitted within 9 months	99.3%	99.2%	99.2%	99.4%	99.3%	99.5%	99.5%
Submitted within 10 months	99.5%	99.5%	99.4%	99.6%	99.5%	99.7%	99.6%
Submitted within 11 months	99.7%	99.7%	99.6%	99.7%	99.7%	99.8%	99.8%
Submitted within 12 months	99.8%	99.8%	99.8%	99.8%	99.8%	99.9%	99.8%
Submitted after 12 months	0.1%	0.2%	0.2%	0.2%	0.1%	0.1%	0.2%
Submitted prior to Service Date	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%

Figure 4-17 and Table 4-7 illustrate that 95.1 percent of **institutional** encounters are submitted to DMAS within a typical run-out period of six months from the last date of service. There is some variation among plans, with Aetna and VA Premier submitting 93.4 and 93.5 percent of encounters within six months, respectively. Within a short run-out period of three months, only 86.9 percent of encounters statewide were submitted, with the highest rate at 93.7 percent for Optima. Given these rates, DMAS and its subcontractors will need to allow sufficient run-out for institutional encounters and assess submission rates by plan prior to conducting any analyses.

Figure 4-17—Cumulative Percentage of Encounters Submitted to DMAS Since Service Month—Institutional Encounters

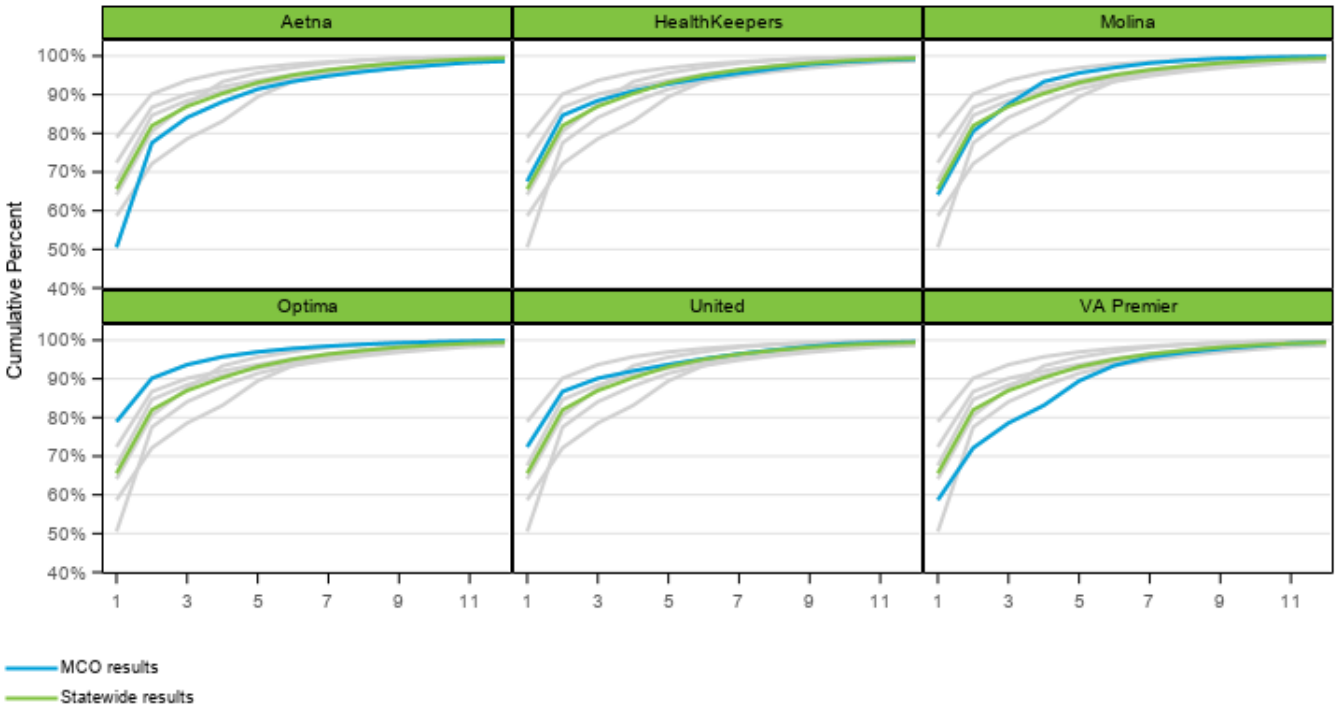


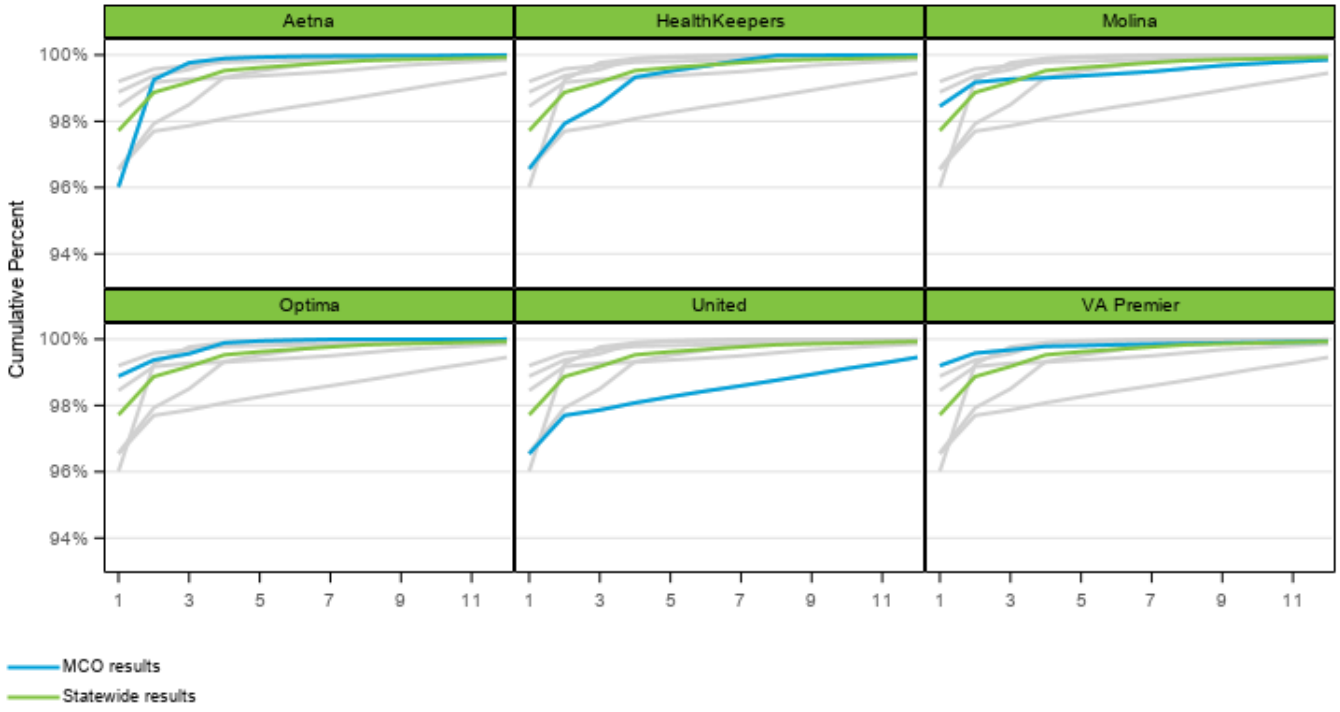
Table 4-7—Cumulative Percentage of Encounters Submitted to DMAS Since Service Month—Institutional Encounters

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 1 month	65.5%	50.5%	67.6%	64.1%	78.9%	72.4%	58.7%
Submitted within 2 months	82.0%	77.5%	84.6%	80.5%	90.1%	86.7%	72.1%
Submitted within 3 months	86.9%	84.1%	88.4%	87.5%	93.7%	90.1%	78.6%
Submitted within 4 months	90.3%	88.1%	90.9%	93.3%	95.7%	92.0%	83.1%
Submitted within 5 months	93.1%	91.4%	92.8%	95.6%	97.0%	93.7%	89.5%
Submitted within 6 months	95.1%	93.4%	94.2%	97.0%	97.8%	95.2%	93.5%
Submitted within 7 months	96.4%	94.8%	95.5%	98.2%	98.5%	96.5%	95.6%
Submitted within 8 months	97.3%	96.0%	96.7%	98.9%	98.9%	97.5%	96.8%

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 9 months	98.2%	96.9%	97.8%	99.3%	99.3%	98.4%	97.7%
Submitted within 10 months	98.7%	97.6%	98.5%	99.6%	99.6%	99.1%	98.5%
Submitted within 11 months	99.2%	98.3%	98.9%	99.8%	99.7%	99.4%	99.2%
Submitted within 12 months	99.4%	98.6%	99.2%	99.9%	99.9%	99.6%	99.5%
Submitted after 12 months	0.6%	1.4%	0.8%	0.1%	0.1%	0.4%	0.5%
Submitted prior to Service Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Figure 4-18 and Table 4-8 show that statewide, 99.2 percent of **pharmacy** encounters were submitted within three months of the service (dispense) date. All plans submitted 96.0 percent or more of encounters within one month. Two plans, however, lagged behind the others, with United [4-3] taking nine to 10 months to surpass a 99 percent submission rate and HealthKeepers taking four months.

Figure 4-18—Cumulative Percentage of Encounters Submitted to DMAS Since Service Month—Pharmacy Encounters



[4-3] DMAS noted that the extra lag from United was due to the resubmission in April 2021 to correct the TPL payment amount. Refer to Table H-17 for more details.

Table 4-8—Cumulative Percentage of Encounters Submitted to DMAS Since Service Month—Pharmacy Encounters

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 1 month	97.7%	96.0%	96.6%	98.5%	98.9%	96.5%	99.2%
Submitted within 2 months	98.9%	99.3%	97.9%	99.2%	99.4%	97.7%	99.6%
Submitted within 3 months	99.2%	99.8%	98.5%	99.3%	99.6%	97.9%	99.7%
Submitted within 4 months	99.5%	99.9%	99.3%	99.3%	99.9%	98.1%	99.8%
Submitted within 5 months	99.6%	99.9%	99.5%	99.4%	99.9%	98.3%	99.8%
Submitted within 6 months	99.7%	100.0%	99.7%	99.4%	100.0%	98.4%	99.8%
Submitted within 7 months	99.8%	100.0%	99.8%	99.5%	100.0%	98.6%	99.9%
Submitted within 8 months	99.8%	100.0%	100.0%	99.6%	100.0%	98.8%	99.9%
Submitted within 9 months	99.9%	100.0%	100.0%	99.7%	100.0%	98.9%	99.9%
Submitted within 10 months	99.9%	100.0%	100.0%	99.7%	100.0%	99.1%	99.9%
Submitted within 11 months	99.9%	100.0%	100.0%	99.8%	100.0%	99.3%	99.9%
Submitted within 12 months	99.9%	100.0%	100.0%	99.9%	100.0%	99.5%	99.9%
Submitted after 12 months	0.1%	0.0%	0.0%	0.1%	0.0%	0.5%	0.1%
Submitted prior to Service Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Field-Level Completeness and Accuracy

Table 4-9 through Table 4-11 provide the percentage of claims present and percentage valid for key data elements across all MCOs. Percentage present is calculated only for fields that are applicable to appropriate claim types (e.g., calculations exclude diagnosis codes from pharmacy encounters or attending provider from professional encounters). Similarly, percentage valid is only calculated for fields in which values are present. For instance, Table 4-9 shows 14.5 percent of professional encounters contained a Referring Provider NPI, but 96.9 percent of those contained valid values.

Professional Encounters

Table 4-9 displays the percentage present and valid values for the key data elements in the professional encounters. [4-4]

[4-4] Reference tables that HSAG utilized to determine valid values for certain data elements may differ from the reference tables DMAS utilizes for its EPS edits. As a result, the percentage of valid values may not reflect exactly what would be captured through DMAS' EPS edits.

Table 4-9—Data Elements Percentage Present and Valid Value—Professional

Field	Percent Present	Percent Valid Value
Member ID	100.0%	97.5%
Header Service From Date	100.0%	>99.9%
Header Service To Date	100.0%	>99.9%
Detail Service From Date	100.0%	>99.9%
Detail Service To Date	100.0%	>99.9%
Billing Provider NPI	100.0%	99.8%
Rendering Provider NPI	100.0%	99.8%
Servicing Provider Taxonomy Code	100.0%	84.9%
Referring Provider NPI	14.5%	96.9%
Primary Diagnosis Codes	100.0%	>99.9%
Secondary Diagnosis Codes	23.6%	>99.9%
CPT/HCPCS Codes	100.0%	>99.9%
CPT/HCPCS Codes with PTP Edits	100.0%	>99.9%
Service Units	100.0%	100.0%
Service Units with MUE Edits	100.0%	98.2%
National Drug Codes	3.3%	99.9%
HCPCS/NDC Combination	84.7%	80.7%
MCO Received Date	100.0%	100.0%
MCO Paid Date	100.0%	100.0%
Header Paid Amount	100.0%	>99.9%
Header TPL Paid Amount	18.7%	97.3%
Detail Paid Amount	100.0%	100.0%
Detail TPL Paid Amount	19.1%	100.0%

Key findings pertaining to field-level completeness for professional encounters statewide are as follows:

- **HCPCS/NDC Combination**[4-5] had an NDC code populated on 84.7 percent of encounters for HCPCS codes requiring NDC codes. The MCOs' rates varied from 67.7 percent (VA Premier) to 99.2 percent (Aetna).
- All fields that were partially populated (e.g., Referring Provider NPI, Secondary Diagnosis Codes, National Drug Codes, and Header/Detail TPL Paid Amounts) are not expected to be present on all claims, as they would only be populated under certain situations.

[4-5] Defined as encounters with HCPCS requiring associated NDC codes through the Medicare Part B Drug and Biological Average Sales Price Quarterly Payment files. Available at: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/2020-asp-drug-pricing-files. Accessed on: Oct 19, 2021. It is also important to note that DMAS has a similar edit in EPS. However, it is based on a proprietary crosswalk from DMAS' pharmacy team.

The key findings pertaining to valid values are as follows:

- **Servicing Provider Taxonomy Code** was valid for 84.9 percent of professional encounters, largely driven by Optima and HealthKeepers, with 69 percent and 71 percent validity, respectively. This was due to provider taxonomy codes not included in the provider reference file.
- HCPCS codes requiring NDC associated codes (**HCPCS/NDC Combination**) were populated with valid NDCs on 80.7 percent of encounters.

Institutional Encounters

Table 4-10 displays the percentage present and valid values for the key data elements in the institutional encounters.

Table 4-10—Data Elements Percentage Present and Valid Value—Institutional

Field	Percent Present	Percent Valid Value
Member ID	100.0%	95.7%
Header Service From Date	100.0%	100.0%
Header Service To Date	100.0%	>99.9%
Detail Service From Date	100.0%	100.0%
Detail Service To Date	100.0%	100.0%
Billing Provider NPI	100.0%	99.8%
Rendering Provider NPI	<0.01%	100.0%
Attending Provider NPI	92.9%	98.9%
Servicing Provider Taxonomy Code	55.6%	90.2%
Referring Provider NPI	1.1%	97.8%
Primary Diagnosis Codes	100.0%	>99.9%
Secondary Diagnosis Codes	98.2%	>99.9%
CPT/HCPCS Codes	77.2%	97.1%
CPT/HCPCS Codes with PTP Edits	77.2%	97.1%
Service Units	100.0%	100.0%
Service Units with MUE Edits	100.0%	99.6%
Primary Surgical Procedure Codes	3.4%	99.8%
Secondary Surgical Procedure Codes	1.8%	99.8%
Revenue Codes	100.0%	100.0%
Diagnosis-Related Groups Codes	4.0%	95.9%
Type of Bill Codes	100.0%	100.0%
National Drug Codes	9.9%	98.0%
HCPCS/NDC Combination	>99.9%	67.5%
MCO Received Date	100.0%	100.0%
MCO Paid Date	100.0%	100.0%
Header Paid Amount	100.0%	>99.9%
Header TPL Paid Amount	32.2%	71.9%
Detail Paid Amount	100.0%	100.0%
Detail TPL Paid Amount	39.8%	100.0%

Key findings pertaining to field-level completeness for institutional encounters statewide are as follows:

- **Servicing Provider Taxonomy Code** was present for only 55.6 percent of institutional encounters, driven largely by Optima, which did not submit any encounters with this field populated. This field was populated for HealthKeepers and Molina on 37 percent and 46 percent of encounters, respectively. VA Premier had a near 100 percent completeness rate.
- **CPT/HCPCS codes** were populated for 77.2 percent of institutional encounters.

- Other fields that are partially populated are not expected to be present on all institutional claims (e.g., Rendering and Referring Provider NPI, Primary & Secondary Surgical Procedure Codes, DRG, NDC, and Header/Detail TPL Paid Amounts).

The key findings pertaining to valid values are as follows:

- **Member ID** was valid for 95.7 percent of encounters, largely due to Member IDs not in the member enrollment file.
- **Servicing Provider Taxonomy Code** was valid for 90.2 percent of encounters.
- HCPCS codes requiring NDC associated codes (**HCPCS/NDC Combination**) were populated with valid NDCs on 67.5 percent of encounters.[4-6]
- The sum of Detail TPL Paid Amount matched **Header TPL Paid Amount** for 71.9 percent of institutional encounters.[4-7]

Pharmacy Encounters

Table 4-11 displays the percentage present and valid values for the key data elements in the pharmacy encounters.

Table 4-11—Data Elements Percentage Present and Valid Value—Pharmacy

Field	Percent Present	Percent Valid Value
Member ID	100.0%	95.3%
DOS	100.0%	100.0%
Billing Provider NPI	100.0%	>99.9%
Prescribing Provider NPI	100.0%	96.7%
National Drug Codes	100.0%	99.5%
MCO Received Date	100.0%	100.0%
MCO Paid Date	100.0%	100.0%
Header Paid Amount	100.0%	100.0%
Header TPL Paid Amount	2.9%	100.0%

All fields analyzed except Header TPL Paid Amount were present on 100 percent of pharmacy encounters, and this field is not expected to be present on all encounters.

The key findings pertaining to valid values are as follows:

- **Member ID** was valid for 95.3 percent of encounters, largely due to Member IDs not in the member enrollment file.
- **Prescribing Provider NPI** was valid for 96.7 percent of encounters.

[4-6] Note that HSAG used a publicly available crosswalk from CMS. Currently, DMAS has a similar edit in EPS. However, it is based on a proprietary crosswalk from DMAS' pharmacy team.
[4-7] Note that DMAS is working with the MCOs to address this issue as of November 2021.

5. Conclusions and Recommendations

Conclusions

A summary of findings from the two activities of the EDV study are presented below.

Information Systems Review

This information systems review provides self-reported qualitative information from all six MCOs regarding the encounter data process: collection, processing, and transmission of encounter data to DMAS. The modular structure of the encounter data processing system ensures that:

- MCOs can submit data and receive feedback about timeliness, accuracy, and completeness.
- EDI file compliance and validation checks (files are in valid formats, data are checked for HIPAA compliance and prepared for business rules processing) are performed on encounter data.
- Data are validated against State business rules (business rules engine).
- Data analyses for program management and decision support is run.

All MCOs describe their ability to develop adaptable data review processes, as well as personnel, departments, software systems, and/or external subcontractors, that can promptly respond to quality issues. MCOs also describe the systems/subcontractor oversight and data remediation activities in place to ensure the completeness and accuracy of data submitted to them or processed on their behalf.

Administrative Profile

Overall, DMAS' encounter data should continue to support analyses utilizing encounter data such as HEDIS performance measure calculation. Data were largely **complete**, **valid**, and **reliable**. While some gaps and data concerns were identified, this should not preclude the State from conducting further analysis given adequate assessment of encounters prior to analysis.

It is clear that the COVID-19 Public Health Emergency (PHE) impacted the volume and rate of encounter submission in early to mid-2020, particularly for institutional and professional encounters; however, there was not a commensurate decline in PMPM paid amounts. This suggests the average cost per claim increased during the early months of the PHE.

Additionally, the administrative profile identified several other potential areas for DMAS to address either internally or in consultation with MCOs.

- The majority of **United pharmacy encounters** had submission dates to DMAS before the MCO payment dates. Encounters with January 2020 payment dates had submission dates to DMAS

after payment, as expected, but encounters throughout the remainder of the year generally had submission dates to DMAS before the MCO payment dates.[5-1]
- Aetna and Molina did not meet a **96 percent submission rate** within 30 days of payment for professional encounters.
- Aetna and VA Premier did not meet a **96 percent submission rate** within 30 days of payment for institutional encounters.
- United and VA Premier did not meet a **99 percent submission rate** within 30 days of payment for pharmacy encounters.
- **Header TPL paid amounts** for the institutional encounters may be incomplete for **Molina** during at least the first half of 2020.
- **Servicing Provider Taxonomy Code** was populated for 55.6 percent of institutional encounters.
- HCPCS codes requiring NDCs did not have NDC codes consistently populated or were populated with inappropriate NDCs for professional encounters, as well as institutional encounters with a type of bill code starting with "13" or "83."

Recommendations

Information Systems Review

To improve the quality of encounter data submissions from MCOs, HSAG offers the following recommendations to assist DMAS and MCOs in addressing opportunities for improvement:

- DMAS should consider conducting validation activities that align with TPI, to forestall potential data quality issues in T-MSIS data extracts routinely submitted to CMS.
- DMAS should consider reviewing the process involved in the identification and handling of duplicate encounters. Duplicate encounters appear to be identified at the header level and may undercount duplicate services reported at the detail level. Additionally, although total charges are incorporated in the de-duplication logic, the specific service or procedure code does not appear to be included.
- Questionnaire responses from some MCOs suggest that they have experienced challenges while using the currently agreed-upon virtual meeting application during communications with DMAS (Google Meets) and recommended a different platform such as WebEx or Zoom.
- Some MCOs report that environmental claims/claims paid to a member are currently not submitted to DMAS because the service provider does not have an NPI. DMAS may wish to consider reviewing the handling of environmental claims and/or claims resulting from services rendered by other providers of non-health-related services who are not eligible for an NPI.

[5-1] Additional details can be found in Appendix Table H-14.

Administrative Profile

- To address the pertinent findings from the administrative profile, HSAG recommends DMAS consider: Collaborating with United to determine the root cause for submission dates to DMAS before the MCO paid dates for pharmacy encounters.
- Continue monitoring timeliness of MCO submission of professional, institutional, and pharmacy encounters and collaborate with MCOs to determine any barriers in timely submission.
- Monitoring TPL paid amount completeness by MCOs to ensure the field is populated as expected and collaborate with Molina to determine a root cause for potentially missing values in the first half of 2020 for institutional encounters.
- Collaborating with MCOs, particularly Optima, to submit Servicing Provider Taxonomy Codes.
- Collaborating with MCOs to ensure NDCs are submitted and are appropriate for qualifying HCPCS codes in professional encounters, as well as institutional encounters with a type of bill code starting with "13" or "83."
- Build on current reporting dashboards and tools to include additional metrics related to data quality and completeness. Metrics may include those covered in this EDV study, the Data Quality Scorecard, or T-MSIS TPI not already covered.
- Leverage data quality reporting tools from CMS (such as DQ Atlas and/or Imersis) to align internal encounter data quality monitoring with T-MSIS extracts sent to CMS. Internal data monitoring may be used to quickly identify the root cause of potential problem areas identified from CMS tools.

Study Limitations

The list below displays study limitations for the reader to consider:

- Findings from the information systems review were based on self-reported questionnaire responses submitted to HSAG by MCOs. HSAG did not validate the responses for accuracy.
- The findings from the administrative profile were associated with encounters with dates of service between January 1, 2020, and December 31, 2020. As such, results may not reflect the current quality of DMAS' encounter data or changes implemented since the data extraction in July 2021. In addition, the COVID-19 PHE impacted the service utilization in 2020 and please use caution when comparing these results to other time periods.
- Reference tables that HSAG utilized to determine valid values for certain data elements may differ from the reference tables DMAS utilizes for its EPS edits. As a result, the percentage of valid values may not reflect exactly what would be captured through DMAS' EPS edits.

Appendix A. Blank Questionnaire for DMAS

2020-2021 Encounter Data Validation Questionnaire for DMAS

Overview

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, the Virginia Department of Medical Assistance Services (DMAS) requires its Commonwealth Coordinated Care (CCC) Plus and Medallion 4.0 contracted managed care organizations (MCOs) to submit high-quality encounter data. DMAS relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During state fiscal year (SFY) 2020-2021, DMAS contracted Health Services Advisory Group, Inc. (HSAG) to conduct an encounter data validation (EDV) study. In alignment with the CMS External Quality Review (EQR) Protocol 5, Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan[1], HSAG will conduct the following two core evaluation activities for the EDV study:

- Information systems (IS) review—assessment of DMAS' and the MCOs' information systems and processes. The goal of this activity is to examine the extent to which DMAS' and the MCOs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5.
- Administrative profile—analysis of DMAS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity is to evaluate the extent to which the encounter data in DMAS' Encounters Processing Solution (EPS) database are complete, accurate, and submitted by the MCOs in a timely manner for encounters with dates of service in calendar year 2020. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

The IS review will include an evaluation of the MCOs' processes for collecting, maintaining, and submitting encounter data to DMAS and on the strengths and limitations of the MCOs' information systems in promoting and maintaining quality encounter data. Similarly, HSAG will also evaluate DMAS processes for collecting and managing the MCO-submitted encounter data. In alignment with Activity 1: Review State Requirements in the CMS EQR Protocol 5, HSAG has developed the following EDV focused questionnaire to gather information regarding DMAS' information systems and data processing procedures for both the CCC Plus and Medallion 4.0 programs. This IS review will enable HSAG to understand how various systems interact to determine whether such interactions have an impact on DMAS' ability to receive and maintain complete and accurate data.

HSAG will conduct the IS Review for the following six MCOs for both the CCC Plus and Medallion 4.0 programs:

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 5 Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan.* Protocol 5. October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html

- Aetna Better Health of Virginia (Aetna)
- HealthKeepers, Inc. (HealthKeepers)
- Magellan Complete Care of Virginia (Magellan)
- Optima Family Care (Optima)
- UnitedHealthcare of the Mid-Atlantic, Inc. (United)
- Virginia Premier Health Plan, Inc. (VA Premier)

General Instructions

HSAG developed the following questionnaire customized in collaboration with DMAS to gather both general information and specific procedures for data processing, personnel, and data acquisition capabilities. The questionnaire is divided into the following four domains:

Section A: *Encounter Data Sources and Systems*

Section B: *Data Exchange Policies and Procedures*

Section C: *Management of Encounter Data: Collection, Storage, and Processing*

Section D: *Encounter Data Quality Monitoring and Reporting*

Please provide comprehensive answers to the questions in each section of the questionnaire and attach supporting documentation (e.g., policies and procedures, data layouts, data flow diagrams, sample reports, sample data, etc.), where applicable. Please note that HSAG has received documentation from DMAS to facilitate the development of this questionnaire. As such, for questions that require supporting documentation and the documents have previously been submitted to HSAG, please note the filename(s) that are applicable to the respective questions. If different staff members within DMAS are responsible for different aspects of the processes, please distribute multiple copies of the questionnaire and ensure that each group provides answers to the applicable questions in each section. **Responses do not need to be merged into a single final version; uploading multiple sections and documents is acceptable.**

Upon evaluating answers to the questionnaire and additional documentation, HSAG's EDV team may conduct additional follow-up with the DMAS via email or conference calls.

Submission of Questionnaire and Documentation

- DMAS should upload the completed questionnaire and supporting documentation electronically to HSAG's Secure Access File Exchange (SAFE) site, https://safe.hsag.com/ in DMAS' folder and project subfolder labeled "Encounter Data Validation."
- Please contact Kari Vanderslice via phone at 602-801-6967 or via e-mail at KVanderslice@hsag.com for assistance with access to HSAG's SAFE site.
- HSAG requests that DMAS upload the completed questionnaire, and any attachments, to HSAG's SAFE site no later than **July 21, 2021**. Upon completion of upload, please notify Lacey Hinton via e-mail at LHinton@hsag.com.

- Please provide the descriptions for the acronyms used in your responses in the table below or spell them out when using the acronyms for the first time.

Acronym	Description

CY 2020 Encounter Data Validation—DMAS Focused Questionnaire

Section A: Encounter Data Sources and Systems

Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename(s) in your response. In the case of file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to the question. It is not required to resubmit the file(s).

1. Describe the process flows and system architecture used to import, process, and store encounter data submitted by the MCOs. Please include any supporting documentation available including, but not limited to, information system schemas, processing diagrams, and file/table layouts. If the process differs by encounter type (e.g., medical, vision, pharmacy), provide separate updates for each encounter type and scenario. If the response for the CCC Plus and Medallion 4.0 programs are different, please note the differences or provide responses to each program separately.

Claim Type	Process Flow
837 Professional	
837 Institutional	
Pharmacy	
<insert claim type>	

2. For each key source of data, provide a description of the encounters received from each MCO (including its subcontractors), and the frequency of receipt. If the response for the CCC Plus and Medallion 4.0 programs are different, please note the differences or provide responses to each program separately. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

MCO Name (*Acronym*)	Data Source[1]	Description of Data Received	Frequency[2]
MCO A	*Pharmacy*	*Files are submitted using the NCPDP D.0 format.*	*Weekly*
Aetna	Institutional		
	Professional		

MCO Name (*Acronym*)	Data Source[1]	Description of Data Received	Frequency[2]
	Pharmacy		
	Vision		
	Non-Emergency Transportation		
	Other (*list and describe*[3])		
HealthKeepers	Institutional		
	Professional		
	Pharmacy		
	Vision		
	Non-Emergency Transportation		
	Other (*list and describe*[3])		
Magellan	Institutional		
	Professional		
	Pharmacy		
	Vision		
	Non-Emergency Transportation		
	Other (*list and describe*[3])		
Optima	Institutional		
	Professional		
	Pharmacy		
	Vision		
	Non-Emergency Transportation		
	Other (*list and describe*[3])		
United	Institutional		
	Professional		
	Pharmacy		
	Vision		
	Non-Emergency Transportation		
	Other (*list and describe*[3])		
VA Premier	Institutional		
	Professional		
	Pharmacy		
	Vision		
	Non-Emergency Transportation		
	Other (*list and describe*[3])		

[1] These sources represent encounter submissions from the MCOs including their subcontractors, if any. If the subcontractors submit data files directly to DMAS, separate rows should be added for the subcontractors.

[2] Frequency = Daily, weekly, twice a month, monthly, every other month, etc.

[3] Examples include hearing, chiropractic, laboratory, etc.

3. Using the table below, list and describe the function and role of any organizational units responsible for importing, processing, and storing encounters. *Note: The table can be expanded if additional rows are required.*

	Department	Function/ Role	# of Staff
1			
2			
3			
4			
5			

4. Describe all system/processing edits conducted on incoming encounters prior to accepting/loading the data to DMAS' final database for DMAS' end-users. For example, please provide details on how DMAS assesses whether the encounter is for the correct contract (i.e., CCC Plus versus Medallion 4.0).

5. How does DMAS process data exceptions? For example, when an encounter is not in a valid format, contains invalid values, or includes erroneous field logic, describe the processes (manual or automatic) used to process the submission.

6. Does DMAS provide any type of response file or feedback to the MCOs submitting the encounters? If YES, please describe the process used to provide feedback to the MCOs including any process flows and report layouts.

7. Are multiple systems used to process encounters submitted by the MCOs?

System	Purpose/Role

8. If multiple systems are used to process encounters, describe how encounters are ultimately merged into a single encounter data platform. Include a data flow diagram, if needed.

9. Please describe the process used by the MCOs to resubmit updated, modified, or corrected encounters. Provide any documentation or policies and procedures related to the resubmission of encounter files or records.

9a. How are updated records flagged in DMAS' system?	
9b. Are the original encounters stored in the encounter data system or deleted?	
9c. Provide details on how replacement transactions are processed when target transaction is in active failed validation status.	

10. The following questions address the collection, use, and maintenance of provider data and enrollment data.

Provider Data	
10a. Outline the path DMAS' Medicaid provider data follow from collection to maintenance.	

EDV QUESTIONNAIRE FOR DMAS

10b. Describe DMAS' procedures for overseeing and ensuring the completeness of provider data.	
10c. Describe DMAS' procedures for overseeing and ensuring the accuracy of provider data.	
10d. Describe the process for cross-checking encounters with provider data (e.g., list any procedures for reconciling differences between provider information submitted on the encounter and DMAS' provider data).	
10e. Describe how DMAS uses provider data submitted by the MCOs to conduct evaluations on the encounter data, if applicable.	
Enrollment data	
10f. Outline the path DMAS' Medicaid enrollment data follow from collection to maintenance.	
10g. Describe DMAS' procedures for overseeing and ensuring the completeness of enrollment data.	
10h. Describe DMAS' procedures for overseeing and ensuring the accuracy of enrollment data.	
10i. How often is Medicaid enrollment information updated for DMAS and the MCOs?	
10j. Describe the process for crosschecking encounters with enrollment data (e.g., list any procedures for reconciling differences between member information submitted on the encounter and DMAS' enrollment data).	

Section B: Data Exchange Policies and Procedures

Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response. In the case of file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to the question. It is not required to resubmit the file(s).

1. Please describe the data exchange process between the MCOs and DMAS. Include details outlining the organizational and operational policies and procedures related to the MCOs' encounter data submissions. Provide copies of all policies and procedures, manuals, file specifications, etc., that outline the procedures that govern the transmission of data between the MCOs and DMAS.

2. What is DMAS' policy regarding Medicaid encounter audits? Are Medicaid encounters audited regularly? Randomly? If yes, please provide the relevant documentation.

3. Describe the process DMAS has in place to ensure that updates to DMAS' requirements for data submission are implemented and communicated to each MCO. Please provide any documentation, if available.

4. Describe the testing policies and processes DMAS has in place when MCOs have any major changes affecting the encounter data (e.g., a new subcontractor or a new software). Please provide any documentation, if available, to describe the testing process from the time when the MCO

EDV QUESTIONNAIRE FOR DMAS

notifies DMAS of the change to the time when DMAS approves the MCO to submit the encounter data to the EPS production environment.

5. Describe how information systems failure affects encounters and the measures taken to prevent failure.

5a. Describe how the loss of Medicaid encounters and other related data is prevented when systems fail.	
5b. How frequently are system back-ups performed?	
5c. How are the back-ups tested to make sure the back-ups are functional?	
5d. How often are back-ups tested for functionality?	
5e. How is Medicaid data corruption prevented due to a system failure or program error?	
5f. Describe the controls used to ensure all data entered in the system are fully accounted for (e.g., batch control sheets)?	

Section C: Management of Encounter Data: Collection, Storage, and Processing

Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response. In the case of file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to the question. It is not required to resubmit the file(s).

1. Please attach a flowchart outlining the structure of your complete management information systems. Provide any documentation regarding data integration policies and procedures.

2. For each database described in Question 1, please highlight all internal and external data inputs and processes. Identify any processes in place that modify the data as it moves from one database to another.

Input Data	Output Data	Processes that Modify Data

3. Describe the procedure for consolidating Medicaid claims/encounter, member, and provider data for reporting (whether it is a relational database or file extracts).

3a. How many different data sources are merged to create reports?	
3b. What control processes are in place to ensure data merges are accurate and complete?	

3c. What control processes are in place to ensure that no extraneous data are captured (e.g., lack of specificity in patient identifiers may lead to inclusion of non-eligible members or double counting)?	

4. Describe the algorithms used to check the reasonableness of data integrated for purposes of reporting or creating data marts.

5. Do your current system documentation and file layouts clearly delineate derived and non-derived data fields? If YES, please describe the fields that are derived and the point in the encounter data process at which they are created.

Derived Field	Point in Process When Field is Calculated	Algorithm for Calculating the Field

6. Describe the policies and procedures used to identify duplicate or missing records in the MCOs' regular encounter submissions.

6a. List policies and procedures used to identify duplicates.	
6b. When duplicates are identified, how are the affected records processed and what information is returned to the MCOs?	
6c. List policies and procedures used to identify missing records.	

6d. When missing records are identified, what information is returned to the MCOs?	

7. During the processing of the MCOs' encounter data submissions, describe the modifications or reformatting using specific data field names and specific examples (e.g., zeros are added to the beginning of values in any specific field to pad the results to a length of a specific number of characters). *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Field Name	Modifications/ Reformatting (include examples)	Encounter Types Affected (e.g., All, Pharmacy, Medical)
Rendering Provider NPI	*When rendering provider NPI is missing, fill in with billing provider NPI.*	*837P*

8. Explain the code and/or field mapping processes performed during data processing and provide reference table(s) and/or source of the reference table(s), as appropriate. How often are each of the reference table(s) updated? Monthly, quarterly, annually, never, etc.? *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Field	Description of Mapping	Source of Reference Table	Frequency of Updating Reference Table
Rendering Provider NPI	*Map to reference table*	*Provider enrollment file*	*Quarterly*

Section D: Encounter Data Quality Monitoring and Reporting

Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response. In the case of file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to the question. It is not required to resubmit the file(s).

1. Describe how DMAS monitors encounter data submitted by the MCOs for completeness, accuracy, and timeliness. Please include metrics in place including defined error thresholds and standards. If regular reports are used, submit a recent report example.

Measure	Description	Metrics
CCC Plus		
Completeness		
Accuracy		
Timeliness		
Medallion 4.0		
Completeness		
Accuracy		
Timeliness		

2. Does DMAS have performance standards, beyond what is described in the MCO contract requirements, in place regarding the submission, accuracy, and timeliness of encounter data? If YES, provide documentation of the performance standards and describe how the performance standards are communicated to the MCOs.

3. Are the MCOs required to submit reports on encounter data submission activities (e.g., submission statistics) to DMAS? If YES, please describe the reporting process and submit a recent example of these reports for each MCO and other applicable documents.

4. Does DMAS use a specific format to provide feedback to the MCOs on their submissions? If YES, please describe the files used to provide feedback to the MCOs.

5. What is the average percentage of encounters (by MCO) submitted to DMAS that get rejected by DMAS? *Note: The table can be expanded if additional columns are required.*

MCO	Professional	Institutional	Pharmacy
Aetna			
HealthKeepers			
Magellan			
Optima			
United			
VA Premier			

6. Describe how data in DMAS' encounter data system/data warehouse are used (e.g., rate-setting, HEDIS reporting, etc.)

7. Does DMAS collect capitated encounters (e.g., encounters submitted by the MCOs' capitated providers/provider groups) from its MCOs?

7a. What are DMAS' requirements for submitting pricing information on capitated encounters?	
7b. Does DMAS monitor capitated encounters for unallowable services? If YES, describe the type of reporting that is available.	
7c. If NO, does DMAS maintain a list of allowable/unallowable services? If DMAS maintains a list of allowable/unallowable services, please provide supporting document(s).	

Appendix B. Blank Questionnaire for the MCOs

2020–2021 Encounter Data Validation Questionnaire for MCOs

Overview

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, the Virginia Department of Medical Assistance Services (DMAS) requires its Commonwealth Coordinated Care (CCC) Plus and Medallion 4.0 contracted managed care organizations (MCOs) to submit high-quality encounter data. DMAS relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During state fiscal year (SFY) 2020-2021, DMAS contracted Health Services Advisory Group, Inc. (HSAG) to conduct an encounter data validation (EDV) study. In alignment with the CMS External Quality Review (EQR) Protocol 5, Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan[1], HSAG will conduct the following two core evaluation activities for the EDV study:

- Information systems (IS) review—assessment of DMAS' and the MCOs' information systems and processes. The goal of this activity is to examine the extent to which DMAS' and the MCOs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5.
- Administrative profile—analysis of DMAS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity is to evaluate the extent to which the encounter data in DMAS' Encounters Processing Solution (EPS) database are complete, accurate, and submitted by the MCOs in a timely manner for encounters with dates of service in calendar year 2020. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

The IS review will include an evaluation of the MCOs' processes for collecting, maintaining, and submitting encounter data to DMAS and on the strengths and limitations of the MCOs' information systems in promoting and maintaining quality encounter data. Similarly, HSAG will also evaluate DMAS processes for collecting and managing the MCO-submitted encounter data. In alignment with Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5, HSAG has developed the following EDV focused questionnaire to gather information regarding each MCO's information systems and data processing procedures for both the CCC Plus and Medallion 4.0 programs. The IS review will enable HSAG to understand how various systems interact to determine whether such interactions have an impact on the MCOs' ability to submit complete and accurate data.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 5 Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan.* Protocol 5. October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html

General Instructions

HSAG developed the following questionnaire customized in collaboration with DMAS to gather both general information and specific procedures for data processing, personnel, and data acquisition capabilities. The information requested below pertains to the collection and processing of data for the MCO's Medallion 4.0 and CCC Plus lines of business. The questionnaire is divided into the following four domains:

Section A: *Encounter Data Sources and Systems*

Section B: *Data Exchange Policies and Procedures*

Section C: Payment *Structures of Encounter Data*

Section D: *Encounter Data Quality Monitoring and Reporting*

Each participating MCO must complete all sections of the following questionnaire, providing comprehensive answers to the questions and attaching supporting documentation (e.g., policies and procedures, data layouts, data flow diagrams, sample reports, sample data, etc.), where applicable. If a MCO uses different data systems for Medallion 4.0 and CCC Plus, provide separate responses for each line of business specific to procedures related to the processing of DMAS claims and encounters. If different staff members within your MCO are responsible for different aspects of the processes, please distribute multiple copies of the questionnaire and ensure that each group provides answers to the applicable questions in each section. **Responses do not need to be merged into a single final version; uploading multiple sections and documents is acceptable.**

HSAG is aware that each MCO is submitting responses to the Information Systems Capabilities Assessment Tool (ISCAT) to HSAG by June 18, 2021. While the ISCAT focuses on the data used for calculating performance measures required by DMAS, this questionnaire focuses on all types of claims/encounters submitted to DMAS. With that in mind, if the response provided in the ISCAT is applicable to a question in this questionnaire, your MCO can direct HSAG to the specific ISCAT response.

Upon evaluating answers to the questionnaire and additional documentation, HSAG's EDV team may conduct additional follow-up with the MCOs via email or conference calls.

Submission of Questionnaire and Documentation

- Each MCO should upload the completed questionnaire and supporting documentation electronically to HSAG's Secure Access File Exchange (SAFE) site, https://safe.hsag.com/ in your specific MCO folder and project subfolder labeled "Encounter Data Validation."
- Please contact Kari Vanderslice via phone at 602-801-6967 or via e-mail at KVanderslice@hsag.com for assistance with access to HSAG's SAFE site.
- HSAG requests that MCOs upload the completed questionnaires, and any attachments, to HSAG's SAFE site no later than **July 21, 2021**. Upon completion of upload, please notify Lacey Hinton via e-mail at LHinton@hsag.com.

- Please provide the descriptions for the acronyms used in your responses in the table below or spell them out when using the acronyms for the first time.

Acronym	Description

2020-2021 Encounter Data Validation—MCO Focused Questionnaire

Section A: Encounter Data Sources and Systems

MCO Name	
Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If your MCO uses the same data system for multiple clients or lines of business, please limit your responses to specific procedures related to the processing of DMAS' claims and encounters. If supplemental files or supporting documents are provided, please note the filename(s) in your response.

1. Using a list or data flow diagram, outline the path your MCO's encounter data follow from the time a member receives a service(s) until the encounter is processed by DMAS. If the data path differs by or within a claim type, provide a separate list or data flow diagram for each claim type and scenario. Be sure to identify any subcontractors responsible for processing the data and the associated processes with the subcontractors. *Note: The first section of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Source[1]	Data Flow	Supporting Document
Paper Claims	*All paper claims are received via mail. Paper claims are date stamped upon receipt and scanned with optical character recognition (OCR) software and converted to 837 files for electronic processing. The remaining process is the same as the claims in electronic format.*	*<insert file name>*
Medical		
Pharmacy		
Vision		
Non-Emergency Transportation		
<insert other subcontractors[2]>		

[1] These sources represent claims/encounter submissions from the rendering provider to your MCO or subcontractor.
[2] Examples include hearing, chiropractic, laboratory, etc.

2. For each key source of data (i.e., all data your MCO receives that are included in the encounter data submissions to DMAS for the CCC Plus and Medallion 4.0 programs), provide a description of the files received, the frequency of receipt, and the approximate percentage of claims submitted by capitated versus fee-for-service (FFS) providers. If the response for the CCC Plus and Medallion 4.0 programs are different, please note the differences or provide responses to each program separately. *Note: The first section of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Source[1]	Description of Data Received (Including Format)	Frequency[2]	Approximate Percentage of Claims from Capitated Providers
Pharmacy	*We receive point of service claims submitted by retail pharmacies from our vendor, Express Scripts. Files are submitted using the NCPDP D.0 format.*	*Weekly*	*Medallion 4.0: 30%; CCC Plus: 35%*
Medical in 837 Professional Format			
Medical in 837 Institutional Format			
Pharmacy			
Vision			
Non-Emergency Transportation			
<insert other subcontractors[3]>			

[1] These sources represent claims/encounter submissions from the rendering provider to your MCO or subcontractor.
[2] Frequency = Daily, weekly, twice a month, monthly, every other month, etc.
[3] Examples include hearing, chiropractic, laboratory, etc.

3. For each key source of data, provide a description of the software used to receive data, validate data, and prepare outbound encounters for submission to DMAS. *Note: The first section of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Source[1]	Software Used to Receive Data	Software Used to Validate Data	Software Used to Generate Encounters for DMAS
Paper claims	*Convert to 837 format through an optical character recognition (OCR) software by <insert name>*	*Facets*	*Encounter Data Manager*
Medical in 837 Professional Format			
Medical in 837 Institutional Format			
Pharmacy			
Vision			
Non-Emergency Transportation			
<insert other subcontractors[2]>			

[1] These sources represent claims/encounter submissions from the rendering provider to your MCO or subcontractor.
[2] Examples include hearing, chiropractic, laboratory, etc.

4. For encounters submitted to DMAS through 837 professional and institutional formats, please describe the software used for the Electronic Data Interchange (EDI) compliance checks and the Workgroup for Electronic Data Interchange Strategic National Implementation Process (WEDI SNIP) levels that are used in the EDI compliance checks.

Data Source[1]	Software for EDI Compliance Check	WEDI SNIP Level
Vision claims		*Levels 1 and 2*
Medical in 837 Professional Format		
Medical in 837 Institutional Format		
Vision		
Non-Emergency Transportation		
<insert other subcontractors[2]>		

[1] These sources represent claims/encounter submissions from the rendering provider to your MCO or subcontractor.
[2] Examples include hearing, chiropractic, laboratory, etc.

5. Please specify the modifications, reformatting or changes made to the claims/encounter data to accommodate DMAS' encounter data submission standards. Describe the modifications or reformatting using specific data field names and examples. If a vendor prepares the encounter data submission for your MCO, please specify the modifications made by the vendor and additional modifications made by the MCO separately. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Type	Field	Modification Details	Modification Made By
Vision Claims	*Provider ID*	*Zeros are added to the beginning of values in the Provider ID field to pad the results to a standard length of characters (e.g., 00003126).*	*MCO*

6. Please specify how your MCO prepares/enriches data elements that are not on the claims from providers but required by DMAS. Describe the source of the data and process to create these data elements. If a vendor prepares the encounter data submission for your MCO, please specify the modifications made by the vendor and additional modifications made by the MCO separately. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Type	Field	Source Data and Creation Process	Modification Made By
Professional Claims	*Taxonomy Code*	*Obtain taxonomy codes from a reference file by linking with provider NPI and procedure code.*	*MCO*

7. Describe the types of validation performed on claims, the percentage of validated claims, and the types of claims validated. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Types of Claims/Data Elements Validated	Description of Validation Performed	Percentage of Claims Validated
Vision/Diagnosis codes	*Validate code is accurate against reference table.*	*99%*

8. Describe any code and/or field mapping performed during data processing and validation prior to adjudicating claims for payment processing, including those maintained by vendors/subcontractors, as appropriate. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Field	Description of Mapping	Source of Reference Table	Frequency of Updating Reference Table
Rendering Provider NPI	*Map to reference table*	*Provider enrollment file*	*Quarterly*

9. Describe any code and/or field mapping performed during data processing for submission to DMAS, including those maintained by vendors/ subcontractors, as appropriate. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Field	Description of Mapping	Source of Reference Table	Frequency of Updating Reference Table
Subcontractor ID	*Map to correct value assigned by DMAS for each program and sender*	*N/A*	*Whenever change occurs*

Field	Description of Mapping	Source of Reference Table	Frequency of Updating Reference Table

10. Describe the process to identify duplicate claims. Provide details on the fields used to identify duplicates, where in the process the duplicates are identified and how they are handled.

11. Describe the types of claims/encounters that are not submitted to DMAS (e.g., paid, denied, voided, adjusted claims).

12. Describe the process to submit denied or partially denied claims/encounters to DMAS. List measures taken to ensure that denied claims/encounters do not include paid service lines.

13. Describe the process to submit adjustments/replacement/void/corrections (collectively referred to as adjustments) to encounters that have previously been submitted to DMAS.

13a. What is the process to identify encounters for which adjustments are required?	
13b. Describe the process to submit adjustments.	

13c. How long does it take from identification to re-submission for encounters needing adjustments?	
13d. If adjustments are not submitted, describe why these encounters were not submitted.	

14. The following questions address the collection, use, and submission of provider data and enrollment data.

Provider Data	
14a. Data collected and maintained by?	☐ By the MCO ☐ By a subcontractor
14b. List name of vendor and type of data maintained (e.g., Vendor X for all vision services)	
14c. List vendor's responsibilities in collecting and maintaining the data	
14d. Describe flow of data from collection to maintenance including processes associated with the subcontractor	
14e. Describe the process for linking data to claims/encounters including any procedures for reconciling differences between data submitted on the claim/encounter and your provider data	
Enrollment data	
14f. Data collected and maintained by?	☐ By the MCO ☐ By a subcontractor
14g. List name of vendor and type of data maintained (e.g., Vendor X for all vision services)	
14h. List vendor's responsibilities in collecting and maintaining the data	

14i. Describe flow of data from collection to maintenance including processes associated with the subcontractor	
14j. Describe the process for linking data to claims/encounters including any procedures for reconciling differences between data submitted on the claim/encounter and your enrollment data	

Section B: Data Exchange Policies and Procedures

MCO Name	
Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response.

1. Describe the encounter data submission process used by your MCO. Include details outlining the organizational and operational policies and procedures related to your encounter data submissions and how your MCO enforces the policies and procedures.

1a. What is the frequency of encounter submission to DMAS?	
1b. List whether encounters are submitted directly or through vendor/subcontractor.	
1c. Describe the encounter submission process.	
1d. Describe policies and procedures related to encounter submission process.	
1e. Measures taken to enforce policies and procedures.	

2. List the point(s) of contact at your MCO and their role in the encounter data submission processes to DMAS. *Note: The table can be expanded if additional rows are required.*

Point of Contact	Description of Data Submission Responsibility

Section C: Payment Structures of Encounter Data

MCO Name	
Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response.

1. How are claims paid (e.g., percent of billed, line-by-line, case rate, etc.)? If different methods exist, please add to the table below and then list them by percentage of claim dollars for each payment type.

Payment Type	Inpatient	Outpatient	Pharmacy	Long Term Care
CCC Plus				
Percent of Billed				
Line-by-line				
Per-diem				
Variable Per Diem				
Capitation				
DRG				
Negotiated (Flat) Rate				
Ingredient Cost (for Pharmacy)				
Other (Please describe)				
Other (Please describe)				
Total	**100%**	**100%**	**100%**	**100%**

Payment Type	Inpatient	Outpatient	Pharmacy	Long Term Care
Medallion 4.0				
Percent of Billed				
Line-by-line				
Per-diem				
Variable Per Diem				
Capitation				
DRG				
Negotiated (Flat) Rate				
Ingredient Cost (for Pharmacy)				
Other (Please describe)				
Other (Please describe)				
Total	**100%**	**100%**	**100%**	**100%**

2. Describe how each of the payment arrangements listed above are reflected in the encounter data submissions. If outpatient visits are paid through sub-capitated arrangements, please describe how your MCO determines the paid amount submitted to DMAS.

Inpatient	
Outpatient	
Pharmacy	
Long Term Care	

3. Are any services submitted to the MCO under bundle-payment structures? If so, what services are submitted for bundled-payments? For example, if delivery services are considered bundle payments, please specify whether encounters on both delivery and all prenatal/postpartum services are collected by your MCO.

4. Describe the process for collecting coordination of benefits/third party liability (TPL) data, submitting encounters with TPL and TPL payments. Provide separate responses for different types of claims including pharmacy encounters.

4a. How is other insurance data collected? Are your MCO's subcontracted vendors required to collect other insurance data?	
4b. How are claims processed with TPL, including if other insurance is submitted after initial claim processing?	
4c. What source data is used to verify the accuracy of the third-party claims information? Where does your MCO store payment information and the source data? How is third party information populated onto encounters submitted to DMAS.	
4d. What are the measures taken to ensure accuracy of the TPL payment amount?	

5. Describe the process to capture, monitor accuracy, and submit zero-pay claims to DMAS.

5a. Describe scenarios creating zero-pay amounts for your MCO (e.g., full payment by TPL, exceeding MCO's allowed amount).	
5b. How are zero-pay claims reflected in the encounter data?	
5c. Are zero-pay claims for sub-capitated providers processed and submitted to DMAS? If so, describe how the completeness and accuracy of the claims are assessed.	

6. Describe the process for submitting pricing information on capitated encounters.

Section D: Encounter Data Quality Monitoring and Reporting

MCO Name	
Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response.

1. Describe how you monitor data provided by a third-party, vendor, subcontractor, or provider for completeness, accuracy, and timeliness. If regular reports are used, submit a recent report example. If there are any concerns on the completeness, accuracy, and timeliness of data received, list the concerns under the description column.

Measure	Description	Metrics
Data from Vendors/ Subcontractors/ Third-party		
Completeness		
Accuracy		
Timeliness		
Data from Providers		
Completeness		
Accuracy		
Timeliness		

2. Describe the process to monitor the status of encounter data submitted to DMAS. Include monitoring and reporting mechanisms, pertinent supporting policies, procedures, and sample reports.

3. Using the table below, please identify which transaction response files are used to support your encounter data submission activities and how the responses are tracked in your data system. If the transaction response files are used to support encounter data submission activities ("YES"), describe how the data are used in the last column and whether the transaction responses are stored in the MCO's data system. If the transaction responses are not used to support encounter data submission activities ("NO"), explain the reason why in the last column and whether the transaction responses are stored in the MCO's data system. *Note: The table can be expanded if additional rows are required.*

Transaction Response	Used to Support Encounter Data Submission?	Explanation of Transaction Response Use and Storage in the MCO's Data System
277	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

4. List the average rejection/pend rate for the different types of claims/encounters. If the rejection rate is not available for each claim type, include the average overall rate in the last row.

Claim/Encounter	Percentage of encounters submitted to DMAS that are rejected by DMAS' EDI translator	Percentage of encounters submitted to DMAS that pass EDI translator but fail the EPS business rules
Institutional		
Professional		
Pharmacy		
<Insert Vendor>		
Overall Rate		

5. Describe your MCO's process for reconciling files rejected by DMAS' EDI translator, including key policies and procedures for the identification, correction, and subsequent resubmission of encounters to DMAS.

6. Describe your MCO's process for reconciling transactions that fail EPS business rules, including key policies and procedures for the identification, correction, and subsequent resubmission of these encounters to DMAS.

7. Describe how data in your MCO's encounter data system/data warehouse are used (e.g., rate-setting, HEDIS reporting, etc.)

8. What internal challenges do you face in submitting encounter data to DMAS?

9. What external challenges do you face in submitting encounter data to DMAS? For example, are there challenges with DMAS' EDI translator or the EPS.

10. What changes in processes or additional resources and support from DMAS would you find most helpful in overcoming your challenges with successfully submitting encounter data to DMAS?

11. Do you have any upcoming changes to your encounter submission process that may impact your answers to the questions above? If yes, what changes are expected and when are they likely to become effective?

Attestation Statement

I hereby certify that I have reviewed the information entered on this questionnaire and that, to the best of my knowledge, the information is complete and accurate as of the date below.

_____ _____

Signature of CEO or responsible individual Date

_____

Print name and title

Appendix C. Information Systems Review Results for DMAS and Statewide Administrative Profile Results

Information Systems Review

Encounter Data Quality Monitoring and Reporting

Cleary defined expectations are essential to MCOs' timely submission of accurate, high-quality encounter data to DMAS, as well as ensuring consistency in MCOs' encounter reporting.

Monitoring Encounter Data Submissions (for Completeness, Accuracy, and Timeliness), Capitated Encounters, etc.

DMAS reports having performance standards (beyond what is described in the MCO contract requirement) in place regarding the submission, accuracy, and timeliness of encounter data, and communicating those standards to MCOs. However, at the time questionnaire responses were received from DMAS, monitoring reports to identify noncovered services designated as paid by the MCO with no enhanced benefit flag were yet to be developed or distributed.

DMAS submits T-MSIS data extracts to CMS regularly as required. However, it is not clear the extent to which internal data quality monitoring activities relate to TPI. To rectify any outstanding data quality issues in T-MSIS extracts, DMAS may consider conducting validation activities that align with TPIs.

Duplicate encounters appear to be identified at the header level and may undercount duplicate services reported at the detail level. Additionally, although total charges are incorporated in the de-duplication logic, the specific service or procedure does not appear to be included. CMS defines "duplicates" as "multiple encounters submitted for the same service, to the same member, by the same provider, on the same date."[C-1] Other states have included additional fields to identify duplicate encounters, such as procedure code (CPT/HCPCS), procedure modifiers, and in some cases, tooth number/surface.

Administrative Profile

This section will present the statewide results for the administrative profile analyses by claim type.

[C-1] Ibid.

Encounter Data Completeness

Table C-1 provides encounter data volume results for statewide professional encounters.

Table C-1—Encounter Volume—Professional Encounters—Statewide

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	1,284,163	242,623	5,292.8
February 2020	1,189,079	242,371	4,906.0
March 2020	1,175,471	243,039	4,836.6
April 2020	1,054,585	246,346	4,280.9
May 2020	1,109,185	250,232	4,432.6
June 2020	1,168,561	252,349	4,630.7
July 2020	1,226,635	254,213	4,825.2
August 2020	1,220,252	256,448	4,758.3
September 2020	1,278,719	257,799	4,960.1
October 2020	1,359,820	259,496	5,240.2
November 2020	1,275,151	260,946	4,886.6
December 2020	1,310,193	262,555	4,990.2

Table C-2 provides encounter data volume results for statewide institutional encounters.

Table C-2—Encounter Volume—Institutional Encounters—Statewide

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	119,970	242,623	494.5
February 2020	113,002	242,371	466.2
March 2020	96,675	243,039	397.8
April 2020	69,585	246,346	282.5
May 2020	83,859	250,232	335.1
June 2020	97,705	252,349	387.2
July 2020	103,648	254,213	407.7
August 2020	101,124	256,448	394.3
September 2020	103,422	257,799	401.2
October 2020	109,341	259,496	421.4
November 2020	99,529	260,946	381.4
December 2020	98,607	262,555	375.6

Table C-3 provides encounter data volume results for statewide pharmacy encounters.

Table C-3—Encounter Volume—Pharmacy Encounters—Statewide

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	600,772	242,623	2,476.2
February 2020	559,571	242,371	2,308.7
March 2020	634,712	243,039	2,611.6
April 2020	577,824	246,346	2,345.6
May 2020	546,698	250,232	2,184.8
June 2020	558,949	252,349	2,215.0
July 2020	566,655	254,213	2,229.1
August 2020	547,333	256,448	2,134.3
September 2020	543,950	257,799	2,110.0
October 2020	547,295	259,496	2,109.1
November 2020	518,907	260,946	1,988.6
December 2020	546,181	262,555	2,080.3

Table C-4 provides paid amount and TPL amount results for statewide professional encounters.

Table C-4—Paid Amount and TPL Amount—Professional Encounters—Statewide

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	174,015,298	717.2	17,580,495	72.5
February 2020	162,419,110	670.1	18,613,209	76.8
March 2020	163,349,322	672.1	17,635,817	72.6
April 2020	150,509,623	611.0	14,308,502	58.1
May 2020	161,729,867	646.3	15,323,839	61.2
June 2020	163,749,756	648.9	17,191,259	68.1
July 2020	176,937,263	696.0	17,284,656	68.0
August 2020	175,386,681	683.9	17,351,798	67.7
September 2020	164,732,737	639.0	18,741,762	72.7
October 2020	175,635,962	676.8	20,034,767	77.2
November 2020	167,446,617	641.7	18,407,373	70.5
December 2020	171,531,163	653.3	19,201,841	73.1

Table C-5 provides paid amount and TPL amount results for statewide institutional encounters.

Table C-5—Paid Amount and TPL Amount—Institutional Encounters—Statewide

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	167,398,616	690.0	52,114,708	214.8
February 2020	150,946,551	622.8	47,848,170	197.4
March 2020	157,837,597	649.4	44,486,107	183.0
April 2020	135,024,536	548.1	35,395,083	143.7
May 2020	143,798,323	574.7	38,164,644	152.5
June 2020	157,614,554	624.6	42,856,911	169.8
July 2020	171,604,554	675.0	44,913,084	176.7
August 2020	169,036,594	659.1	43,965,944	171.4
September 2020	163,084,267	632.6	44,654,157	173.2
October 2020	172,633,183	665.3	51,646,759	199.0
November 2020	161,803,291	620.1	46,575,476	178.5
December 2020	165,675,469	631.0	50,880,224	193.8

Table C-6 provides paid amount and TPL amount results for statewide pharmacy encounters.

Table C-6—Paid Amount and TPL Amount—Pharmacy Encounters—Statewide

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	57,484,008	236.9	2,045,942	8.4
February 2020	55,698,281	229.8	1,846,952	7.6
March 2020	65,567,169	269.8	2,108,139	8.7
April 2020	63,647,747	258.4	1,744,338	7.1
May 2020	59,107,281	236.2	1,643,034	6.6
June 2020	62,411,359	247.3	1,611,727	6.4
July 2020	62,772,508	246.9	1,702,078	6.7
August 2020	59,804,797	233.2	1,521,771	5.9
September 2020	61,529,913	238.7	1,395,257	5.4
October 2020	62,366,832	240.3	1,270,791	4.9
November 2020	60,604,376	232.2	1,332,920	5.1
December 2020	67,259,894	256.2	1,329,820	5.1

Table C-7 provides the percentage of duplicate encounters for all three encounters.

Table C-7—Percentage of Duplicate Encounters—Statewide

Claim Type	Total Records	Number of Duplicate Records	Percent of Duplicates
Professional Encounters	25,320,239	416,884	1.6%
Institutional Encounters	6,685,407	48,662	0.7%
Pharmacy Encounters	6,753,296	504	<0.1%

Encounter Data Timeliness

Table C-8 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for statewide professional encounters.

Table C-8—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Professional Encounters—Statewide

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
Prior January 2020	99.8%	99.9%	99.9%	99.9%	99.9%
January 2020	96.4%	99.0%	99.2%	99.5%	99.5%
February 2020	98.8%	99.2%	99.5%	99.5%	99.6%
March 2020	97.9%	99.1%	99.9%	99.9%	99.9%
April 2020	99.0%	99.9%	99.9%	99.9%	99.9%
May 2020	94.3%	97.1%	97.2%	97.6%	97.7%
June 2020	94.4%	95.1%	95.8%	96.1%	98.9%
July 2020	91.2%	94.2%	94.8%	98.8%	99.9%
August 2020	93.2%	94.3%	97.5%	98.7%	98.7%
September 2020	92.7%	97.1%	98.1%	98.1%	98.3%
October 2020	94.7%	97.1%	97.2%	97.7%	97.8%
November 2020	95.4%	95.5%	98.0%	98.0%	98.2%
December 2020	92.4%	97.2%	98.1%	98.2%	98.9%
January 2021	96.1%	98.8%	98.9%	99.2%	100.0%
February 2021	97.0%	99.4%	99.7%	100.0%	100.0%
March 2021	97.0%	99.4%	99.9%	100.0%	100.0%

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
April 2021	97.1%	97.4%	100.0%	100.0%	100.0%
May 2021	99.2%	100.0%	100.0%	100.0%	100.0%
June 2021	99.7%	99.7%	99.7%	99.7%	99.7%

Table C-9 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for statewide institutional encounters.

Table C-9—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Institutional Encounters—Statewide

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	80.2%	80.3%	80.3%	80.3%	80.4%
February 2020	96.6%	96.7%	96.7%	96.7%	99.4%
March 2020	97.9%	97.9%	97.9%	98.4%	99.7%
April 2020	97.9%	97.9%	98.3%	99.7%	99.7%
May 2020	93.7%	97.5%	98.7%	98.7%	99.0%
June 2020	94.2%	95.3%	95.5%	95.7%	99.4%
July 2020	89.5%	92.0%	92.2%	95.3%	95.4%
August 2020	96.5%	97.4%	97.5%	97.5%	97.6%
September 2020	97.6%	98.0%	98.0%	98.1%	98.1%
October 2020	96.3%	96.9%	97.1%	97.2%	97.3%
November 2020	97.5%	97.7%	97.8%	97.9%	98.6%
December 2020	97.4%	97.6%	97.8%	98.5%	99.0%
January 2021	98.4%	98.6%	98.7%	99.2%	99.6%
February 2021	97.0%	98.5%	98.9%	99.8%	100.0%
March 2021	98.0%	98.7%	99.5%	100.0%	100.0%
April 2021	96.4%	98.9%	100.0%	100.0%	100.0%
May 2021	98.4%	99.9%	100.0%	100.0%	100.0%
June 2021	85.4%	85.4%	85.4%	85.4%	85.4%

Table C-10 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for Statewide pharmacy encounters.

Table C-10—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Pharmacy Encounters—Statewide

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	97.7%	99.6%	99.6%	99.6%	99.6%
February 2020	96.8%	96.9%	96.9%	96.9%	96.9%
March 2020	92.2%	92.2%	92.3%	92.3%	92.3%
April 2020	91.9%	92.1%	92.1%	92.1%	92.1%
May 2020	91.4%	91.5%	91.5%	91.5%	91.5%
June 2020	94.9%	94.9%	94.9%	94.9%	94.9%
July 2020	92.8%	92.8%	92.8%	92.8%	92.8%
August 2020	91.5%	91.5%	91.5%	91.5%	91.5%
September 2020	85.4%	92.2%	92.2%	92.4%	92.5%
October 2020	92.5%	92.5%	92.6%	92.6%	92.6%
November 2020	91.6%	91.6%	91.6%	91.6%	91.7%
December 2020	92.4%	92.5%	92.5%	92.5%	92.7%
January 2021	77.6%	77.6%	77.6%	78.1%	78.1%
February 2021	80.0%	80.0%	81.1%	81.2%	81.2%
March 2021	98.0%	98.0%	98.0%	98.0%	98.0%
April 2021	82.1%	82.1%	82.1%	82.1%	82.1%
May 2021	94.3%	94.3%	94.3%	94.3%	94.3%
June 2021	98.4%	98.4%	98.4%	98.4%	98.4%

Table C-11 provides lag triangles for statewide professional encounters. Additional details provided include MM and claims PMPM.

Table C-11—Encounters Lag Triangle—Professional Encounters—Statewide

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
APR19		1					1						2
JUN18				1									1
201911	126												126
201912	557	203	2										762
202001	196,193	531	228	1									196,953
202002	861,336	155,740	535	90	1								1,017,702
202003	283,344	908,145	239,394	373	98						1	1	1,431,356
202004	54,700	189,693	836,285	180,135	410	113				1		2	1,261,339
202005	28,588	42,592	170,908	786,061	222,203	466	195	7		1			1,251,021
202006	13,409	28,221	34,596	108,884	711,797	189,154	261	75					1,086,397
202007	9,071	10,358	16,009	29,997	141,666	708,128	160,352	489	32	1			1,076,103
202008	9,345	9,060	12,820	22,697	43,657	246,117	902,553	214,465	368	33	1		1,461,116
202009	9,011	4,909	7,276	14,269	25,657	44,132	170,361	830,763	173,342	302	30		1,280,052
202010	5,650	5,517	7,889	10,562	13,079	24,552	53,157	174,334	927,042	301,053	520	40	1,523,395
202011	4,284	5,009	6,474	18,146	64,381	68,920	84,698	95,411	218,740	929,279	227,414	408	1,723,164
202012	3,306	3,290	3,319	4,078	6,704	10,287	15,570	21,943	46,885	166,831	871,118	241,390	1,394,721
202101	5,110	6,571	4,175	3,149	5,654	6,727	11,688	11,861	26,512	44,890	173,934	888,414	1,188,685
202102	2,575	2,803	3,432	3,166	3,865	5,115	9,386	14,449	22,332	47,375	104,857	230,782	450,137
202103	1,988	1,755	2,813	3,740	4,204	5,005	6,586	8,514	12,599	20,542	25,906	57,641	151,293
202104	888	1,046	1,972	3,010	3,523	4,111	6,405	8,162	12,528	16,135	18,385	26,760	102,925
202105	1,544	1,272	1,076	1,460	3,140	4,483	4,720	23,655	30,085	34,086	35,069	39,381	179,971
202106	1,554	1,381	1,254	1,177	1,718	2,481	3,802	4,364	6,098	6,254	7,861	10,599	48,543
202107	176	208	221	183	238	507	754	828	1,209	1,188	1,309	1,661	8,482
Total	1,492,755	1,378,305	1,350,678	1,191,179	1,251,995	1,320,298	1,430,489	1,409,320	1,477,772	1,567,971	1,466,405	1,497,079	16,834,246
MM	242,623	242,371	243,039	246,346	250,232	252,349	254,213	256,448	257,799	259,496	260,946	262,555	3,028,417
PMPM	**6.153**	**5.687**	**5.557**	**4.835**	**5.003**	**5.232**	**5.627**	**5.496**	**5.732**	**6.042**	**5.620**	**5.702**	**5.557**

Table C-12 provides lag triangles for statewide institutional encounters. Additional details provided include MM and claims PMPM.

Table C-12—Encounters Lag Triangle—Institutional Encounters—Statewide

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	12,006												12,006
202002	57,340	11,195											68,535
202003	25,970	69,099	14,545										109,614
202004	6,577	17,788	52,922	5,893	1								83,181
202005	3,578	4,790	16,147	40,887	9,245								74,647
202006	8,974	2,590	3,276	10,619	43,048	10,591							79,098
202007	2,607	2,697	3,003	3,513	13,150	50,739	8,235						83,944
202008	1,431	1,463	1,642	2,092	4,894	19,136	56,510	12,714					99,882
202009	1,504	1,979	4,530	3,975	5,565	7,717	18,480	54,437	9,957				108,144
202010	970	1,000	1,132	1,782	4,469	5,095	6,527	18,550	67,520	17,038			124,083
202011	834	701	690	653	1,011	1,460	5,174	5,942	14,156	62,219	13,279		106,119
202012	519	502	578	742	1,069	1,330	2,410	3,855	4,689	17,935	59,733	15,516	108,878
202101	373	351	350	410	587	2,109	2,396	1,245	2,163	4,661	17,249	59,534	91,428
202102	549	577	582	567	795	848	1,438	1,554	1,791	2,430	4,206	14,641	29,978
202103	435	471	541	549	646	809	1,144	1,225	1,413	1,977	2,573	5,121	16,904
202104	238	349	415	417	515	602	1,747	1,810	1,907	2,229	2,603	3,291	16,123
202105	142	205	207	379	531	791	1,600	1,672	1,670	1,892	1,959	2,149	13,197
202106	353	345	279	254	247	463	1,944	1,767	2,167	1,662	1,465	1,639	12,585
202107	645	538	517	333	366	81	137	130	217	269	248	284	3,765
Total	125,045	116,640	101,356	73,065	86,139	101,771	107,742	104,901	107,650	112,312	103,315	102,175	1,242,111
MM	242,623	242,371	243,039	246,346	250,232	252,349	254,213	256,448	257,799	259,496	260,946	262,555	3,028,417
PMPM	**0.515**	**0.481**	**0.417**	**0.297**	**0.344**	**0.403**	**0.424**	**0.409**	**0.418**	**0.433**	**0.396**	**0.389**	**0.411**

Table C-13 provides lag triangles for statewide pharmacy encounters. Additional details provided include MM and claims PMPM.

Table C-13—Encounters Lag Triangle—Pharmacy Encounters—Statewide

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	207,141												207,141
202002	365,440	203,391											568,831
202003	12,264	346,676	233,715										592,655
202004	1,882	5,601	393,479	287,208									688,170
202005	11,437	1,388	4,040	283,645	241,309								541,819
202006	463	548	1,240	3,268	296,114	202,054							503,687
202007	297	303	714	2,248	7,071	350,620	272,163						633,416
202008	279	348	480	240	747	3,024	268,308	216,964					490,390
202009	42	45	67	342	499	1,868	16,456	318,895	144,763				482,977
202010	61	66	71	106	124	229	2,168	6,303	388,929	280,516			678,573
202011	9	16	23	24	40	94	3,686	849	3,286	251,644	245,466		505,137
202012	173	7	19	12	18	33	69	429	1,551	9,184	264,319	349,787	625,601
202101	12	5	3	9	11	19	26	93	1,515	1,623	3,634	186,504	193,454
202102	13	27	25	27	22	34	46	99	125	216	1,079	3,729	5,442
202103	75	65	69	63	69	93	2,678	2,487	2,596	2,821	3,115	4,096	18,227
202104	1,033	949	1,120	1,009	937	1,041	1,019	981	941	1,008	1,009	1,095	12,142
202105	117	60	56	98	148	157	177	336	299	161	167	215	1,991
202106	216	225	266	255	226	245	294	241	252	266	240	312	3,038
202107						1	4	4	3	4	8	581	605
Total	600,954	559,720	635,387	578,554	547,335	559,512	567,094	547,681	544,260	547,443	519,037	546,319	6,753,296
MM	242,623	242,371	243,039	246,346	250,232	252,349	254,213	256,448	257,799	259,496	260,946	262,555	3,028,417
PMPM	**2.477**	**2.309**	**2.614**	**2.349**	**2.187**	**2.217**	**2.231**	**2.136**	**2.111**	**2.110**	**1.989**	**2.081**	**2.234**

Field-Level Completeness and Accuracy

Table C-14 provides a summary of the field-level completeness and accuracy for statewide professional encounters.

Table C-14—Data Element Completeness and Accuracy for Professional Encounters—Statewide

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	16,834,246	16,834,246	100.0%	16,411,912	16,834,246	97.5%
Header Service From Date	16,834,246	16,834,246	100.0%	16,834,238	16,834,246	>99.9%
Header Service To Date	16,834,246	16,834,246	100.0%	16,820,399	16,834,246	>99.9%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Detail Service From Date	25,320,239	25,320,239	100.0%	25,320,231	25,320,239	>99.9%
Detail Service To Date	25,320,239	25,320,239	100.0%	25,301,299	25,320,239	>99.9%
Billing Provider NPI	16,834,246	16,834,246	100.0%	16,803,668	16,834,246	99.8%
Rendering Provider NPI	16,834,246	16,834,246	100.0%	16,803,437	16,834,246	99.8%
Servicing Provider Taxonomy Code	25,320,239	25,320,239	100.0%	21,486,141	25,320,239	84.9%
Referring Provider NPI	2,443,014	16,834,246	14.5%	2,367,925	2,443,014	96.9%
Primary Diagnosis Codes	16,834,246	16,834,246	100.0%	16,834,107	16,834,246	>99.9%
Secondary Diagnosis Codes	3,976,894	16,834,246	23.6%	10,865,442	10,865,589	>99.9%
CPT/HCPCS Codes	25,320,239	25,320,239	100.0%	25,320,076	25,320,239	>99.9%
CPT/HCPCS Codes with PTP Edits	25,320,239	25,320,239	100.0%	25,317,776	25,320,239	>99.9%
Service Units	25,320,239	25,320,239	100.0%	25,320,239	25,320,239	100.0%
Service Units with MUE Edits	5,560,585	5,560,585	100.0%	5,462,859	5,560,585	98.2%
National Drug Codes	836,373	25,320,239	3.3%	835,275	836,373	99.9%
HCPCS/NDC Combination	154,521	182,407	84.7%	124,722	154,521	80.7%
MCO Received Date	25,320,239	25,320,239	100.0%	25,320,239	25,320,239	100.0%
MCO Paid Date	25,320,239	25,320,239	100.0%	25,320,239	25,320,239	100.0%
Header Paid Amount	16,834,246	16,834,246	100.0%	16,833,741	16,834,246	>99.9%
Header TPL Paid Amount	3,141,481	16,834,246	18.7%	3,055,906	3,141,481	97.3%
Detail Paid Amount	25,320,239	25,320,239	100.0%	25,320,239	25,320,239	100.0%
Detail TPL Paid Amount	4,825,063	25,320,239	19.1%	4,825,063	4,825,063	100.0%

Table C-15 provides a summary of the field-level completeness and accuracy for statewide institutional encounters.

Table C-15—Data Element Completeness and Accuracy for Institutional Encounters—Statewide

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	1,242,111	1,242,111	100.0%	1,189,256	1,242,111	95.7%
Header Service From Date	1,242,111	1,242,111	100.0%	1,242,111	1,242,111	100.0%
Header Service To Date	1,242,111	1,242,111	100.0%	1,242,110	1,242,111	>99.9%
Detail Service From Date	6,685,407	6,685,407	100.0%	6,685,407	6,685,407	100.0%
Detail Service To Date	6,685,407	6,685,407	100.0%	6,685,407	6,685,407	100.0%
Billing Provider NPI	1,242,111	1,242,111	100.0%	1,240,100	1,242,111	99.8%
Rendering Provider NPI	754	1,242,111	<0.01%	754	754	100.0%
Attending Provider NPI	1,154,398	1,242,111	92.9%	1,141,415	1,154,398	98.9%
Servicing Provider Taxonomy Code	3,716,233	6,685,407	55.6%	3,353,751	3,716,233	90.2%
Referring Provider NPI	13,376	1,242,111	1.1%	13,087	13,376	97.8%
Primary Diagnosis Codes	1,242,111	1,242,111	100.0%	1,242,110	1,242,111	>99.9%
Secondary Diagnosis Codes	1,219,881	1,242,111	98.2%	9,530,224	9,530,261	>99.9%
CPT/HCPCS Codes	5,158,756	6,685,407	77.2%	5,011,336	5,158,756	97.1%
CPT/HCPCS Codes with PTP Edits	5,158,756	6,685,407	77.2%	5,007,888	5,158,756	97.1%
Service Units	6,685,407	6,685,407	100.0%	6,685,407	6,685,407	100.0%
Service Units with MUE Edits	2,260,738	2,260,738	100.0%	2,252,678	2,260,738	99.6%
Primary Surgical Procedure Codes	42,320	1,242,111	3.4%	42,253	42,320	99.8%
Secondary Surgical Procedure Codes	22,886	1,242,111	1.8%	69,761	69,884	99.8%
Revenue Codes	6,685,407	6,685,407	100.0%	6,685,407	6,685,407	100.0%
Diagnosis-Related Groups Codes	49,117	1,242,111	4.0%	47,115	49,117	95.9%
Type of Bill Codes	1,242,111	1,242,111	100.0%	1,242,111	1,242,111	100.0%
National Drug Codes	663,087	6,685,407	9.9%	650,058	663,087	98.0%
HCPCS/NDC Combination	320,586	320,762	>99.9%	216,468	320,586	67.5%
MCO Received Date	6,685,407	6,685,407	100.0%	6,685,407	6,685,407	100.0%
MCO Paid Date	6,685,407	6,685,407	100.0%	6,685,407	6,685,407	100.0%
Header Paid Amount	1,242,111	1,242,111	100.0%	1,242,059	1,242,111	>99.9%
Header TPL Paid Amount	400,206	1,242,111	32.2%	287,593	400,206	71.9%
Detail Paid Amount	6,685,407	6,685,407	100.0%	6,685,407	6,685,407	100.0%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Detail TPL Paid Amount	2,658,823	6,685,407	39.8%	2,658,823	2,658,823	100.0%

Table C-16 provides a summary of the field-level completeness and accuracy for statewide pharmacy encounters.

Table C-16—Data Element Completeness and Accuracy for Pharmacy Encounters—Statewide

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	6,753,296	6,753,296	100.0%	6,435,391	6,753,296	95.3%
DOS	6,753,296	6,753,296	100.0%	6,753,296	6,753,296	100.0%
Billing Provider NPI	6,753,296	6,753,296	100.0%	6,751,152	6,753,296	>99.9%
Prescribing Provider NPI	6,753,296	6,753,296	100.0%	6,529,747	6,753,296	96.7%
National Drug Codes	6,753,296	6,753,296	100.0%	6,722,454	6,753,296	99.5%
MCO Received Date	6,753,296	6,753,296	100.0%	6,753,296	6,753,296	100.0%
MCO Paid Date	6,753,296	6,753,296	100.0%	6,753,296	6,753,296	100.0%
Header Paid Amount	6,753,296	6,753,296	100.0%	6,753,296	6,753,296	100.0%
Header TPL Paid Amount	193,317	6,753,296	2.9%	193,317	193,317	100.0%

Appendix D. Information Systems Review and Administrative Profile Results for Aetna Better Health of Virginia (Aetna)

Information Systems Review

Table D-1—Acronym/Abbreviation List and Description (Provided by Aetna)

Abbreviation/Acronym	Description
QNXT	Claim processing system used to adjudicate claims for Aetna Better Health of Virginia.
Edifecs	Encounter data processing system
EDI	Electronic data interchange used to submit claims electronically
ANSI X12	American National Standards Institute X12, refers to the American EDI (Electronic Data Interchange) standard developed in 1979

Encounter Data Sources and Systems

Data Sources and Validation Processes

Prior to submission of encounter data to DMAS, encounter data are validated and processed, and an EDI compliance check is carried out. Paper claims are date stamped on receipt, scanned with optical character recognition (OCR) software, and converted to 837 files for electronic processing. Aetna employs a range of tools/software to perform these processes.

Edifecs is used to validate encounter data, generate/prepare outbound encounters for submission to DMAS, and perform EDI compliance checks on encounters submitted to DMAS through 837P and 837I formats, for the majority of the encounter types. In addition to Edifecs, the subcontractor encounter system is used to generate outbound pharmacy, vision, nonemergency transportation, Public Partnerships (PPL), and Consumer Direct Care Network (CDCN) encounters for submission to DMAS. Frequency of receipt for data sources (i.e., all data received that are included in the encounter data submissions to DMAS) include daily (for medical 837P and 837I), biweekly (for vision), and weekly for the remainder, including medical 837P and 837I claims.

Claims/encounter data are not modified to accommodate DMAS' encounter data submission standards. For medical 837P and 837I claims, QNXT claims are extracted to the Edifecs encounter management system. Encounters are then exported and submitted to DMAS in the state-specified format. Data received from the provider or an intermediary are not altered or changed. For all subcontractors, files that fail validation are rejected back to the subcontractor along with an error report for correction. Files are not submitted to the State until they have passed validation. If a claim with missing required data, or containing invalid data, passes through the initial point of entry and into QNXT, the claim is voided and returned to the provider with detailed information explaining why the claim was not processed—missing or invalid date of service, charges, diagnosis, CPT, provider name, etc.

Validation Performed on Claims

All claims are validated across, but are not limited to, the following domains:

- Coding
- Timely filing
- Prior authorization requirements
- Benefit application (including limitations and exclusions)
- Coordination of benefits application, and claims history review for duplicate claim
- Manual pricing application
- Special provider agreements
- Modifier discounts
- Claims bundling/unbundling

For validation of 837P and 837I encounters, data must pass HIPAA validation. Files that fail validation are rejected back to the subcontractor along with an error report for correction. Files are not submitted to the State until they have passed validation. Percentage of validated 837P and 837I claims, as well as claims from all subcontractors, is 100 percent. Diagnostic and procedure codes are validated through reference dictionaries. These checks also validate if a diagnosis or procedure billed is gender or age appropriate. Claims that fail the check are denied.

Duplicate, Denied, and Adjusted Claims

For duplicate claims identification, editing is invoked to identify claims with the same member, provider, service, and date of service as part of the claim adjudication process (batch and manual adjudication). These are then denied as duplicates. Procedure modifier codes may be used to allow for the service to be paid for multiple times within the same day without counting as duplicates.

Adjustment claims are submitted with a frequency code of 7 and reference the original claim being replaced. Aetna allows 30 days between the paid date and resubmission of encounters.

Collection, Use, and Submission of Provider and Enrollment Data

Provider Data

Provider data are collected and maintained by Aetna and Subcontractors. For instance, Vision Services and HearUSA maintain Aetna's provider networks and send provider data to Aetna, for feeding to its (i.e., Aetna's) online provider search engine and encounter reconciliation. The process for linking data is in two parts. For the first part, claims prior to adjudication are matched with existing provider data. For the second part, encounters reconcile to the list of existing provider data.

Enrollment Data

Enrollment data are collected and maintained by Aetna. The claims/encounters are verified against the enrollment data from DMAS that come to the plan on the 834 file. The system validates the date of service against the members' enrollment segment within QNXT to determine if the member was eligible on the date of service; the system will automatically deny the claim using the appropriate HIPAA-approved remittance comment, Automated. Encounters submit the enrollment information that is adjudicated against the claim in QNXT.

Data Exchange Policies and Procedures

Encounters are submitted to DMAS weekly and directly from Aetna (i.e., not through a subcontractor). A manual or scheduled export process is initiated in the encounter management system, creating HIPAA-compliant files according to pre-defined parameters. Third-party subcontractor files are validated for HIPAA compliance and imported into the encounter management system. All files are submitted to the appropriate regulatory agency and archived in accordance with record retention guidelines.

In accordance with measures taken to enforce policies and procedures, when a claim requires adjusting in the upstream claims processing system, audits are performed at both claim and encounter levels to ensure staff have followed the appropriate policies and procedures.

Payment Structures of Encounter Data

Table D-2 shows a summary of how claims are paid.

Table D-2—Claim Payment Methods

Payment Type	Inpatient	Outpatient	Pharmacy	Long-Term Care
CCC Plus				
Percent of Billed	0.0%	2.6%	0.0%	0.1%
Line-by-Line	0.9%	12.9%	4.9%	1.9%
Per Diem	24.8%	5.8%	0.0%	97.9%
DRG	74.3%	0.0%	0.0%	0.0%
Negotiated (Flat) Rate	0.0%	4.5%	0.0%	0.0%
Other (Ambulatory Surgery)	0.0%	73.8%	94.0%	0.0%
Other (Per Unit)	0.0%	0.3%	1.0%	0.0%
Total	**100%**	**100%**	**100%**	**100%**

For inpatient, outpatient, pharmacy, and long-term care, all paid amounts align with the paid amount reflected in the claim processing system and the remit/explanation of payment (EOP) issued to the provider. No services are submitted under bundle-payment structures.

Claims With Third-Party Liability

A summary of the process for collecting, coordinating benefits/TPL data, submitting encounters with TPL, and processing TPL payments is described in Table D-3.

Table D-3—Process for Collecting Coordination of Benefits/TPL Data, Processing Encounters With TPL Data, and TPL Payments

How other insurance data are collected	Other insurance data are collected through a variety of methods. Aetna's TPL department is notified of known third-party resource information provided by the State through the enrollment process based on the information obtained through the enrollee's eligibility determination. The TPL department also receives third-party information from other internal departments such as Provider Services, Claims Inquiry/Claims Research, Enrollee Services, and Case Management. This information is shared with subcontractors that are responsible for the payment of covered services for enrollees.
How claims are processed with TPL	The adjudication process allows for the coordination of primary prior payments if the member is identified as having coverage with another carrier. If a claim is received without an EOB, the claim is denied.
Source data used to verify accuracy of third-party claims information	The source data are validated by QNXT during the adjudication process. Payment information from the third-party payer is stored in QNXT. The third-party payer information is extracted from the claim in QNXT and populated in the encounter data.
Measures taken to ensure accuracy of TPL payment amount	Aetna maintains a current TPL resource file that contains enrollees' current TPL information, including coverage that has ended for the enrollment. Aetna has policies and procedures in place to ensure that Medicaid is the payer of last resort, in accordance with federal regulations, and engages in coordination of benefits practices so that Medicaid is the payer of last resort after all other sources of payment have been exhausted.

Processing Zero-Paid Claims

Claims are zero-paid if the primary payer has paid more than the Medicaid allowable amount. Zero-paid claims are reflected in the encounter data as paid claims with the paid amount equaling zero.

Encounter Data Quality Monitoring and Reporting

For accuracy, subcontractor encounter data are received from the subcontractors in the State/CMS compliant X12/NCPDP file formats. Files are then subjected to HIPAA SNIP levels 1 through 4 editing before submitting to the State. Files that fail validation are rejected back to the subcontractor along with an error report for correction. Files are not submitted to the State until they have passed validation. Aetna uses a series of reports to monitor, identify, track, and resolve errors in the encounter management system or with an encounter file. Table D-4 lists the average rejection/pend rate for

claim/encounter types. Although not included in this table, overall rates are inclusive of rejection/pend rates for dental encounters.

Table D-4—Average Rejection/Pend Rate for Different Claims/Encounter Types

Claim/Encounter	Percentage of Encounters Submitted to DMAS That are Rejected by DMAS' EDI Translator	Percentage of Encounters Submitted to DMAS That Pass EDI Translator but Fail the EPS Business Rules
Institutional	1.40%	1.02%
Professional	0.03%	0.02%
Pharmacy	0.03%	0.01%
Vision	0.00%	2.30%
Transportation	0.00%	0.01%
Consumer Direct (CDCN)	0.00%	0.05%
Consumer Direct (PPL)	0.00%	2.90%
Overall Rate	**0.49%**	**0.80%**

Uses of Encounter Data

Prior to calculating metrics that use multiple data extracts (e.g., claims/encounter, member enrollment, or provider data), Aetna conducts referential integrity checks on key fields, such as member key and provider key, which are used to link files together. Aetna uses claims/encounter data to calculate Healthcare Effectiveness Data and Information Set (HEDIS®)[D-1] rates and monitor claim submission volume. To assess reasonability of calculated rates and claim volume, HEDIS rates are compared to internal and national NCQA benchmarks while enrollment member months are compared to Aetna's internally generated enrollment and membership data.

Challenges

There are no internal/external challenges faced in submitting encounter data to DMAS, and no additional support is needed from DMAS for the successful submission of encounter data.

[D-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Administrative Profile

This section provides administrative analysis results for Aetna by claim type.

Encounter Data Completeness

Table D-5 provides encounter data volume results for Aetna's professional encounters.

Table D-5—Encounter Volume—Professional Encounters—Aetna

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	199,905	36,609	5,460.5
February 2020	184,188	36,528	5,042.4
March 2020	178,413	36,624	4,871.5
April 2020	159,402	37,187	4,286.5
May 2020	165,921	37,786	4,391.1
June 2020	179,250	38,042	4,711.9
July 2020	187,658	38,285	4,901.6
August 2020	187,638	38,411	4,885.0
September 2020	196,606	38,568	5,097.6
October 2020	204,974	38,770	5,286.9
November 2020	192,327	38,952	4,937.5
December 2020	198,199	39,212	5,054.5

Table D-6 provides encounter data volume results for Aetna's institutional encounters.

Table D-6—Encounter Volume—Institutional Encounters—Aetna

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	19,602	36,609	535.4
February 2020	18,089	36,528	495.2
March 2020	14,888	36,624	406.5
April 2020	10,622	37,187	285.6
May 2020	13,166	37,786	348.4
June 2020	15,450	38,042	406.1
July 2020	16,176	38,285	422.5
August 2020	15,695	38,411	408.6
September 2020	15,996	38,568	414.7
October 2020	16,831	38,770	434.1
November 2020	15,550	38,952	399.2
December 2020	15,308	39,212	390.4

Table D-7 provides encounter data volume results for Aetna's pharmacy encounters.

Table D-7—Encounter Volume—Pharmacy Encounters—Aetna

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	83,234	36,609	2,273.6
February 2020	77,488	36,528	2,121.3
March 2020	87,567	36,624	2,391.0
April 2020	81,660	37,187	2,195.9
May 2020	78,727	37,786	2,083.5
June 2020	80,672	38,042	2,120.6
July 2020	81,219	38,285	2,121.4
August 2020	77,278	38,411	2,011.9
September 2020	74,743	38,568	1,938.0
October 2020	77,364	38,770	1,995.5
November 2020	73,687	38,952	1,891.7
December 2020	77,401	39,212	1,973.9

Table D-8 provides paid amount and TPL amount results for Aetna's professional encounters.

Table D-8—Paid Amount and TPL Amount—Professional Encounters—Aetna

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	24,018,024	656.1	3,486,873	95.2
February 2020	22,117,503	605.5	3,622,053	99.2
March 2020	21,917,175	598.4	3,367,166	91.9
April 2020	20,486,082	550.9	2,573,917	69.2
May 2020	21,537,210	570.0	2,777,523	73.5
June 2020	21,906,824	575.9	3,228,353	84.9
July 2020	23,708,585	619.3	3,063,052	80.0
August 2020	24,075,132	626.8	3,019,816	78.6
September 2020	22,694,177	588.4	3,162,645	82.0
October 2020	24,274,090	626.1	3,088,296	79.7
November 2020	22,855,478	586.8	2,879,506	73.9
December 2020	23,953,373	610.9	3,063,906	78.1

Table D-9 provides paid amount and TPL amount results for Aetna's institutional encounters.

Table D-9—Paid Amount and TPL Amount—Institutional Encounters—Aetna

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	25,941,885	708.6	12,291,576	335.8
February 2020	23,411,049	640.9	10,705,230	293.1
March 2020	23,639,485	645.5	8,633,795	235.7
April 2020	20,440,697	549.7	6,677,995	179.6
May 2020	22,136,733	585.8	6,997,267	185.2
June 2020	23,343,602	613.6	8,099,266	212.9
July 2020	26,420,603	690.1	7,987,744	208.6
August 2020	26,238,501	683.1	8,395,953	218.6
September 2020	25,155,673	652.2	8,080,600	209.5
October 2020	25,798,956	665.4	8,066,847	208.1
November 2020	24,371,286	625.7	7,324,317	188.0
December 2020	24,817,644	632.9	8,509,311	217.0

Table D-10 provides paid amount and TPL amount results for Aetna's pharmacy encounters.

Table D-10—Paid Amount and TPL Amount—Pharmacy Encounters—Aetna

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	7,724,318	211.0	233,555	6.4
February 2020	7,911,142	216.6	240,360	6.6
March 2020	9,186,349	250.8	272,457	7.4
April 2020	8,598,620	231.2	183,719	4.9
May 2020	7,824,842	207.1	210,198	5.6
June 2020	8,592,065	225.9	162,232	4.3
July 2020	8,771,156	229.1	195,870	5.1
August 2020	8,107,234	211.1	212,412	5.5
September 2020	7,607,520	197.2	174,385	4.5
October 2020	7,921,748	204.3	154,212	4.0
November 2020	7,487,173	192.2	153,574	3.9
December 2020	8,146,849	207.8	152,202	3.9

Table D-11 provides the percentage of duplicate encounters for all three encounters.

Table D-11—Percentage of Duplicate Encounters—Aetna

Claim Type	Total Records	Number of Duplicate Records	Percent of Duplicates
Professional Encounters	3,981,222	34,317	0.9%
Institutional Encounters	1,133,847	5,128	0.5%
Pharmacy Encounters	951,195	29	<0.1%

Encounter Data Timeliness

Table D-12 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for Aetna's professional encounters.

Table D-12—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Professional Encounters—Aetna

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
Prior January 2020	99.7%	100.0%	100.0%	100.0%	100.0%
January 2020	97.5%	99.3%	99.3%	99.3%	99.3%
February 2020	99.1%	99.6%	99.6%	99.6%	99.6%
March 2020	99.8%	99.9%	100.0%	100.0%	100.0%
April 2020	99.9%	100.0%	100.0%	100.0%	100.0%
May 2020	65.5%	82.6%	82.8%	85.6%	85.6%
June 2020	60.9%	65.8%	70.5%	72.6%	92.4%
July 2020	60.9%	66.2%	67.9%	93.4%	99.9%
August 2020	67.0%	67.3%	89.2%	97.4%	97.4%
September 2020	72.1%	93.4%	99.6%	99.6%	99.7%
October 2020	93.4%	99.3%	99.3%	99.4%	99.4%
November 2020	86.2%	86.2%	99.6%	99.7%	99.7%
December 2020	73.0%	94.9%	99.8%	99.8%	99.8%
January 2021	84.2%	99.8%	99.8%	99.8%	99.9%
February 2021	93.2%	99.7%	99.8%	99.9%	100.0%
March 2021	91.1%	98.1%	99.9%	100.0%	100.0%
April 2021	93.6%	94.9%	100.0%	100.0%	100.0%
May 2021	97.4%	100.0%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table D-13 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for Aetna's institutional encounters.

Table D-13—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Institutional Encounters—Aetna

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	99.8%	99.8%	99.8%	99.8%	99.8%
February 2020	99.7%	99.9%	99.9%	99.9%	99.9%
March 2020	99.5%	99.6%	99.6%	99.6%	99.6%
April 2020	99.8%	99.8%	99.8%	99.8%	99.8%
May 2020	71.7%	93.4%	93.7%	93.7%	95.6%
June 2020	71.6%	73.6%	74.8%	75.9%	98.4%
July 2020	74.2%	78.4%	79.1%	98.0%	98.7%
August 2020	87.9%	91.5%	91.9%	92.0%	92.1%
September 2020	94.1%	96.2%	96.3%	96.5%	96.6%
October 2020	94.6%	95.7%	95.8%	96.0%	96.0%
November 2020	95.7%	96.2%	96.3%	96.3%	96.3%
December 2020	95.6%	96.0%	96.0%	96.0%	96.2%
January 2021	97.4%	97.4%	97.4%	97.6%	98.2%
February 2021	95.6%	97.0%	97.9%	99.1%	100.0%
March 2021	97.6%	98.1%	98.8%	100.0%	100.0%
April 2021	98.4%	99.5%	100.0%	100.0%	100.0%
May 2021	99.3%	100.0%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table D-14 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for Aetna's pharmacy encounters.

Table D-14—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Pharmacy Encounters—Aetna

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	98.7%	98.7%	98.7%	98.7%	98.7%
February 2020	99.8%	99.8%	99.8%	99.9%	100.0%
March 2020	99.8%	99.8%	99.8%	99.9%	100.0%
April 2020	99.8%	99.8%	99.8%	100.0%	100.0%
May 2020	99.9%	99.9%	100.0%	100.0%	100.0%
June 2020	99.9%	100.0%	100.0%	100.0%	100.0%
July 2020	99.9%	100.0%	100.0%	100.0%	100.0%
August 2020	99.9%	99.9%	100.0%	100.0%	100.0%
September 2020	99.6%	99.6%	99.8%	100.0%	100.0%
October 2020	99.6%	99.8%	100.0%	100.0%	100.0%
November 2020	99.7%	99.9%	100.0%	100.0%	100.0%
December 2020	99.8%	99.9%	100.0%	100.0%	100.0%
January 2021	99.8%	99.9%	99.9%	100.0%	100.0%
February 2021	100.0%	100.0%	100.0%	100.0%	100.0%
March 2021	100.0%	100.0%	100.0%	100.0%	100.0%
April 2021	100.0%	100.0%	100.0%	100.0%	100.0%
May 2021	100.0%	100.0%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table D-15 provides lag triangles for Aetna's professional encounters. Additional details provided include MM and claims PMPM.

Table D-15—Encounters Lag Triangle—Professional Encounters—Aetna

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
201911	60												60
201912	127	94											221
202001	13,275	67	76										13,418
202002	121,323	7,281	86	28									128,718
202003	76,863	147,418	25,844	35	28								250,188
202004	11,435	44,054	134,664	16,141	101	40				1		1	206,437
202005	3,367	6,459	27,176	105,003	5,065	61	46	4					147,181
202006	1,876	3,035	5,930	25,533	65,486	10,352	42	2					112,256
202007	1,785	1,836	3,048	5,641	31,967	72,598	3,197	4					120,076
202008	1,555	1,511	2,292	3,721	9,081	40,373	93,454	13,532	10	18			165,547
202009	797	1,004	1,605	5,537	11,877	12,951	32,454	91,570	9,395				167,190
202010	687	848	1,303	1,503	2,224	3,679	12,254	33,566	113,356	20,327	101	12	189,860
202011	1,462	2,113	2,811	13,646	57,361	58,087	67,899	66,906	88,132	153,996	13,322	67	525,802
202012	394	420	532	758	989	1,497	2,555	3,863	7,787	31,476	106,512	15,643	172,426
202101	458	329	421	362	385	636	1,045	1,804	4,345	7,865	30,360	117,058	165,068
202102	975	584	895	1,267	1,151	1,225	3,096	5,814	3,556	20,403	65,551	73,203	177,720
202103	106	269	596	1,283	1,137	1,131	1,331	1,428	1,939	3,343	5,195	17,365	35,123
202104	66	100	362	562	513	569	644	796	1,311	2,083	2,679	4,474	14,159
202105	131	192	161	304	690	667	906	815	1,516	1,518	1,952	2,605	11,457
202106	387	229	142	170	354	523	1,100	1,105	1,608	1,621	1,800	2,216	11,255
202107	34	42	23	12	21	112	113	117	280	224	214	202	1,394
Total	237,163	217,885	207,967	181,506	188,430	204,501	220,136	221,326	233,235	242,875	227,686	232,846	2,615,556
MM	36,609	36,528	36,624	37,187	37,786	38,042	38,285	38,411	38,568	38,770	38,952	39,212	454,974
PMPM	**6.478**	**5.965**	**5.678**	**4.881**	**4.987**	**5.376**	**5.750**	**5.762**	**6.047**	**6.265**	**5.845**	**5.938**	**5.748**

Table D-16 provides lag triangles for Aetna's institutional encounters. Additional details provided include MM and claims PMPM.

Table D-16—Encounters Lag Triangle—Institutional Encounters—Aetna

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	577												577
202002	8,947	136											9,083
202003	7,043	11,324	971										19,338
202004	1,359	4,169	8,709	327									14,564
202005	503	838	3,392	5,498	175								10,406
202006	289	414	613	2,546	5,038	645							9,545
202007	149	227	259	342	2,388	5,778	242						9,385
202008	145	174	196	228	828	3,892	5,190	52					10,705
202009	136	172	167	214	445	1,310	6,165	7,525	453				16,587
202010	252	247	325	918	3,184	3,135	2,901	5,592	9,344	1,104			27,002
202011	184	146	127	153	331	405	550	1,110	3,919	8,411	773		16,109
202012	73	77	75	166	270	356	443	548	818	4,557	7,654	583	15,620
202101	109	76	77	100	109	141	199	270	460	1,060	4,974	8,876	16,451
202102	127	129	109	99	136	146	198	145	244	482	809	3,918	6,542
202103	24	48	64	71	57	59	67	121	141	228	432	788	2,100
202104	31	43	54	145	140	130	134	131	178	239	338	472	2,035
202105	27	33	27	53	71	117	95	127	259	273	297	339	1,718
202106	26	47	14	12	38	56	764	670	732	755	764	746	4,624
202107	557	455	446	275	327	24	25	21	30	36	38	39	2,273
Total	20,558	18,755	15,625	11,147	13,537	16,194	16,973	16,312	16,578	17,145	16,079	15,761	194,664
MM	36,609	36,528	36,624	37,187	37,786	38,042	38,285	38,411	38,568	38,770	38,952	39,212	454,974
PMPM	**0.562**	**0.513**	**0.427**	**0.300**	**0.358**	**0.426**	**0.443**	**0.425**	**0.430**	**0.442**	**0.413**	**0.402**	**0.428**

Table D-17 provides lag triangles for Aetna's pharmacy encounters. Additional details provided include MM and claims PMPM.

Table D-17—Encounters Lag Triangle—Pharmacy Encounters—Aetna

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	536												536
202002	80,321	7,221											87,542
202003	1,469	68,009	5,936										75,414
202004	434	1,606	80,059	16,549									98,648
202005	127	403	995	63,643	9,814								74,982
202006	9	31	215	747	66,776	4,697							72,475
202007	115	188	312	636	1,841	74,672	14,372						92,136
202008	23	9	33	42	193	437	53,434	481					54,652
202009	3	7	15	24	66	775	12,946	74,614	831				89,281
202010	21	18	9	20	26	64	374	1,659	72,322	33,062			107,575
202011			1		2	3	43	173	738	37,633	113		38,706
202012	167		5	1	5	12	23	321	788	6,314	72,268	39,924	119,828
202101	10			1	2	3	6	5	37	292	967	36,026	37,349
202102	6	8	6	8	6	10	15	15	34	56	282	1,063	1,509
202103			2	1	4	6	9	6	4	7	50	294	383
202104				1			1	2	2	7	10	79	102
202105					4	8	5	12	8	6	5	15	63
202106								2	1	2	2	7	14
Total	83,241	77,500	87,588	81,673	78,739	80,687	81,228	77,290	74,765	77,379	73,697	77,408	951,195
MM	36,609	36,528	36,624	37,187	37,786	38,042	38,285	38,411	38,568	38,770	38,952	39,212	454,974
PMPM	**2.274**	**2.122**	**2.392**	**2.196**	**2.084**	**2.121**	**2.122**	**2.012**	**1.939**	**1.996**	**1.892**	**1.974**	**2.094**

Field-Level Completeness and Accuracy

Table D-18 provides a summary of the field-level completeness and accuracy for Aetna's professional encounters.

Table D-18—Data Element Completeness and Accuracy for Professional Encounters—Aetna

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	2,615,556	2,615,556	100.0%	2,562,455	2,615,556	98.0%
Header Service From Date	2,615,556	2,615,556	100.0%	2,615,556	2,615,556	100.0%
Header Service To Date	2,615,556	2,615,556	100.0%	2,612,966	2,615,556	>99.9%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Detail Service From Date	3,981,222	3,981,222	100.0%	3,981,222	3,981,222	100.0%
Detail Service To Date	3,981,222	3,981,222	100.0%	3,977,872	3,981,222	>99.9%
Billing Provider NPI	2,615,556	2,615,556	100.0%	2,615,290	2,615,556	>99.9%
Rendering Provider NPI	2,615,556	2,615,556	100.0%	2,615,184	2,615,556	>99.9%
Servicing Provider Taxonomy Code	3,981,222	3,981,222	100.0%	3,954,644	3,981,222	99.3%
Referring Provider NPI	416,896	2,615,556	15.9%	403,481	416,896	96.8%
Primary Diagnosis Codes	2,615,556	2,615,556	100.0%	2,615,556	2,615,556	100.0%
Secondary Diagnosis Codes	658,528	2,615,556	25.2%	1,824,186	1,824,186	100.0%
CPT/HCPCS Codes	3,981,222	3,981,222	100.0%	3,981,208	3,981,222	>99.9%
CPT/HCPCS Codes with PTP Edits	3,981,222	3,981,222	100.0%	3,980,863	3,981,222	>99.9%
Service Units	3,981,222	3,981,222	100.0%	3,981,222	3,981,222	100.0%
Service Units with MUE Edits	926,468	926,468	100.0%	907,574	926,468	98.0%
National Drug Codes	111,994	3,981,222	2.8%	111,806	111,994	99.8%
HCPCS/NDC Combination	23,722	23,918	99.2%	17,613	23,722	74.2%
MCO Received Date	3,981,222	3,981,222	100.0%	3,981,222	3,981,222	100.0%
MCO Paid Date	3,981,222	3,981,222	100.0%	3,981,222	3,981,222	100.0%
Header Paid Amount	2,615,556	2,615,556	100.0%	2,615,556	2,615,556	100.0%
Header TPL Paid Amount	600,501	2,615,556	23.0%	588,346	600,501	98.0%
Detail Paid Amount	3,981,222	3,981,222	100.0%	3,981,222	3,981,222	100.0%
Detail TPL Paid Amount	1,106,908	3,981,222	27.8%	1,106,908	1,106,908	100.0%

Table D-19 provides a summary of the field-level completeness and accuracy for Aetna's institutional encounters.

Table D-19—Data Element Completeness and Accuracy for Institutional Encounters—Aetna

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	194,664	194,664	100.0%	188,555	194,664	96.9%
Header Service From Date	194,664	194,664	100.0%	194,664	194,664	100.0%
Header Service To Date	194,664	194,664	100.0%	194,664	194,664	100.0%
Detail Service From Date	1,133,847	1,133,847	100.0%	1,133,847	1,133,847	100.0%
Detail Service To Date	1,133,847	1,133,847	100.0%	1,133,847	1,133,847	100.0%
Billing Provider NPI	194,664	194,664	100.0%	194,638	194,664	>99.9%
Rendering Provider NPI	251	194,664	0.1%	251	251	100.0%
Attending Provider NPI	194,532	194,664	>99.9%	191,249	194,532	98.3%
Servicing Provider Taxonomy Code	961,878	1,133,847	84.8%	826,635	961,878	85.9%
Referring Provider NPI	0	194,664	0.0%	NA	NA	NA
Primary Diagnosis Codes	194,664	194,664	100.0%	194,664	194,664	100.0%
Secondary Diagnosis Codes	192,158	194,664	98.7%	1,566,376	1,566,376	100.0%
CPT/HCPCS Codes	898,414	1,133,847	79.2%	872,710	898,414	97.1%
CPT/HCPCS Codes with PTP Edits	898,414	1,133,847	79.2%	872,340	898,414	97.1%
Service Units	1,133,847	1,133,847	100.0%	1,133,847	1,133,847	100.0%
Service Units with MUE Edits	328,029	328,029	100.0%	326,646	328,029	99.6%
Primary Surgical Procedure Codes	5,696	194,664	2.9%	5,678	5,696	99.7%
Secondary Surgical Procedure Codes	3,203	194,664	1.6%	9,103	9,118	99.8%
Revenue Codes	1,133,847	1,133,847	100.0%	1,133,847	1,133,847	100.0%
Diagnosis-Related Groups Codes	9,659	194,664	5.0%	9,658	9,659	>99.9%
Type of Bill Codes	194,664	194,664	100.0%	194,664	194,664	100.0%
National Drug Codes	151,534	1,133,847	13.4%	150,979	151,534	99.6%
HCPCS/NDC Combination	51,468	51,475	>99.9%	35,803	51,468	69.6%
MCO Received Date	1,133,847	1,133,847	100.0%	1,133,847	1,133,847	100.0%
MCO Paid Date	1,133,847	1,133,847	100.0%	1,133,847	1,133,847	100.0%
Header Paid Amount	194,664	194,664	100.0%	194,664	194,664	100.0%
Header TPL Paid Amount	84,819	194,664	43.6%	84,366	84,819	99.5%
Detail Paid Amount	1,133,847	1,133,847	100.0%	1,133,847	1,133,847	100.0%
Detail TPL Paid Amount	612,393	1,133,847	54.0%	612,393	612,393	100.0%

Table D-20 provides a summary of the field-level completeness and accuracy for Aetna's pharmacy encounters.

Table D-20—Data Element Completeness and Accuracy for Pharmacy Encounters—Aetna

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	951,195	951,195	100.0%	912,294	951,195	95.9%
DOS	951,195	951,195	100.0%	951,195	951,195	100.0%
Rendering Provider NPI	951,195	951,195	100.0%	951,195	951,195	100.0%
Billing Provider NPI	951,195	951,195	100.0%	937,730	951,195	98.6%
National Drug Codes	951,195	951,195	100.0%	945,789	951,195	99.4%
MCO Received Date	951,195	951,195	100.0%	951,195	951,195	100.0%
MCO Paid Date	951,195	951,195	100.0%	951,195	951,195	100.0%
Header Paid Amount	951,195	951,195	100.0%	951,195	951,195	100.0%
Header TPL Paid Amount	8,647	951,195	0.9%	8,647	8,647	100.0%

Appendix E. Information Systems Review and Administrative Profile Results for HealthKeepers, Inc. (HealthKeepers)

Information Systems Review

Table E-1—Acronym/Abbreviation List and Description (Provided by HealthKeepers)

Abbreviation/Acronym	Description
AEON reports	Anthem Encounters Online knowledge is an encounters' reporting tool that was built in our Edifecs platform
CCC Plus	Commonwealth Coordinated Care Plus
COB	Coordination of benefits
CSV	Comma separated value
CVSC	CVS Caremark is a pharmacy benefit manager (PBM)
DDC	Definite duplicate claim
DMAS	Department of Medical Assistance Services
EDI	Electronic data exchange
Edifecs	Provider name for EDI software tool
EDV	Encounter data validation
EIDS	Electronic information delivery system
EMS	Encounter Management System is CVSC's encounter system
EOP	Explanation of payment
Facets	Software tool which automates and streamlines critical business functions across the enterprise, including member enrollment, premium billing, claims processing, and customer service
FFS	Fee-for-service
IRX	IngenioRx is Anthem's PBM
LTSS	Long-term services and supports
MCO	Managed care organization
NCPDP	National Council for Prescription Drug Programs
ASH	Abortion, Sterilization, Hysterectomy
SA	Service authorization

Encounter Data Sources and Systems

Data Sources and Validation Processes

Prior to encounter data submission to DMAS, encounter data are validated and processed, and an EDI compliance check is carried out. HealthKeepers employs a range of tools/software to perform these processes.

Edifecs software is used to validate encounter data, generate/prepare outbound encounters for submission to DMAS, and perform an EDI compliance check on encounters submitted to DMAS through 837P and 837I formats, for the majority of the encounter types. In addition to Edifecs, HIPAA compliance checker, RxClaim encounter management system, and Facil EDI are also used to validate, prepare, and perform compliance checks on encounter data, including data from subcontractors, nonemergency transportation, chiropractic/acupuncture, and laboratory. Edifecs is used to validate and prepare all other outbound encounters, including subcontractors, for submission to DMAS.

Frequency of receipt for all encounter types (i.e., all data received that are included in the encounter data submissions to DMAS) is Monday through Friday for 837P and 837I encounters, and daily for pharmacy encounters. The approximate percentage of medical claims (837P) received from capitated providers is 2 percent, and for paper claims the percentage is 1.8 percent.

Fields affected by modifications made to encounter data to accommodate DMAS' submission standards as well as created data elements/fields not on claims from providers but required by DMAS are shown in the table.

Table E-2—Data Sources and Fields Affected by Modification of Existing Fields or New Field Creation to Accommodate DMAS' Submission Standards

Data Source	Field	Modification Made by	Created Field	Modification Made by
Encounters	DRG	MCO encounter analyst	Taxonomy	MCO encounter analyst
			Billing P.O. Box address	MCO encounter analyst
Pharmacy	N/A	N/A	Cardholder fields	CVSC

Validation Performed on Claims

HealthKeepers conducts a random statistically valid monthly audit to evaluate the financial, payment, and statistical accuracy of claims processing. For pharmacy claims, validation entails checking lock-in status, pharmacy type, excluded provider, and network status. Validation is performed on 100 percent of pharmacy claims.

Duplicate, Denied, and Adjusted Claims

During the claim adjudication process, pharmacy duplicate claims are identified and rejected using pharmacy ID, Rx#, fill date, and refill number. Duplicate medical claims are identified when the system detects another claim with the same member ID, provider ID, procedure code or revenue code, exact charges, and date of service. Exact duplicates are denied. For inexact duplicates, a claim inquiry is initiated to differentiate the two claims.

Payment Structures of Encounter Data

Pharmacy claims are paid based on the contractual allowable amounts between CVS and retail pharmacies with consideration to the MCO formulary. Medical claims are assigned a claim ID and processed through a series of edits. Claims either auto-adjudicate or are suspended (pend) for manual review. Primary pend reasons are due to authorization and coordination of benefits with primary carrier. Providers receive an EOP for all processed claims—paid and denied—to provide explanation of final disposition.

Table E-3 provides a summary of how claims are paid. Claims in "Other" include ambulance reimbursement, case rate reimbursement, outpatient hospital, and manual pricing reimbursements. Claims in "Other N/A" include claims where noncovered or no pricing front-end edits applied as well as limitations on same-date services. Details are as shown.

Table E-3—Claim Payment Methods

Payment Type	Inpatient	Outpatient	Pharmacy	Long-Term Care
CCC Plus				
Percent of Billed	0.03%	0.03%	0	63.29%
Line-by-Line	75.91%	78.51%	0	33.92%
Per Diem	10.86%	3.74%	0	0.04%
Capitation	0	1.15%	0	0
DRG	2.82%	0	0	0.02%
Negotiated (Flat) Rate	0.69%	0.92%	0	0.35%
Ingredient Cost (for Pharmacy)	0	0	100%	0
Other	0.52%	7.62%	0	0
Other N/A	9.17%	8.04%	0	2.38%
Total	**100%**	**100%**	**100%**	**100%**

For inpatient, outpatient, and long-term care, encounters would reflect the same payment amount as received from the claim adjudication system. For pharmacy, encounters would reflect the amount paid to the pharmacy by PBM at the time of adjudication. No services are submitted to the MCO under bundle-payment structures.

Claims With Third-Party Liability

A summary of the process for collecting, coordinating benefits/TPL data, submitting encounters with TPL, and processing TPL payments is described in Table E-4.

Table E-4—Process for Collecting Coordination of Benefits/TPL, Processing Encounters with TPL Data, and TPL Payments

How other insurance data are collected	Pharmacy—CVSC relies on the MCO to provide information about a member's primary coverage via the eligibility file.
	Coverage information for medical claims is identified using two types of information:
	• Coverage leads, which are sourced from:
	  – Member and provider correspondence, provider claims submissions that include EOPs.
	  – Various data analytics indicating a record needs to be reviewed.
	  – Member input.
	• Verified records apply business rules to other coverage files to ensure data integrity. The VA TPL file is received and processed by HealthKeepers using this automated system logic.
	Once a policy is validated through these processes, it is added to the member's record and incorporated into the claims coordination process.

How claims are processed with TPL	Coordination between primary and TPL is conducted if a claim has an attached EOB from the primary carrier. If no primary carrier EOB is submitted with the claim, and the member has active other health insurance (OHI) coverage on file, then the claim is denied. The EOP would indicate to resubmit with the primary carrier's EOP. When TPL/EOB information is submitted after claim is processed, the claim is adjusted to include primary EOB information. Once claims are adjudicated and payments disbursed, data are analyzed to retrospectively identify opportunities for COB or TPL recoveries. Two passes are used to ensure claims impacted by member OHI changes are reviewed for potential recovery. • The first pass leverages the validated OHI associated with the member's Anthem record. When overpayments are identified, providers are offered the option of refunding overpayment directly to HealthKeepers Inc., or offsetting future payments by the overpayment amount. Provider is allowed a minimum of 45 days to respond to a written request. Once confirmation is received, individual claim record is adjusted, and the record configured to either accept a refund or withhold future payments up to the overpayment amount. • The second pass leverages a national subcontractor to compare claims information against the subcontractor's data repository that contains health information from more than 150 health insurance organizations. Comparison against this data repository is made to identify and bill for payment the appropriate primary carrier.
Source data used to verify accuracy of third-party claims information	Data supporting EOP are stored with the COB application, and primary payment information may be retrieved electronically.

Measures taken to ensure accuracy of TPL payment amount	When a claim is processed with TPL, a quality team of auditors audit any adjudicated claims before the claim is finalized and any payment or EOP is sent out. The audits will review the claim and ensure the analyst followed the processing instructions and that the claim is adjudicated properly.

Zero-Paid Claims

Medical zero-paid claims (non-denied/non-capitated) are considered in the same manner as a paid claim, but the paid amounts on the service lines will be "$0." For pharmacy, CVSC submits all claims with their adjudicated values via the guidance of DMAS and the NCPDP D.0 encounter guidelines.

Regardless of provider payment setup, all claims are provided to DMAS in the encounter process, including the only capitated provider, LabCorp. LabCorp is reimbursed a per member per month fee for capitated members. The encounter data do not include pricing.

Encounter Data Quality Monitoring and Reporting

In monitoring data provided by subcontractors, the requirement is achieving 98 percent or above completeness, accuracy, and timeliness within 30 days of paid date. Completeness, accuracy, and timeliness are monitored in AEON reports, which compare received encounter data with cash disbursement journals and submitted encounters.

Overall, fewer than four out of 1 million claims were rejected by the EDI translator, and less than 0.03 percent of claims passed the EDI translator but failed EPS business rules (ranging between virtually 0 percent [vision] and 0.0784 percent [professional]).

The encounter data system/warehouse is used to complete comprehensive reporting and enable data quality, control, and consistency. The data warehouses maximize capacity for data analytics and afford the flexibility to produce targeted reporting to support State customers, risk-adjustment, rate-setting, and business processes and enhance provider and member services and support.

Minimal challenges are faced while obtaining compliant data from providers or subcontractors for submission of encounter data to DMAS.

Administrative Profile

This section provides administrative analysis results for HealthKeepers by claim type.

Encounter Data Completeness

Table E-5 provides encounter data volume results for HealthKeepers' professional encounters.

Table E-5—Encounter Volume—Professional Encounters—HealthKeepers

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	377,740	68,390	5,523.3
February 2020	349,790	68,532	5,104.0
March 2020	347,602	68,844	5,049.1
April 2020	311,951	69,796	4,469.5
May 2020	324,575	70,890	4,578.6
June 2020	336,986	71,651	4,703.2
July 2020	358,745	72,233	4,966.5
August 2020	360,753	72,664	4,964.7
September 2020	389,951	73,088	5,335.4
October 2020	419,306	73,642	5,693.8
November 2020	395,551	74,073	5,340.0
December 2020	412,696	74,607	5,531.6

Table E-6 provides encounter data volume results for HealthKeepers' institutional encounters.

Table E-6—Encounter Volume—Institutional Encounters—HealthKeepers

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	30,062	68,390	439.6
February 2020	27,959	68,532	408.0
March 2020	23,963	68,844	348.1
April 2020	16,527	69,796	236.8
May 2020	19,545	70,890	275.7
June 2020	23,135	71,651	322.9
July 2020	24,869	72,233	344.3
August 2020	24,125	72,664	332.0

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
September 2020	25,287	73,088	346.0
October 2020	27,145	73,642	368.6
November 2020	24,878	74,073	335.9
December 2020	24,717	74,607	331.3

Table E-7 provides encounter data volume results for HealthKeepers' pharmacy encounters.

Table E-7—Encounter Volume—Pharmacy Encounters—HealthKeepers

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	161,187	68,390	2,356.9
February 2020	152,121	68,532	2,219.7
March 2020	172,422	68,844	2,504.5
April 2020	156,325	69,796	2,239.7
May 2020	147,841	70,890	2,085.5
June 2020	151,724	71,651	2,117.5
July 2020	151,740	72,233	2,100.7
August 2020	147,066	72,664	2,023.9
September 2020	147,897	73,088	2,023.5
October 2020	150,315	73,642	2,041.2
November 2020	140,654	74,073	1,898.9
December 2020	148,912	74,607	1,996.0

Table E-8 provides paid amount and TPL amount results for HealthKeepers' professional encounters.

Table E-8—Paid Amount and TPL Amount—Professional Encounters—HealthKeepers

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	56,136,693	820.8	5,336,807	78.0
February 2020	52,351,156	763.9	5,571,617	81.3
March 2020	53,924,441	783.3	5,186,833	75.3
April 2020	49,697,694	712.0	3,856,768	55.3
May 2020	53,431,337	753.7	3,549,460	50.1
June 2020	53,989,679	753.5	3,946,024	55.1
July 2020	58,761,730	813.5	4,276,094	59.2

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
August 2020	58,718,298	808.1	4,360,398	60.0
September 2020	54,815,249	750.0	5,280,805	72.3
October 2020	57,801,788	784.9	6,348,632	86.2
November 2020	57,037,490	770.0	5,856,711	79.1
December 2020	57,893,894	776.0	6,013,394	80.6

Table E-9 provides paid amount and TPL amount results for HealthKeepers' institutional encounters.

Table E-9—Paid Amount and TPL Amount—Institutional Encounters—HealthKeepers

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	43,193,083	631.6	17,154,068	250.8
February 2020	37,060,545	540.8	15,527,309	226.6
March 2020	38,186,825	554.7	14,601,599	212.1
April 2020	32,519,963	465.9	11,811,782	169.2
May 2020	35,936,591	506.9	11,183,610	157.8
June 2020	40,262,655	561.9	12,751,006	178.0
July 2020	41,919,255	580.3	12,303,213	170.3
August 2020	40,523,854	557.7	11,600,033	159.6
September 2020	39,213,202	536.5	12,889,323	176.4
October 2020	43,746,396	594.0	16,435,575	223.2
November 2020	41,645,690	562.2	15,622,858	210.9
December 2020	40,311,856	540.3	15,887,146	212.9

Table E-10 provides paid amount and TPL amount results for HealthKeepers' pharmacy encounters.

Table E-10—Paid Amount and TPL Amount—Pharmacy Encounters—HealthKeepers

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	15,013,903	219.5	789,536	11.5
February 2020	15,125,869	220.7	677,054	9.9
March 2020	17,926,779	260.4	781,662	11.4
April 2020	18,031,128	258.3	687,310	9.8
May 2020	16,342,211	230.5	701,590	9.9
June 2020	17,865,867	249.3	653,053	9.1
July 2020	17,534,311	242.7	714,513	9.9
August 2020	17,053,670	234.7	630,567	8.7
September 2020	18,227,742	249.4	623,671	8.5
October 2020	18,704,271	254.0	533,603	7.2
November 2020	17,796,497	240.3	613,112	8.3
December 2020	20,913,887	280.3	664,841	8.9

Table E-11 provides the percentage of duplicate encounters for all three encounters.

Table E-11—Percentage of Duplicate Encounters—HealthKeepers

Claim Type	Total Records	Number of Duplicate Records	Percent of Duplicates
Professional Encounters	7,197,444	62,415	0.9%
Institutional Encounters	1,413,468	4,288	0.3%
Pharmacy Encounters	1,829,043	83	<0.1%

Encounter Data Timeliness

Table E-12 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for HealthKeepers' professional encounters.

Table E-12—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Professional Encounters—HealthKeepers

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
Prior January 2020	100.0%	100.0%	100.0%	100.0%	100.0%
January 2020	97.6%	98.1%	98.8%	99.9%	100.0%
February 2020	98.4%	99.0%	99.9%	99.9%	99.9%
March 2020	98.3%	99.9%	99.9%	99.9%	99.9%
April 2020	96.8%	99.8%	99.8%	99.8%	99.9%
May 2020	99.8%	99.8%	99.8%	99.9%	99.9%
June 2020	99.8%	99.8%	99.8%	99.9%	100.0%
July 2020	93.4%	99.6%	99.7%	99.8%	99.8%
August 2020	97.0%	97.2%	97.3%	97.3%	97.3%
September 2020	93.8%	94.9%	95.0%	95.0%	95.0%
October 2020	92.8%	92.9%	93.0%	93.0%	93.1%
November 2020	93.9%	93.9%	93.9%	94.0%	94.5%
December 2020	93.6%	93.6%	93.7%	94.2%	96.6%
January 2021	96.1%	96.3%	96.7%	97.4%	100.0%
February 2021	97.1%	98.1%	98.8%	99.9%	100.0%
March 2021	98.7%	99.3%	99.5%	100.0%	100.0%
April 2021	94.9%	95.0%	100.0%	100.0%	100.0%
May 2021	99.0%	100.0%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table E-13 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for HealthKeepers' institutional encounters.

Table E-13—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Institutional Encounters—HealthKeepers

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	99.9%	99.9%	99.9%	99.9%	99.9%
February 2020	99.8%	99.8%	99.9%	99.9%	99.9%
March 2020	99.1%	99.1%	99.1%	99.1%	99.1%
April 2020	99.0%	99.0%	99.1%	99.1%	99.1%
May 2020	98.7%	98.8%	98.8%	98.8%	98.8%
June 2020	98.8%	98.8%	98.9%	98.9%	98.9%
July 2020	89.3%	96.7%	97.0%	97.4%	97.5%
August 2020	94.6%	96.3%	96.4%	96.5%	96.6%
September 2020	95.2%	95.3%	95.5%	95.5%	95.5%
October 2020	91.9%	93.0%	93.2%	93.3%	93.8%
November 2020	95.3%	95.3%	95.3%	95.9%	98.5%
December 2020	95.3%	95.4%	96.0%	98.6%	99.9%
January 2021	97.2%	97.9%	98.4%	99.8%	99.9%
February 2021	98.7%	99.3%	99.6%	99.8%	100.0%
March 2021	97.4%	98.0%	98.3%	100.0%	100.0%
April 2021	90.9%	96.3%	100.0%	100.0%	100.0%
May 2021	93.8%	99.7%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table E-14 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for HealthKeepers' pharmacy encounters.

Table E-14—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Pharmacy Encounters—HealthKeepers

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	97.3%	100.0%	100.0%	100.0%	100.0%
February 2020	99.6%	100.0%	100.0%	100.0%	100.0%
March 2020	99.7%	99.7%	100.0%	100.0%	100.0%
April 2020	100.0%	100.0%	100.0%	100.0%	100.0%
May 2020	100.0%	100.0%	100.0%	100.0%	100.0%
June 2020	100.0%	100.0%	100.0%	100.0%	100.0%
July 2020	100.0%	100.0%	100.0%	100.0%	100.0%
August 2020	100.0%	100.0%	100.0%	100.0%	100.0%
September 2020	100.0%	100.0%	100.0%	100.0%	100.0%
October 2020	100.0%	100.0%	100.0%	100.0%	100.0%
November 2020	100.0%	100.0%	100.0%	100.0%	100.0%
December 2020	100.0%	100.0%	100.0%	100.0%	100.0%
January 2021	100.0%	100.0%	100.0%	100.0%	100.0%
February 2021	96.7%	96.9%	99.7%	100.0%	100.0%
March 2021	100.0%	100.0%	100.0%	100.0%	100.0%
April 2021	100.0%	100.0%	100.0%	100.0%	100.0%
May 2021	100.0%	100.0%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table E-15 provides lag triangles for HealthKeepers' professional encounters. Additional details provided include MM and claims PMPM.

Table E-15—Encounters Lag Triangle—Professional Encounters—HealthKeepers

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
201911	62												62
201912	166	103	2										271
202001	39,059	87	123	1									39,270
202002	270,571	23,045	88	55	1								293,760
202003	90,397	303,156	54,380	50	60							1	448,044
202004	17,135	52,142	263,607	32,489	46	63							365,482
202005	8,796	12,217	57,187	268,068	68,562	124	146	3					415,103
202006	4,002	5,269	9,062	28,171	236,623	56,194	27	69					339,417
202007	1,620	1,683	3,008	5,761	31,100	196,465	16,232	45	26				255,940
202008	4,084	2,790	3,860	6,345	12,660	100,854	334,376	74,572					539,541
202009	1,391	1,630	1,918	2,175	3,743	8,453	36,972	242,696	40,422				339,400
202010	1,894	1,918	2,582	3,230	3,936	5,791	11,211	42,895	309,561	104,780			487,798
202011	1,234	983	1,080	1,711	2,090	3,258	5,532	7,901	30,799	259,928	65,622		380,138
202012	629	543	1,149	1,012	2,502	2,491	3,997	4,320	10,639	43,957	270,228	54,685	396,152
202101	2,393	3,276	1,719	1,178	1,862	2,206	4,096	4,080	8,159	13,913	53,887	293,569	390,338
202102	452	908	1,013	719	1,024	1,566	2,647	3,278	4,684	7,679	11,408	57,062	92,440
202103	859	593	1,169	1,232	1,412	1,679	2,345	3,162	4,086	6,135	7,235	14,719	44,626
202104	336	547	1,128	1,279	1,689	1,924	3,061	4,206	6,086	7,482	7,721	9,318	44,777
202105	771	761	442	679	1,173	1,396	1,837	20,728	25,621	28,771	27,202	30,201	139,582
202106	142	152	161	123	268	501	680	864	1,604	1,207	1,580	2,158	9,440
202107	131	156	183	151	193	356	529	590	614	620	697	950	5,170
Total	446,124	411,959	403,861	354,429	368,944	383,321	423,688	409,409	442,301	474,472	445,580	462,663	5,026,751
MM	68,390	68,532	68,844	69,796	70,890	71,651	72,233	72,664	73,088	73,642	74,073	74,607	858,410
PMPM	**6.523**	**6.011**	**5.866**	**5.078**	**5.204**	**5.350**	**5.866**	**5.634**	**6.052**	**6.443**	**6.015**	**6.201**	**5.854**

Table E-16 provides lag triangles for HealthKeepers' institutional encounters. Additional details provided include MM and claims PMPM.

Table E-16—Encounters Lag Triangle—Institutional Encounters—HealthKeepers

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	2,112												2,112
202002	15,800	1,106											16,906
202003	7,870	19,393	3,188										30,451
202004	1,504	4,590	14,296	1,067									21,457
202005	1,184	1,096	4,086	11,120	2,639								20,125
202006	414	501	812	2,513	10,948	2,478							17,666
202007	200	218	301	463	2,959	10,531	200						14,872
202008	429	366	458	444	1,332	7,865	17,962	3,583					32,439
202009	208	206	259	244	387	708	3,046	13,875	2,951				21,884
202010	212	197	242	288	401	553	865	3,297	16,114	4,179			26,348
202011	307	231	260	165	236	363	533	791	3,172	15,383	2,771		24,212
202012	101	79	93	91	139	174	269	360	726	4,231	14,969	2,515	23,747
202101	49	61	79	64	73	135	138	233	459	995	4,489	16,183	22,958
202102	237	199	199	219	314	320	297	508	573	616	1,078	3,736	8,296
202103	147	170	182	228	269	345	452	480	444	657	703	1,175	5,252
202104	100	210	285	167	203	242	1,210	1,238	1,233	1,347	1,451	1,502	9,188
202105	26	44	41	45	80	210	547	431	299	292	271	326	2,612
202106	246	180	166	139	78	202	233	181	328	293	160	224	2,430
202107	80	76	58	49	28	21	64	58	140	143	107	138	962
Total	31,226	28,923	25,005	17,306	20,086	24,147	25,816	25,035	26,439	28,136	25,999	25,799	303,917
MM	68,390	68,532	68,844	69,796	70,890	71,651	72,233	72,664	73,088	73,642	74,073	74,607	858,410
PMPM	**0.457**	**0.422**	**0.363**	**0.248**	**0.283**	**0.337**	**0.357**	**0.345**	**0.362**	**0.382**	**0.351**	**0.346**	**0.354**

Table E-17 provides lag triangles for HealthKeepers' pharmacy encounters. Additional details provided include MM and claims PMPM.

Table E-17—Encounters Lag Triangle—Pharmacy Encounters—HealthKeepers

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202002	139,777	11,703											151,480
202003	9,005	136,857	12,168										158,030
202004	887	2,506	157,929	32,334									193,656
202005	11,191	640	1,403	121,641	19,007								153,882
202006	303	349	650	1,074	126,148	9,073							137,597
202007	43	40	245	1,224	2,292	141,006	27,440						172,290
202008	8	7	22	33	303	1,002	118,936	12,680					132,991
202009	23	22	25	30	63	560	1,876	129,489	1,211				133,299
202010	21	25	33	41	44	78	863	1,947	142,690	64,660			210,402
202011	1	4	8	5	7	13	20	446	894	81,219	51,337		133,954
202012			5	4	5	8	15	39	486	1,204	85,199	77,458	164,423
202101	1	5	2	4	4	5	8	13	47	450	611	66,292	67,442
202102	5	8	8	5	6	8	15	57	45	62	539	1,094	1,852
202103			1				2,574	2,403	2,563	2,746	2,917	3,412	16,616
202104	9	11	3	8	28	47	59	47	27	27	106	63	435
202105		1		1	1	1	1	3	5	6	4	10	33
202106	2	2		1		1				4	4	64	78
202107						1		1		1	2	578	583
Total	161,276	152,180	172,502	156,405	147,908	151,803	151,807	147,125	147,968	150,379	140,719	148,971	1,829,043
MM	68,390	68,532	68,844	69,796	70,890	71,651	72,233	72,664	73,088	73,642	74,073	74,607	858,410
PMPM	**2.358**	**2.221**	**2.506**	**2.241**	**2.086**	**2.119**	**2.102**	**2.025**	**2.025**	**2.042**	**1.900**	**1.997**	**2.135**

Field-Level Completeness and Accuracy

Table E-18 provides a summary of the field-level completeness and accuracy for HealthKeepers' professional encounters.

Table E-18—Data Element Completeness and Accuracy for Professional Encounters—HealthKeepers

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	5,026,751	5,026,751	100.0%	4,884,280	5,026,751	97.2%
Header Service From Date	5,026,751	5,026,751	100.0%	5,026,743	5,026,751	>99.9%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Header Service To Date	5,026,751	5,026,751	100.0%	5,023,674	5,026,751	>99.9%
Detail Service From Date	7,197,444	7,197,444	100.0%	7,197,436	7,197,444	>99.9%
Detail Service To Date	7,197,444	7,197,444	100.0%	7,193,431	7,197,444	>99.9%
Billing Provider NPI	5,026,751	5,026,751	100.0%	5,026,043	5,026,751	>99.9%
Rendering Provider NPI	5,026,751	5,026,751	100.0%	5,024,509	5,026,751	>99.9%
Servicing Provider Taxonomy Code	7,197,444	7,197,444	100.0%	5,102,764	7,197,444	70.9%
Referring Provider NPI	712,255	5,026,751	14.2%	679,183	712,255	95.4%
Primary Diagnosis Codes	5,026,751	5,026,751	100.0%	5,026,738	5,026,751	>99.9%
Secondary Diagnosis Codes	1,042,198	5,026,751	20.7%	2,804,973	2,804,994	>99.9%
CPT/HCPCS Codes	7,197,444	7,197,444	100.0%	7,197,432	7,197,444	>99.9%
CPT/HCPCS Codes with PTP Edits	7,197,444	7,197,444	100.0%	7,197,104	7,197,444	>99.9%
Service Units	7,197,444	7,197,444	100.0%	7,197,444	7,197,444	100.0%
Service Units with MUE Edits	1,299,801	1,299,801	100.0%	1,284,308	1,299,801	98.8%
National Drug Codes	236,352	7,197,444	3.3%	235,959	236,352	99.8%
HCPCS/NDC Combination	48,541	54,002	89.9%	38,316	48,541	78.9%
MCO Received Date	7,197,444	7,197,444	100.0%	7,197,444	7,197,444	100.0%
MCO Paid Date	7,197,444	7,197,444	100.0%	7,197,444	7,197,444	100.0%
Header Paid Amount	5,026,751	5,026,751	100.0%	5,026,751	5,026,751	100.0%
Header TPL Paid Amount	1,385,597	5,026,751	27.6%	1,351,548	1,385,597	97.5%
Detail Paid Amount	7,197,444	7,197,444	100.0%	7,197,444	7,197,444	100.0%
Detail TPL Paid Amount	1,987,282	7,197,444	27.6%	1,987,282	1,987,282	100.0%

Table E-19 provides a summary of the field-level completeness and accuracy for HealthKeepers' institutional encounters.

Table E-19—Data Element Completeness and Accuracy for Institutional Encounters—HealthKeepers

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	303,917	303,917	100.0%	286,461	303,917	94.3%
Header Service From Date	303,917	303,917	100.0%	303,917	303,917	100.0%
Header Service To Date	303,917	303,917	100.0%	303,917	303,917	100.0%
Detail Service From Date	1,413,468	1,413,468	100.0%	1,413,468	1,413,468	100.0%
Detail Service To Date	1,413,468	1,413,468	100.0%	1,413,468	1,413,468	100.0%
Billing Provider NPI	303,917	303,917	100.0%	303,888	303,917	>99.9%
Rendering Provider NPI	0	303,917	0.0%	NA	NA	NA
Attending Provider NPI	299,215	303,917	98.5%	291,852	299,215	97.5%
Servicing Provider Taxonomy Code	516,594	1,413,468	36.5%	410,551	516,594	79.5%
Referring Provider NPI	5,281	303,917	1.7%	5,060	5,281	95.8%
Primary Diagnosis Codes	303,917	303,917	100.0%	303,917	303,917	100.0%
Secondary Diagnosis Codes	300,554	303,917	98.9%	2,355,536	2,355,550	>99.9%
CPT/HCPCS Codes	1,110,778	1,413,468	78.6%	1,079,227	1,110,778	97.2%
CPT/HCPCS Codes with PTP Edits	1,110,778	1,413,468	78.6%	1,078,626	1,110,778	97.1%
Service Units	1,413,468	1,413,468	100.0%	1,413,468	1,413,468	100.0%
Service Units with MUE Edits	457,474	457,474	100.0%	455,681	457,474	99.6%
Primary Surgical Procedure Codes	10,218	303,917	3.4%	10,206	10,218	99.9%
Secondary Surgical Procedure Codes	5,492	303,917	1.8%	17,646	17,665	99.9%
Revenue Codes	1,413,468	1,413,468	100.0%	1,413,468	1,413,468	100.0%
Diagnosis-Related Groups Codes	13,460	303,917	4.4%	11,595	13,460	86.1%
Type of Bill Codes	303,917	303,917	100.0%	303,917	303,917	100.0%
National Drug Codes	137,614	1,413,468	9.7%	134,233	137,614	97.5%
HCPCS/NDC Combination	67,287	67,416	99.8%	43,000	67,287	63.9%
MCO Received Date	1,413,468	1,413,468	100.0%	1,413,468	1,413,468	100.0%
MCO Paid Date	1,413,468	1,413,468	100.0%	1,413,468	1,413,468	100.0%
Header Paid Amount	303,917	303,917	100.0%	303,917	303,917	100.0%
Header TPL Paid Amount	135,453	303,917	44.6%	119,303	135,453	88.1%
Detail Paid Amount	1,413,468	1,413,468	100.0%	1,413,468	1,413,468	100.0%
Detail TPL Paid Amount	677,286	1,413,468	47.9%	677,286	677,286	100.0%

Table E-20 provides a summary of the field-level completeness and accuracy for HealthKeepers' pharmacy encounters.

Table E-20—Data Element Completeness and Accuracy for Pharmacy Encounters—HealthKeepers

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	1,829,043	1,829,043	100.0%	1,710,421	1,829,043	93.5%
DOS	1,829,043	1,829,043	100.0%	1,829,043	1,829,043	100.0%
Billing Provider NPI	1,829,043	1,829,043	100.0%	1,828,833	1,829,043	>99.9%
Prescribing Provider NPI	1,829,043	1,829,043	100.0%	1,732,631	1,829,043	94.7%
National Drug Codes	1,829,043	1,829,043	100.0%	1,819,502	1,829,043	99.5%
MCO Received Date	1,829,043	1,829,043	100.0%	1,829,043	1,829,043	100.0%
MCO Paid Date	1,829,043	1,829,043	100.0%	1,829,043	1,829,043	100.0%
Header Paid Amount	1,829,043	1,829,043	100.0%	1,829,043	1,829,043	100.0%
Header TPL Paid Amount	29,826	1,829,043	1.6%	29,826	29,826	100.0%

Appendix F. Information Systems Review and Administrative Profile Results for Molina Complete Care (Molina)

Information Systems Review

Table F-1—Acronym/Abbreviation List and Description (Provided by Molina)

Acronym	Description
EMS	Edifecs Encounter Management System
SH	Shared Health
EDM	Encounter data management
EPS	Encounter processing solution
VM	Vendor management
TPL	Third-party liability
COB	Coordination of benefits

Encounter Data Sources and Systems

Data Sources and Validation Processes

Prior to encounter data submission to DMAS, encounter data are validated and processed, and an EDI compliance check is carried out. Molina uses a range of software to perform these processes. Facets, First Rx, ProClaim, 1 EDI source tool, and Verifier are used to validate encounters; Edifecs, First Rx, Seeburger Business Integration, 1 EDI Source Tool, and Annkissam EDI are used for generating and preparing outbound encounters; and Edifecs, First Rx, Optum Transaction Integrity, 1 EDI Source Tool, and Annkissam EDI are used for carrying out EDI compliance checks.

Frequency of receipt for all encounter types—i.e., all data received that are included in the encounter data submissions to DMAS—varies from daily (paper and medical 837P and 837I files), to weekly (pharmacy, nonemergency transportation, and CD/FEA 837P files), to bimonthly (vision 837P files).

Fields affected by modifications made to encounter data to accommodate DMAS' submission standards as well as created data elements/fields not on claims from providers but required by DMAS are shown in Table F-2.

Table F-2—Data Sources and Fields Affected by Modification of Existing Fields or New Field Creation, to Accommodate DMAS' Submission Standards

Data Source	Field	Modification Made by	Created Field	Modification Made by
Medical in 837P and I	Other payers, service line	SH on behalf of MCO	Enhanced benefit indicator	SH on behalf of MCO

Data Source	Field	Modification Made by	Created Field	Modification Made by
Vision (VSP)	Taxonomy code	VSP	Enhanced benefit indicator in 837P and claim number	VSP
Non-Emergency Transportation (Veyo) 837P			Enhanced benefit indicator	Veyo
CD/FEA (Aces$)	4-character Service Center ID, ambulance pick-up and drop-off, EVV time, attendant info, date paid	Aces$	Enhanced benefit indicator, file names and K3, all in 837P	Aces$

Validation Performed on Claims

Table F-3—Summary of Validation Performed on Claims

Data Elements Validated	Validation Performed	Percent of Claims Validated
Vision/Diagnosis codes; Vision/Modifiers; Vision/Service Description; and Vision/Dollar Amounts	Upfront edits in the claim system, post-adjudication validation against reference tables and Optum validation on final 837	100%
• Non-emergency transportation (NEMT)/Location Codes • NEMT/Diagnosis Code • NEMT/Provider Payment Amount • NEMT/Date of Payment; Date of Receipt/Date of Adjudication	• For location codes, the address and trip reasons are used as reference to capture the accurate location codes • The diagnosis code cannot be null or empty • The provider payment amount cannot be null or empty • The date of payment, date of receipt, and/or date of adjudication cannot be null or empty	100%
CD/FEA EVV Data	Validate start date/time is before end date/time; validate services do not overlap for the same consumer; validate EVV provider (worker) shifts do not overlap; validate timesheet date is before check date; validate time is in correct format	100%

Data Elements Validated	Validation Performed	Percent of Claims Validated
All Medical Claims	All claims are validated for correct coding at the EDI gateway (including paper claims once scanned). Validation includes member matching, appropriateness/completeness of claim form for all required fields according to CMS guidelines. Additionally, the system will edit against claims to determine if service is payable for the billing provider (using assigned provider agreement IDs) and/or other edits such as procedure/age appropriateness, duplicate submissions, corrected claims etc.	100%

Codes and/or fields on which mapping is performed during data processing and validation prior to adjudicating claims for payment processing, and during data processing for submission to DMAS, are shown in Table F-4.

Table F-4—Code and/or Field Mapping

Field	Source of Reference Table	Frequency of Updating Reference Table
Mapping Performed Prior to Claims Adjudication for Payment Processing		
• Vision NPI-Rendering and NPI-Billing Provider CD/FEA Consumer authorization	• Vision NPI-Rendering and NPI-Billing Provider: NPPES Registry • CD/FEA Consumer authorization: Consumer data uploaded into EDI Autoclaim system	Weekly
• NEMT/Rendering Provider NPI • NEMT/Location codes, NEMT/Procedure codes • CD/FEA Copay Amount	• Rendering Provider NPI: File provided by MCO • Location and Procedure codes: Codes provided by MCO • Copay amount: Uploaded Services	1:1 comparison
• Medical—Member Matching on Member ID, DOB, and Name • Provider Matching on Tax ID #, Billing NPI, and Rendering NPI	• Member matching: Member Enrollment File • Provider matching: Provider Data Management	Ongoing

Field	Source of Reference Table	Frequency of Updating Reference Table
Mapping Performed During Data Processing for Submission to DMAS		
Subcontractor ID	DMAS assigned subcontractor IDs	Whenever change occurs

Duplicate Claims Processing

For medical 837I and 837P claims, the first instance of a claim is processed if there are multiple duplicate submissions submitted in the same EDI file, and exact duplicates are rejected back to the provider. Also, a claim is not rejected; rather, it is denied as a duplicate in the system if it is a duplicate claim and submitted 45 days after the original submission and is an exact duplicate to a claim on file.

Data Exchange Policies and Procedures

Encounter submission to DMAS occurs weekly through subcontractor Shared Health, on behalf of Molina. Complete, timely, reasonable, and accurate encounter data for paid and denied services are submitted to DMAS within 30 days of MCC VA's weekly payment cycle, using the form and manner specified by DMAS with the required data elements and submission requirements. A weekly reconciliation of encounter files submitted to results posted in DMAS' EPS is performed to enforce policies and procedures related to the encounter submission process.

Payment Structures of Encounter Data

Table F-5 shows a summary of how claims are paid.

Table F-5—Claim Payment Methods

Payment Type	Inpatient	Outpatient	Pharmacy	Long-Term Care
CCC Plus				
Percent of Billed	0	1.60%	0	0.77%
Line-by-Line	97.49%	98.40%	0	93.97%
Per Diem	0.22%	0	0	5.22%
DRG	2.28%	0	0	0
Negotiated (Flat) Rate	0	0	0	0.03%
Pharmacy (AWP minus a discount)	0	0	100%	0
Total	**100%**	**100%**	**100%**	**100%**

Table F-6 shows payment arrangements and how they are reflected in the encounter data submissions.

Table F-6—Payment Arrangements in Encounter Data Submissions

Inpatient, Outpatient, and Long-Term Care	Paid amount reflects what the rendering provider was paid for service provision to the member. Detailed adjudication/payment information is reported when possible.
Pharmacy	Pricing is a pass-through model defined as AWP minus a discount = Ingredient Cost.

A summary of the process for collecting, coordinating benefits/TPL data, submitting encounters with TPL, and processing TPL payments is described in Table F-7.

Table F-7—Process for Collecting Coordination of Benefits/TPL, Processing Encounters with TPL Data, and TPL Payments

How other insurance data are collected	Contractor and subcontractors are required to submit TPL adjudication/payment information. Each third-party payer's adjudication information is reported separately.
How claims are processed with TPL	If Medicare payment is involved with the claim, the contractor is required to submit the Medicare adjudication/payment information in addition to its own payment information, including Medicare crossover claims submitted to the Medicaid plan/MCO for which there is no Medicaid/MCO payment required and claims in which there was a "zero payment" by Medicare. In addition, any claims for which the Medicaid plan/MCO was responsible for the Medicare covered services as a Medicare Advantage (MA) plan or Dual Eligible Special Needs Plan (D-SNP) plan. The plans calculate and separately record the Medicare and Medicaid liability for claim payment made to a provider as both the Medicare (MA or D-SNP) and Medicaid payer. Medical—Primary and secondary insurance coverage is stored on the member record. If primary insurance is present, the claim is processed to coordinate the benefits. If other insurance is presented after initial claim processing, the original claim is processed to coordinate the benefits or denied if the primary carrier's EOB is not submitted to MCC. Pharmacy (MRx)—Primary and secondary insurance coverage is stored on the member record. If primary insurance is present for an MCC VA member and the claim is submitted to MRx without another coverage code, the claim is denied with direction to submit to the primary payer. If other insurance is presented after initial claim processing, the initial claim would need to be reversed before being submitted to the primary payer.
Source data used to verify accuracy of third-party claims information	If there is more than one third-party payment involved, each must have an adjudication reported separately.

Measures taken to ensure accuracy of TPL payment amount	Internal audits of claim processing and payment are conducted, and MCC contracts with a subcontractor to provide third-party recovery and prospective identification of other coverage information.

Zero-Paid Claims

Zero-paid claims are considered an approved claim with a paid amount of $0.00 and only occur under special circumstances. Zero-paid claims are created if a crossover or commercial claim does not require Medicaid or MCO payment, or a TPL with zero payment. Claims are automatically checked to ensure the claim line is marked as denied with a value of $0.00.

Encounter Data Quality Monitoring and Reporting

For data monitoring, completeness, accuracy, and timeliness metrics for data from third-parties/ subcontractors are the same as those for providers:

- Completeness: 837I and 837P: >98% and <102%; NCPDP: >99.5% and <100.5%
- Accuracy: Goal to have all submitted encounters in a "passed" status
- Timeliness: 837I and 837P: 98%; NCPDP: 99.5%

Table F-8 summarizes the average rejection/pend rate for claim/encounter types. Although not included in this table, overall rates are inclusive of rejection/pend rates for dental encounters.

Table F-8—Average Rejection/Pend Rate for Different Claims/Encounter Types

Claim/Encounter Timespan: 7/1/2020 to 6/30/2021	Percentage of Encounters Submitted to DMAS That are Rejected by DMAS' EDI Translator	Percentage of Encounters Submitted to DMAS That Pass EDI Translator but Fail the EPS Business Rules[F-1]
Institutional (Medical)	*7.59%*	*1.34%*
Professional (Medical, Vision, NEMT, and CD/FEA)	*2.27%*	*0.63%*
Pharmacy (MRx)	*1.40%*	*0.24%*
Overall Rate	**3.75%**	**0.62%**

[F-1] HSAG assumes Molina originally reported the percentage of claims that passed EPS business rules rather than the percentage that failed and has reported the appropriate figures in this table.

Uses of Encounter Data

The encounter data system/data warehouse collects 100 percent of all encounter data, paid and denied for covered and supplemental benefit services to members, including data from subcontractors. These data are then used to understand member-, provider-, and population-level utilization patterns, to understand trends at a service category level, risk-stratify membership, and measure financial performance.

Challenges

Challenges faced in submitting encounter data to DMAS are presented in Table F-9.

Table F-9—Encounter Data Submission Challenges

Internal Challenges	External Challenges
• 834 does not include carrier code for TPL making matching difficult • Manual documentation and monitoring for the current override process	• Repository of the EDI translator rules (compliance check) • Reporting on informational edits when applicable

Automation to the override/exclude process would allow for timely review/revision and resolution.

Administrative Profile

This section provides administrative analysis results for Molina by claim type.

Encounter Data Completeness

Table F-10 provides encounter data volume results for Molina's professional encounters.

Table F-10—Encounter Volume—Professional Encounters—Molina

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	102,249	23,025	4,440.8
February 2020	95,243	22,899	4,159.3
March 2020	94,381	22,980	4,107.1
April 2020	84,942	23,412	3,628.1
May 2020	90,567	23,957	3,780.4
June 2020	95,934	24,237	3,958.2
July 2020	100,360	24,544	4,089.0
August 2020	101,569	24,696	4,112.8
September 2020	106,629	24,893	4,283.5
October 2020	111,477	25,132	4,435.7
November 2020	104,832	25,296	4,144.2
December 2020	109,126	25,461	4,286.0

Table F-11 provides encounter data volume results for Molina's institutional encounters.

Table F-11—Encounter Volume—Institutional Encounters—Molina

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	11,550	23,025	501.6
February 2020	11,112	22,899	485.3
March 2020	10,001	22,980	435.2
April 2020	7,893	23,412	337.1
May 2020	9,245	23,957	385.9
June 2020	10,305	24,237	425.2
July 2020	10,840	24,544	441.7
August 2020	10,503	24,696	425.3
September 2020	10,918	24,893	438.6
October 2020	11,382	25,132	452.9
November 2020	10,260	25,296	405.6
December 2020	10,306	25,461	404.8

Table F-12 provides encounter data volume results for Molina's pharmacy encounters.

Table F-12—Encounter Volume—Pharmacy Encounters—Molina

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	38,656	23,025	1,678.9
February 2020	35,496	22,899	1,550.1
March 2020	39,910	22,980	1,736.7
April 2020	36,435	23,412	1,556.3
May 2020	35,922	23,957	1,499.4
June 2020	37,932	24,237	1,565.0
July 2020	38,622	24,544	1,573.6
August 2020	37,155	24,696	1,504.5
September 2020	36,796	24,893	1,478.2
October 2020	35,270	25,132	1,403.4
November 2020	36,449	25,296	1,440.9
December 2020	38,423	25,461	1,509.1

Table F-13 provides paid amount and TPL amount results for Molina's professional encounters.

Table F-13—Paid Amount and TPL Amount—Professional Encounters—Molina

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	12,770,546	554.6	2,185,457	94.9
February 2020	12,210,932	533.3	2,376,683	103.8
March 2020	12,205,134	531.1	2,358,233	102.6
April 2020	11,233,418	479.8	2,091,458	89.3
May 2020	12,495,556	521.6	2,326,985	97.1
June 2020	12,790,549	527.7	2,559,317	105.6
July 2020	13,695,448	558.0	2,653,597	108.1
August 2020	13,839,153	560.4	2,461,523	99.7
September 2020	12,808,014	514.5	2,485,192	99.8
October 2020	13,482,266	536.5	2,590,278	103.1
November 2020	12,566,923	496.8	2,387,738	94.4
December 2020	13,286,864	521.9	2,565,640	100.8

Table F-14 provides paid amount and TPL amount results for Molina's institutional encounters.

Table F-14—Paid Amount and TPL Amount—Institutional Encounters—Molina

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	19,433,799	844.0	27,172	1.2
February 2020	17,205,702	751.4	38,348	1.7
March 2020	18,868,519	821.1	32,468	1.4
April 2020	17,119,081	731.2	37,812	1.6
May 2020	17,844,957	744.9	95,025	4.0
June 2020	18,550,801	765.4	128,117	5.3
July 2020	20,817,717	848.2	534,223	21.8
August 2020	19,841,506	803.4	1,512,046	61.2
September 2020	19,659,753	789.8	2,100,681	84.4
October 2020	20,404,552	811.9	2,182,300	86.8
November 2020	19,008,806	751.5	2,024,738	80.0
December 2020	19,492,428	765.6	2,108,330	82.8

Table F-15 provides paid amount and TPL amount results for Molina's pharmacy encounters.

Table F-15—Paid Amount and TPL Amount—Pharmacy Encounters—Molina

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	4,331,297	188.1	293,228	12.7
February 2020	4,158,782	181.6	248,423	10.8
March 2020	4,796,370	208.7	272,362	11.9
April 2020	4,455,325	190.3	177,345	7.6
May 2020	4,425,526	184.7	114,163	4.8
June 2020	4,698,895	193.9	173,671	7.2
July 2020	4,996,330	203.6	162,792	6.6
August 2020	4,538,449	183.8	126,760	5.1
September 2020	4,982,374	200.2	141,828	5.7
October 2020	4,697,267	186.9	110,926	4.4
November 2020	4,994,934	197.5	122,207	4.8
December 2020	5,118,954	201.1	129,594	5.1

Table F-16 provides the percentage of duplicate encounters for all three encounters.

Table F-16—Percentage of Duplicate Encounters—Molina

Claim Type	Total Records	Number of Duplicate Records	Percent of Duplicates
Professional Encounters	2,321,067	122,259	5.3%
Institutional Encounters	741,194	776	0.1%
Pharmacy Encounters	447,074	0	0.0%

Encounter Data Timeliness

Table F-17 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for Molina's professional encounters.

Table F-17—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Professional Encounters—Molina

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	60.0%	93.9%	94.0%	94.1%	94.1%
February 2020	93.7%	95.1%	95.4%	95.5%	95.5%
March 2020	99.2%	99.3%	99.5%	99.5%	99.5%
April 2020	99.4%	99.4%	99.6%	99.6%	99.6%
May 2020	99.4%	99.6%	99.6%	99.6%	99.7%
June 2020	99.7%	99.7%	99.7%	99.8%	99.8%
July 2020	91.0%	95.3%	99.6%	99.8%	99.8%
August 2020	88.2%	99.7%	99.8%	99.8%	99.8%
September 2020	99.8%	99.8%	99.9%	99.9%	99.9%
October 2020	88.6%	99.0%	99.5%	99.8%	99.9%
November 2020	98.2%	99.2%	99.5%	99.6%	99.8%
December 2020	89.9%	99.7%	99.8%	99.9%	99.9%
January 2021	99.7%	99.8%	99.9%	99.9%	99.9%
February 2021	96.9%	100.0%	100.0%	100.0%	100.0%
March 2021	99.9%	100.0%	100.0%	100.0%	100.0%
April 2021	99.9%	100.0%	100.0%	100.0%	100.0%
May 2021	99.9%	100.0%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table F-18 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for Molina's institutional encounters.

Table F-18—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Institutional Encounters—Molina

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	99.9%	100.0%	100.0%	100.0%	100.0%
February 2020	99.9%	100.0%	100.0%	100.0%	100.0%
March 2020	100.0%	100.0%	100.0%	100.0%	100.0%
April 2020	99.7%	99.9%	100.0%	100.0%	100.0%
May 2020	99.8%	100.0%	100.0%	100.0%	100.0%
June 2020	99.8%	99.9%	99.9%	100.0%	100.0%
July 2020	100.0%	100.0%	100.0%	100.0%	100.0%
August 2020	99.9%	100.0%	100.0%	100.0%	100.0%
September 2020	99.9%	99.9%	100.0%	100.0%	100.0%
October 2020	97.2%	99.4%	99.9%	99.9%	99.9%
November 2020	98.8%	99.8%	99.9%	99.9%	100.0%
December 2020	99.9%	99.9%	99.9%	100.0%	100.0%
January 2021	99.8%	99.8%	100.0%	100.0%	100.0%
February 2021	93.7%	100.0%	100.0%	100.0%	100.0%
March 2021	99.9%	100.0%	100.0%	100.0%	100.0%
April 2021	100.0%	100.0%	100.0%	100.0%	100.0%
May 2021	100.0%	100.0%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table F-19 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for Molina's pharmacy encounters.

Table F-19—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Pharmacy Encounters—Molina

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	99.3%	99.3%	99.3%	99.3%	99.3%
February 2020	99.5%	99.5%	99.5%	99.5%	99.5%
March 2020	99.4%	99.4%	99.4%	99.4%	99.4%
April 2020	99.5%	99.5%	99.5%	99.5%	99.5%
May 2020	99.3%	99.3%	99.3%	99.3%	99.3%
June 2020	99.3%	99.3%	99.3%	99.3%	99.3%
July 2020	99.4%	99.4%	99.4%	99.4%	99.4%
August 2020	99.0%	99.0%	99.0%	99.0%	99.0%
September 2020	99.0%	99.0%	99.0%	99.0%	99.0%
October 2020	99.3%	99.3%	99.3%	99.3%	99.3%
November 2020	99.5%	99.5%	99.5%	99.5%	99.6%
December 2020	99.5%	99.5%	99.6%	99.6%	99.9%
January 2021	99.3%	99.3%	99.3%	99.8%	100.0%
February 2021	100.0%	100.0%	100.0%	100.0%	100.0%
March 2021	100.0%	100.0%	100.0%	100.0%	100.0%
April 2021	100.0%	100.0%	100.0%	100.0%	100.0%
May 2021	100.0%	100.0%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table F-20 provides lag triangles for Molina's professional encounters. Additional details provided include MM and claims PMPM.

Table F-20—Encounters Lag Triangle—Professional Encounters—Molina

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	13,228												13,228
202002	58,530	13,206											71,736
202003	30,323	61,483	13,886										105,692
202004	5,625	27,945	61,689	18,277									113,536
202005	3,423	4,911	25,240	54,126	16,632								104,332
202006	1,891	1,975	4,192	15,673	61,444	21,545							106,720
202007	1,244	1,337	1,528	2,713	16,069	54,820	19,054						96,765
202008	453	587	1,026	2,128	3,562	19,631	49,203	13,827					90,417
202009	5,403	569	823	1,208	1,600	6,739	36,604	68,769	23,178				144,893
202010	820	401	824	1,417	1,329	3,989	5,922	25,783	75,094	24,805			140,384
202011	242	288	383	377	657	962	1,868	3,999	15,733	75,263	17,861		117,633
202012	290	333	364	457	576	955	2,000	3,255	5,621	22,011	76,072	26,649	138,583
202101	306	312	260	275	360	462	1,112	1,106	2,444	4,447	21,558	68,546	101,188
202102	80	156	288	171	276	402	750	1,047	1,635	2,153	4,003	26,203	37,164
202103	52	100	222	244	291	353	610	915	1,271	2,129	2,766	4,838	13,791
202104	45	36	53	185	191	224	394	484	723	955	1,005	1,436	5,731
202105	21	18	26	81	175	320	337	406	614	762	865	1,168	4,793
202106	375	340	328	299	389	457	362	385	522	619	907	985	5,968
202107							22	21	7		16	41	107
Total	122,351	113,997	111,132	97,631	103,551	110,859	118,238	119,997	126,842	133,144	125,053	129,866	1,412,661
MM	23,025	22,899	22,980	23,412	23,957	24,237	24,544	24,696	24,893	25,132	25,296	25,461	290,532
PMPM	**5.314**	**4.978**	**4.836**	**4.170**	**4.322**	**4.574**	**4.817**	**4.859**	**5.095**	**5.298**	**4.944**	**5.101**	**4.859**

Table F-21 provides lag triangles for Molina's institutional encounters. Additional details provided include MM and claims PMPM.

Table F-21—Encounters Lag Triangle—Institutional Encounters—Molina

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	1,663												1,663
202002	5,659	1,216											6,875
202003	2,591	5,305	1,061										8,957
202004	722	2,977	6,066	1,131	1								10,897
202005	325	715	1,697	4,262	1,063								8,062
202006	336	393	654	1,697	5,898	1,917							10,895
202007	153	165	243	407	1,064	5,937	471						8,440
202008	155	199	243	277	582	1,517	3,781	560					7,314
202009	103	96	123	163	318	629	1,464	4,405	940				8,241
202010	76	75	74	75	116	201	518	955	6,707	1,797			10,594
202011	38	41	37	55	74	121	3,025	2,240	1,748	6,455	1,385		15,219
202012	33	38	49	57	63	124	746	1,667	929	1,937	6,431	1,900	13,974
202101	22	23	32	34	53	61	157	166	262	621	1,826	6,191	9,448
202102	26	41	46	37	67	57	561	457	321	278	373	1,580	3,844
202103	10	19	33	33	47	55	222	185	197	234	288	599	1,922
202104	15	9	9	13	25	37	178	133	106	114	175	188	1,002
202105	8	11	5	12	17	31	33	46	48	67	70	101	449
202106	4	4	6		12	32	37	38	87	105	60	70	455
Total	11,939	11,327	10,378	8,253	9,400	10,719	11,193	10,852	11,345	11,608	10,608	10,629	128,251
MM	23,025	22,899	22,980	23,412	23,957	24,237	24,544	24,696	24,893	25,132	25,296	25,461	290,532
PMPM	**0.519**	**0.495**	**0.452**	**0.353**	**0.392**	**0.442**	**0.456**	**0.439**	**0.456**	**0.462**	**0.419**	**0.417**	**0.442**

Table F-22 provides lag triangles for Molina's pharmacy encounters. Additional details provided include MM and claims PMPM.

Table F-22—Encounters Lag Triangle—Pharmacy Encounters—Molina

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	24,934												24,934
202002	13,101	29,433											42,534
202003	281	5,620	30,476										36,377
202004	50	150	8,830	24,439									33,469
202005	14	55	297	11,417	29,269								41,052
202006	13	12	71	317	5,911	28,295							34,619
202007	10	19	12	44	463	9,164	33,746						43,458
202008	2	2	6	12	16	197	4,312	29,533					34,080
202009			4	1	2	6	221	6,849	26,269				33,352
202010	8	11	9	15	12	10	67	313	9,942	29,541			39,928
202011	1	3	3	4	3	7	3	8	193	5,145	29,860		35,230
202012			2		1	3	5	10	24	320	6,022	27,785	34,172
202101					1	2	2	9	7	26	330	10,265	10,642
202102					1			8	8	9	20	137	183
202103	75	65	65	61	65	73	86	70	12	15	21	53	661
202104	62	60	56	41	48	38	16	40	68	81	52	42	604
202105	106	45	44	85	131	139	160	313	270	130	138	139	1,700
202106		21	35								1		57
202107							4	3	3	3	6	3	22
Total	38,657	35,496	39,910	36,436	35,923	37,934	38,622	37,156	36,796	35,270	36,450	38,424	447,074
MM	23,025	22,899	22,980	23,412	23,957	24,237	24,544	24,696	24,893	25,132	25,296	25,461	290,532
PMPM	**1.679**	**1.550**	**1.737**	**1.556**	**1.499**	**1.565**	**1.574**	**1.505**	**1.478**	**1.403**	**1.441**	**1.509**	**1.541**

Field-Level Completeness and Accuracy

Table F-23 provides a summary of the field-level completeness and accuracy for Molina's professional encounters.

Table F-23—Data Element Completeness and Accuracy for Professional Encounters—Molina

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	1,412,661	1,412,661	100.0%	1,365,206	1,412,661	96.6%
Header Service From Date	1,412,661	1,412,661	100.0%	1,412,661	1,412,661	100.0%
Header Service To Date	1,412,661	1,412,661	100.0%	1,412,661	1,412,661	100.0%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Detail Service From Date	2,321,067	2,321,067	100.0%	2,321,067	2,321,067	100.0%
Detail Service To Date	2,321,067	2,321,067	100.0%	2,321,067	2,321,067	100.0%
Billing Provider NPI	1,412,661	1,412,661	100.0%	1,406,074	1,412,661	99.5%
Rendering Provider NPI	1,412,661	1,412,661	100.0%	1,407,411	1,412,661	99.6%
Servicing Provider Taxonomy Code	2,321,067	2,321,067	100.0%	2,295,271	2,321,067	98.9%
Referring Provider NPI	320,754	1,412,661	22.7%	304,950	320,754	95.1%
Primary Diagnosis Codes	1,412,661	1,412,661	100.0%	1,412,660	1,412,661	>99.9%
Secondary Diagnosis Codes	375,865	1,412,661	26.6%	1,057,927	1,057,929	>99.9%
CPT/HCPCS Codes	2,321,067	2,321,067	100.0%	2,321,051	2,321,067	>99.9%
CPT/HCPCS Codes with PTP Edits	2,321,067	2,321,067	100.0%	2,320,733	2,321,067	>99.9%
Service Units	2,321,067	2,321,067	100.0%	2,321,067	2,321,067	100.0%
Service Units with MUE Edits	502,592	502,592	100.0%	493,323	502,592	98.2%
National Drug Codes	84,352	2,321,067	3.6%	84,191	84,352	99.8%
HCPCS/NDC Combination	14,088	14,601	96.5%	10,904	14,088	77.4%
MCO Received Date	2,321,067	2,321,067	100.0%	2,321,067	2,321,067	100.0%
MCO Paid Date	2,321,067	2,321,067	100.0%	2,321,067	2,321,067	100.0%
Header Paid Amount	1,412,661	1,412,661	100.0%	1,412,661	1,412,661	100.0%
Header TPL Paid Amount	272,668	1,412,661	19.3%	269,028	272,668	98.7%
Detail Paid Amount	2,321,067	2,321,067	100.0%	2,321,067	2,321,067	100.0%
Detail TPL Paid Amount	421,428	2,321,067	18.2%	421,428	421,428	100.0%

Table F-24 provides a summary of the field-level completeness and accuracy for Molina's institutional encounters.

Table F-24—Data Element Completeness and Accuracy for Institutional Encounters—Molina

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	128,251	128,251	100.0%	121,949	128,251	95.1%
Header Service From Date	128,251	128,251	100.0%	128,251	128,251	100.0%
Header Service To Date	128,251	128,251	100.0%	128,250	128,251	>99.9%
Detail Service From Date	741,194	741,194	100.0%	741,194	741,194	100.0%
Detail Service To Date	741,194	741,194	100.0%	741,194	741,194	100.0%
Billing Provider NPI	128,251	128,251	100.0%	126,641	128,251	98.7%
Rendering Provider NPI	282	128,251	0.2%	282	282	100.0%
Attending Provider NPI	52,434	128,251	40.9%	52,191	52,434	99.5%
Servicing Provider Taxonomy Code	339,029	741,194	45.7%	333,906	339,029	98.5%
Referring Provider NPI	119	128,251	<0.01%	118	119	99.2%
Primary Diagnosis Codes	128,251	128,251	100.0%	128,251	128,251	100.0%
Secondary Diagnosis Codes	114,502	128,251	89.3%	788,920	788,928	>99.9%
CPT/HCPCS Codes	575,404	741,194	77.6%	553,361	575,404	96.2%
CPT/HCPCS Codes with PTP Edits	575,404	741,194	77.6%	553,210	575,404	96.1%
Service Units	741,194	741,194	100.0%	741,194	741,194	100.0%
Service Units with MUE Edits	194,612	194,612	100.0%	193,976	194,612	99.7%
Primary Surgical Procedure Codes	4,049	128,251	3.2%	4,036	4,049	99.7%
Secondary Surgical Procedure Codes	2,153	128,251	1.7%	5,353	5,376	99.6%
Revenue Codes	741,194	741,194	100.0%	741,194	741,194	100.0%
Diagnosis-Related Groups Codes	7,128	128,251	5.6%	7,121	7,128	>99.9%
Type of Bill Codes	128,251	128,251	100.0%	128,251	128,251	100.0%
National Drug Codes	91,531	741,194	12.3%	90,419	91,531	98.8%
HCPCS/NDC Combination	32,198	32,198	100.0%	20,608	32,198	64.0%
MCO Received Date	741,194	741,194	100.0%	741,194	741,194	100.0%
MCO Paid Date	741,194	741,194	100.0%	741,194	741,194	100.0%
Header Paid Amount	128,251	128,251	100.0%	128,251	128,251	100.0%
Header TPL Paid Amount	14,484	128,251	11.3%	11,654	14,484	80.5%
Detail Paid Amount	741,194	741,194	100.0%	741,194	741,194	100.0%
Detail TPL Paid Amount	134,352	741,194	18.1%	134,352	134,352	100.0%

Table F-25 provides a summary of the field-level completeness and accuracy for Molina's pharmacy encounters.

Table F-25—Data Element Completeness and Accuracy for Pharmacy Encounters—Molina

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	447,074	447,074	100.0%	420,016	447,074	93.9%
DOS	447,074	447,074	100.0%	447,074	447,074	100.0%
Billing Provider NPI	447,074	447,074	100.0%	445,140	447,074	99.6%
Prescribing Provider NPI	447,074	447,074	100.0%	407,770	447,074	91.2%
National Drug Codes	447,074	447,074	100.0%	445,419	447,074	99.6%
MCO Received Date	447,074	447,074	100.0%	447,074	447,074	100.0%
MCO Paid Date	447,074	447,074	100.0%	447,074	447,074	100.0%
Header Paid Amount	447,074	447,074	100.0%	447,074	447,074	100.0%
Header TPL Paid Amount	36,892	447,074	8.3%	36,892	36,892	100.0%

Appendix G. Information Systems Review and Administrative Profile Results for Optima Health (Optima)

Information Systems Review

Table G-1—Acronym/Abbreviation List and Description (Provided by Optima)

Acronym	Description
DMAS	Department of Medical Assistance Services
OHCC	Optima Health Community Care
OHP	Optima Health Plan
SMH	Sentara Mental Health
CSC	Computer Science Corporation
TCL	Terminal Control Language
CNT	Count
EDI	Electronic data interchange
HE	Hold entry
MH	Mental health
BH	Behavioral health
EPS	Encounter processing solution
CCC	Commonwealth Community Care
HCFA	Health Care Finance Administration
UB	Uniform billing
NPI	National provider identifier
COB	Coordination of benefits
NCPDP	National Council for Prescription Drug Programs

Encounter Data Sources and Systems

Data Sources and Validation Processes

Prior to encounter data submission to DMAS, encounter data are validated and processed, and an EDI compliance check is carried out using appropriate software. CSC/Wintegrate is used to validate encounter data, generate/prepare outbound encounters for submission to DMAS, and conduct EDI compliance checks on encounters submitted to DMAS through 837P and 837I formats, for the vast majority of the encounter types. In addition to CSC/Wintegrate, RxClaim is used for EDV (pharmacy), and a web-based graphical user interface (GUI) application that works in conjunction with RxClaim is used to generate outbound pharmacy encounters for submission to DMAS.

Frequency of receipt for data sources (i.e., all data received that are included in the encounter data submissions to DMAS) range from as frequently as daily (medical 837P and 837I files), to weekly (pharmacy, vision, and consumer directed), or even biweekly (nonemergency transportation encounters).

Fields affected by modifications made to encounter data to accommodate DMAS' submission standards as well as created data elements/fields not on claims from providers but required by DMAS are shown in Table G-2.

Table G-2—Data Sources and Fields Affected by Modification of Existing Fields or New Field Creation, to Accommodate DMAS' Submission Standards

Data Source	Field	Modification Made by	Created Field	Modification Made by
Institutional Claims	Bill Type	MCO	NA	NA
Professional and Institutional Claims	NA	NA	Taxonomy Code, ZIP Codes, 2400-Service Line – K3 Segment	MCO

A 1 percent stratified random sample of claims is reviewed weekly using the claim image to validate the following fields for medical and behavioral health claims (A 1 percent sample each, for manually processed claims and auto-adjudicated claims): member demographics, provider information, dates of service, charges, CPT, HCPCS, diagnosis codes, place of service, units, referring provider, and attending provider.

Codes and/or fields on which mapping is performed during data processing and validation prior to adjudicating claims for payment processing, and during data processing for submission to DMAS, are shown in Table G-3.

Table G-3—Code and/or Field Mapping

Field	Source of Reference Table	Frequency of Updating Reference Table
Mapping Performed Prior to Claims Adjudication for Payment Processing		
• Transmit • Error (Reject codes)	• Transmit: Transmit types table • Error: Validity table ADHCB820.ERRORS	As needed (new requirement)
• Account • Claim Number or Reference No (Some claim numbers are sent, but most are auto-generated) • Load Date (Creation date) • Claim Information (ANSI837 segments) • Form Type (HCFC or UB)	• Account: Account where claim is created • Claim/Reference No.: Master claims • Load date: Internal clock • Claim Information: ADHCB820.TAPE.OPT (output record)	N/A

Field	Source of Reference Table	Frequency of Updating Reference Table
	• Form type: Program 822.1 is HCFA; Program 822.2 is UB	
• Provider (Provider determination process in 822) • Member (Member determination process in 822)	• Provider: ADHCO820.TAXID, NPI.TAXON, NPI.PHYSXREF, Physician, Physician.TAXID, etc. • Member: Members, Subscribers, Group, LOB, etc.	• Provider: Physician setup • Member: Member Setup
Mapping Performed During Data Processing for Submission to DMAS		
Filing Indicator	CSC/Wintegrate	As needed for COB
2010BB-Payer Name; CR1-Ambulance Transport Information; 2400-Service Line (transportation claims)	DMAS companion guide	Always

Duplicate, Denied, and Adjusted Claims

Duplicates are automatically identified by comparing member number, subcontractor number, date of service, procedure code, and total charges of the current claim to claims that are stored in the member's claim history. Then, a warning message alerts the processor of a possible duplicate claim for any claims manually worked. If a claim was fully electronic, the claim will be denied accordingly.

Environmental claims are not submitted to DMAS because the company rendering the service does not have an NPI number; for example, building access ramps to a member's home or claims paid directly to the member.

Submission of partially denied claims/encounters to DMAS: Fully and partially denied claims are submitted to DMAS the same way that paid claims are submitted. These claims go through internal checks to ensure compliance and appropriate adjudication.

Claims Adjudication

For encounters that require adjustments, the previously paid claim is adjusted by reversing the original claim and creating a new claim. When the original claim is reversed, a voided claim is created that has the same claim ID number as the original but with an "R" as a prefix, and a new final claim is created. This new claim contains all the information and the claim ID from the original but has an "N" as a prefix. R claims (voided claims) are sent to DMAS to void out the original claim that was processed. N claims (the original claim but with the necessary adjustments) are sent to DMAS as if they are a new claim.

The length of time taken from identification to resubmission for encounters needing adjustments varies depending on the adjustment need on the claim.

Data Exchange Policies and Procedures

All medical and mental health claims are uploaded and sent to DMAS weekly. Record control totals are logged for each encounter extract file that is created daily. Production 837 files are uploaded manually each week to DMAS' secure web-based portal. A confirmation email is sent, and a response file is created and downloaded. All encounters are submitted to DMAS in a timely manner except for those held on an internal error report that prevent OHCC from transmitting the claim. These errors are manually reviewed, and claims that can be corrected are updated and transmitted to DMAS as soon as possible.[G-1] For claims that are rejected due to front-end edits on the DMAS system, claim references are received the same day as submitted and are researched for errors. Once corrected, they are resubmitted to DMAS.

Payment Structures of Encounter Data

Although the subcontractor for vision and NEMT is capitated, providers are paid using an FFS model. Less than 5 percent of professional claims are submitted by capitated providers. Table G-4 shows a summary of how claims are paid.

Table G-4—Claim Payment Methods

Payment Type	Inpatient	Outpatient	Pharmacy	Long-Term Care
CCC Plus				
Percent of Billed	0.9%	2.5%		
Line-by-Line	0.8%	44.8%	100%	
Per Diem	10.5%	6.6%		2.5%
DRG	82.4%			
Other (MISC)	5.4%	8.8%		12.0%
Other (OP-EAPG)		37.3%		
Other (RUG)				85.5%
Total	**100%**	**100%**	**100%**	**100%**

Inpatient, outpatient, and long-term care claims are included on standard encounter data submissions, and pharmacy claims are submitted separately. There are no specific indicators to identify inpatient.

[G-1] For example, if a valid diagnosis pointer is not included, the encounter will be rejected when transmitted to DMAS, and OHCC must wait until the provider submits a corrected claim.

Optima Health uses the DMAS bundled payment methodology for reimbursement of obstetrical services (OB). The methodology is intended to provide a flat fee post-delivery for various professional services rendered through postpartum.

Third-Party Liability

Optima contracts with third-party subcontractors to identify and/or recover overpayments related to COB/TPL. Overpayments are recovered from commercial payers in instances where Optima paid inappropriately as primary. Optima collects other insurance data from several sources including unverified other coverage information sourced by DMAS via the 834; TPL verification based on other coverage information included in an EOB from the primary payer; TPL information sourced by Health Management Services (HMS), a third-party subcontractor; and information gathered from member or provider calls. Optima uses subcontractors to data mine all paid claims to determine if the claims were paid appropriately within the context of COB. HMS mines medical and pharmacy claims, and determines if members have other coverage for the dates of service. A recovery department uses reporting to verify the accuracy of third-party claims processing. Payment information is stored in Optima's claims processing system as well as a data warehouse. TPL/COB information is populated at the header and claim line levels on encounters that are submitted to DMAS. To ensure accuracy of the TPL payment amount, Optima reviews a random sample of all claims paid monthly for accuracy which includes claims with TPL payment.

Zero-Paid Claims

Zero-paid claims are created in instances where primary insurance paid the allowable, and the provider billed $0 (sometimes done when billing surgical follow-up days), for capitated service, or denied service (as duplicate claim, not authorized, not a covered service, etc.). All claims from these identified scenarios are sent to DMAS via the encounter process. Zero-paid claims are submitted as an approved claim with a paid amount of $0.00.

Encounter Data Quality Monitoring and Reporting

Optima uses a subcontractor auditing program to monitor encounter data from subcontractors/third parties for completeness. The auditing program also conducts a series of automated checks to monitor data accuracy (e.g., ensure provider NPIs are supplied, payment dates occur after service dates). Encounters are submitted daily and monitored weekly to assess timely submission. Notifications are sent if an encounter submission has not been received as expected. Average rejection/pend rate for claim/encounter types is shown in Table G-5. Although not included in this table, overall rates are inclusive of rejection/pend rates for dental encounters.

Table G-5—Average Rejection/Pend Rate for Different Claims/Encounter Types

Claim/Encounter	Percentage of Encounters Submitted to DMAS That are Rejected by DMAS' EDI Translator	Percentage of Encounters Submitted to DMAS That Pass EDI Translator but Fail the EPS Business Rules
Institutional	*<.01%*	*0.69%*
Professional	*<.01%*	0.27%

Claim/Encounter	Percentage of Encounters Submitted to DMAS That are Rejected by DMAS' EDI Translator	Percentage of Encounters Submitted to DMAS That Pass EDI Translator but Fail the EPS Business Rules
Pharmacy	*<.01%*	0.04%
Transportation	*<.01%*	0.93%
Vision	*<.01%*	0.56%
Consumer Directed	*<.01%*	0.02%
Overall Rate	***<.01%***	**0.24%**

Challenges

Turnaround time of IT implementing necessary changes to comply with DMAS' changes or updates is an internal challenge faced in submitting encounter data to DMAS. External challenges faced include:

- Limiting files to 4999 claims or less causing a large amount of unnecessary file tracking and reconciliation.
- EPS does not allow submission of adjustment or void claims if the original failed in EPS. This is counterproductive because the reason for the adjustment or void is because the original failed.
- The DMAS scorecard does not have enough granular information regarding how some of the metrics are calculated (e.g., provider payment timeliness). The scorecard indicates that Optima is not meeting payment timeliness, contrary to internal reports. More information regarding how some of the metrics are calculated is needed.
- DMAS is often late to update its system with NDCs and sometimes is selective with codes updated and added to its system.

Changing the monthly meeting platform—Optima cited issues with Google Meets and recommended WebEx or Zoom.

Finally, Optima Health will be transitioning from claims processing in CSC to a new program called QNXT. This is slated to occur over the next two years ending in 2023. After this transition, essentially all processes described in this information systems review will change.

Administrative Profile

This section provides administrative analysis results for Optima by claim type.

Encounter Data Completeness

Table G-6 provides encounter data volume results for Optima's professional encounters.

Table G-6—Encounter Volume—Professional Encounters—Optima

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	227,189	40,158	5,657.4
February 2020	210,791	40,143	5,251.0
March 2020	207,958	40,223	5,170.1
April 2020	187,212	40,764	4,592.6
May 2020	199,036	41,224	4,828.2
June 2020	211,288	41,551	5,085.0
July 2020	220,663	41,872	5,269.9
August 2020	218,167	42,468	5,137.2
September 2020	215,479	42,732	5,042.6
October 2020	236,924	42,969	5,513.8
November 2020	221,746	43,116	5,143.0
December 2020	224,137	43,335	5,172.2

Table G-7 provides encounter data volume results for Optima's institutional encounters.

Table G-7—Encounter Volume—Institutional Encounters—Optima

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	23,818	40,158	593.1
February 2020	22,846	40,143	569.1
March 2020	19,280	40,223	479.3
April 2020	13,531	40,764	331.9
May 2020	16,592	41,224	402.5
June 2020	19,811	41,551	476.8
July 2020	20,990	41,872	501.3
August 2020	20,589	42,468	484.8

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
September 2020	20,663	42,732	483.5
October 2020	21,913	42,969	510.0
November 2020	19,255	43,116	446.6
December 2020	19,055	43,335	439.7

Table G-8 provides encounter data volume results for Optima's pharmacy encounters.

Table G-8—Encounter Volume—Pharmacy Encounters—Optima

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	116,712	40,158	2,906.3
February 2020	107,377	40,143	2,674.9
March 2020	123,047	40,223	3,059.1
April 2020	110,650	40,764	2,714.4
May 2020	104,682	41,224	2,539.3
June 2020	106,673	41,551	2,567.3
July 2020	104,927	41,872	2,505.9
August 2020	101,200	42,468	2,383.0
September 2020	104,181	42,732	2,438.0
October 2020	103,156	42,969	2,400.7
November 2020	97,430	43,116	2,259.7
December 2020	102,644	43,335	2,368.6

Table G-9 provides paid amount and TPL amount results for Optima's professional encounters.

Table G-9—Paid Amount and TPL Amount—Professional Encounters—Optima

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	33,482,247	833.8	2,716,256	67.6
February 2020	31,262,335	778.8	2,839,838	70.7
March 2020	30,641,706	761.8	2,797,190	69.5
April 2020	28,836,266	707.4	2,476,878	60.8
May 2020	30,657,754	743.7	2,866,329	69.5
June 2020	31,289,515	753.0	3,252,892	78.3
July 2020	32,862,907	784.8	3,341,988	79.8

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
August 2020	31,845,823	749.9	3,255,871	76.7
September 2020	29,244,108	684.4	3,183,026	74.5
October 2020	32,330,425	752.4	3,261,576	75.9
November 2020	30,095,891	698.0	3,021,477	70.1
December 2020	30,725,323	709.0	3,072,625	70.9

Table G-10 provides paid amount and TPL amount results for Optima's institutional encounters.

Table G-10—Paid Amount and TPL Amount—Institutional Encounters—Optima

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	28,464,802	708.8	12,427,228	309.5
February 2020	27,159,373	676.6	10,920,176	272.0
March 2020	28,531,963	709.3	11,171,248	277.7
April 2020	23,470,630	575.8	8,989,437	220.5
May 2020	24,315,238	589.8	11,299,515	274.1
June 2020	26,373,679	634.7	12,387,114	298.1
July 2020	29,852,983	713.0	12,885,221	307.7
August 2020	30,190,229	710.9	12,660,518	298.1
September 2020	28,601,565	669.3	11,121,967	260.3
October 2020	29,414,706	684.6	12,079,529	281.1
November 2020	28,058,400	650.8	9,955,572	230.9
December 2020	29,137,746	672.4	11,288,758	260.5

Table G-11 provides paid amount and TPL amount results for Optima's pharmacy encounters.

Table G-11—Paid Amount and TPL Amount—Pharmacy Encounters—Optima

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	12,006,745	299.0	231,446	5.8
February 2020	11,024,026	274.6	210,336	5.2
March 2020	12,946,284	321.9	304,078	7.6
April 2020	13,031,761	319.7	273,933	6.7
May 2020	12,032,142	291.9	236,141	5.7
June 2020	12,477,974	300.3	259,136	6.2
July 2020	11,954,130	285.5	277,697	6.6
August 2020	11,166,904	262.9	271,433	6.4
September 2020	12,125,800	283.8	184,348	4.3
October 2020	12,001,128	279.3	187,214	4.4
November 2020	12,213,942	283.3	139,993	3.2
December 2020	13,110,106	302.5	111,110	2.6

Table G-12 provides the percentage of duplicate encounters for all three encounters.

Table G-12—Percentage of Duplicate Encounters—Optima

Claim Type	Total Records	Number of Duplicate Records	Percent of Duplicates
Professional Encounters	4,295,803	55,856	1.3%
Institutional Encounters	1,242,936	3,253	0.3%
Pharmacy Encounters	1,284,466	364	<0.1%

Encounter Data Timeliness

Table G-13 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for Optima's professional encounters.

Table G-13—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Professional Encounters—Optima

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
Prior January 2020	99.7%	99.7%	99.7%	99.7%	99.7%
January 2020	100.0%	100.0%	100.0%	100.0%	100.0%
February 2020	100.0%	100.0%	100.0%	100.0%	100.0%
March 2020	96.2%	99.9%	100.0%	100.0%	100.0%
April 2020	99.9%	99.9%	99.9%	99.9%	99.9%
May 2020	100.0%	100.0%	100.0%	100.0%	100.0%
June 2020	100.0%	100.0%	100.0%	100.0%	100.0%
July 2020	99.9%	99.9%	99.9%	99.9%	99.9%
August 2020	99.8%	99.8%	99.8%	99.8%	99.8%
September 2020	99.3%	99.3%	99.3%	99.3%	99.5%
October 2020	99.2%	99.2%	99.6%	99.8%	99.8%
November 2020	99.2%	99.5%	99.8%	99.8%	99.9%
December 2020	99.7%	99.8%	99.8%	99.9%	100.0%
January 2021	99.8%	99.8%	99.9%	100.0%	100.0%
February 2021	99.6%	99.9%	100.0%	100.0%	100.0%
March 2021	99.7%	100.0%	100.0%	100.0%	100.0%
April 2021	99.6%	100.0%	100.0%	100.0%	100.0%
May 2021	100.0%	100.0%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table G-14 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for Optima's institutional encounters.

Table G-14—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Institutional Encounters—Optima

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	99.5%	100.0%	100.0%	100.0%	100.0%
February 2020	99.9%	100.0%	100.0%	100.0%	100.0%
March 2020	100.0%	100.0%	100.0%	100.0%	100.0%
April 2020	99.9%	100.0%	100.0%	100.0%	100.0%
May 2020	100.0%	100.0%	100.0%	100.0%	100.0%
June 2020	99.9%	99.9%	99.9%	99.9%	99.9%
July 2020	100.0%	100.0%	100.0%	100.0%	100.0%
August 2020	99.9%	99.9%	99.9%	100.0%	100.0%
September 2020	99.9%	99.9%	99.9%	100.0%	100.0%
October 2020	99.9%	100.0%	100.0%	100.0%	100.0%
November 2020	99.9%	100.0%	100.0%	100.0%	100.0%
December 2020	99.6%	99.6%	99.6%	100.0%	100.0%
January 2021	100.0%	100.0%	100.0%	100.0%	100.0%
February 2021	99.8%	100.0%	100.0%	100.0%	100.0%
March 2021	99.8%	99.9%	99.9%	100.0%	100.0%
April 2021	100.0%	100.0%	100.0%	100.0%	100.0%
May 2021	99.8%	100.0%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table G-15 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for Optima's pharmacy encounters.

Table G-15—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Pharmacy Encounters—Optima

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	100.0%	100.0%	100.0%	100.0%	100.0%
February 2020	100.0%	100.0%	100.0%	100.0%	100.0%
March 2020	100.0%	100.0%	100.0%	100.0%	100.0%
April 2020	100.0%	100.0%	100.0%	100.0%	100.0%
May 2020	100.0%	100.0%	100.0%	100.0%	100.0%
June 2020	100.0%	100.0%	100.0%	100.0%	100.0%
July 2020	100.0%	100.0%	100.0%	100.0%	100.0%
August 2020	100.0%	100.0%	100.0%	100.0%	100.0%
September 2020	100.0%	100.0%	100.0%	100.0%	100.0%
October 2020	99.9%	100.0%	100.0%	100.0%	100.0%
November 2020	100.0%	100.0%	100.0%	100.0%	100.0%
December 2020	100.0%	100.0%	100.0%	100.0%	100.0%
January 2021	100.0%	100.0%	100.0%	100.0%	100.0%
February 2021	100.0%	100.0%	100.0%	100.0%	100.0%
March 2021	98.4%	100.0%	100.0%	100.0%	100.0%
April 2021	100.0%	100.0%	100.0%	100.0%	100.0%
May 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table G-16 provides lag triangles for Optima's professional encounters. Additional details provided include MM and claims PMPM.

Table G-16—Encounters Lag Triangle—Professional Encounters—Optima

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
APR19		1					1						2
JUN18				1									1
201911	4												4
201912	264	6											270
202001	63,322	377	29										63,728
202002	156,753	66,502	361	7									223,623
202003	24,220	135,584	59,901	288	10						1		220,004
202004	6,348	24,688	139,531	38,340	260	8						1	209,176
202005	3,579	5,700	24,974	141,622	52,799	281	3						228,958
202006	2,370	2,928	4,386	14,273	128,610	45,837	192	4					198,600
202007	1,771	2,298	3,407	5,993	27,382	137,708	58,675	438	6	1			237,679
202008	1,131	1,545	2,042	2,861	5,112	39,370	157,963	55,295	358	15	1		265,693
202009	569	597	982	1,614	2,463	4,439	20,989	152,259	40,193	289	11		224,405
202010	706	744	1,205	1,563	1,628	3,285	7,414	30,688	156,665	67,826	379	5	272,108
202011	392	503	550	699	1,048	1,566	2,687	5,909	28,423	154,499	58,892	330	255,498
202012	1,374	1,382	543	859	776	1,647	1,668	3,067	11,047	32,992	146,173	71,218	272,746
202101	1,184	1,864	1,038	687	1,252	1,234	2,734	2,028	5,507	8,104	35,242	139,135	200,009
202102	193	301	360	348	537	708	953	1,395	2,806	4,267	6,433	31,212	49,513
202103	79	114	229	376	473	627	786	1,026	1,897	3,247	3,555	7,521	19,930
202104	80	125	152	463	530	697	1,412	1,506	2,163	2,302	3,040	4,038	16,508
202105	402	111	273	149	390	500	730	438	828	1,039	2,497	1,739	9,096
202106	71	82	111	88	120	316	405	507	766	932	1,010	1,961	6,369
202107	11	10	13	20	19	32	51	79	268	291	306	370	1,470
Total	264,823	245,462	240,087	210,251	223,409	238,255	256,663	254,639	250,927	275,804	257,540	257,530	2,975,390
MM	40,158	40,143	40,223	40,764	41,224	41,551	41,872	42,468	42,732	42,969	43,116	43,335	500,555
PMPM	**6.595**	**6.115**	**5.969**	**5.158**	**5.419**	**5.734**	**6.130**	**5.996**	**5.872**	**6.419**	**5.973**	**5.943**	**5.944**

Table G-17 provides lag triangles for Optima's institutional encounters. Additional details provided include MM and claims PMPM.

Table G-17—Encounters Lag Triangle—Institutional Encounters—Optima

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	6,035												6,035
202002	12,585	5,360											17,945
202003	2,841	12,780	4,539										20,160
202004	903	2,570	9,667	1,441									14,581
202005	757	1,049	3,854	9,418	3,237								18,315
202006	445	498	600	1,462	9,757	3,763							16,525
202007	345	334	434	697	2,430	13,559	5,371						23,170
202008	144	186	194	244	427	1,498	12,151	4,944					19,788
202009	140	157	157	259	345	505	2,112	11,518	3,797				18,990
202010	153	179	180	182	260	380	812	2,894	13,703	5,566			24,309
202011	111	88	76	97	114	199	440	829	1,886	12,677	4,867		21,384
202012	57	67	72	76	118	133	245	415	848	2,557	11,655	6,700	22,943
202101	54	62	43	32	57	72	136	202	366	636	1,643	9,438	12,741
202102	52	63	69	55	70	97	119	164	250	349	690	1,860	3,838
202103	23	18	27	40	62	74	103	101	167	207	356	708	1,886
202104	16	24	20	23	46	80	84	126	151	198	259	465	1,492
202105	5	11	21	14	26	47	81	88	98	130	183	234	938
202106	22	23	17	16	29	40	107	87	188	128	178	221	1,056
202107	6	4	7	6	7	19	27	34	34	57	88	90	379
Total	24,694	23,473	19,977	14,062	16,985	20,466	21,788	21,402	21,488	22,505	19,919	19,716	246,475
MM	40,158	40,143	40,223	40,764	41,224	41,551	41,872	42,468	42,732	42,969	43,116	43,335	500,555
PMPM	**0.615**	**0.585**	**0.497**	**0.345**	**0.412**	**0.493**	**0.520**	**0.504**	**0.503**	**0.524**	**0.462**	**0.455**	**0.493**

Table G-18 provides lag triangles for Optima's pharmacy encounters. Additional details provided include MM and claims PMPM.

Table G-18—Encounters Lag Triangle—Pharmacy Encounters—Optima

	Service Month												
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	67,693												67,693
202002	48,073	55,499											103,572
202003	534	51,110	85,085										136,729
202004	127	316	37,343	67,164									104,950
202005	26	76	338	42,933	55,728								99,101
202006	43	56	109	398	48,258	71,790							120,654
202007	2	18	42	71	540	34,127	55,766						90,566
202008	230	300	357	102	74	557	44,471	48,588					94,679
202009	7	10	7	253	319	416	683	52,202	66,088				119,985
202010			3	5	10	15	628	487	37,654	56,062			94,864
202011	3	2	1	2	5	31	3,550	55	513	45,896	46,260		96,318
202012	1	5	4	3	2	4	7	17	61	491	50,199	65,947	116,741
202101				2			2	20	29	717	938	36,157	37,865
202102		5	6	4	2	2	4	4	9	9	46	500	591
202103			1			14	9	3	4	8	21	66	126
202104	1						1			5	1	7	15
202105									5	6	1	4	16
202106				1									1
Total	116,740	107,397	123,296	110,938	104,938	106,956	105,121	101,376	104,363	103,194	97,466	102,681	1,284,466
MM	40,158	40,143	40,223	40,764	41,224	41,551	41,872	42,468	42,732	42,969	43,116	43,335	500,555
PMPM	**2.907**	**2.675**	**3.065**	**2.721**	**2.546**	**2.574**	**2.511**	**2.387**	**2.442**	**2.402**	**2.261**	**2.369**	**2.572**

Field-Level Completeness and Accuracy

Table G-19 provides a summary of the field-level completeness and accuracy for Optima's professional encounters.

Table G-19—Data Element Completeness and Accuracy for Professional Encounters—Optima

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	2,975,390	2,975,390	100.0%	2,893,900	2,975,390	97.3%
Header Service From Date	2,975,390	2,975,390	100.0%	2,975,390	2,975,390	100.0%
Header Service To Date	2,975,390	2,975,390	100.0%	2,967,401	2,975,390	99.7%
Detail Service From Date	4,295,803	4,295,803	100.0%	4,295,803	4,295,803	100.0%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Detail Service To Date	4,295,803	4,295,803	100.0%	4,284,564	4,295,803	99.7%
Billing Provider NPI	2,975,390	2,975,390	100.0%	2,952,590	2,975,390	99.2%
Rendering Provider NPI	2,975,390	2,975,390	100.0%	2,952,851	2,975,390	99.2%
Servicing Provider Taxonomy Code	4,295,803	4,295,803	100.0%	2,969,010	4,295,803	69.1%
Referring Provider NPI	0	2,975,390	0.0%	NA	NA	NA
Primary Diagnosis Codes	2,975,390	2,975,390	100.0%	2,975,383	2,975,390	>99.9%
Secondary Diagnosis Codes	749,346	2,975,390	25.2%	2,039,418	2,039,423	>99.9%
CPT/HCPCS Codes	4,295,803	4,295,803	100.0%	4,295,708	4,295,803	>99.9%
CPT/HCPCS Codes with PTP Edits	4,295,803	4,295,803	100.0%	4,294,847	4,295,803	>99.9%
Service Units	4,295,803	4,295,803	100.0%	4,295,803	4,295,803	100.0%
Service Units with MUE Edits	1,103,211	1,103,211	100.0%	1,092,762	1,103,211	99.1%
National Drug Codes	116,462	4,295,803	2.7%	116,388	116,462	>99.9%
HCPCS/NDC Combination	28,138	38,166	73.7%	24,972	28,138	88.7%
MCO Received Date	4,295,803	4,295,803	100.0%	4,295,803	4,295,803	100.0%
MCO Paid Date	4,295,803	4,295,803	100.0%	4,295,803	4,295,803	100.0%
Header Paid Amount	2,975,390	2,975,390	100.0%	2,975,280	2,975,390	>99.9%
Header TPL Paid Amount	460,232	2,975,390	15.5%	459,477	460,232	99.8%
Detail Paid Amount	4,295,803	4,295,803	100.0%	4,295,803	4,295,803	100.0%
Detail TPL Paid Amount	706,827	4,295,803	16.5%	706,827	706,827	100.0%

Table G-20 provides a summary of the field-level completeness and accuracy for Optima's institutional encounters.

Table G-20—Data Element Completeness and Accuracy for Institutional Encounters—Optima

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	246,475	246,475	100.0%	235,146	246,475	95.4%
Header Service From Date	246,475	246,475	100.0%	246,475	246,475	100.0%
Header Service To Date	246,475	246,475	100.0%	246,475	246,475	100.0%
Detail Service From Date	1,242,936	1,242,936	100.0%	1,242,936	1,242,936	100.0%
Detail Service To Date	1,242,936	1,242,936	100.0%	1,242,936	1,242,936	100.0%
Billing Provider NPI	246,475	246,475	100.0%	246,135	246,475	99.9%
Rendering Provider NPI	0	246,475	0.0%	NA	NA	NA
Attending Provider NPI	241,701	246,475	98.1%	241,226	241,701	99.8%
Servicing Provider Taxonomy Code	0	1,242,936	0.0%	0	0	—
Referring Provider NPI	0	246,475	0.0%	NA	NA	NA
Primary Diagnosis Codes	246,475	246,475	100.0%	246,475	246,475	100.0%
Secondary Diagnosis Codes	246,475	246,475	100.0%	1,701,092	1,701,092	100.0%
CPT/HCPCS Codes	963,198	1,242,936	77.5%	942,101	963,198	97.8%
CPT/HCPCS Codes with PTP Edits	963,198	1,242,936	77.5%	941,683	963,198	97.8%
Service Units	1,242,936	1,242,936	100.0%	1,242,936	1,242,936	100.0%
Service Units with MUE Edits	437,167	437,167	100.0%	435,983	437,167	99.7%
Primary Surgical Procedure Codes	8,745	246,475	3.5%	8,735	8,745	99.9%
Secondary Surgical Procedure Codes	4,413	246,475	1.8%	13,872	13,896	99.8%
Revenue Codes	1,242,936	1,242,936	100.0%	1,242,936	1,242,936	100.0%
Diagnosis-Related Groups Codes	12,091	246,475	4.9%	11,973	12,091	99.0%
Type of Bill Codes	246,475	246,475	100.0%	246,475	246,475	100.0%
National Drug Codes	70,019	1,242,936	5.6%	67,239	70,019	96.0%
HCPCS/NDC Combination	58,158	58,162	>99.9%	39,123	58,158	67.3%
MCO Received Date	1,242,936	1,242,936	100.0%	1,242,936	1,242,936	100.0%
MCO Paid Date	1,242,936	1,242,936	100.0%	1,242,936	1,242,936	100.0%
Header Paid Amount	246,475	246,475	100.0%	246,454	246,475	>99.9%
Header TPL Paid Amount	87,419	246,475	35.5%	6,616	87,419	7.6%
Detail Paid Amount	1,242,936	1,242,936	100.0%	1,242,936	1,242,936	100.0%
Detail TPL Paid Amount	633,124	1,242,936	50.9%	633,124	633,124	100.0%

Table G-21 provides a summary of the field-level completeness and accuracy for Optima's pharmacy encounters.

Table G-21—Data Element Completeness and Accuracy for Pharmacy Encounters—Optima

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	1,284,466	1,284,466	100.0%	1,222,204	1,284,466	95.2%
DOS	1,284,466	1,284,466	100.0%	1,284,466	1,284,466	100.0%
Billing Provider NPI	1,284,466	1,284,466	100.0%	1,284,466	1,284,466	100.0%
Prescribing Provider NPI	1,284,466	1,284,466	100.0%	1,284,442	1,284,466	>99.9%
National Drug Codes	1,284,466	1,284,466	100.0%	1,278,238	1,284,466	99.5%
MCO Received Date	1,284,466	1,284,466	100.0%	1,284,466	1,284,466	100.0%
MCO Paid Date	1,284,466	1,284,466	100.0%	1,284,466	1,284,466	100.0%
Header Paid Amount	1,284,466	1,284,466	100.0%	1,284,466	1,284,466	100.0%
Header TPL Paid Amount	62,445	1,284,466	4.9%	62,445	62,445	100.0%

Appendix H. Information Systems Review and Administrative Profile Results for UnitedHealthcare of the Mid-Atlantic, Inc. (United)

Information Systems Review

Table H-1—Acronym/Abbreviation List and Description (Provided by United)

Acronym	Description
TPL	Third-party liability
CMS	Centers for Medicare & Medicaid Services
EOB	Explanation of benefits
EOMB	Explanation of Medicare benefits
CPT	Current procedural terminology
D-SNP	Dual Eligible Special Needs Plans
DMAS	Department of Medical Assistance Services (Commonwealth of Virginia Medicaid)
CSP Facets	Community Strategic Platform (UnitedHealthcare Medicaid claims platform)
NEMIS	National Encounter Management Information System
PPL	Public Partnerships LLC, self-directed home care subcontractor
UHC	UnitedHealthcare
EPS	Encounter Processing System
PDAD	Provider Data Analytics and Delivery

Encounter Data Sources and Systems

Data Sources and Validation Processes

Paper claims are received at the Regional Mail Office (RMO) and converted to electronic 837 format using fine reader OCR software. Prior to encounter data submission to DMAS, encounter data are validated and processed, and an EDI compliance check is carried out. United uses a variety of software to perform these processes. The NEMIS validation and adjustment engine is used to validate all encounter data formats. In addition, Optum Transaction Validation Manager, Version 20.5 is used to validate medical 837P and 837I encounters. NEMIS Extract/Generate is used to generate outbound encounters for submission to DMAS and for encounters submitted to DMAS through 837P and 837I formats, and Optum Transaction Testing Service is used for EDI compliance check.

837P and 837I (medical, vision, nonemergency transportation, PPL, and D-SNP) and NCPDP (pharmacy) encounters are submitted weekly. The percentage of claims submitted by capitated providers is 0 percent for all data sources.

Fields affected by modifications made to encounter data to accommodate DMAS' submission standards as well as created data elements/fields not on claims from providers but required by DMAS are shown in Table H-2.

Table H-2—Data Sources and Field Affected by Modification of Existing Fields and New Field Creation to Accommodate DMAS' Submission Standards

Data Source	Field	Modification Made by	Created Field	Modification Made by
Professional Claims	Member Zip Code – N403	NEMIS	Taxonomy Code	NEMIS
Institutional Claims			Taxonomy Code; Payment Reduction amount – K301	NEMIS
Institutional and Professional Claims			Payment Reduction amount – K301	NEMIS

Validation Performed on Claims

A stratified random sample of claims are pulled weekly for validating claim payment and process adherence. Claims are stratified based on the amount paid of the claim. For both CY 2020 and 2021 through the current year, the percentage of claims validated was 0.03 percent. Payment Integrity Pre-Pay Audit reviews claims for defects over a specific dollar threshold (includes all Medallion and Children's Health Insurance Program [CHIP] and CCC Plus/Long-term Care [LTC]). Prior to final adjudication, if the claim reimbursement amount is greater than $5,000 for a facility claim or $9,000 for a professional claim, the system pends the claim for review. The review will determine if the claim payment is appropriate and release for final adjudication. The audit is conducted on 25 percent of claims that meet threshold.

Automated Field-Level Validation

United performs field-level validation on all encounters it processes:

- ICD-10-CM and ICD-10-Procedure Coding System (PCS) codes are validated against reference tables updated quarterly or annually.
- NDC codes are validated against reference tables updated monthly.
- Provider information (e.g., NPI, taxonomy, DEA) are validated against reference tables updated daily or weekly.

Duplicate, Denied, and Adjusted Claims

Duplicate criteria use date of service, type of service, procedure code, modifier, diagnosis code, units billed, revenue code, place of service, charge, provider, and bill type to identify possible duplicates. Depending on how close the submission is to matching a prior paid claim, the system will either auto-deny or trigger a warning for manual intervention by a processor.

Submission of Partially Denied Claims/Encounters to DMAS

The claim (header) level payment status is sent as paid if any line on the claim was paid and sent as denied if all lines on the claim were denied. The line level payment status is sent as paid if there is a payment made to the provider by United or the member. Otherwise, the line payment status is sent as denied. For pharmacy claim types, a separate point-of-sale reject file is received from the PBM, and all those encounters are submitted as denied to DMAS.

Encounters which require adjustments are identified when the prior version reference number is populated. Adjustment claims are evaluated to determine the status of the original claim and assign the appropriate action of hold for response or submit as a void or replacement. Submitted status flags are updated on each header and detail record when they are included in an encounter submission file. These submitted flags ensure the encounters previously submitted are not resubmitted in a later submission, unless specifically required for a void or replacement submission. If the encounter is identified as having a technical issue, identification to encounter adjustment resubmission usually occurs within 14 days. If a claim needs reprocessing or there is need for a corrected claim from the provider, encounter adjustment usually occurs within 45 to 60 days, but may take up to 90 days. One reason adjustments to encounters that have previously been submitted to DMAS are not submitted is because of delays in getting corrected claims from the provider.

Data Exchange Policies and Procedures

For medical and subcontractors, the frequency of encounter submission to DMAS is weekly. For pharmacy, encounter submissions happen on calendar days 4, 9, 14,19, 24, and 29 of every month. Encounters are submitted directly from United's NEMIS system. Following the claims extracts, all claims passing validations are automatically included in the regularly scheduled encounter submission file for the week using the latest DMAS EDI companion guides and technical manuals. United schedules at minimum a weekly encounter submission of claims processed in the prior week or subcontractor encounters received in the prior week.

Payment Structures of Encounter Data

Table H-3 summarizes how claims are paid.

Table H-3—Claim Payment Methods

Payment Type	Inpatient	Outpatient	Pharmacy	Long-Term Care
CCC Plus				
Percent of Billed	35%	36%		20%
Per Diem	13%	13%		58%
DRG	38%	0%		14%
Other (EAPG)		38%		

Payment Type	Inpatient	Outpatient	Pharmacy	Long-Term Care
CCC Plus				
Other (External Price/Manual)	14%	13%		8%
Other			100% claims for covered prescription services are paid at the lesser of the contracted network AWP discount, MAC, or U&C, plus a dispensing fee.	
Total	**100%**	**100%**	**100%**	**100%**

Bundled Payments

Although there are no bundled payments, United does have a reimbursement policy for maternity/prenatal claims that pay as a bundle. For inpatient encounters, bundled payment paid amounts are reported on the first line; and if the payment is line specific, the paid amount is reported on the applicable line. For outpatient and LTC, bundled payment paid amounts are reported on the first line; and if the payment is line specific, the paid amount is reported on the applicable line. For pharmacy, the payment arrangement is not identifiable as the basis of reimbursement is not requested in the DMAS NCPDP companion guide.

Claims With Third-Party Liability

Medical claims for which a member has insurance in addition to Medicaid are flagged and sent to coordination of benefits with Medicare or other payer. If there is no EOB/EOMB, then the claim is denied. United stores TPL payment information on the line-level of the claims, which is used in adjudication of the final paid claim.

Process to Capture, Monitor Accuracy, and Submit Zero-Paid Claims to DMAS

A zero-paid amount can result from the primary carrier payment being more than the MCO's allowable amount. A zero-paid amount can also result when there is no patient responsibility left by the primary carrier. In both scenarios, the primary carrier's payment is considered payment in full. Zero-paid claims are reflected in the encounter data with a denied status.

Encounter Data Quality Monitoring and Reporting

Table H-4 shows how data provided by a third-party, subcontractor, or provider are monitored for completeness, accuracy, and timeliness.

Table H-4—Measures for Monitoring Encounter Data

Measure	Description
Data From Subcontractors/Third Party	
Completeness	Subcontractor data load monitoring report (tracks historical volume by receipt month and date of service) is used to identify anomalies in claim volume and address with the subcontractor.
Accuracy	The accuracy of the subcontractor encounter data is monitored, starting with verifying all the records received from the subcontractor are loaded upon receipt and all the required fields for encounter submission are received. Encounter rejects are communicated back to the subcontractor to improve the ongoing accuracy of the encounter data. The encounter data received from the subcontractor are used both for encounter submissions and internal operational reporting.
Timeliness	Encounter data received from subcontractors are compared to weekly payment cycle reports to ensure all encounter data are being received in a timely manner from date of payment to be submitted to DMAS within the contractual time frame.
Data from Providers	
Completeness	Reporting exists to ensure all claims adjudicated in the claims system are loaded into the encounter system and for submission to DMAS. This is monitored weekly and monthly to ensure there is no gap between claim system and encounter system data. Providers are responsible for submitting complete data regardless of whether United pays for the service on a FFS basis through submission of a claim or if the service is covered under a capitation agreement, where the provider submits the record as an encounter. All providers are required to submit zero-paid claims, including COB claims or claims covered under capitation, which process through United's claims system and are subject to the same edits and validations as FFS claims. General data validation is applied to the claims during the load process to ensure all the HIPAA-required fields are present and in the correct data format. Encounters failing these edits are bypassed with an error reason for manual review.
Accuracy	CSP Facets has an automated provider selection based on specific criteria (e.g., Tax ID, NPI, provider type, City/State match). CSP Facets also has a warning message that prompts the claims examiner to review provider data manually.

Measure	Description
	All providers billed on a claim are captured and stored in the NEMIS "As-Submitted" provider tables. These tables capture the provider data exactly as it was received on the claim and sent to the Commonwealth of Virginia on the encounter files as such. Data captured include both primary and secondary providers at line and document levels. The encounters failing validation are reviewed by the dedicated encounter business analyst by researching original claim submissions from the provider, the claim system, and subcontractors as potential sources. DMAS encounter edits are reviewed weekly to identify data quality issues for resolution.
Timeliness	United schedules at minimum a weekly encounter submission of claims processed in the prior week or subcontractor encounters received in the prior week. The weekly encounter submission timeliness report is monitored by the encounter business analyst to identify any claim types that are aging and need additional work to ensure they are submitted in a timely manner. This process ensures timely encounter submissions, submitted within 30 days of the day the health plan pays the claim.

Average rejection/pend rate for claim/encounter types:

- Zero percent of encounters submitted to DMAS are rejected by DMAS' EDI translator.
- Overall, up to 0.5 percent of encounters submitted to DMAS pass the EDI translator but fail the EPS business rules, with the highest rate reported for professional claims—0.8 percent.

Encounters that fail the EPS business rules are flagged for review, and new claims are generated for submission within 24 hours. Encounters from subcontractors are shared with the subcontractor to identify claim payment changes needed to prevent future rejections.

With respect to usage of data in the encounter data system/data warehouse, significant data analytics is performed with the data warehouse tool. Activities included but are not limited to the following:

- Identification of member "gaps in care"
- Identification of members with chronic conditions
- Stratification/Risk assessment of members
- Clinical review
- Medical trend review
- Post-payment payment integrity
- Enrollment analysis
- Financial review
- Process improvement program outcomes analysis

- Rate setting review
- Health Equity analysis
- Medication adherence
- Actuarial analysis

Neither internal nor external challenges have been identified with submitting encounter data to DMAS.

There are no changes or additional resources needed from DMAS at this time, and there will be no upcoming changes to the encounter submission process.

Administrative Profile

This section provides administrative analysis results for United by claim type.

Encounter Data Completeness

Table H-5 provides encounter data volume results for United's professional encounters.

Table H-5—Encounter Volume—Professional Encounters—United

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	111,481	27,745	4,018.1
February 2020	101,514	27,686	3,666.6
March 2020	100,746	27,755	3,629.8
April 2020	90,940	28,131	3,232.7
May 2020	95,789	28,744	3,332.5
June 2020	100,813	29,032	3,472.5
July 2020	106,137	29,297	3,622.8
August 2020	100,717	30,074	3,349.0
September 2020	108,762	30,346	3,584.1
October 2020	114,710	30,520	3,758.5
November 2020	108,807	30,958	3,514.7
December 2020	109,055	31,279	3,486.5

Table H-6 provides encounter data volume results for United's institutional encounters.

Table H-6—Encounter Volume—Institutional Encounters—United

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	12,042	27,745	434.0
February 2020	11,351	27,686	410.0
March 2020	9,954	27,755	358.6
April 2020	7,542	28,131	268.1
May 2020	8,688	28,744	302.3
June 2020	9,719	29,032	334.8
July 2020	10,225	29,297	349.0
August 2020	10,420	30,074	346.5
September 2020	10,506	30,346	346.2
October 2020	11,197	30,520	366.9
November 2020	10,491	30,958	338.9
December 2020	10,559	31,279	337.6

Table H-7 provides encounter data volume results for United's pharmacy encounters.

Table H-7—Encounter Volume—Pharmacy Encounters—United

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	48,509	27,745	1,748.4
February 2020	45,096	27,686	1,628.8
March 2020	51,436	27,755	1,853.2
April 2020	46,641	28,131	1,658.0
May 2020	43,550	28,744	1,515.1
June 2020	44,189	29,032	1,522.1
July 2020	44,664	29,297	1,524.5
August 2020	42,403	30,074	1,410.0
September 2020	43,254	30,346	1,425.4
October 2020	44,050	30,520	1,443.3
November 2020	41,958	30,958	1,355.3
December 2020	44,611	31,279	1,426.2

Table H-8 provides paid amount and TPL amount results for United's professional encounters.

Table H-8—Paid Amount and TPL Amount—Professional Encounters—United

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	14,416,334	519.6	1,426,189	51.4
February 2020	13,510,438	488.0	1,562,948	56.5
March 2020	13,696,073	493.5	1,481,817	53.4
April 2020	12,829,867	456.1	1,269,154	45.1
May 2020	13,774,831	479.2	1,463,173	50.9
June 2020	14,173,262	488.2	1,728,708	59.5
July 2020	15,445,950	527.2	1,834,972	62.6
August 2020	14,966,982	497.7	1,749,194	58.2
September 2020	14,365,041	473.4	1,952,308	64.3
October 2020	15,362,801	503.4	1,944,471	63.7
November 2020	14,762,527	476.9	1,704,387	55.1
December 2020	15,087,663	482.4	1,908,158	61.0

Table H-9 provides paid amount and TPL amount results for United's institutional encounters.

Table H-9—Paid Amount and TPL Amount—Institutional Encounters—United

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	19,856,413	715.7	8,386,039	302.3
February 2020	18,185,456	656.8	8,777,796	317.0
March 2020	19,553,639	704.5	8,326,495	300.0
April 2020	17,902,914	636.4	6,384,832	227.0
May 2020	18,202,043	633.2	6,893,575	239.8
June 2020	18,808,206	647.8	7,414,762	255.4
July 2020	22,105,588	754.5	8,683,010	296.4
August 2020	21,773,459	724.0	7,266,960	241.6
September 2020	20,659,697	680.8	7,448,974	245.5
October 2020	22,406,343	734.2	9,146,433	299.7

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
November 2020	20,618,908	666.0	7,905,595	255.4
December 2020	23,272,200	744.0	9,137,243	292.1

Table H-10 provides paid amount and TPL amount results for United's pharmacy encounters.

Table H-10—Paid Amount and TPL Amount—Pharmacy Encounters—United

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	4,491,444	161.9	177,806	6.4
February 2020	4,160,932	150.3	219,676	7.9
March 2020	4,960,605	178.7	297,363	10.7
April 2020	4,865,060	172.9	245,134	8.7
May 2020	4,670,539	162.5	220,991	7.7
June 2020	4,691,729	161.6	228,074	7.9
July 2020	4,857,774	165.8	243,239	8.3
August 2020	4,519,900	150.3	184,086	6.1
September 2020	4,673,930	154.0	174,318	5.7
October 2020	4,777,089	156.5	184,452	6.0
November 2020	4,771,450	154.1	205,561	6.6
December 2020	5,120,567	163.7	166,065	5.3

Table H-11 provides the percentage of duplicate encounters for all three encounters.

Table H-11—Percentage of Duplicate Encounters—United

Claim Type	Total Records	Number of Duplicate Records	Percent of Duplicates
Professional Encounters	2,121,521	4,559	0.2%
Institutional Encounters	534,196	3,530	0.7%
Pharmacy Encounters	540,929	27	<0.1%

Encounter Data Timeliness

Table H-12 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for United's professional encounters.

Table H-12—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Professional Encounters—United

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	99.8%	99.9%	99.9%	99.9%	100.0%
February 2020	99.8%	99.9%	99.9%	100.0%	100.0%
March 2020	99.8%	99.8%	99.9%	99.9%	100.0%
April 2020	99.9%	99.9%	100.0%	100.0%	100.0%
May 2020	99.4%	99.6%	100.0%	100.0%	100.0%
June 2020	99.9%	99.9%	100.0%	100.0%	100.0%
July 2020	99.7%	99.8%	99.8%	99.8%	99.8%
August 2020	99.5%	99.6%	99.6%	99.6%	99.6%
September 2020	90.0%	99.1%	99.6%	99.6%	99.8%
October 2020	93.8%	99.6%	99.6%	99.7%	99.7%
November 2020	99.6%	99.6%	99.8%	99.8%	99.8%
December 2020	99.6%	99.7%	99.8%	99.8%	99.8%
January 2021	99.7%	99.7%	99.7%	99.8%	100.0%
February 2021	89.0%	99.6%	99.6%	100.0%	100.0%
March 2021	87.1%	99.7%	100.0%	100.0%	100.0%
April 2021	99.6%	99.9%	100.0%	100.0%	100.0%
May 2021	99.9%	100.0%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table H-13 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for United's institutional encounters.

Table H-13—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Institutional Encounters—United

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	100.0%	100.0%	100.0%	100.0%	100.0%
February 2020	100.0%	100.0%	100.0%	100.0%	100.0%
March 2020	100.0%	100.0%	100.0%	100.0%	100.0%
April 2020	100.0%	100.0%	100.0%	100.0%	100.0%
May 2020	100.0%	100.0%	100.0%	100.0%	100.0%
June 2020	100.0%	100.0%	100.0%	100.0%	100.0%
July 2020	98.9%	98.9%	98.9%	99.0%	99.0%
August 2020	96.0%	96.0%	96.1%	96.1%	96.1%
September 2020	95.5%	95.5%	95.5%	95.5%	95.5%
October 2020	95.6%	95.7%	95.7%	95.7%	95.7%
November 2020	94.9%	95.0%	95.0%	95.0%	95.0%
December 2020	95.2%	95.2%	95.2%	95.2%	97.0%
January 2021	97.0%	97.0%	97.0%	97.5%	100.0%
February 2021	97.6%	97.6%	98.1%	100.0%	100.0%
March 2021	96.8%	98.0%	100.0%	100.0%	100.0%
April 2021	98.2%	100.0%	100.0%	100.0%	100.0%
May 2021	100.0%	100.0%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table H-14 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for United's pharmacy encounters.

Table H-14—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Pharmacy Encounters—United

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	97.8%	97.8%	97.8%	97.8%	97.8%
February 2020	38.1%	38.1%	38.1%	38.1%	38.1%
March 2020	0.7%	0.7%	0.7%	0.7%	0.7%
April 2020	0.7%	0.7%	0.7%	0.7%	0.7%
May 2020	0.8%	0.8%	0.8%	0.8%	0.8%
June 2020	39.3%	39.3%	39.3%	39.3%	39.3%
July 2020	0.3%	0.4%	0.4%	0.4%	0.4%
August 2020	0.3%	0.3%	0.3%	0.3%	0.3%
September 2020	0.7%	0.7%	0.7%	0.7%	0.7%
October 2020	0.9%	0.9%	0.9%	0.9%	0.9%
November 2020	1.6%	1.6%	1.6%	1.6%	2.0%
December 2020	0.5%	0.5%	0.5%	0.9%	2.5%
January 2021	0.2%	0.2%	0.3%	2.3%	2.3%
February 2021	0.1%	0.1%	0.5%	0.5%	0.5%
March 2021	0.0%	0.6%	0.6%	0.6%	0.6%
May 2021	56.0%	56.0%	56.0%	56.0%	56.0%

Table H-15 provides lag triangles for United's professional encounters. Additional details provided include MM and claims PMPM.

Table H-15—Encounters Lag Triangle—Professional Encounters—United

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	24,390												24,390
202002	75,551	17,488											93,039
202003	12,096	75,818	24,539										112,453
202004	2,594	7,838	66,795	16,051									93,278
202005	3,260	4,626	9,526	70,285	28,284								115,981
202006	853	1,235	4,279	6,088	61,538	25,178							99,171
202007	471	568	963	2,464	6,478	57,331	24,475						92,750
202008	487	607	949	1,384	3,525	19,265	78,163	28,623					133,003
202009	232	288	447	653	1,006	2,174	6,408	68,365	15,868				95,441
202010	372	375	460	486	784	1,611	4,413	8,878	67,555	18,503			103,437
202011	213	315	431	589	786	1,008	1,599	2,794	31,727	92,566	24,459		156,487
202012	166	169	249	369	495	583	790	1,250	2,425	9,339	78,709	20,157	114,701
202101	271	188	207	218	748	963	1,346	977	2,366	3,685	12,825	86,814	110,608
202102	54	137	144	154	150	180	271	463	659	1,145	2,019	6,733	12,109
202103	23	101	158	159	158	299	388	500	891	1,373	1,665	4,449	10,164
202104	55	37	72	204	218	269	224	350	618	1,244	1,273	2,086	6,650
202105	23	19	31	37	215	336	277	280	402	662	622	913	3,817
202106	136	124	196	306	296	351	713	692	814	852	956	1,041	6,477
202107			2		5	7	39	21	40	53	76	98	341
Total	121,247	109,933	109,448	99,447	104,686	109,555	119,106	113,193	123,365	129,422	122,604	122,291	1,384,297
MM	27,745	27,686	27,755	28,131	28,744	29,032	29,297	30,074	30,346	30,520	30,958	31,279	351,567
PMPM	**4.370**	**3.971**	**3.943**	**3.535**	**3.642**	**3.774**	**4.065**	**3.764**	**4.065**	**4.241**	**3.960**	**3.910**	**3.937**

Table H-16 provides lag triangles for United's institutional encounters. Additional details provided include MM and claims PMPM.

Table H-16—Encounters Lag Triangle—Institutional Encounters—United

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	1,619												1,619
202002	7,016	1,304											8,320
202003	1,926	6,984	1,183										10,093
202004	630	1,780	6,059	475									8,944
202005	335	514	1,902	5,339	1,088								9,178
202006	166	162	226	1,008	5,298	1,087							7,947
202007	187	188	236	316	1,501	6,995	1,326						10,749
202008	138	134	148	171	280	935	6,111	1,329					9,246
202009	106	131	131	115	134	268	1,585	6,070	914				9,454
202010	48	76	81	90	118	231	390	1,865	7,391	1,499			11,789
202011	74	78	77	66	70	125	209	309	1,120	6,949	1,348		10,425
202012	45	53	58	75	94	97	135	155	263	1,341	6,215	961	9,492
202101	44	32	20	27	31	61	80	121	203	410	1,905	7,386	10,320
202102	47	57	68	72	85	85	88	106	134	194	341	1,291	2,568
202103	34	28	23	34	36	43	52	73	89	136	184	381	1,113
202104	29	20	25	29	44	48	65	73	113	149	141	218	954
202105	15	21	24	28	28	37	493	606	582	636	625	574	3,669
202106	24	62	49	37	31	51	81	90	128	133	123	143	952
202107	2	3	6	3	4	17	21	17	13	33	15	17	151
Total	12,485	11,627	10,316	7,885	8,842	10,080	10,636	10,814	10,950	11,480	10,897	10,971	126,983
MM	27,745	27,686	27,755	28,131	28,744	29,032	29,297	30,074	30,346	30,520	30,958	31,279	351,567
PMPM	**0.450**	**0.420**	**0.372**	**0.280**	**0.308**	**0.347**	**0.363**	**0.360**	**0.361**	**0.376**	**0.352**	**0.351**	**0.362**

Table H-17 provides lag triangles for United's pharmacy encounters. Additional details provided include MM and claims PMPM.

Table H-17—Encounters Lag Triangle—Pharmacy Encounters—United

	Service Month												
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	36,252												36,252
202002	10,673	36,670											47,343
202003	494	6,976	39,871										47,341
202004	92	420	10,022	36,216									46,750
202005	24	87	455	9,025	32,410								42,001
202006	11	39	62	429	9,706	35,278							45,525
202007	6	6	31	60	547	7,373	33,673						41,696
202008		14	35	20	67	570	9,528	32,708					42,942
202009			4	12	16	71	548	8,156	34,071				42,878
202010				4	1	11	37	571	7,585	32,777			40,986
202011					7	11	12	63	635	9,813	34,873		45,414
202012							5	18	59	455	5,565	33,701	39,803
202101	1			1	1	6	4	23	47	80	578	9,300	10,041
202102								2	13	31	71	555	672
202103				1					1	13	40	136	191
202104	961	878	1,061	959	858	955	941	890	841	876	821	884	10,925
202105	11	14	12	12	12	8	11	7	9	11	17	37	161
202106	1	1	1	1	2	2							8
Total	48,526	45,105	51,554	46,740	43,627	44,285	44,759	42,438	43,261	44,056	41,965	44,613	540,929
MM	27,745	27,686	27,755	28,131	28,744	29,032	29,297	30,074	30,346	30,520	30,958	31,279	351,567
PMPM	**1.749**	**1.629**	**1.857**	**1.662**	**1.518**	**1.525**	**1.528**	**1.411**	**1.426**	**1.444**	**1.356**	**1.426**	**1.544**

Field-Level Completeness and Accuracy

Table H-18 provides a summary of the field-level completeness and accuracy for United's professional encounters.

Table H-18—Data Element Completeness and Accuracy for Professional Encounters—United

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	1,384,297	1,384,297	100.0%	1,351,489	1,384,297	97.6%
Header Service From Date	1,384,297	1,384,297	100.0%	1,384,297	1,384,297	100.0%
Header Service To Date	1,384,297	1,384,297	100.0%	1,384,297	1,384,297	100.0%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Detail Service From Date	2,121,521	2,121,521	100.0%	2,121,521	2,121,521	100.0%
Detail Service To Date	2,121,521	2,121,521	100.0%	2,121,521	2,121,521	100.0%
Billing Provider NPI	1,384,297	1,384,297	100.0%	1,384,161	1,384,297	>99.9%
Rendering Provider NPI	1,384,297	1,384,297	100.0%	1,384,074	1,384,297	>99.9%
Servicing Provider Taxonomy Code	2,121,521	2,121,521	100.0%	2,117,038	2,121,521	99.8%
Referring Provider NPI	294,292	1,384,297	21.3%	287,935	294,292	97.8%
Primary Diagnosis Codes	1,384,297	1,384,297	100.0%	1,384,297	1,384,297	100.0%
Secondary Diagnosis Codes	329,332	1,384,297	23.8%	871,397	871,416	>99.9%
CPT/HCPCS Codes	2,121,521	2,121,521	100.0%	2,121,507	2,121,521	>99.9%
CPT/HCPCS Codes with PTP Edits	2,121,521	2,121,521	100.0%	2,121,414	2,121,521	>99.9%
Service Units	2,121,521	2,121,521	100.0%	2,121,521	2,121,521	100.0%
Service Units with MUE Edits	450,260	450,260	100.0%	441,435	450,260	98.0%
National Drug Codes	71,436	2,121,521	3.4%	71,264	71,436	99.8%
HCPCS/NDC Combination	16,513	16,955	97.4%	13,404	16,513	81.2%
MCO Received Date	2,121,521	2,121,521	100.0%	2,121,521	2,121,521	100.0%
MCO Paid Date	2,121,521	2,121,521	100.0%	2,121,521	2,121,521	100.0%
Header Paid Amount	1,384,297	1,384,297	100.0%	1,384,297	1,384,297	100.0%
Header TPL Paid Amount	180,902	1,384,297	13.1%	151,403	180,902	83.7%
Detail Paid Amount	2,121,521	2,121,521	100.0%	2,121,521	2,121,521	100.0%
Detail TPL Paid Amount	247,942	2,121,521	11.7%	247,942	247,942	100.0%

Table H-19 provides a summary of the field-level completeness and accuracy for United's institutional encounters.

Table H-19—Data Element Completeness and Accuracy for Institutional Encounters—United

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	126,983	126,983	100.0%	122,313	126,983	96.3%
Header Service From Date	126,983	126,983	100.0%	126,983	126,983	100.0%
Header Service To Date	126,983	126,983	100.0%	126,983	126,983	100.0%
Detail Service From Date	534,196	534,196	100.0%	534,196	534,196	100.0%
Detail Service To Date	534,196	534,196	100.0%	534,196	534,196	100.0%
Billing Provider NPI	126,983	126,983	100.0%	126,977	126,983	>99.9%
Rendering Provider NPI	221	126,983	0.2%	221	221	100.0%
Attending Provider NPI	126,936	126,983	>99.9%	126,194	126,936	99.4%
Servicing Provider Taxonomy Code	292,054	534,196	54.7%	256,055	292,054	87.7%
Referring Provider NPI	2,413	126,983	1.9%	2,373	2,413	98.3%
Primary Diagnosis Codes	126,983	126,983	100.0%	126,983	126,983	100.0%
Secondary Diagnosis Codes	126,983	126,983	100.0%	1,140,251	1,140,254	>99.9%
CPT/HCPCS Codes	338,177	534,196	63.3%	315,104	338,177	93.2%
CPT/HCPCS Codes with PTP Edits	338,177	534,196	63.3%	314,483	338,177	93.0%
Service Units	534,196	534,196	100.0%	534,196	534,196	100.0%
Service Units with MUE Edits	148,710	148,710	100.0%	148,401	148,710	99.8%
Primary Surgical Procedure Codes	5,257	126,983	4.1%	5,250	5,257	99.9%
Secondary Surgical Procedure Codes	2,988	126,983	2.4%	9,400	9,410	99.9%
Revenue Codes	534,196	534,196	100.0%	534,196	534,196	100.0%
Diagnosis-Related Groups Codes	6,405	126,983	5.0%	6,394	6,405	99.8%
Type of Bill Codes	126,983	126,983	100.0%	126,983	126,983	100.0%
National Drug Codes	32,659	534,196	6.1%	32,218	32,659	98.6%
HCPCS/NDC Combination	21,496	21,498	>99.9%	14,177	21,496	66.0%
MCO Received Date	534,196	534,196	100.0%	534,196	534,196	100.0%
MCO Paid Date	534,196	534,196	100.0%	534,196	534,196	100.0%
Header Paid Amount	126,983	126,983	100.0%	126,983	126,983	100.0%
Header TPL Paid Amount	45,709	126,983	36.0%	33,600	45,709	73.5%
Detail Paid Amount	534,196	534,196	100.0%	534,196	534,196	100.0%
Detail TPL Paid Amount	242,981	534,196	45.5%	242,981	242,981	100.0%

Table H-20 provides a summary of the field-level completeness and accuracy for United's pharmacy encounters.

Table H-20—Data Element Completeness and Accuracy for Pharmacy Encounters—United

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	540,929	540,929	100.0%	514,052	540,929	95.0%
DOS	540,929	540,929	100.0%	540,929	540,929	100.0%
Billing Provider NPI	540,929	540,929	100.0%	540,929	540,929	100.0%
Prescribing Provider NPI	540,929	540,929	100.0%	540,925	540,929	>99.9%
National Drug Codes	540,929	540,929	100.0%	539,167	540,929	99.7%
MCO Received Date	540,929	540,929	100.0%	540,929	540,929	100.0%
MCO Paid Date	540,929	540,929	100.0%	540,929	540,929	100.0%
Header Paid Amount	540,929	540,929	100.0%	540,929	540,929	100.0%
Header TPL Paid Amount	38,982	540,929	7.2%	38,982	38,982	100.0%

Appendix I. Information Systems Review and Administrative Profile Results for Virginia Premier Health Plan, Inc. (VA Premier)

Information Systems Review

Table I-1—Acronym/Abbreviation List and Description (Provided by VA Premier)

Acronym	Description
CAP	Claims Adjudication Platform
DMAS	Department of Medical Assistance Services
EDI	Electronic data interchange
SFTP	Secure file transfer protocol
NCPDP	National Council for Prescription Drug Programs
EDM	Encounter data manager
SET	Southeast Transportation
VPHP	Virginia Premier Health Plan

Encounter Data Sources and Systems

Data Sources and Validation Processes

Prior to encounter data submission to DMAS, encounter data are validated and processed, and an EDI compliance check is carried out. VA Premier uses several software applications to complete these processes.

The EDM tool is used to validate encounter data, generate/prepare outbound encounters for submission to DMAS, and perform EDI compliance checks on encounters submitted to DMAS through 837P and 837I formats for the vast majority of the encounter types. In addition to the EDM tool and its resources, DMAS' EDI Check is also used to generate outbound encounters (consumer directed) for submission to DMAS and to complete for EDI compliance checks. Finally, Facets I and EDM are also used for data validation and encounter processing.

Frequency of receipt for data sources (i.e., all data received that are included in the encounter data submissions to DMAS) range from as frequently as biweekly (consumer directed) to weekly (medical 837P and 837I, pharmacy, and nonemergency transportation), or even bimonthly (vision encounters).

All professional and institutional claims were paid to providers as FFS, while all claims for pharmacy, vision, nonemergency transportation, consumer directed services, and Kaiser Permanente were capitated.

Table I-2 shows fields modified to accommodate DMAS' submission standards.

Table I-2—Data Sources and Fields Affected by Modification of Existing Fields and New Field Creation to Accommodate DMAS' Submission Standards

Data Source	Field	Modification Made by	Created Field	Modification Made by
Subcontractor ID	Interchange Sender ID and Application Sender's Code	MCO/ Subcontractors	NA	NA
Professional and Institutional Claims	2300-Claim information – K3 Segment	MCO	NA	NA
All Claims	NA	NA	ZIP Code; Member Demographic	MCO
All Claims	NA	NA	2300 Claim Information K3-File Information	MCO/ Subcontractors

A 1 percent stratified random sample of medical and behavioral health claims is reviewed weekly, one sample each for manually processed claims and auto-adjudicated claims. The review includes member demographic information, provider information, dates of service, charges, CPT codes, HCPCS, diagnosis codes, place of service, units of service, referring provider, and attending provider.

Field mapping and automated validation

Claims data are mapped and validated at two points in processing:

1. Prior to adjudication for payment
2. During processing for submission to DMAS

During the first stage, the provider enrollment file is used as a reference table for processing and validating rendering and billing provider NPIs and Taxpayer Identification Number (TIN). The member enrollment file is used to validate member name and IDs. QNXT reference tables are used to validate condition, patient status, place of service, revenue codes, admission source, provider taxonomy, bill type, type of service, procedure, diagnosis, occurrence, and modifier codes. Reference tables are updated on a schedule according to federal guidance.

For mapping performed during data processing for submission to DMAS, the source of reference table for 2010BB-Payer Name, CR1- ambulance transport information, and 2400-Service Line (transportation claims) is the DMAS companion guide, and the reference tables are updated as they are available. The EDM tool is the source of reference table for filing indicator, and frequency of updating the reference table is as needed for coordination of benefits.

Duplicate Claims

To identify duplicate claims, the system evaluates incoming claims at the beginning of the adjudication process. A claim or claim line is denied as a duplicate if the comparison to historical claim matches:

- Same member, same date of service, same service code, same modifier, and same rendering physician.
- Same member, same date of service, same service code, same modifier, same pay to provider, and same rendering physician.

Environmental claims are not submitted to DMAS because the companies rendering the service do not have an NPI number (e.g., building access ramps to a member's home or claims paid to the member).

Denied and partially denied claims are submitted to DMAS the same way that paid claims are submitted. These claims go through internal checks to ensure compliance.

Data Exchange Policies and Procedures

Policies and procedures are reviewed on a continuous basis (biweekly/quarterly), and meetings are held with internal teams, CTS developers, and subcontractors to ensure contractual obligations are being followed and policies and procedures are enforced. VPHP addresses DMAS-communicated issues within 30 calendar days from notification. Encounter certifications are submitted monthly, summarizing all accepted encounters for the prior calendar month.

Payment Structures of Encounter Data

Table I-3 shows a summary of how claims are paid.

Table I-3—Claim Payment Methods

Payment Type	Inpatient	Outpatient	Pharmacy	Long Term Care
CCC Plus				
Line-by-Line		61.64%	99%	25.58%
Per Diem	5.40%	<1.00%		0.65%
DRG	93.60%			<1.00%
Negotiated (Flat) Rate	1.00%		1%	40.31%
Other (SNF [Resource Utilization Grouper-RUG])				32.46%
Other (OP-EAPG)		37.36%		
Total	**100%**	**100%**	**100%**	**100%**

Inpatient, outpatient, and LTC claims are included on standard encounter data submissions. There are no specific indicators to identify inpatient claims separate from other medical claims.

VA Premier uses the DMAS bundled payment methodology for reimbursement of obstetrical services (OB). The methodology is intended to provide a flat fee post-delivery for various professional services rendered through postpartum.

Third-Party Liability

The VPHP contracts with third-party subcontractors to identify and/or recover overpayments related to COB/TPL. Overpayments are recovered from commercial payers in instances where VPHP paid inappropriately as primary.

VPHP collects other insurance data from several sources: unverified other coverage information sourced by DMAS via the 834; TPL verification based on other coverage information received on an EOB from the primary payer; and TPL information sourced by HMS, a third-party subcontractor. VA Premier is currently working to engage with another third-party subcontractor, Syrtis, which performs a process similar to HMS' process.

VPHP uses subcontractors to data mine all paid claims to determine if the claims were paid appropriately within the context of COB. HMS mines medical and pharmacy claims, and determines if the members have other coverage for the dates of service.

Zero-Paid Claims

Claims with a payment amount of $0.00 are created under the following scenarios:

- Any clam wherein Medicaid is not the primary insurer if the primary insurance has paid in full
- Services that are already included in a bundled payment
- Improper billing

Encounter Data Quality Monitoring and Reporting

Acceptance rates for encounters are monitored weekly. VA Premier's EDI clearinghouse verifies that all claims submitted by providers are HIPAA compliant.

For data monitoring for completeness, accuracy, and timeliness, no metrics reports have been created at this time for data from subcontractors/third parties or providers.

Average rejection/pend rates for claim/encounter types are listed in Table I-4.

Table I-4—Average Rejection /Pend Rate for Different Claims/Encounter Types

Claim/Encounter	Percentage of Encounters Submitted to DMAS That are Rejected by DMAS' EDI Translator	Percentage of Encounters Submitted to DMAS That Pass EDI Translator but Fail the EPS Business Rules
Institutional	*Managed Long Term Services and Supports (MLTSS): less than 1%*	*MLTSS: 8%*
Professional	*MLTSS: less than 1%*	*MLTSS: less than 2%*

Claim/Encounter	Percentage of Encounters Submitted to DMAS That are Rejected by DMAS' EDI Translator	Percentage of Encounters Submitted to DMAS That Pass EDI Translator but Fail the EPS Business Rules
Pharmacy	*MLTSS: less than 1%*	*MLTSS: less than 1%*
SET	*No production submissions have occurred. This subcontractor is still in the Testing/ Approval stage with DMAS.*	*No production submissions have occurred. This subcontractor is still in the Testing/ Approval stage with DMAS.*
Vision	*MLTSS: less than 1%*	*MLTSS: less than 1%*
Consumer Directed	*MLTSS: less than 1%*	*MLTSS: less than 1%*

Challenges

One internal challenge VA Premier faced in submitting encounter data to DMAS is the turnaround time of EDM developers implementing necessary changes to comply with DMAS' changes or updates.

External challenges include DMAS' delay in getting NDCs loaded into its system and the system's inability to allow a replacement claim to correct a previously submitted claim that may have failed for any number of reasons. In addition, VA Premier indicated wanting to receive the encounter data quality scorecard in a timely manner. VA Premier also indicated it would be helpful to know why specific NDCs are not being added to the background tables and why DMAS is behind in adding ICD and procedure code updates into DMAS' system.

Administrative Profile

This section provides administrative analysis results for VA Premier by claim type.

Encounter Data Completeness

Table I-5 provides encounter data volume results for VA Premier's professional encounters.

Table I-5—Encounter Volume—Professional Encounters—VA Premier

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	265,599	46,696	5,687.8
February 2020	247,553	46,583	5,314.2
March 2020	246,371	46,613	5,285.5
April 2020	220,138	47,056	4,678.2
May 2020	233,297	47,631	4,898.0
June 2020	244,290	47,836	5,106.8
July 2020	253,072	47,982	5,274.3
August 2020	251,408	48,135	5,223.0
September 2020	261,292	48,172	5,424.1
October 2020	272,429	48,463	5,621.4
November 2020	251,888	48,551	5,188.1
December 2020	256,980	48,661	5,281.0

Table I-6 provides encounter data volume results for VA Premier's institutional encounters.

Table I-6—Encounter Volume—Institutional Encounters—VA Premier

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	22,896	46,696	490.3
February 2020	21,645	46,583	464.7
March 2020	18,589	46,613	398.8
April 2020	13,470	47,056	286.3
May 2020	16,623	47,631	349.0
June 2020	19,285	47,836	403.1
July 2020	20,548	47,982	428.2
August 2020	19,792	48,135	411.2

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
September 2020	20,052	48,172	416.3
October 2020	20,873	48,463	430.7
November 2020	19,095	48,551	393.3
December 2020	18,662	48,661	383.5

Table I-7 provides encounter data volume results for VA Premier's pharmacy encounters.

Table I-7—Encounter Volume—Pharmacy Encounters—VA Premier

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
January 2020	152,474	46,696	3,265.2
February 2020	141,993	46,583	3,048.2
March 2020	160,330	46,613	3,439.6
April 2020	146,113	47,056	3,105.1
May 2020	135,976	47,631	2,854.8
June 2020	137,759	47,836	2,879.8
July 2020	145,483	47,982	3,032.0
August 2020	142,231	48,135	2,954.8
September 2020	137,079	48,172	2,845.6
October 2020	137,140	48,463	2,829.8
November 2020	128,729	48,551	2,651.4
December 2020	134,190	48,661	2,757.6

Table I-8 provides paid amount and TPL amount results for VA Premier's professional encounters.

Table I-8—Paid Amount and TPL Amount—Professional Encounters—VA Premier

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	33,191,454	710.8	2,428,912	52.0
February 2020	30,966,746	664.8	2,640,070	56.7
March 2020	30,964,793	664.3	2,444,577	52.4
April 2020	27,426,296	582.8	2,040,327	43.4
May 2020	29,833,180	626.3	2,340,368	49.1
June 2020	29,599,926	618.8	2,475,965	51.8
July 2020	32,462,644	676.6	2,114,952	44.1

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
August 2020	31,941,292	663.6	2,504,996	52.0
September 2020	30,806,147	639.5	2,677,785	55.6
October 2020	32,384,592	668.2	2,801,514	57.8
November 2020	30,128,308	620.5	2,557,553	52.7
December 2020	30,584,046	628.5	2,578,118	53.0

Table I-9 provides paid amount and TPL amount results for VA Premier's institutional encounters.

Table I-9—Paid Amount and TPL Amount—Institutional Encounters—VA Premier

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	30,508,635	653.3	1,828,624	39.2
February 2020	27,924,427	599.5	1,879,311	40.3
March 2020	29,057,166	623.4	1,720,502	36.9
April 2020	23,571,251	500.9	1,493,225	31.7
May 2020	25,362,761	532.5	1,695,653	35.6
June 2020	30,275,612	632.9	2,076,648	43.4
July 2020	30,488,408	635.4	2,519,674	52.5
August 2020	30,469,044	633.0	2,530,433	52.6
September 2020	29,794,376	618.5	3,012,612	62.5
October 2020	30,862,230	636.8	3,736,075	77.1
November 2020	28,100,201	578.8	3,742,395	77.1
December 2020	28,643,596	588.6	3,949,437	81.2

Table I-10 provides paid amount and TPL amount results for VA Premier's pharmacy encounters.

Table I-10—Paid Amount and TPL Amount—Pharmacy Encounters—VA Premier

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
January 2020	13,916,300	298.0	320,371	6.9
February 2020	13,317,531	285.9	251,103	5.4
March 2020	15,750,782	337.9	180,217	3.9
April 2020	14,665,852	311.7	176,898	3.8
May 2020	13,812,022	290.0	159,950	3.4
June 2020	14,084,829	294.4	135,560	2.8
July 2020	14,658,807	305.5	107,965	2.3
August 2020	14,418,639	299.5	96,512	2.0
September 2020	13,912,547	288.8	96,708	2.0
October 2020	14,265,330	294.4	100,384	2.1
November 2020	13,340,381	274.8	98,473	2.0
December 2020	14,849,530	305.2	106,007	2.2

Table I-11 provides the percentage of duplicate encounters for all three encounters.

Table I-11—Percentage of Duplicate Encounters—VA Premier

Claim Type	Total Records	Number of Duplicate Records	Percent of Duplicates
Professional Encounters	5,403,182	137,478	2.5%
Institutional Encounters	1,619,766	31,687	2.0%
Pharmacy Encounters	1,700,589	1	<0.1%

Encounter Data Timeliness

Table I-12 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for VA Premier's professional encounters.

Table I-12—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Professional Encounters—VA Premier

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	99.8%	100.0%	100.0%	100.0%	100.0%
February 2020	100.0%	100.0%	100.0%	100.0%	100.0%
March 2020	96.2%	96.2%	99.9%	99.9%	99.9%
April 2020	100.0%	100.0%	100.0%	100.0%	100.0%
May 2020	100.0%	100.0%	100.0%	100.0%	100.0%
June 2020	100.0%	100.0%	100.0%	100.0%	100.0%
July 2020	100.0%	100.0%	100.0%	100.0%	100.0%
August 2020	100.0%	100.0%	100.0%	100.0%	100.0%
September 2020	99.5%	99.5%	99.5%	99.5%	100.0%
October 2020	97.6%	97.6%	97.7%	100.0%	100.0%
November 2020	98.0%	98.0%	100.0%	100.0%	100.0%
December 2020	97.9%	99.7%	100.0%	100.0%	100.0%
January 2021	100.0%	100.0%	100.0%	100.0%	100.0%
February 2021	99.9%	100.0%	100.0%	100.0%	100.0%
March 2021	100.0%	100.0%	100.0%	100.0%	100.0%
April 2021	100.0%	100.0%	100.0%	100.0%	100.0%
May 2021	100.0%	100.0%	100.0%	100.0%	100.0%
June 2021	98.2%	98.2%	98.2%	98.2%	98.2%

Table I-13 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for VA Premier's institutional encounters.

Table I-13—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Institutional Encounters—VA Premier

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	0.0%	0.0%	0.0%	0.0%	0.7%
February 2020	81.9%	81.9%	81.9%	81.9%	96.9%
March 2020	90.2%	90.2%	90.2%	92.6%	99.9%
April 2020	90.1%	90.1%	92.1%	99.9%	99.9%
May 2020	88.4%	92.1%	99.8%	99.8%	99.8%
June 2020	93.5%	99.8%	99.9%	99.9%	99.9%
July 2020	78.5%	78.5%	78.5%	78.5%	78.5%
August 2020	99.7%	99.7%	99.7%	99.7%	99.7%
September 2020	99.8%	99.8%	99.8%	99.9%	99.9%
October 2020	99.0%	99.0%	99.1%	99.7%	99.7%
November 2020	99.5%	99.6%	99.7%	99.7%	99.7%
December 2020	99.0%	99.7%	99.7%	99.7%	99.8%
January 2021	99.3%	99.3%	99.3%	99.7%	99.8%
February 2021	96.5%	96.5%	97.4%	99.9%	100.0%
March 2021	97.5%	98.4%	99.9%	100.0%	100.0%
April 2021	95.7%	99.8%	100.0%	100.0%	100.0%
May 2021	99.6%	100.0%	100.0%	100.0%	100.0%
June 2021	38.3%	38.3%	38.3%	38.3%	38.3%

Table I-14 provides the percentage of encounters submitted to DMAS within 30, 60, 90, 120, and 150 days since the MCO payment date for VA Premier's pharmacy encounters.

Table I-14—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Pharmacy Encounters—VA Premier

MCO Payment Month	Submitted Within 30 Days	Submitted Within 60 Days	Submitted Within 90 Days	Submitted Within 120 Days	Submitted Within 150 Days
January 2020	95.8%	99.8%	99.8%	99.8%	99.8%
February 2020	99.7%	99.7%	99.8%	99.8%	99.8%
March 2020	99.8%	99.8%	99.9%	99.9%	99.9%
April 2020	99.3%	99.8%	99.8%	99.8%	99.8%
May 2020	99.8%	99.8%	99.8%	99.8%	99.8%
June 2020	99.8%	99.8%	99.8%	99.8%	99.8%
July 2020	99.8%	99.8%	99.8%	99.8%	99.8%
August 2020	99.8%	99.8%	99.8%	99.8%	99.8%
September 2020	71.8%	98.9%	98.9%	99.7%	99.8%
October 2020	99.8%	99.8%	99.8%	99.8%	99.8%
November 2020	99.8%	99.8%	99.8%	99.8%	99.8%
December 2020	99.8%	99.8%	99.8%	99.8%	99.8%
January 2021	99.9%	100.0%	100.0%	100.0%	100.0%
February 2021	100.0%	100.0%	100.0%	100.0%	100.0%
March 2021	100.0%	100.0%	100.0%	100.0%	100.0%
April 2021	100.0%	100.0%	100.0%	100.0%	100.0%
May 2021	100.0%	100.0%	100.0%	100.0%	100.0%
June 2021	100.0%	100.0%	100.0%	100.0%	100.0%

Table I-15 provides lag triangles for VA Premier's professional encounters. Additional details provided include MM and claims PMPM.

Table I-15—Encounters Lag Triangle—Professional Encounters—VA Premier

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	42,919												42,919
202002	178,608	28,218											206,826
202003	49,445	184,686	60,844										294,975
202004	11,563	33,026	169,999	58,837	3	2							273,430
202005	6,163	8,679	26,805	146,957	50,861					1			239,466
202006	2,417	13,779	6,747	19,146	158,096	30,048							230,233
202007	2,180	2,636	4,055	7,425	28,670	189,206	38,719	2					272,893
202008	1,635	2,020	2,651	6,258	9,717	26,624	189,394	28,616					266,915
202009	619	821	1,501	3,082	4,968	9,376	36,934	207,104	44,286	13	19		308,723
202010	1,171	1,231	1,515	2,363	3,178	6,197	11,943	32,524	204,811	64,812	40	23	329,808
202011	741	807	1,219	1,124	2,439	4,039	5,113	7,902	23,926	193,027	47,258	11	287,606
202012	453	443	482	623	1,366	3,114	4,560	6,188	9,366	27,056	193,424	53,038	300,113
202101	498	602	530	429	1,047	1,226	1,355	1,866	3,691	6,876	20,062	183,292	221,474
202102	821	717	732	507	727	1,034	1,669	2,452	8,992	11,728	15,443	36,369	81,191
202103	869	578	439	446	733	916	1,126	1,483	2,515	4,315	5,490	8,749	27,659
202104	306	201	205	317	382	428	670	820	1,627	2,069	2,667	5,408	15,100
202105	196	171	143	210	497	1,264	633	988	1,104	1,334	1,931	2,755	11,226
202106	443	454	316	191	291	333	542	811	784	1,023	1,608	2,238	9,034
Total	301,047	279,069	278,183	247,915	262,975	273,807	292,658	290,756	301,102	312,254	287,942	291,883	3,419,591
MM	46,696	46,583	46,613	47,056	47,631	47,836	47,982	48,135	48,172	48,463	48,551	48,661	572,379
PMPM	**6.447**	**5.991**	**5.968**	**5.269**	**5.521**	**5.724**	**6.099**	**6.040**	**6.251**	**6.443**	**5.931**	**5.998**	**5.974**

Table I-16 provides lag triangles for VA Premier's institutional encounters. Additional details provided include MM and claims PMPM.

Table I-16—Encounters Lag Triangle—Institutional Encounters—VA Premier

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202002	7,333	2,073											9,406
202003	3,699	13,313	3,603										20,615
202004	1,459	1,702	8,125	1,452									12,738
202005	474	578	1,216	5,250	1,043								8,561
202006	7,324	622	371	1,393	6,109	701							16,520
202007	1,573	1,565	1,530	1,288	2,808	7,939	625						17,328
202008	420	404	403	728	1,445	3,429	11,315	2,246					20,390
202009	811	1,217	3,693	2,980	3,936	4,297	4,108	11,044	902				32,988
202010	229	226	230	229	390	595	1,041	3,947	14,261	2,893			24,041
202011	120	117	113	117	186	247	417	663	2,311	12,344	2,135		18,770
202012	210	188	231	277	385	446	572	710	1,105	3,312	12,809	2,857	23,102
202101	95	97	99	153	264	1,639	1,686	253	413	939	2,412	11,460	19,510
202102	60	88	91	85	123	143	175	174	269	511	915	2,256	4,890
202103	197	188	212	143	175	233	248	265	375	515	610	1,470	4,631
202104	47	43	22	40	57	65	76	109	126	182	239	446	1,452
202105	61	85	89	227	309	349	351	374	384	494	513	575	3,811
202106	31	29	27	50	59	82	722	701	704	248	180	235	3,068
Total	24,143	22,535	20,055	14,412	17,289	20,165	21,336	20,486	20,850	21,438	19,813	19,299	241,821
MM	46,696	46,583	46,613	47,056	47,631	47,836	47,982	48,135	48,172	48,463	48,551	48,661	572,379
PMPM	**0.517**	**0.484**	**0.430**	**0.306**	**0.363**	**0.422**	**0.445**	**0.426**	**0.433**	**0.442**	**0.408**	**0.397**	**0.423**

Table I-17 provides lag triangles for VA Premier's pharmacy encounters. Additional details provided include MM and claims PMPM.

Table I-17—Encounters Lag Triangle—Pharmacy Encounters—VA Premier

Service Month													
Submission Month	**202001**	**202002**	**202003**	**202004**	**202005**	**202006**	**202007**	**202008**	**202009**	**202010**	**202011**	**202012**	**Total**
202001	77,726												77,726
202002	73,495	62,865											136,360
202003	481	78,104	60,179										138,764
202004	292	603	99,296	110,506									210,697
202005	55	127	552	34,986	95,081								130,801
202006	84	61	133	303	39,315	52,921							92,817
202007	121	32	72	213	1,388	84,278	107,166						193,270
202008	16	16	27	31	94	261	37,627	92,974					131,046
202009	9	6	12	22	33	40	182	47,585	16,293				64,182
202010	11	12	17	21	31	51	199	1,326	118,736	64,414			184,818
202011	4	7	10	13	16	29	58	104	313	71,938	83,023		155,515
202012	5	2	3	4	5	6	14	24	133	400	45,066	104,972	150,634
202101			1	1	3	3	4	23	1,348	58	210	28,464	30,115
202102	2	6	5	10	7	14	12	13	16	49	121	380	635
202103								5	12	32	66	135	250
202104					3	1	1	2	3	12	19	20	61
202105						1		1	2	2	2	10	18
202106	213	201	230	252	224	242	294	239	251	260	233	241	2,880
Total	152,514	142,042	160,537	146,362	136,200	137,847	145,557	142,296	137,107	137,165	128,740	134,222	1,700,589
MM	46,696	46,583	46,613	47,056	47,631	47,836	47,982	48,135	48,172	48,463	48,551	48,661	572,379
PMPM	**3.266**	**3.049**	**3.444**	**3.110**	**2.859**	**2.882**	**3.034**	**2.956**	**2.846**	**2.830**	**2.652**	**2.758**	**2.974**

Field-Level Completeness and Accuracy

Table I-18 provides a summary of the field-level completeness and accuracy for VA Premier's professional encounters.

Table I-18—Data Element Completeness and Accuracy for Professional Encounters—VA Premier

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	3,419,591	3,419,591	100.0%	3,354,582	3,419,591	98.1%
Header Service From Date	3,419,591	3,419,591	100.0%	3,419,591	3,419,591	100.0%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Header Service To Date	3,419,591	3,419,591	100.0%	3,419,400	3,419,591	>99.9%
Detail Service From Date	5,403,182	5,403,182	100.0%	5,403,182	5,403,182	100.0%
Detail Service To Date	5,403,182	5,403,182	100.0%	5,402,844	5,403,182	>99.9%
Billing Provider NPI	3,419,591	3,419,591	100.0%	3,419,510	3,419,591	>99.9%
Rendering Provider NPI	3,419,591	3,419,591	100.0%	3,419,408	3,419,591	>99.9%
Servicing Provider Taxonomy Code	5,403,182	5,403,182	100.0%	5,047,414	5,403,182	93.4%
Referring Provider NPI	698,817	3,419,591	20.4%	692,376	698,817	99.1%
Primary Diagnosis Codes	3,419,591	3,419,591	100.0%	3,419,473	3,419,591	>99.9%
Secondary Diagnosis Codes	821,625	3,419,591	24.0%	2,267,541	2,267,641	>99.9%
CPT/HCPCS Codes	5,403,182	5,403,182	100.0%	5,403,170	5,403,182	>99.9%
CPT/HCPCS Codes with PTP Edits	5,403,182	5,403,182	100.0%	5,402,815	5,403,182	>99.9%
Service Units	5,403,182	5,403,182	100.0%	5,403,182	5,403,182	100.0%
Service Units with MUE Edits	1,278,253	1,278,253	100.0%	1,243,457	1,278,253	97.3%
National Drug Codes	215,777	5,403,182	4.0%	215,667	215,777	>99.9%
HCPCS/NDC Combination	23,519	34,765	67.7%	19,513	23,519	83.0%
MCO Received Date	5,403,182	5,403,182	100.0%	5,403,182	5,403,182	100.0%
MCO Paid Date	5,403,182	5,403,182	100.0%	5,403,182	5,403,182	100.0%
Header Paid Amount	3,419,591	3,419,591	100.0%	3,419,196	3,419,591	>99.9%
Header TPL Paid Amount	241,581	3,419,591	7.1%	236,104	241,581	97.7%
Detail Paid Amount	5,403,182	5,403,182	100.0%	5,403,182	5,403,182	100.0%
Detail TPL Paid Amount	354,676	5,403,182	6.6%	354,676	354,676	100.0%

Table I-19 provides a summary of the field-level completeness and accuracy for VA Premier's institutional encounters.

Table I-19—Data Element Completeness and Accuracy for Institutional Encounters—VA Premier

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	241,821	241,821	100.0%	234,832	241,821	97.1%
Header Service From Date	241,821	241,821	100.0%	241,821	241,821	100.0%
Header Service To Date	241,821	241,821	100.0%	241,821	241,821	100.0%
Detail Service From Date	1,619,766	1,619,766	100.0%	1,619,766	1,619,766	100.0%
Detail Service To Date	1,619,766	1,619,766	100.0%	1,619,766	1,619,766	100.0%
Billing Provider NPI	241,821	241,821	100.0%	241,821	241,821	100.0%
Rendering Provider NPI	0	241,821	0.0%	NA	NA	NA
Attending Provider NPI	239,580	241,821	99.1%	238,703	239,580	99.6%
Servicing Provider Taxonomy Code	1,606,678	1,619,766	99.2%	1,526,604	1,606,678	95.0%
Referring Provider NPI	5,563	241,821	2.3%	5,536	5,563	99.5%
Primary Diagnosis Codes	241,821	241,821	100.0%	241,820	241,821	>99.9%
Secondary Diagnosis Codes	239,209	241,821	98.9%	1,978,049	1,978,061	>99.9%
CPT/HCPCS Codes	1,272,785	1,619,766	78.6%	1,248,833	1,272,785	98.1%
CPT/HCPCS Codes with PTP Edits	1,272,785	1,619,766	78.6%	1,247,546	1,272,785	98.0%
Service Units	1,619,766	1,619,766	100.0%	1,619,766	1,619,766	100.0%
Service Units with MUE Edits	694,746	694,746	100.0%	691,991	694,746	99.6%
Primary Surgical Procedure Codes	8,355	241,821	3.5%	8,348	8,355	>99.9%
Secondary Surgical Procedure Codes	4,637	241,821	1.9%	14,387	14,419	99.8%
Revenue Codes	1,619,766	1,619,766	100.0%	1,619,766	1,619,766	100.0%
Diagnosis-Related Groups Codes	374	241,821	0.2%	374	374	100.0%
Type of Bill Codes	241,821	241,821	100.0%	241,821	241,821	100.0%
National Drug Codes	179,730	1,619,766	11.1%	174,970	179,730	97.4%
HCPCS/NDC Combination	89,979	90,013	>99.9%	63,757	89,979	70.9%
MCO Received Date	1,619,766	1,619,766	100.0%	1,619,766	1,619,766	100.0%
MCO Paid Date	1,619,766	1,619,766	100.0%	1,619,766	1,619,766	100.0%
Header Paid Amount	241,821	241,821	100.0%	241,790	241,821	>99.9%
Header TPL Paid Amount	32,322	241,821	13.4%	32,054	32,322	99.2%
Detail Paid Amount	1,619,766	1,619,766	100.0%	1,619,766	1,619,766	100.0%
Detail TPL Paid Amount	358,687	1,619,766	22.1%	358,687	358,687	100.0%

Table I-20 provides a summary of the field-level completeness and accuracy for VA Premier's pharmacy encounters.

Table I-20—Data Element Completeness and Accuracy for Pharmacy Encounters—VA Premier

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Member ID	1,700,589	1,700,589	100.0%	1,656,404	1,700,589	97.4%
DOS	1,700,589	1,700,589	100.0%	1,700,589	1,700,589	100.0%
Billing Provider NPI	1,700,589	1,700,589	100.0%	1,700,589	1,700,589	100.0%
Prescribing Provider NPI	1,700,589	1,700,589	100.0%	1,626,249	1,700,589	95.6%
National Drug Codes	1,700,589	1,700,589	100.0%	1,694,339	1,700,589	99.6%
MCO Received Date	1,700,589	1,700,589	100.0%	1,700,589	1,700,589	100.0%
MCO Paid Date	1,700,589	1,700,589	100.0%	1,700,589	1,700,589	100.0%
Header Paid Amount	1,700,589	1,700,589	100.0%	1,700,589	1,700,589	100.0%
Header TPL Paid Amount	16,525	1,700,589	1.0%	16,525	16,525	100.0%