Commonwealth of Virginia
Department of
Medical Assistance Services

2020–2021 Medallion 4.0 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 Medallion 4.0 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 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' 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.

[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,

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:

- 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.
- Although the Data Quality Scorecard (DQS) is currently on backlog, HSAG recommends that DMAS consider expediting the DQS for Medallion 4.0 to the extent possible.

Administrative Profile

Overall, DMAS' encounter data should support future analyses 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 MCO payment dates.[1-3]
  - **Impact**: Discrepancies in the submission date to DMAS in relation to the 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.
- Molina and VA Premier had low completeness for **header third-party liability (TPL) amount paid** for institutional encounters.
  - **Impact**: Financial analysis incorporating TPL paid amounts for 2020 will result in artificially low values, particularly for Molina and VA Premier, if stratified by MCO.
  - **Recommendation**: DMAS should monitor TPL completeness by MCOs to ensure the field is populated as expected and collaborate with Molina and VA Premier to determine a root cause.
- For institutional and pharmacy encounters, three MCOs did not meet the submission standards within 30 days for each type of encounter.
  - **Impact**: DMAS requires MCOs to submit 96 percent of institutional encounters within 30 days and three MCOs did not meet this criterion. In addition, three MCOs 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 institutional and pharmacy encounters and collaborate with MCOs to determine any barriers in timely submission.

[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.

- **Healthcare Common Procedure Coding System/Current Procedural Terminology (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."
  - **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.
- **Servicing Provider Taxonomy Code** was populated for 30 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 83.9 percent for Aetna).
  - **Recommendation**: DMAS should work with its MCOs, particularly Optima and VA Premier to submit codes for this field. VA Premier had nearly 100 percent completeness for its Commonwealth Coordinated Care (CCC) Plus program; DMAS should work with VA Premier to identify differences in processing this field for the Medallion 4.0 program.

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 DQS, 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.

2. Overview and Methodology

Overview

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, DMAS requires its Medallion 4.0 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 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 Medallion 4.0 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 Medallion 4.0 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 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 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. Of note, if the Member IDs were 11 digits plus an alpha character (i.e., for newborns), HSAG evaluated whether the first 11 digits were matching with the first 11 digits for female members in the member file. • Enrolled in a specific MCO on the date of service • Member Date of Birth is on or before detail date of service

Key Data Elements	837P Encounters	837I Encounters	NCPDP Encounters	Criteria for Validity
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
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)

Key Data Elements	837P Encounters	837I Encounters	NCPDP Encounters	Criteria for Validity
Secondary Diagnosis Codes H	✓	✓		In national ICD-10-CM diagnosis code sets for the correct code year
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

[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.

[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.

[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.

Key Data Elements	837P Encounters	837I Encounters	NCPDP Encounters	Criteria for Validity
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]
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.

[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.

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.

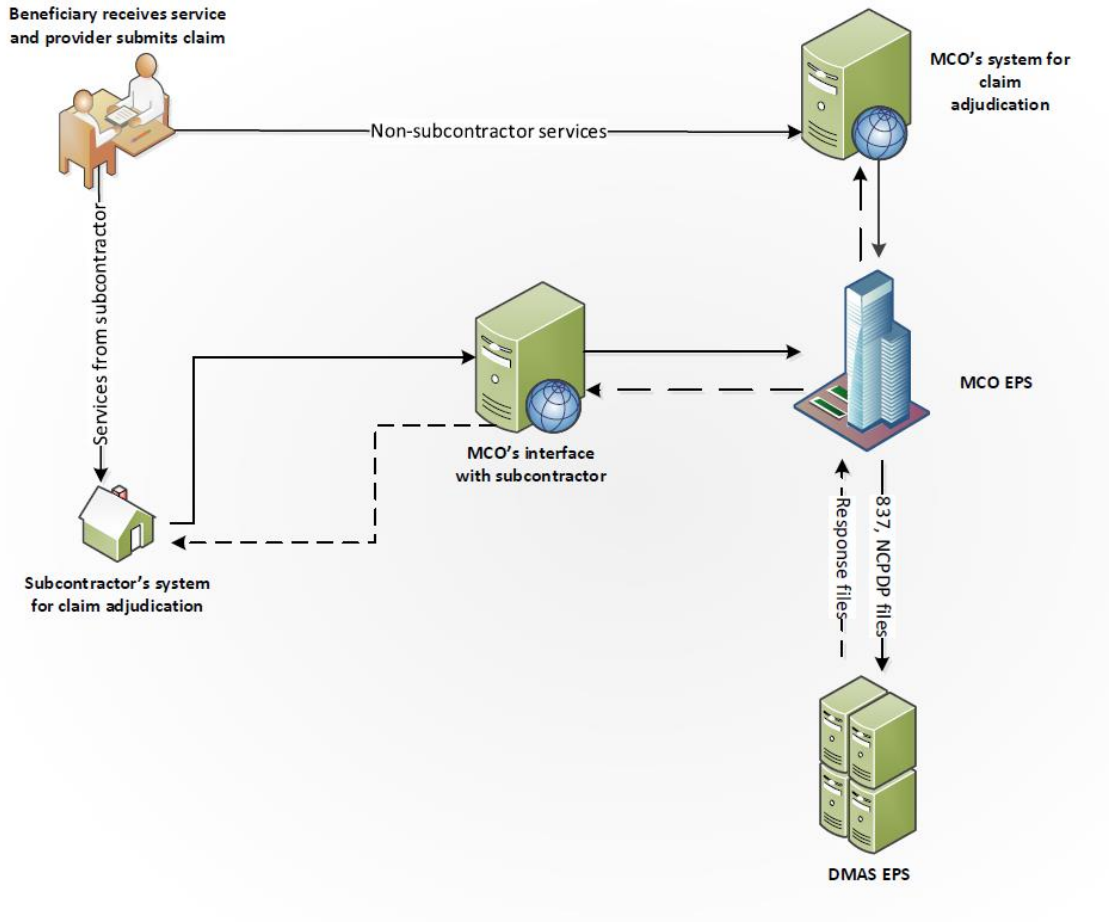
Encounter Data Sources and Systems

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. These files may have been generated initially by the MCO and/or its subcontractors in a different format. Table 3-1 shows the source, format, and frequency of data submission to DMAS for all six MCOs. Aetna, Molina, and UnitedHealthcare did not report having any capitated arrangements with providers. HealthKeepers reported that 8 percent of medical (837P) claims were for capitated providers, and Optima reported less than 5 percent. Although Optima's subcontractor for vision and nonemergency transportation is capitated, providers are paid fee-for-service. VA Premier reported capitated payment arrangements for all encounters among the following sources: pharmacy, vision, nonemergency transportation (NEMT), consumer directed, and from Kaiser Permanente.

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). MCOshandled 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 and 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 DQS.

[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

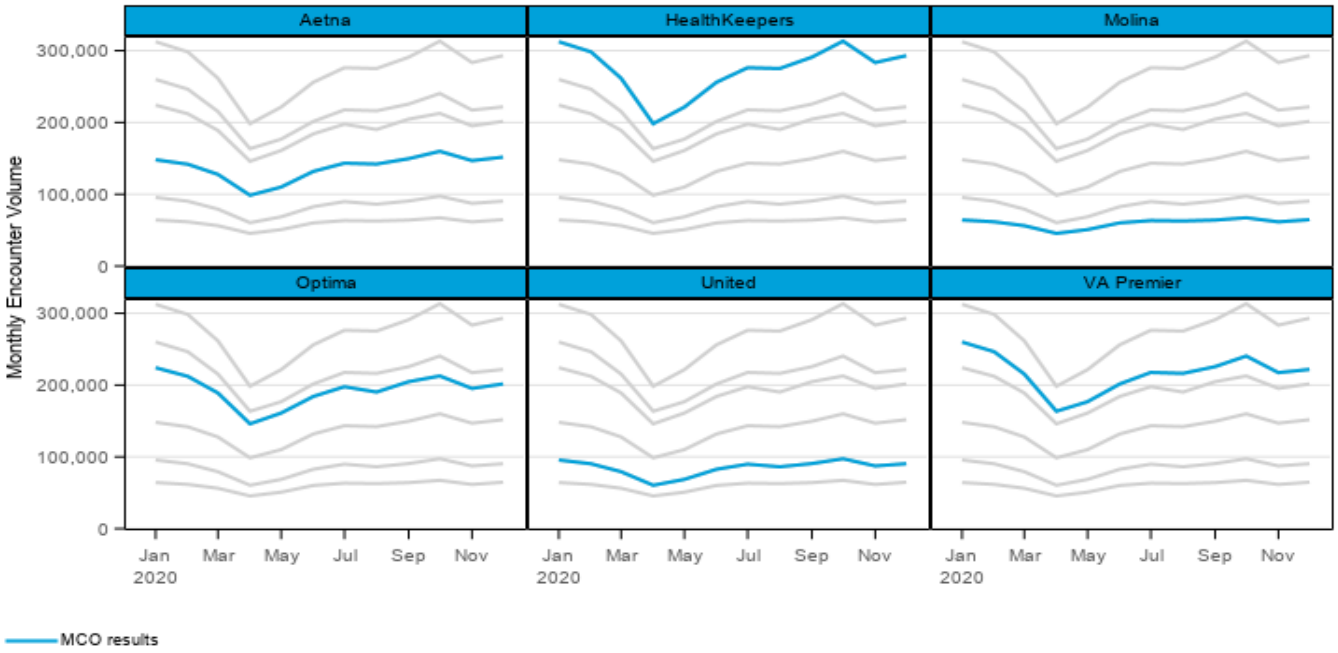


Figure 4-2 provides the monthly encounter volume for institutional encounters. The volume of institutional encounters declined substantially in the first four months of 2020, primarily due to the PHE, and recovered to near pre-pandemic levels by October 2020. Claim volume for HealthKeepers declined by 61 percent between January and April 2020.

Figure 4-2—Monthly Encounter Volume—Institutional Encounters

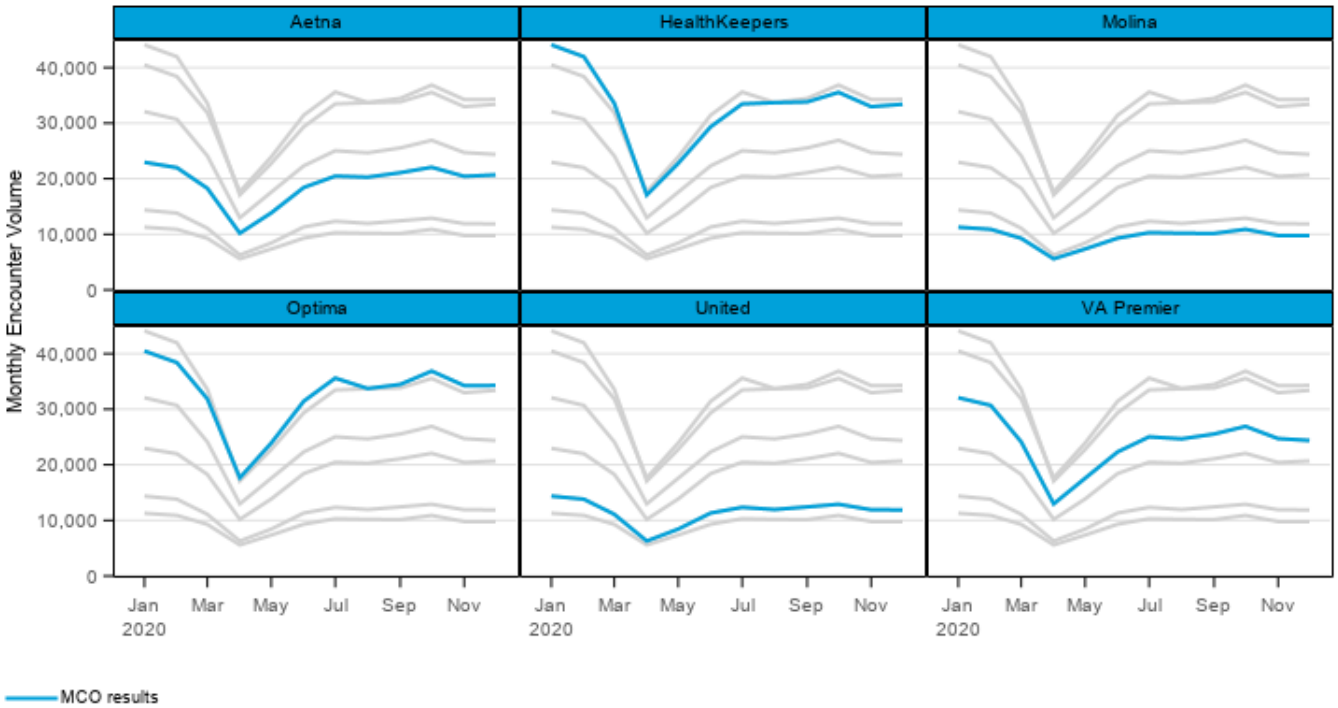
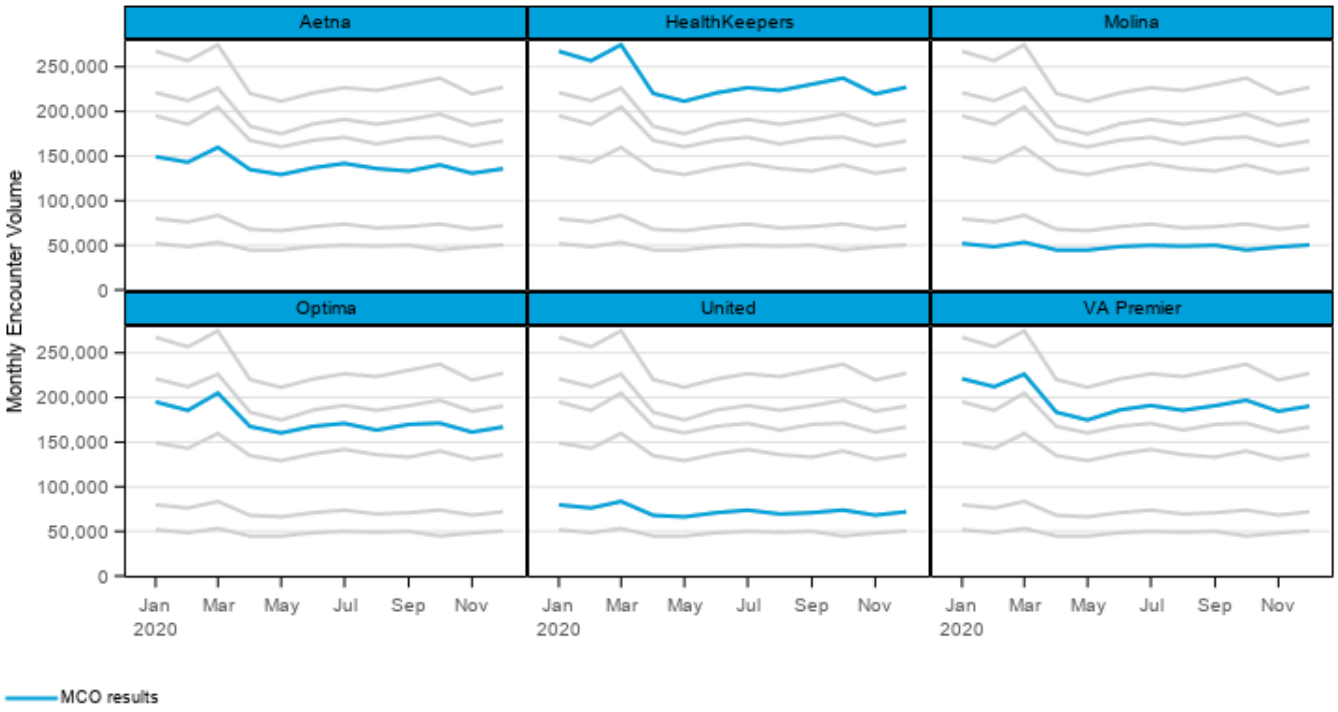


Figure 4-3 provides the monthly encounter volume for pharmacy encounters. All MCOs exhibited a sustained decline following the COVID-19 PHE beginning in March/April 2020. The average claim volume for HealthKeepers declined by 11.8 percent after March 2020, while Molina exhibited a decline of only 3 percent in average monthly claim volume.

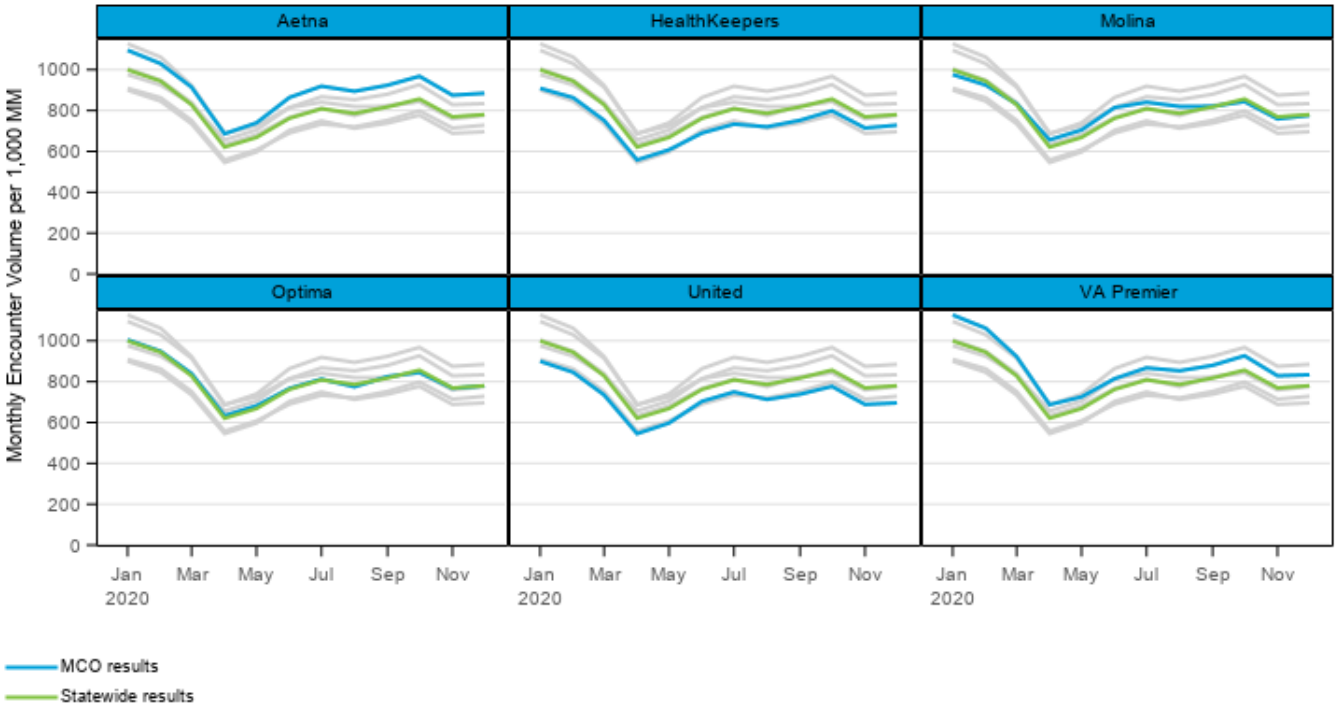
Figure 4-3—Monthly Encounter Volume—Pharmacy Encounters



Monthly Encounter Volume per 1,000 MM

Figure 4-4 provides the monthly encounter volume per 1,000 MM for professional encounters. All plans exhibited similar trends and volume of **professional** encounters per 1,000 MM, with a steady decline from January 2020 at approximately 1,000 encounters per 1,000 MM (or one encounter per MM) to approximately 620 visits per 1,000 MM by April 2020, a decline of 38 percent.

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



Similar to professional encounters, Figure 4-5 shows that MCOs tracked similar trends in monthly **institutional** encounter volume per 1,000 MM. Statewide, encounters fell from approximately 150 per 1,000 MM to approximately 62 per 1,000 MM, a decline of 59 percent.

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

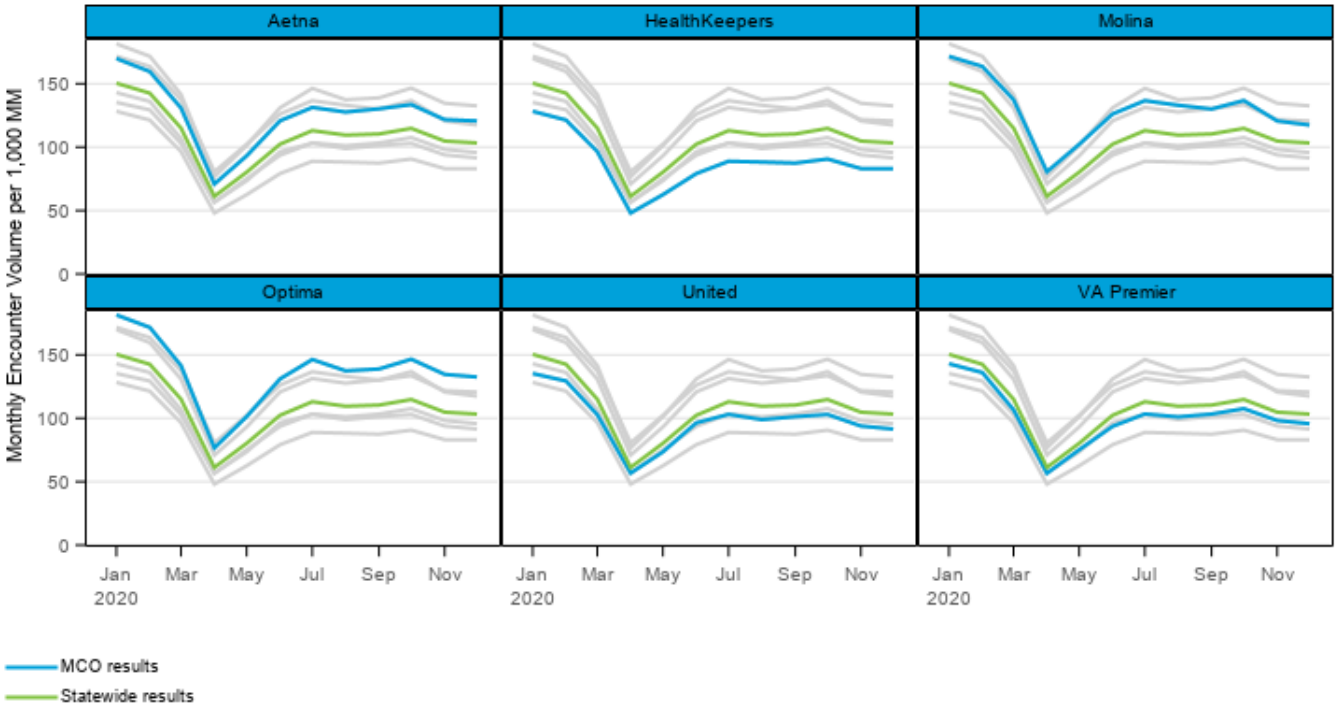
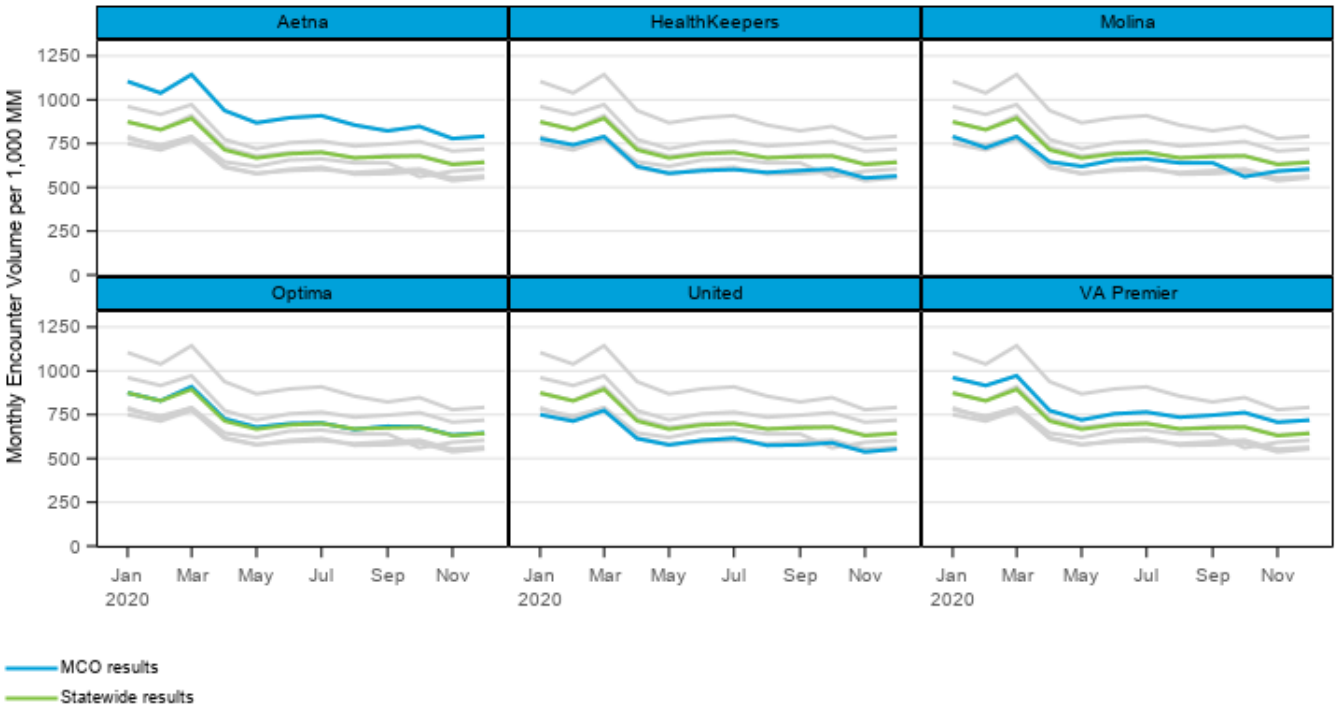


Figure 4-6 shows slightly declining pharmacy encounter volume per 1,000 MM throughout 2020, with the largest decline occurring between March and April 2020. Claim volume statewide fell from an average of approximately 830 encounters per 1,000 MM in first quarter 2020 to 670 per 1,000 MM for the remainder of the year.

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



Paid Amount PMPM

Figure 4-7 provides the paid amount PMPM for **professional** encounters. Statewide, professional encounters averaged $105 throughout 2020, exhibiting a similar—but not quite as severe—decline in the first quarter as encounter volume per 1,000 MM. Statewide, PMPM paid amounts fell by 29 percent between January and April 2020 compared to 38 percent for encounter volume per 1,000 MM.

Figure 4-7—Paid Amount PMPM—Professional Encounters

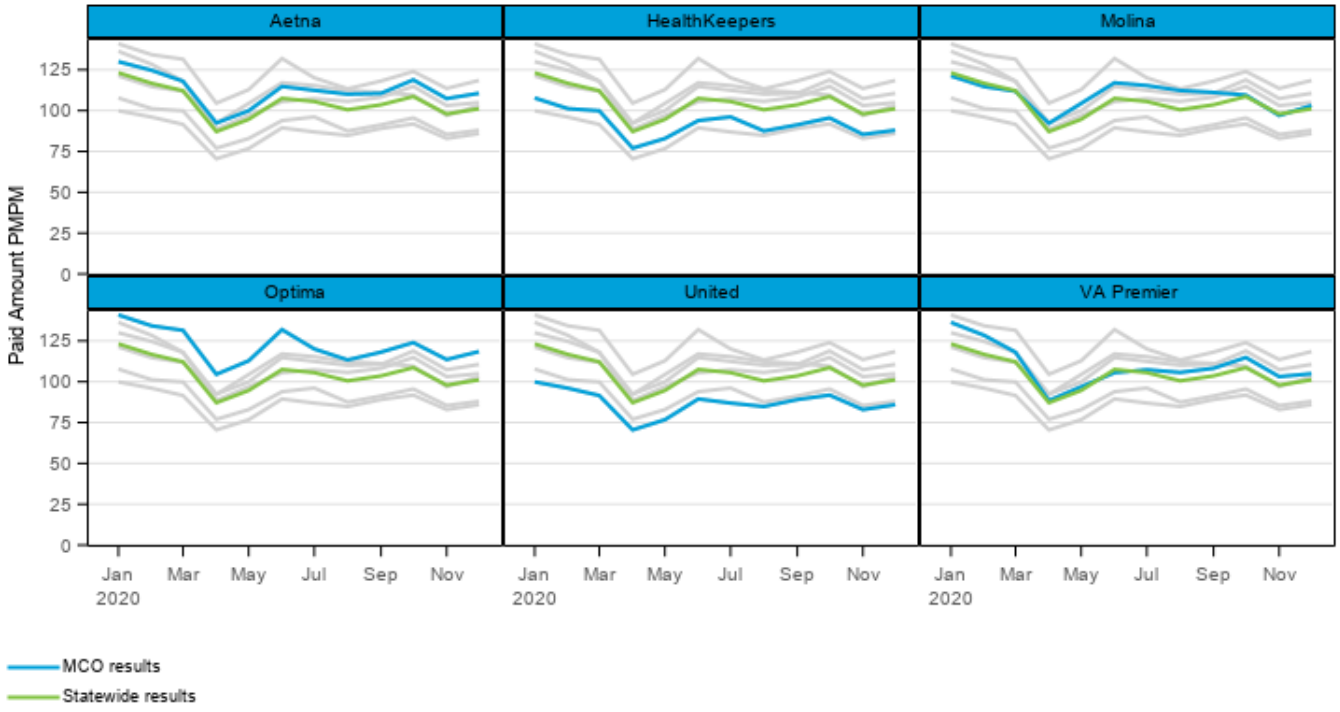


Figure 4-8 shows that the average PMPM paid amount for **institutional** encounters was $107 excluding April 2020, which had a PMPM paid amount of only $75. Molina had the highest PMPM paid amount, averaging $140 throughout the year.

Figure 4-8—Paid Amount PMPM—Institutional Encounters

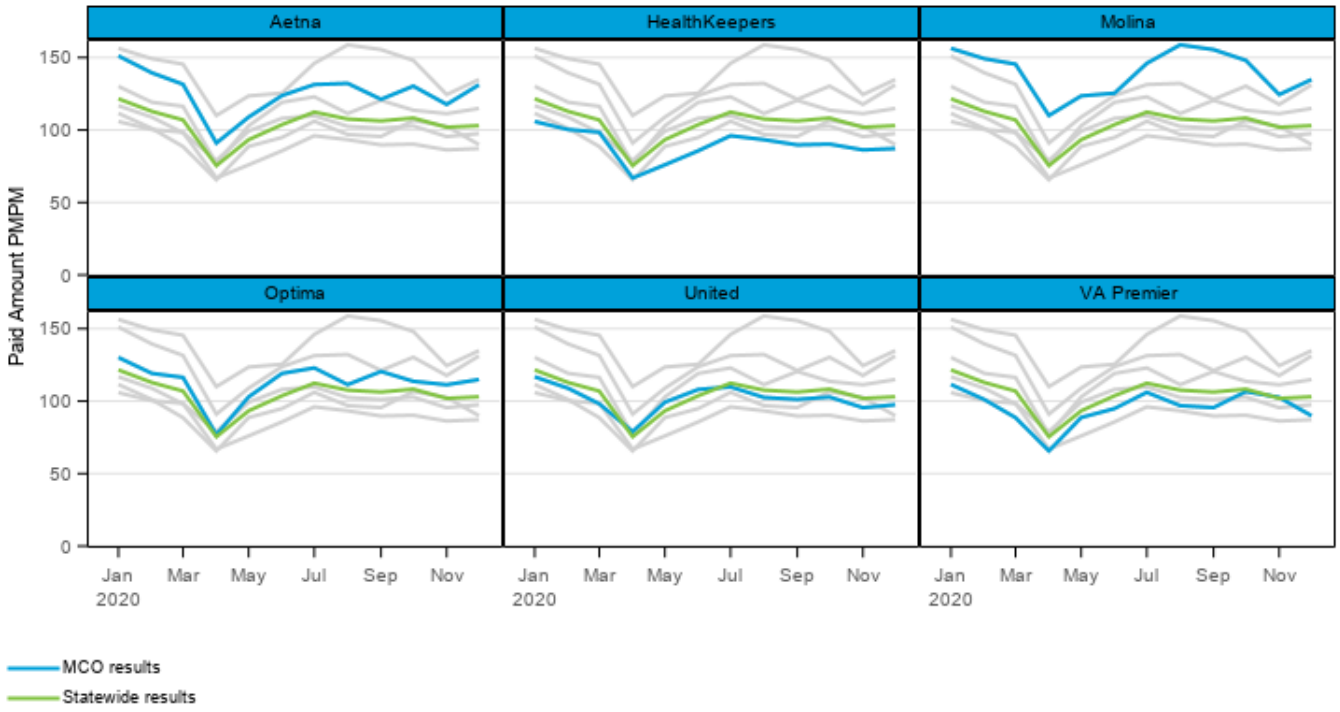
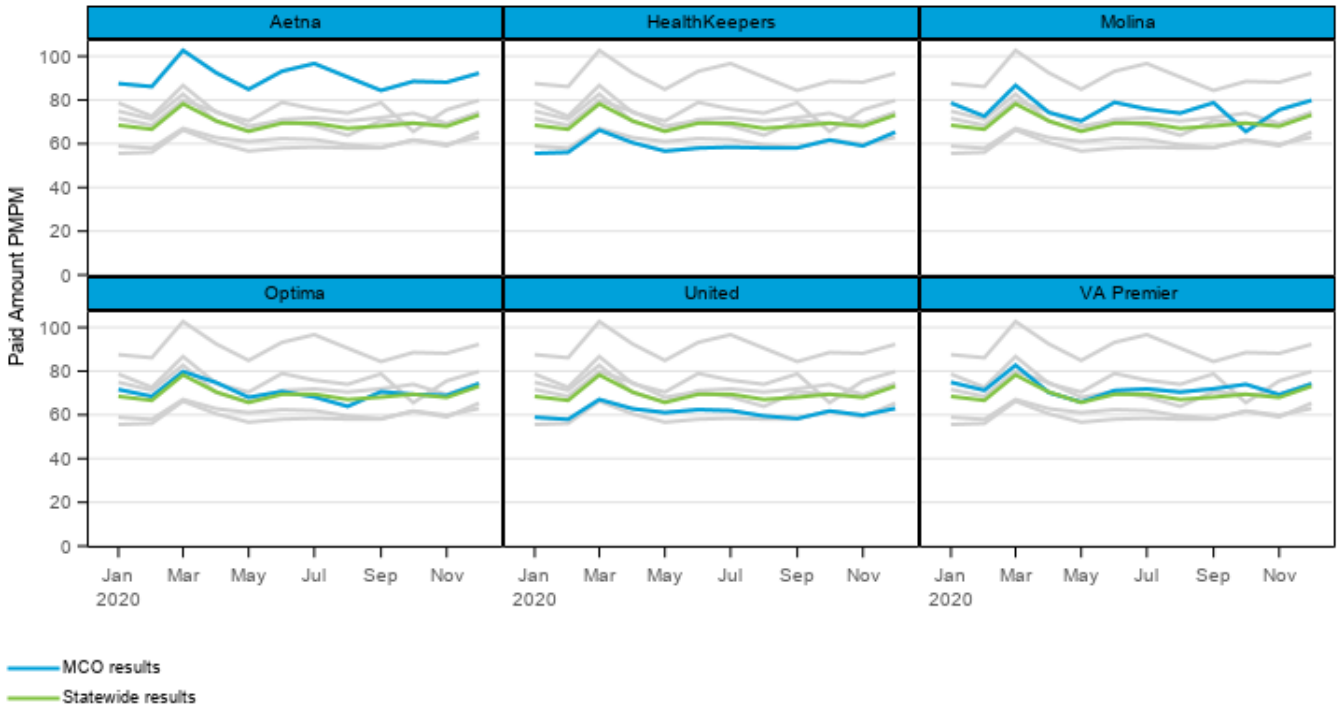


Figure 4-9 shows PMPM paid amounts among **pharmacy** encounters was steady throughout the year in comparison to professional and institutional encounters, averaging $69 statewide with a slight increase in March and no material decline in April 2020 from the COVID-19 PHE.

Figure 4-9—Paid Amount PMPM—Pharmacy Encounters



TPL Paid Amount PMPM

Figure 4-10 shows that the TPL paid amount PMPM for professional encounters, while low, varied substantially across plans and within plans over time. This variation and low rate were likely due to sparseness in the data, as Table 4-9 in the Field-Level Completeness and Accuracy section shows 1.8 percent of professional encounters had a TPL header paid amount populated.

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

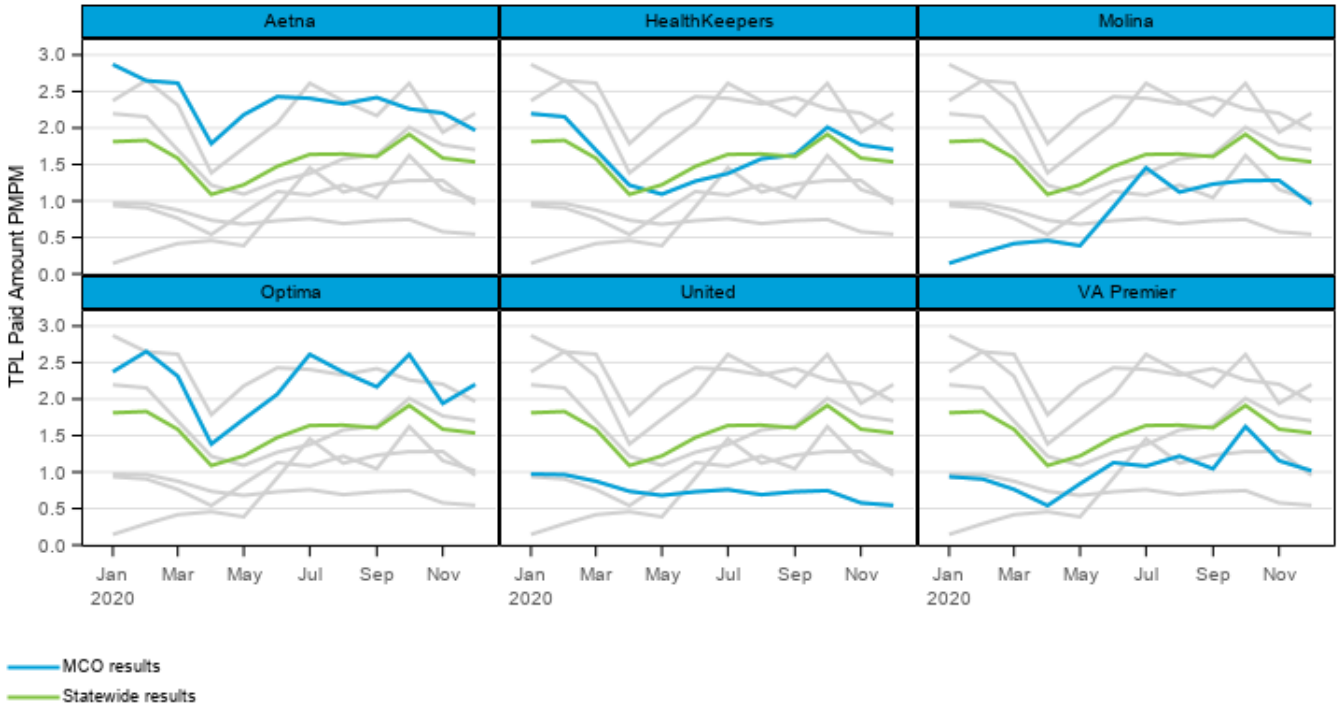


Figure 4-11 shows that Molina and VA Premier had low TPL paid amount PMPM for **institutional** encounters compared to other plans, averaging well under $1 PMPM, while other MCOs ranged between approximately $2.50 and $12.50 PMPM. Appendices F and I show that the field level completeness for Header TPL Paid Amount was 0.1 percent and 0.3 percent for Molina and VA Premier, respectively. Other MCOs had a completeness rate of at least 2 percent.

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

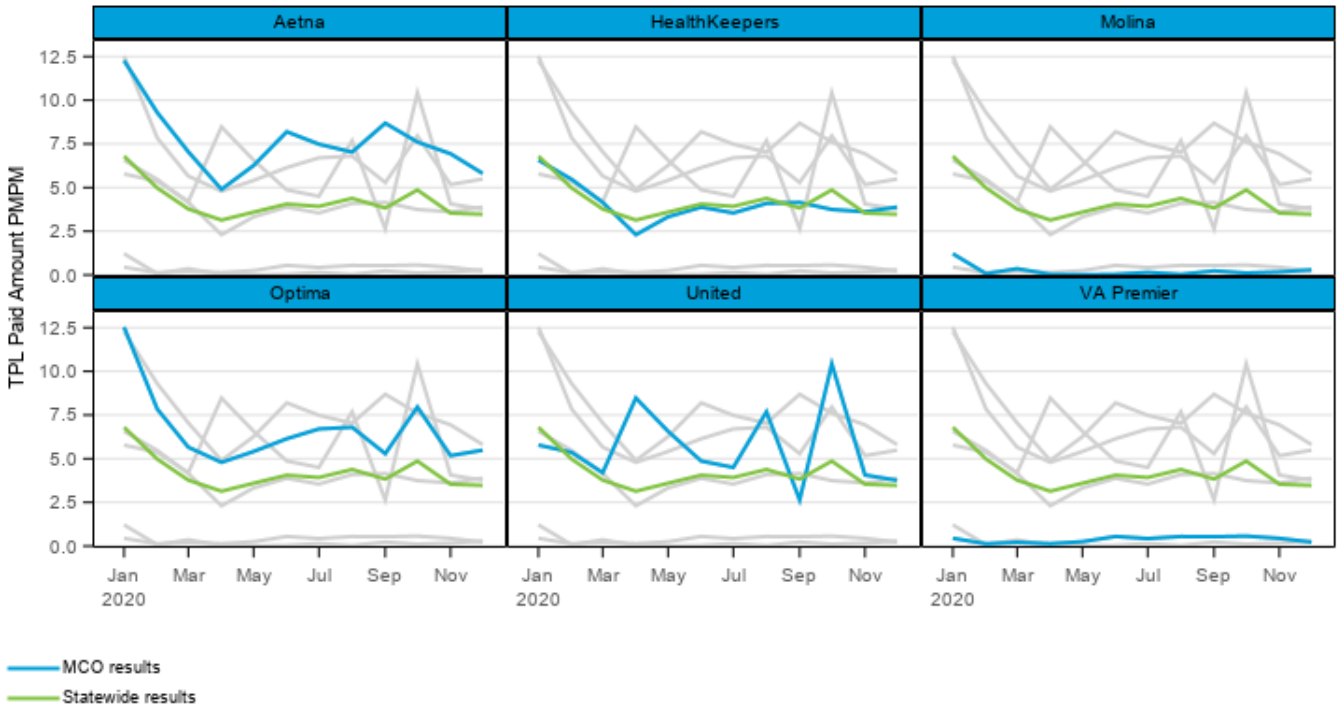
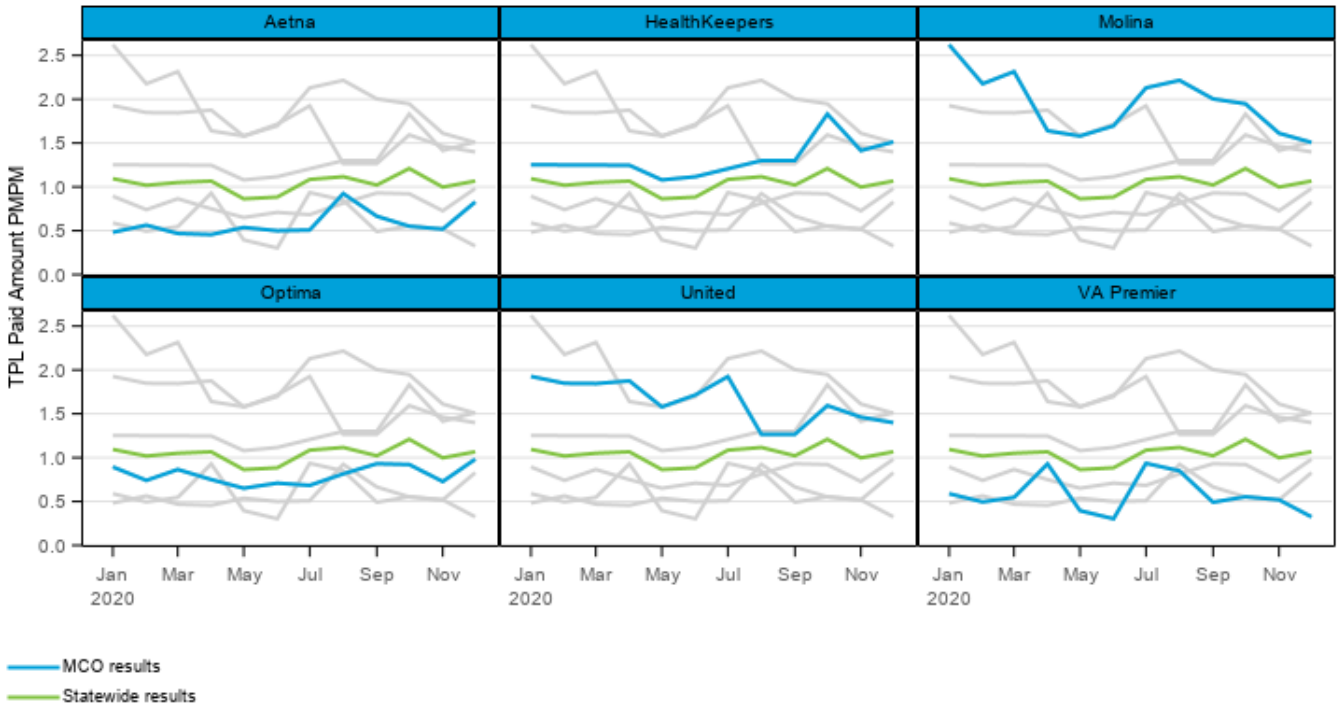


Figure 4-12 shows the TPL paid amount PMPM for **pharmacy** encounters averaged approximately $1. There was no indication of substantive data gaps.

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 DMAS, 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 for Identifying Duplicate Encounters

Field/Description	Professional	Facility	Pharmacy
Member ID	✓	✓	✓
Detail line number	✓	✓	✓
Claim Type		✓	
Revenue Code		✓	

[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.

Field/Description	Professional	Facility	Pharmacy
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 encounters for all three encounter types. Overall, there were few duplicate encounters, with 0.6 percent for professional encounters, largely driven by Molina at 3.0 percent. Among institutional encounters, only 0.3 percent were identified as duplicates; HealthKeepers had the highest rate at only 0.6 percent. The number of duplicates among pharmacy encounters was negligible, with only 844 statewide out of more than 10 million.

Table 4-2—Percentage of Duplicate Encounters

Field	Percent Duplicate		
	Professional Encounters	Institutional Encounters	Pharmacy Encounters
Statewide	**0.6%**	**0.3%**	**<0.1%**
Aetna	0.2%	0.3%	<0.1%
HealthKeepers	0.6%	0.6%	<0.1%
Molina	3.0%	0.0%	0.0%
Optima	0.8%	0.1%	<0.1%
United	0.0%	0.2%	<0.1%
VA Premier	0.2%	0.3%	<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 98.3 percent of encounters within 30 days of payment, ranging from 96.1 (HealthKeepers) to 99.9 percent (VA Premier). All MCOs met the submission standard of 96 percent within 30 days.

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

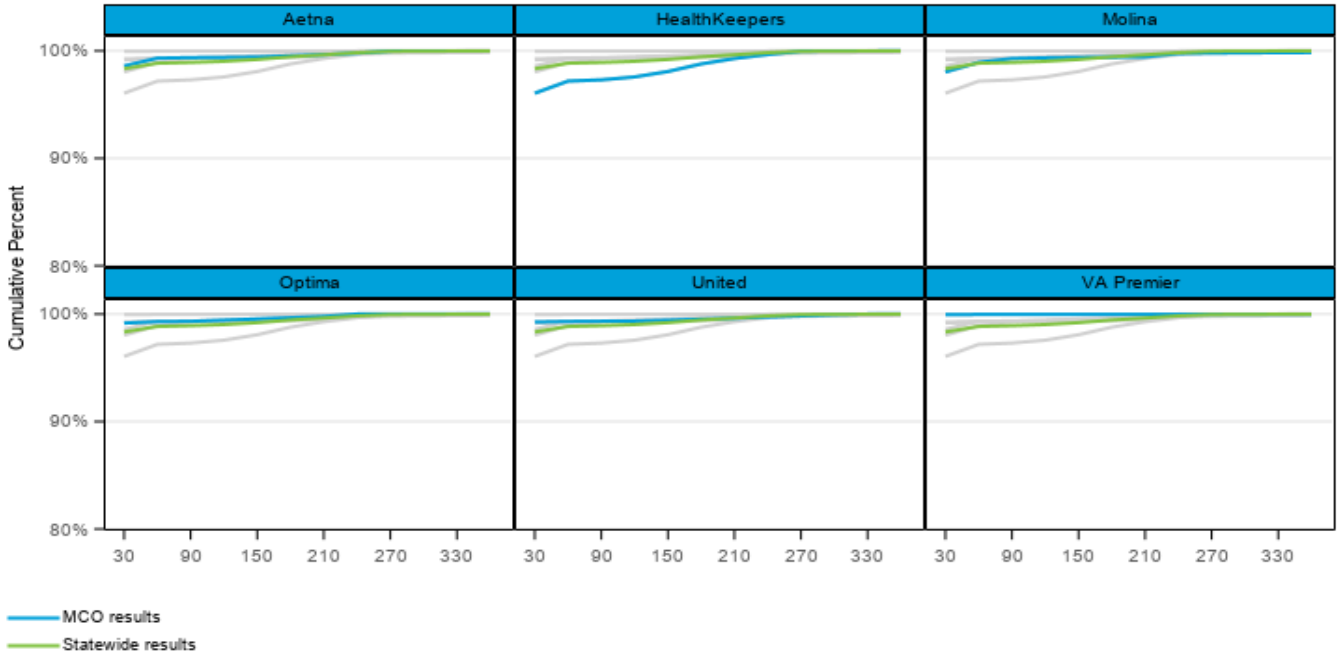


Table 4-3—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Professional Encounters

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 30 days	98.3%	98.6%	96.1%	98.0%	99.2%	99.3%	99.9%
Submitted within 60 days	98.8%	99.3%	97.2%	98.9%	99.3%	99.3%	100.0%
Submitted within 90 days	98.9%	99.4%	97.3%	99.3%	99.3%	99.3%	100.0%
Submitted within 120 days	99.0%	99.4%	97.6%	99.4%	99.4%	99.4%	100.0%
Submitted within 150 days	99.2%	99.4%	98.1%	99.4%	99.5%	99.4%	100.0%
Submitted within 180 days	99.4%	99.5%	98.8%	99.4%	99.7%	99.5%	100.0%
Submitted within 210 days	99.6%	99.6%	99.3%	99.4%	99.8%	99.6%	100.0%
Submitted within 240 days	99.8%	99.8%	99.7%	99.8%	100.0%	99.7%	100.0%
Submitted within 270 days	100.0%	100.0%	100.0%	99.8%	100.0%	99.8%	100.0%
Submitted within 300 days	100.0%	100.0%	100.0%	99.8%	100.0%	99.9%	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%	99.8%	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%	0.1%	0.0%	0.0%	0.0%

Figure 4-14 and Table 4-4 show that Aetna, HealthKeepers, and United lagged behind other plans in submission of **institutional** encounters to DMAS following payment. Statewide, MCOs submitted 94.9 percent of encounters within 30 days; however, Optima had effectively a 100 percent submission rate within 30 days. Table 4-4 also shows that 1.4 percent of encounters from VA Premier had a submission date prior to the paid date.

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

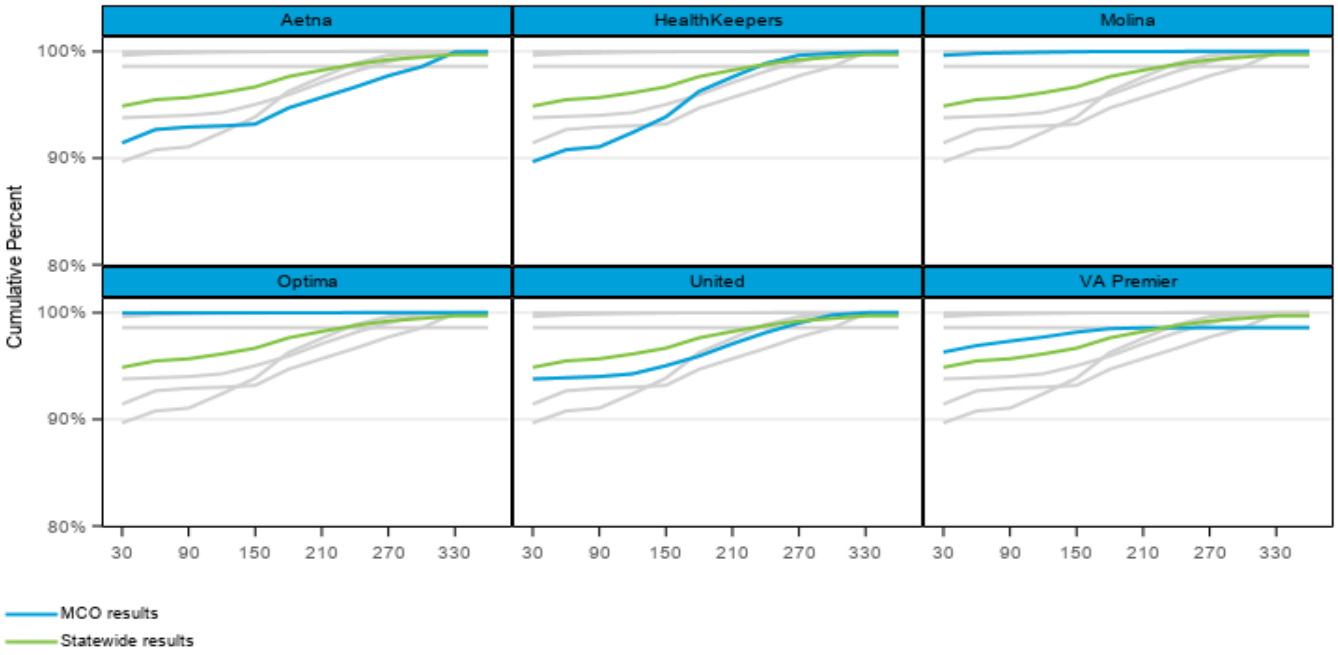


Table 4-4—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Institutional Encounters

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 30 days	94.9%	91.4%	89.7%	99.6%	100.0%	93.8%	96.3%
Submitted within 60 days	95.5%	92.7%	90.8%	99.8%	100.0%	93.9%	96.9%
Submitted within 90 days	95.7%	92.9%	91.0%	99.9%	100.0%	94.0%	97.3%
Submitted within 120 days	96.1%	93.0%	92.4%	99.9%	100.0%	94.3%	97.7%
Submitted within 150 days	96.7%	93.2%	93.9%	100.0%	100.0%	95.0%	98.2%
Submitted within 180 days	97.6%	94.7%	96.3%	100.0%	100.0%	95.9%	98.5%
Submitted within 210 days	98.2%	95.7%	97.6%	100.0%	100.0%	97.1%	98.6%
Submitted within 240 days	98.8%	96.7%	98.9%	100.0%	100.0%	98.1%	98.6%
Submitted within 270 days	99.2%	97.7%	99.6%	100.0%	100.0%	99.0%	98.6%
Submitted within 300 days	99.5%	98.6%	99.8%	100.0%	100.0%	99.8%	98.6%
Submitted within 330 days	99.7%	99.9%	99.9%	100.0%	100.0%	100.0%	98.6%
Submitted within 360 days	99.7%	100.0%	99.9%	100.0%	100.0%	100.0%	98.6%
Submitted after 360 days	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%
Submitted Prior to Paid Date	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	1.4%

Figure 4-15 and Table 4-5 show that Aetna, Molina, and United had lower than a 99 percent submission rate of **pharmacy** encounters within 30 days of payment; however, all plans except United met this threshold within 60 days. The majority of United encounters (86.3 percent) had 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

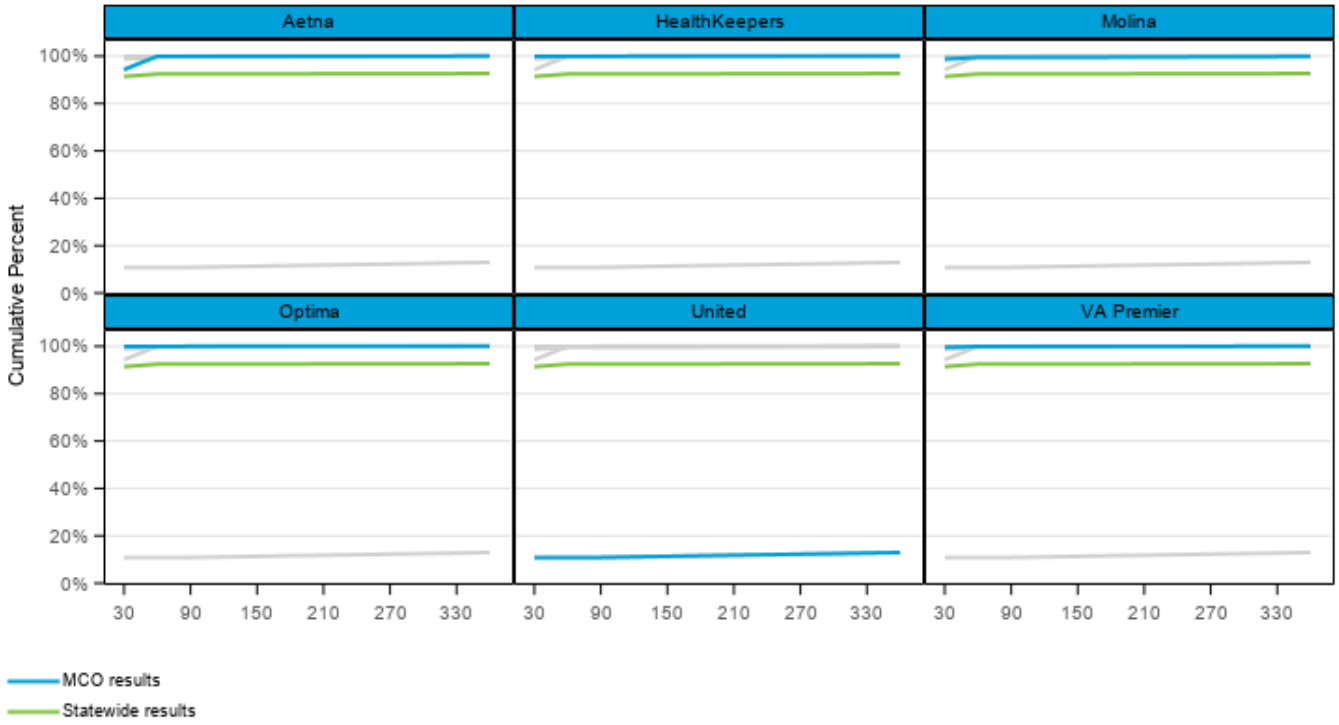


Table 4-5—Cumulative Percentage of Encounters Submitted to DMAS Since MCO Payment Date—Pharmacy Encounters

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 30 days	91.4%	94.3%	100.0%	98.7%	100.0%	10.8%	99.6%
Submitted within 60 days	92.4%	99.9%	100.0%	99.5%	100.0%	10.8%	99.9%
Submitted within 90 days	92.5%	100.0%	100.0%	99.5%	100.0%	10.8%	99.9%
Submitted within 120 days	92.5%	100.0%	100.0%	99.5%	100.0%	11.1%	100.0%
Submitted within 150 days	92.5%	100.0%	100.0%	99.6%	100.0%	11.3%	100.0%
Submitted within 180 days	92.5%	100.0%	100.0%	99.6%	100.0%	11.6%	100.0%
Submitted within 210 days	92.6%	100.0%	100.0%	99.6%	100.0%	11.8%	100.0%
Submitted within 240 days	92.6%	100.0%	100.0%	99.7%	100.0%	12.0%	100.0%
Submitted within 270 days	92.6%	100.0%	100.0%	99.7%	100.0%	12.2%	100.0%
Submitted within 300 days	92.6%	100.0%	100.0%	99.8%	100.0%	12.5%	100.0%

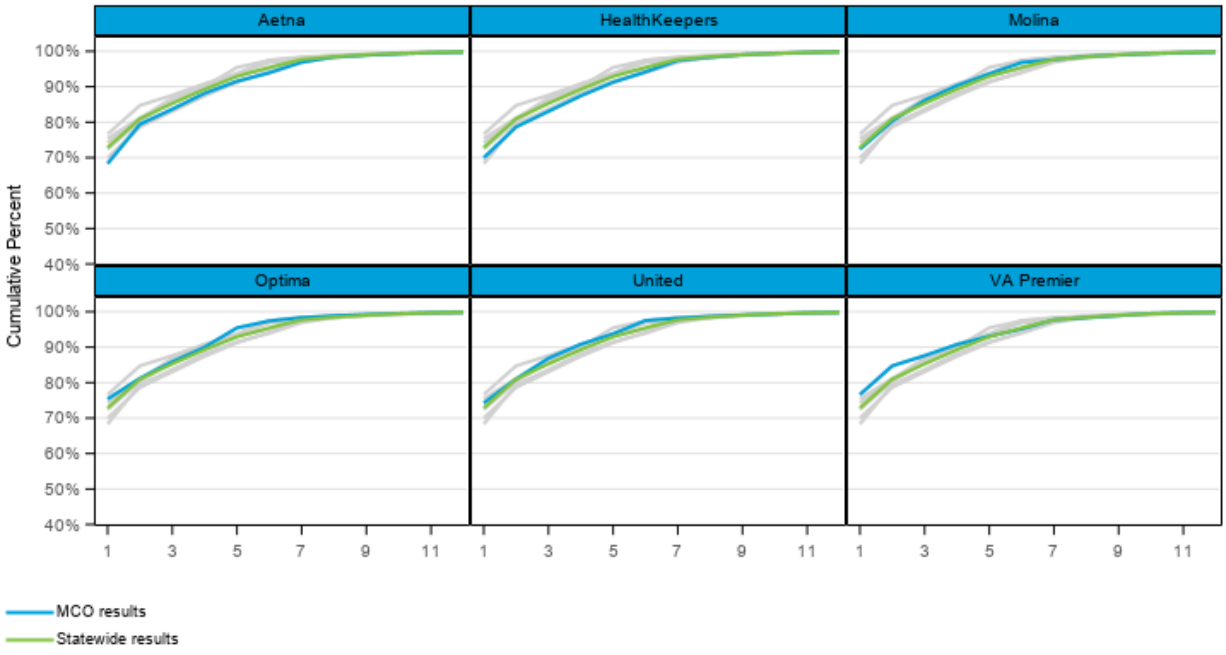
Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 330 days	92.6%	100.0%	100.0%	99.8%	100.0%	12.7%	100.0%
Submitted within 360 days	92.7%	100.0%	100.0%	99.8%	100.0%	12.9%	100.0%
Submitted after 360 days	0.0%	0.0%	0.0%	0.2%	0.0%	0.8%	0.0%
Submitted Prior to Paid Date	7.3%	0.0%	0.0%	0.0%	0.0%	86.3%	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.[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, 95.5 percent of **professional** encounters were submitted within six months from the last date of service, with Aetna and HealthKeepers at a 93.9 percent and 94.2 percent submission rate, respectively.

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



[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.

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	72.9%	68.3%	69.9%	72.4%	75.4%	74.3%	76.6%
Submitted within 2 months	81.0%	79.4%	78.7%	80.3%	81.2%	81.0%	84.7%
Submitted within 3 months	85.3%	83.7%	83.1%	86.1%	85.9%	86.9%	87.6%
Submitted within 4 months	89.3%	88.2%	87.4%	90.3%	90.0%	90.8%	90.7%
Submitted within 5 months	92.9%	91.5%	91.3%	93.6%	95.5%	93.8%	93.1%
Submitted within 6 months	95.5%	93.9%	94.2%	96.8%	97.4%	97.5%	95.2%
Submitted within 7 months	97.7%	96.9%	97.4%	97.7%	98.4%	98.2%	97.7%
Submitted within 8 months	98.5%	98.4%	98.3%	98.6%	98.9%	98.7%	98.3%
Submitted within 9 months	99.0%	98.9%	99.1%	99.0%	99.2%	99.1%	98.9%
Submitted within 10 months	99.4%	99.3%	99.4%	99.3%	99.5%	99.4%	99.5%
Submitted within 11 months	99.7%	99.6%	99.7%	99.6%	99.7%	99.7%	99.7%
Submitted within 12 months	99.8%	99.8%	99.9%	99.8%	99.9%	99.8%	99.9%
Submitted after 12 months	0.2%	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%
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 show that statewide, 94.2 percent of **institutional** encounters were submitted within six months following the date of service, with Aetna and HealthKeepers both at 90.3 percent. Optima had a higher submission rate of 98.7 percent within six months.

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

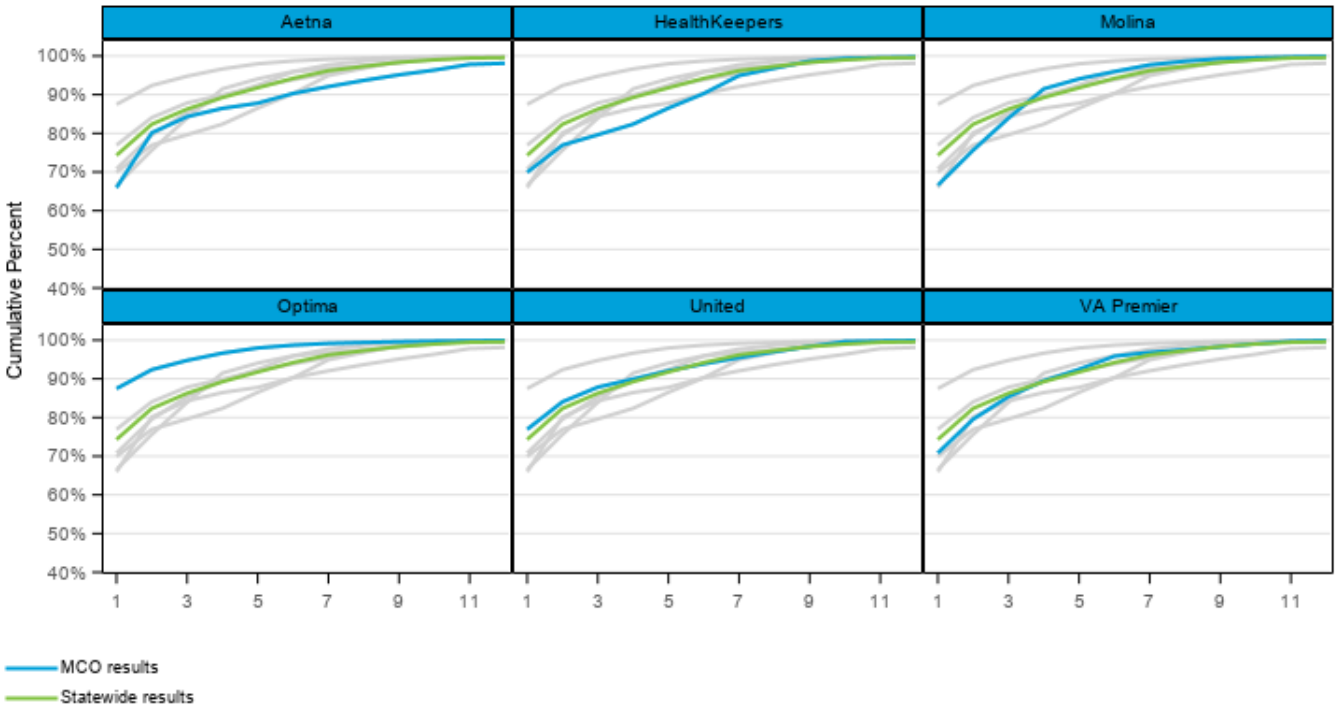


Table 4-7—Cumulative Percentage of Encounters Submitted to DMAS Since Service Month—Institutional Encounters

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 1 month	74.3%	65.9%	69.9%	66.6%	87.5%	76.9%	70.8%
Submitted within 2 months	82.3%	80.1%	76.9%	75.6%	92.4%	84.1%	79.6%
Submitted within 3 months	86.3%	84.3%	79.6%	83.9%	94.8%	87.8%	85.4%
Submitted within 4 months	89.3%	86.5%	82.4%	91.5%	96.6%	89.9%	89.5%
Submitted within 5 months	91.8%	87.8%	86.5%	94.1%	98.0%	92.1%	92.5%
Submitted within 6 months	94.2%	90.3%	90.3%	96.0%	98.7%	93.9%	95.9%
Submitted within 7 months	96.2%	92.1%	94.9%	97.7%	99.2%	95.5%	96.8%
Submitted within 8 months	97.3%	93.7%	96.8%	98.6%	99.4%	97.0%	97.5%
Submitted within 9 months	98.3%	95.1%	98.7%	99.3%	99.6%	98.4%	98.3%
Submitted within 10 months	99.0%	96.3%	99.4%	99.5%	99.8%	99.7%	99.0%
Submitted within 11 months	99.5%	97.8%	99.6%	99.7%	99.9%	99.8%	99.7%
Submitted within 12 months	99.6%	98.1%	99.7%	99.9%	99.9%	99.9%	99.9%
Submitted after 12 months	0.4%	1.9%	0.3%	0.1%	0.1%	0.1%	0.1%
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, all MCOs had a high submission rate of **pharmacy** encounters, at 96.7 percent within 30 days of the service date and 99 percent within 60 days. Aetna had a relatively low rate of 86.4 percent submitted within 30 days; by 60 days, Aetna had a near 100 percent submission rate.

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

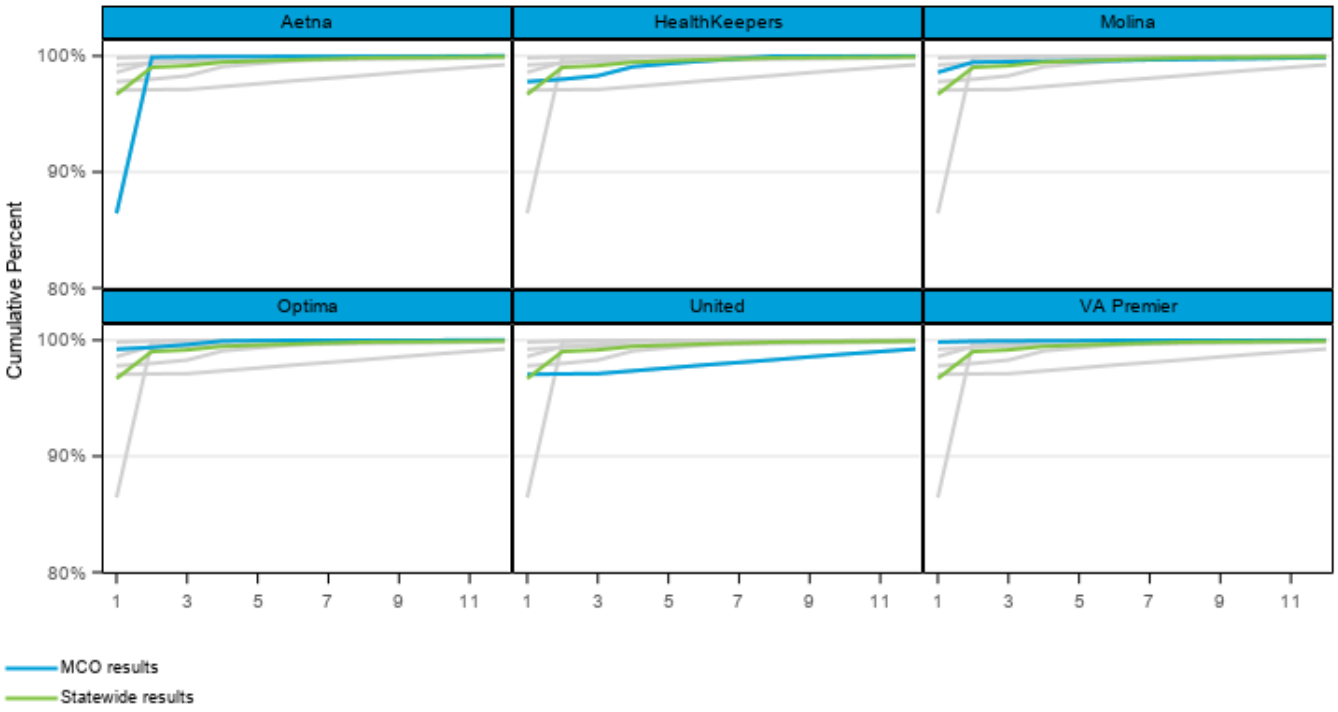


Table 4-8—Cumulative Percentage of Encounters Submitted to DMAS Since Service Month—Pharmacy Encounters

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 1 month	96.7%	86.4%	97.8%	98.6%	99.2%	97.1%	99.8%
Submitted within 2 months	99.0%	99.9%	98.0%	99.5%	99.4%	97.1%	99.9%
Submitted within 3 months	99.2%	99.9%	98.3%	99.5%	99.6%	97.1%	99.9%
Submitted within 4 months	99.5%	99.9%	99.1%	99.5%	99.9%	97.4%	99.9%
Submitted within 5 months	99.6%	100.0%	99.3%	99.6%	100.0%	97.6%	100.0%
Submitted within 6 months	99.7%	100.0%	99.6%	99.6%	100.0%	97.9%	100.0%
Submitted within 7 months	99.8%	100.0%	99.8%	99.7%	100.0%	98.1%	100.0%
Submitted within 8 months	99.8%	100.0%	100.0%	99.7%	100.0%	98.3%	100.0%
Submitted within 9 months	99.9%	100.0%	100.0%	99.7%	100.0%	98.6%	100.0%
Submitted within 10 months	99.9%	100.0%	100.0%	99.8%	100.0%	98.8%	100.0%

Category	Statewide	Aetna	HealthKeepers	Molina	Optima	United	VA Premier
Submitted within 11 months	99.9%	100.0%	100.0%	99.8%	100.0%	99.0%	100.0%
Submitted within 12 months	99.9%	100.0%	100.0%	99.9%	100.0%	99.2%	100.0%
Submitted after 12 months	0.1%	0.0%	0.0%	0.1%	0.0%	0.8%	0.0%
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 that 29.4 percent of professional encounters contained a Referring Provider NPI, but 93.8 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. [4-3]

[4-3] 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%	99.0%
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%	>99.9%
Billing Provider NPI	100.0%	98.2%
Rendering Provider NPI	100.0%	97.4%
Servicing Provider Taxonomy Code	100.0%	84.9%
Referring Provider NPI	29.4%	93.8%
Primary Diagnosis Codes	100.0%	>99.9%
Secondary Diagnosis Codes	43.6%	>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%	99.6%
National Drug Codes	10.0%	99.6%
HCPCS/NDC Combination	65.7%	63.1%
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	1.8%	97.0%
Detail Paid Amount	100.0%	100.0%
Detail TPL Paid Amount	1.6%	100.0%

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

- **HCPCS/NDC Combination**[4-4] had an NDC code populated on 65.7 percent of encounters for HCPCS codes requiring NDC codes. The MCOs' rates varied from 28.2 percent (Optima) to 95.7 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.

[4-4] 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 HealthKeepers, with 67 percent validity. 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 63.1 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%	99.1%
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%	99.3%
Rendering Provider NPI	<0.01%	99.6%
Attending Provider NPI	94.9%	95.6%
Servicing Provider Taxonomy Code	29.2%	79.4%
Referring Provider NPI	1.4%	91.6%
Primary Diagnosis Codes	100.0%	>99.9%
Secondary Diagnosis Codes	98.0%	>99.9%
CPT/HCPCS Codes	79.9%	>99.9%
CPT/HCPCS Codes with PTP Edits	79.9%	99.9%
Service Units	100.0%	100.0%
Service Units with MUE Edits	100.0%	99.7%
Primary Surgical Procedure Codes	4.6%	>99.9%
Secondary Surgical Procedure Code	2.6%	>99.9%
Revenue Codes	100.0%	100.0%
Diagnosis-Related Groups Codes	5.1%	98.6%
Type of Bill Codes	100.0%	100.0%
National Drug Codes	14.1%	97.0%
HCPCS/NDC Combination	>99.9%	65.7%
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	2.1%	73.4%
Detail Paid Amount	100.0%	100.0%
Detail TPL Paid Amount	2.2%	100.0%

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

- **Servicing Provider Taxonomy Code** was present for only 29.2 percent of institutional encounters, driven largely by Optima, which did not submit any encounters with this field populated, and VA Premier, with a 5 percent completion rate. VA Premier had a nearly 100 percent completion rate for its CCC Plus program. This field was populated for HealthKeepers and Molina on 37 percent and 46 percent of encounters, respectively. Aetna had the highest completion rate at 84 percent.
- **CPT/HCPCS codes** were populated for 79.9 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:

- **Servicing Provider Taxonomy Code** was valid for 79.4 percent of encounters. This was due to provider taxonomy codes not included in the provider reference file.
- **Referring Provider NPI** was valid for 91.6 percent of encounters.
- HCPCS codes requiring NDC associated codes (**HCPCS/NDC Combination**) were populated with valid NDCs on 65.7 percent of encounters.[4-5]
- The sum of Detail TPL Paid Amount matched **Header TPL Paid Amount** for 73.4 percent of institutional encounters.

Pharmacy Encounters

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

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

Field	Percent Present	Percent Valid Value
Member ID	100.0%	98.9%
DOS	100.0%	100.0%
Rendering Provider NPI	100.0%	99.4%
Prescribing Provider NPI	100.0%	92.3%
National Drug Codes	100.0%	99.7%
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	2.4%	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 finding pertaining to valid values is that **Prescribing Provider NPI** was valid for 92.3 percent of encounters.

[4-5] 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.

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 support future analyses 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 DMAS 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. While there was also a decline in PMPM paid amounts, the decline was not commensurate in magnitude, suggesting the average cost per claim increased slightly 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]
- Molina and VA Premier had low completeness for **header TPL amount paid** for institutional encounters.
- Three MCOs did not meet a **96 percent submission rate** within 30 days of payment for institutional encounters.
- Three MCOs did not meet a **99 percent submission rate** within 30 days of payment for pharmacy 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."
- **Servicing Provider Taxonomy Code** was populated for 30 percent of institutional encounters.

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.
- Although the DQS is currently on backlog, HSAG recommends that DMAS consider expediting the DQS for Medallion 4.0 to the extent possible.

Administrative Profile

To address the pertinent findings from the administrative profile, HSAG recommends DMAS consider:

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

- Collaborating with United to determine the root cause for submission dates to DMAS before MCO paid dates for pharmacy encounters.
- Monitoring header TPL paid amount completeness by MCOs to ensure the field is populated as expected and collaborate with Molina and VA Premier to determine a root cause for potentially missing values in the institutional encounters.
- Continue monitoring timeliness of MCO submission of institutional and pharmacy encounters and collaborate with MCOs to determine any barriers in timely submission.
- 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."
- Collaborating with MCOs, particularly Optima, to submit Servicing Provider Taxonomy Codes.
- 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 DQS, 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

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 reported having performance standards (beyond what is described in the MCO contract requirement) in place regarding the submission, accuracy, and timeliness of encounter data. The Encounter Evaluation Guide and DQS manual is listed as documentation used to communicate performance standards to the MCOs. However, this scorecard is only available for the CCC Plus line of business. The Medallion 4.0 encounter team, at the time questionnaire responses were received from DMAS, did not have access to the DQS. VA Premier reported that it did not have timely access to the scorecard and Optima did not have a clear understanding of how scorecard metrics are derived (e.g., provider payment timelines), which may have impacted their ability to deliver on DMAS' standards for submission, accuracy, and timeliness of encounter data.

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.

[C-1] Ibid.

Administrative Profile

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

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	1,103,406	1,104,103	999.4
February 2020	1,049,677	1,111,976	944.0
March 2020	928,339	1,120,843	828.3
April 2020	711,546	1,146,645	620.5
May 2020	787,672	1,178,896	668.1
June 2020	915,259	1,201,458	761.8
July 2020	986,934	1,221,010	808.3
August 2020	971,586	1,236,236	785.9
September 2020	1,024,517	1,253,352	817.4
October 2020	1,089,724	1,272,672	856.2
November 2020	990,651	1,288,383	768.9
December 2020	1,021,997	1,310,578	779.8

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	166,043	1,104,103	150.4
February 2020	158,492	1,111,976	142.5
March 2020	128,872	1,120,843	115.0
April 2020	70,155	1,146,645	61.2
May 2020	94,544	1,178,896	80.2
June 2020	122,900	1,201,458	102.3
July 2020	137,964	1,221,010	113.0
August 2020	135,314	1,236,236	109.5
September 2020	138,301	1,253,352	110.3
October 2020	146,037	1,272,672	114.7
November 2020	134,955	1,288,383	104.7
December 2020	135,325	1,310,578	103.3

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	964,412	1,104,103	873.5
February 2020	921,766	1,111,976	828.9
March 2020	1,002,175	1,120,843	894.1
April 2020	818,463	1,146,645	713.8
May 2020	786,443	1,178,896	667.1
June 2020	830,744	1,201,458	691.4
July 2020	853,794	1,221,010	699.3
August 2020	826,704	1,236,236	668.7
September 2020	845,018	1,253,352	674.2
October 2020	863,996	1,272,672	678.9
November 2020	812,192	1,288,383	630.4
December 2020	842,270	1,310,578	642.7

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	135,964,137	123.1	1,996,691	1.8
February 2020	129,743,934	116.7	2,021,287	1.8
March 2020	125,710,738	112.2	1,760,334	1.6
April 2020	99,892,344	87.1	1,228,743	1.1
May 2020	111,552,625	94.6	1,389,728	1.2
June 2020	129,149,892	107.5	1,684,157	1.4
July 2020	128,858,414	105.5	1,959,179	1.6
August 2020	124,248,624	100.5	1,965,157	1.6
September 2020	129,776,727	103.5	1,998,039	1.6
October 2020	138,192,780	108.6	2,390,987	1.9
November 2020	126,122,643	97.9	1,987,402	1.5
December 2020	132,514,635	101.1	1,984,126	1.5

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	134,161,923	121.5	7,507,323	6.8
February 2020	125,488,649	112.9	5,531,770	5.0
March 2020	119,829,819	106.9	4,228,001	3.8
April 2020	86,469,039	75.4	3,596,438	3.1
May 2020	109,986,869	93.3	4,233,271	3.6
June 2020	124,586,774	103.7	4,870,709	4.1
July 2020	137,217,647	112.4	4,788,039	3.9
August 2020	132,971,114	107.6	5,415,769	4.4
September 2020	133,181,276	106.3	4,798,755	3.8
October 2020	137,750,648	108.2	6,186,810	4.9
November 2020	131,277,282	101.9	4,557,023	3.5
December 2020	134,984,687	103.0	4,547,029	3.5

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	75,554,138	68.4	1,207,213	1.1
February 2020	74,051,887	66.6	1,131,688	1.0
March 2020	87,668,882	78.2	1,176,520	1.0
April 2020	80,716,042	70.4	1,222,015	1.1
May 2020	77,376,205	65.6	1,017,438	0.9
June 2020	83,373,408	69.4	1,061,276	0.9
July 2020	84,761,980	69.4	1,324,275	1.1
August 2020	82,850,307	67.0	1,379,434	1.1
September 2020	85,324,384	68.1	1,278,738	1.0
October 2020	88,352,694	69.4	1,538,609	1.2
November 2020	87,544,573	67.9	1,284,516	1.0
December 2020	95,784,013	73.1	1,397,511	1.1

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	23,238,310	138,409	0.6%
Institutional Encounters	5,847,456	16,258	0.3%
Pharmacy Encounters	10,372,291	844	<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	100.0%	100.0%	100.0%	100.0%	100.0%
January 2020	98.7%	99.3%	99.3%	99.6%	99.8%
February 2020	99.5%	99.6%	99.7%	99.8%	99.8%
March 2020	99.6%	99.9%	99.9%	99.9%	99.9%
April 2020	99.1%	99.9%	100.0%	100.0%	100.0%
May 2020	98.2%	99.8%	99.9%	99.9%	99.9%
June 2020	99.6%	99.9%	99.9%	100.0%	100.0%
July 2020	96.0%	99.3%	99.7%	99.7%	99.7%
August 2020	98.5%	99.2%	99.2%	99.2%	99.2%
September 2020	98.7%	98.7%	98.8%	98.8%	98.8%
October 2020	98.1%	98.2%	98.2%	98.3%	98.3%
November 2020	97.9%	97.9%	97.9%	97.9%	98.3%
December 2020	97.7%	97.8%	97.8%	98.2%	99.2%
January 2021	96.4%	96.6%	96.9%	97.6%	98.2%
February 2021	98.4%	99.1%	99.5%	99.9%	100.0%
March 2021	99.4%	99.7%	99.8%	100.0%	100.0%
April 2021	99.2%	99.7%	100.0%	100.0%	100.0%
May 2021	99.3%	100.0%	100.0%	100.0%	100.0%
June 2021	98.7%	98.7%	98.7%	98.7%	98.7%

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	99.3%	99.4%	99.4%	99.4%	99.4%
February 2020	99.3%	99.4%	99.4%	99.5%	99.5%
March 2020	98.0%	98.1%	98.2%	98.4%	99.4%
April 2020	97.8%	98.2%	98.7%	99.7%	99.7%
May 2020	96.8%	98.7%	99.7%	99.7%	99.7%
June 2020	97.9%	99.2%	99.6%	99.6%	99.6%
July 2020	92.1%	95.7%	95.8%	95.9%	95.9%
August 2020	92.9%	93.4%	93.4%	93.4%	93.4%
September 2020	94.5%	94.5%	94.5%	94.5%	94.6%
October 2020	90.8%	91.0%	91.1%	91.2%	91.3%
November 2020	93.7%	93.7%	93.7%	93.7%	96.4%
December 2020	93.3%	93.4%	93.4%	96.1%	97.7%
January 2021	94.5%	94.5%	95.7%	97.7%	98.7%
February 2021	94.5%	96.8%	97.5%	99.1%	100.0%
March 2021	96.2%	98.0%	99.2%	100.0%	100.0%
April 2021	96.6%	98.9%	100.0%	100.0%	100.0%
May 2021	99.0%	100.0%	100.0%	100.0%	100.0%
June 2021	63.4%	63.4%	63.4%	63.4%	63.4%

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	99.4%	99.5%	99.6%	99.6%	99.6%
February 2020	96.9%	96.9%	96.9%	96.9%	96.9%
March 2020	92.0%	92.0%	92.0%	92.0%	92.0%
April 2020	91.7%	91.7%	91.7%	91.7%	91.7%
May 2020	91.2%	91.2%	91.2%	91.2%	91.2%
June 2020	94.6%	94.6%	94.6%	94.6%	94.6%
July 2020	92.3%	92.3%	92.3%	92.3%	92.3%
August 2020	90.8%	90.8%	90.8%	90.8%	90.8%
September 2020	80.2%	91.8%	91.9%	91.9%	91.9%
October 2020	91.9%	92.4%	92.4%	92.4%	92.4%
November 2020	91.0%	91.1%	91.1%	91.1%	91.1%
December 2020	92.1%	92.1%	92.1%	92.2%	92.4%
January 2021	76.5%	76.5%	76.5%	77.2%	77.2%
February 2021	80.0%	80.0%	81.0%	81.0%	81.0%
March 2021	99.9%	99.9%	99.9%	99.9%	99.9%
April 2021	95.0%	95.0%	95.0%	95.0%	95.0%
May 2021	89.7%	93.1%	93.1%	93.1%	93.1%
June 2021	95.3%	95.3%	95.3%	95.3%	95.3%

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**
201912	126												126
202001	277,394	142										1	277,537
202002	635,039	249,333	156										884,528
202003	159,254	699,335	179,600	143									1,038,332
202004	48,094	98,406	355,788	136,274	172								638,734
202005	25,599	32,864	56,191	282,628	136,660	128							534,070
202006	13,867	17,374	20,693	44,614	321,582	156,747	65						574,942
202007	10,589	10,952	9,255	16,224	49,628	361,875	248,383	144					707,050
202008	9,943	9,545	64,435	18,398	27,860	125,590	616,933	303,435	123				1,176,262
202009	6,581	4,777	116,766	166,394	187,825	173,826	85,668	555,741	284,169	98			1,581,845
202010	5,880	6,236	168,392	70,470	88,606	124,216	50,917	87,803	629,891	367,111	140		1,599,662
202011	4,470	4,191	18,839	13,911	12,187	13,149	18,478	31,436	88,133	599,654	315,069	121	1,119,638
202012	3,753	4,444	5,898	3,813	7,156	12,739	13,691	18,200	32,301	86,508	567,432	351,805	1,107,740
202101	6,505	6,778	15,085	11,512	11,626	14,446	10,136	11,954	16,755	36,017	75,283	562,983	779,080
202102	2,366	3,228	4,248	3,286	4,034	5,270	6,666	7,965	10,620	18,190	29,092	68,575	163,540
202103	1,055	1,533	2,804	2,776	4,173	5,625	7,612	9,388	13,198	16,747	24,011	43,368	132,290
202104	948	819	1,571	2,290	3,341	4,354	11,093	12,465	14,373	17,775	22,174	27,539	118,742
202105	1,101	880	936	1,259	2,607	3,921	5,517	14,404	18,158	20,059	21,459	25,663	115,964
202106	1,230	1,042	1,148	1,132	1,547	2,691	6,447	6,861	7,739	8,728	10,428	18,147	67,140
202107	62	86	91	56	87	211	264	325	680	762	641	572	3,837
Total	1,213,856	1,151,965	1,021,896	775,180	859,091	1,004,788	1,081,870	1,060,121	1,116,140	1,171,649	1,065,729	1,098,774	12,621,059
MM	1,104,103	1,111,976	1,120,843	1,146,645	1,178,896	1,201,458	1,221,010	1,236,236	1,253,352	1,272,672	1,288,383	1,310,578	14,446,152
PMPM	**1.099**	**1.036**	**0.912**	**0.676**	**0.729**	**0.836**	**0.886**	**0.858**	**0.891**	**0.921**	**0.827**	**0.838**	**0.876**

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	39,511												39,511
202002	96,142	35,815											131,957
202003	12,982	97,167	31,571										141,720
202004	5,959	11,641	55,636	15,132									88,368
202005	3,397	4,365	9,063	31,059	18,525				1				66,410
202006	1,895	2,814	3,234	4,573	50,674	26,658							89,848
202007	2,826	2,568	2,954	2,707	8,754	64,757	22,961						107,527
202008	1,055	1,096	1,802	1,795	3,854	13,115	69,042	30,084					121,843
202009	1,402	1,784	13,539	12,977	8,000	10,890	16,454	67,679	27,319				160,044
202010	836	832	11,744	1,079	2,267	3,470	4,687	10,164	77,046	37,187			149,312
202011	844	597	723	471	820	1,381	7,116	8,634	13,118	79,371	36,754		149,829
202012	442	441	502	390	836	2,553	2,397	2,820	4,657	10,042	71,770	40,981	137,831
202101	303	328	276	225	357	519	1,193	1,648	2,411	4,872	10,045	68,918	91,095
202102	259	502	888	295	559	753	1,855	2,018	1,874	2,940	3,997	8,781	24,721
202103	250	247	340	232	362	423	855	1,154	1,132	1,728	2,393	5,063	14,179
202104	147	227	391	413	710	725	6,802	6,962	6,811	7,154	6,893	7,858	45,093
202105	155	132	172	140	299	427	3,300	2,599	2,428	2,511	2,491	2,805	17,459
202106	102	116	95	62	132	236	4,279	4,172	4,251	2,967	3,032	3,140	22,584
202107	1,063	1,056	802	439	573	37	56	48	52	86	58	103	4,373
Total	169,570	161,728	133,732	71,989	96,722	125,944	140,997	137,982	141,100	148,858	137,433	137,649	1,603,704
MM	1,104,103	1,111,976	1,120,843	1,146,645	1,178,896	1,201,458	1,221,010	1,236,236	1,253,352	1,272,672	1,288,383	1,310,578	14,446,152
PMPM	**0.154**	**0.145**	**0.119**	**0.063**	**0.082**	**0.105**	**0.115**	**0.112**	**0.113**	**0.117**	**0.107**	**0.105**	**0.111**

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	325,035												325,035
202002	594,722	369,459											964,181
202003	25,616	488,075	421,160										934,851
202004	411	60,940	571,526	332,195									965,072
202005	15,222	339	6,498	468,588	320,506								811,153
202006	55	86	232	15,379	462,655	337,810							816,217
202007	132	138	216	212	870	484,176	373,838						859,582
202008	230	390	522	174	257	6,338	442,703	313,249					763,863
202009	12	18	22	314	404	557	21,306	410,658	232,164				665,455
202010	45	52	37	53	50	139	2,075	94,784	602,662	374,310			1,074,207
202011	9	13	10	14	18	32	5,926	138	653	471,166	398,473		876,452
202012	490	3	4	1	2	11	20	48	243	5,870	402,253	551,140	960,085
202101	17	2	5	12	5	5	20	31	122	2,775	2,197	280,692	285,883
202102			1		10	7	15	20	27	73	144	704	1,001
202103	241	202	220	189	121	133	6,124	5,940	7,221	7,444	6,924	7,513	42,272
202104	2,272	2,190	2,356	2,000	2,029	2,098	2,273	2,119	2,155	2,403	2,261	2,232	26,388
202105	23	17	21	23	27	32	30	27	41	24	35	51	351
202106	14	14	11	7	16	20	15	17	26	33	30	37	240
202107												3	3
Total	964,546	921,938	1,002,841	819,161	786,970	831,358	854,345	827,031	845,314	864,098	812,317	842,372	10,372,291
MM	1,104,103	1,111,976	1,120,843	1,146,645	1,178,896	1,201,458	1,221,010	1,236,236	1,253,352	1,272,672	1,288,383	1,310,578	14,446,152
PMPM	**0.874**	**0.829**	**0.895**	**0.714**	**0.668**	**0.692**	**0.700**	**0.669**	**0.674**	**0.679**	**0.630**	**0.643**	**0.722**

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	12,621,059	12,621,059	100.0%	12,498,254	12,621,059	99.0%
Header Service From Date	12,621,059	12,621,059	100.0%	12,621,059	12,621,059	100.0%
Header Service To Date	12,621,059	12,621,059	100.0%	12,618,168	12,621,059	>99.9%
Detail Service From Date	23,238,310	23,238,310	100.0%	23,238,310	23,238,310	100.0%
Detail Service To Date	23,238,310	23,238,310	100.0%	23,234,194	23,238,310	>99.9%
Billing Provider NPI	12,621,059	12,621,059	100.0%	12,396,361	12,621,059	98.2%
Rendering Provider NPI	12,621,059	12,621,059	100.0%	12,292,615	12,621,059	97.4%
Servicing Provider Taxonomy Code	23,238,310	23,238,310	100.0%	19,722,274	23,238,310	84.9%
Referring Provider NPI	3,704,654	12,621,059	29.4%	3,474,051	3,704,654	93.8%
Primary Diagnosis Codes	12,621,059	12,621,059	100.0%	12,621,027	12,621,059	>99.9%
Secondary Diagnosis Codes	5,497,251	12,621,059	43.6%	12,373,457	12,373,515	>99.9%
CPT/HCPCS Codes	23,238,310	23,238,310	100.0%	23,238,232	23,238,310	>99.9%
CPT/HCPCS Codes with PTP Edits	23,238,310	23,238,310	100.0%	23,224,297	23,238,310	>99.9%
Service Units	23,238,310	23,238,310	100.0%	23,238,310	23,238,310	100.0%
Service Units with MUE Edits	13,109,535	13,109,535	100.0%	13,053,133	13,109,535	99.6%
National Drug Codes	2,334,200	23,238,310	10.0%	2,324,680	2,334,200	99.6%
HCPCS/NDC Combination	422,572	643,082	65.7%	266,611	422,572	63.1%
MCO Received Date	23,238,310	23,238,310	100.0%	23,238,310	23,238,310	100.0%
MCO Paid Date	23,238,310	23,238,310	100.0%	23,238,310	23,238,310	100.0%
Header Paid Amount	12,621,059	12,621,059	100.0%	12,618,048	12,621,059	>99.9%
Header TPL Paid Amount	230,120	12,621,059	1.8%	223,167	230,120	97.0%
Detail Paid Amount	23,238,310	23,238,310	100.0%	23,238,310	23,238,310	100.0%
Detail TPL Paid Amount	365,842	23,238,310	1.6%	365,842	365,842	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	1,603,704	1,603,704	100.0%	1,588,887	1,603,704	99.1%
Header Service From Date	1,603,704	1,603,704	100.0%	1,603,704	1,603,704	100.0%
Header Service To Date	1,603,704	1,603,704	100.0%	1,603,702	1,603,704	>99.9%
Detail Service From Date	5,847,456	5,847,456	100.0%	5,847,456	5,847,456	100.0%
Detail Service To Date	5,847,456	5,847,456	100.0%	5,847,456	5,847,456	100.0%
Billing Provider NPI	1,603,704	1,603,704	100.0%	1,591,978	1,603,704	99.3%
Rendering Provider NPI	807	1,603,704	<0.01%	804	807	99.6%
Attending Provider NPI	1,522,026	1,603,704	94.9%	1,455,502	1,522,026	95.6%
Servicing Provider Taxonomy Code	1,709,884	5,847,456	29.2%	1,357,501	1,709,884	79.4%
Referring Provider NPI	22,568	1,603,704	1.4%	20,671	22,568	91.6%
Primary Diagnosis Codes	1,603,704	1,603,704	100.0%	1,603,702	1,603,704	>99.9%
Secondary Diagnosis Codes	1,571,501	1,603,704	98.0%	6,113,575	6,113,583	>99.9%
CPT/HCPCS Codes	4,673,077	5,847,456	79.9%	4,672,918	4,673,077	>99.9%
CPT/HCPCS Codes with PTP Edits	4,673,077	5,847,456	79.9%	4,667,866	4,673,077	99.9%
Service Units	5,847,456	5,847,456	100.0%	5,847,456	5,847,456	100.0%
Service Units with MUE Edits	3,937,307	3,937,307	100.0%	3,926,595	3,937,307	99.7%
Primary Surgical Procedure Codes	73,714	1,603,704	4.6%	73,683	73,714	>99.9%
Secondary Surgical Procedure Codes	41,531	1,603,704	2.6%	98,869	98,903	>99.9%
Revenue Codes	5,847,456	5,847,456	100.0%	5,847,456	5,847,456	100.0%
Diagnosis-Related Groups Codes	81,355	1,603,704	5.1%	80,176	81,355	98.6%
Type of Bill Codes	1,603,704	1,603,704	100.0%	1,603,704	1,603,704	100.0%
National Drug Codes	825,258	5,847,456	14.1%	800,245	825,258	97.0%
HCPCS/NDC Combination	608,283	608,526	>99.9%	399,812	608,283	65.7%
MCO Received Date	5,847,456	5,847,456	100.0%	5,847,456	5,847,456	100.0%
MCO Paid Date	5,847,456	5,847,456	100.0%	5,847,456	5,847,456	100.0%
Header Paid Amount	1,603,704	1,603,704	100.0%	1,603,666	1,603,704	>99.9%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Header TPL Paid Amount	33,881	1,603,704	2.1%	24,877	33,881	73.4%
Detail Paid Amount	5,847,456	5,847,456	100.0%	5,847,456	5,847,456	100.0%
Detail TPL Paid Amount	126,398	5,847,456	2.2%	126,398	126,398	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	10,372,291	10,372,291	100.0%	10,254,080	10,372,291	98.9%
DOS	10,372,291	10,372,291	100.0%	10,372,291	10,372,291	100.0%
Billing Provider NPI	10,372,291	10,372,291	100.0%	10,309,086	10,372,291	99.4%
Prescribing Provider NPI	10,372,291	10,372,291	100.0%	9,571,372	10,372,291	92.3%
National Drug Codes	10,372,291	10,372,291	100.0%	10,344,374	10,372,291	99.7%
MCO Received Date	10,372,291	10,372,291	100.0%	10,372,291	10,372,291	100.0%
MCO Paid Date	10,372,291	10,372,291	100.0%	10,372,291	10,372,291	100.0%
Header Paid Amount	10,372,291	10,372,291	100.0%	10,372,291	10,372,291	100.0%
Header TPL Paid Amount	248,967	10,372,291	2.4%	248,967	248,967	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
Medallion 4.0				
Line-by-Line	3.4%	2.8%	0.6%	—
Per Diem	12.2%	5.0%	0.0%	—
DRG	84.3%	0.0%	0.0%	—
Negotiated (Flat) Rate	0.0%	1.4%	0.0%	—
Other (Ambulatory Surgery)	0.0%	90.6%	99.4%	—
Other (Per Unit)	0.0%	0.2%	0.0%	—
Total	**100%**	**100%**	**100%**	**100%**

The symbol "—" indicates that the MCO did not submit a response for a cell.

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 HEDIS 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.

Administrative Profile

This section will provide 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	148,000	135,164	1,095.0
February 2020	141,808	137,775	1,029.3
March 2020	127,681	139,636	914.4
April 2020	98,563	143,664	686.1
May 2020	109,990	148,764	739.4
June 2020	131,789	152,561	863.8
July 2020	143,252	155,888	918.9
August 2020	142,036	158,866	894.1
September 2020	149,549	161,907	923.7
October 2020	159,829	165,195	967.5
November 2020	146,847	167,875	874.7
December 2020	151,676	171,506	884.4

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	22,957	135,164	169.8
February 2020	21,984	137,775	159.6
March 2020	18,270	139,636	130.8
April 2020	10,183	143,664	70.9
May 2020	13,850	148,764	93.1
June 2020	18,420	152,561	120.7
July 2020	20,463	155,888	131.3
August 2020	20,275	158,866	127.6

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
September 2020	21,080	161,907	130.2
October 2020	22,058	165,195	133.5
November 2020	20,421	167,875	121.6
December 2020	20,686	171,506	120.6

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	149,281	135,164	1,104.4
February 2020	143,051	137,775	1,038.3
March 2020	159,710	139,636	1,143.8
April 2020	134,814	143,664	938.4
May 2020	129,174	148,764	868.3
June 2020	136,840	152,561	897.0
July 2020	141,660	155,888	908.7
August 2020	135,916	158,866	855.5
September 2020	133,142	161,907	822.3
October 2020	140,025	165,195	847.6
November 2020	130,671	167,875	778.4
December 2020	135,748	171,506	791.5

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	17,565,086	130.0	387,897	2.9
February 2020	17,170,821	124.6	364,678	2.6
March 2020	16,472,287	118.0	365,153	2.6
April 2020	13,277,192	92.4	256,428	1.8
May 2020	14,858,625	99.9	324,306	2.2
June 2020	17,508,695	114.8	370,488	2.4
July 2020	17,521,576	112.4	375,022	2.4
August 2020	17,485,362	110.1	370,127	2.3
September 2020	17,900,326	110.6	391,383	2.4
October 2020	19,624,388	118.8	373,512	2.3
November 2020	18,022,521	107.4	370,032	2.2
December 2020	18,966,349	110.6	337,487	2.0

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	20,424,334	151.1	1,658,339	12.3
February 2020	19,214,174	139.5	1,280,512	9.3
March 2020	18,367,428	131.5	984,233	7.0
April 2020	13,074,211	91.0	703,283	4.9
May 2020	16,199,500	108.9	931,293	6.3
June 2020	18,883,641	123.8	1,249,991	8.2
July 2020	20,477,169	131.4	1,166,281	7.5
August 2020	20,996,269	132.2	1,116,640	7.0
September 2020	19,617,978	121.2	1,405,932	8.7
October 2020	21,519,185	130.3	1,256,264	7.6
November 2020	19,748,954	117.6	1,164,008	6.9
December 2020	22,497,320	131.2	995,372	5.8

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	11,829,099	87.5	65,102	0.5
February 2020	11,864,088	86.1	77,526	0.6
March 2020	14,338,181	102.7	65,332	0.5
April 2020	13,271,790	92.4	65,421	0.5
May 2020	12,626,662	84.9	79,887	0.5
June 2020	14,212,075	93.2	76,133	0.5
July 2020	15,068,259	96.7	79,117	0.5
August 2020	14,373,283	90.5	146,623	0.9
September 2020	13,658,010	84.4	107,652	0.7
October 2020	14,621,555	88.5	90,955	0.6
November 2020	14,791,420	88.1	86,915	0.5
December 2020	15,820,260	92.2	141,991	0.8

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

Table D-11—Percentage of Duplicate Encounters

Claim Type	Total Records	Number of Duplicate Records	Percent of Duplicates
Professional Encounters	3,468,657	5,805	0.2%
Institutional Encounters	831,354	2,755	0.3%
Pharmacy Encounters	1,670,211	25	<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

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	99.9%	99.9%	99.9%	99.9%	99.9%
March 2020	99.9%	99.9%	99.9%	99.9%	99.9%
April 2020	99.9%	100.0%	100.0%	100.0%	100.0%
May 2020	88.7%	99.6%	99.8%	99.9%	100.0%
June 2020	97.8%	99.5%	99.8%	99.9%	99.9%
July 2020	98.0%	99.8%	99.9%	99.9%	100.0%
August 2020	99.6%	99.8%	99.9%	99.9%	99.9%
September 2020	99.3%	99.5%	99.5%	99.5%	99.5%
October 2020	98.8%	98.9%	98.9%	98.9%	98.9%
November 2020	98.4%	98.4%	98.4%	98.4%	98.4%
December 2020	98.7%	98.7%	98.7%	98.7%	98.7%
January 2021	98.8%	98.8%	98.8%	98.8%	99.1%
February 2021	98.6%	98.9%	99.0%	99.4%	100.0%
March 2021	99.3%	99.3%	99.7%	100.0%	100.0%
April 2021	98.7%	99.3%	100.0%	100.0%	100.0%
May 2021	99.6%	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

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	99.8%	99.8%	99.8%	99.8%	99.8%
March 2020	96.6%	96.6%	96.6%	96.6%	96.6%
April 2020	99.2%	99.2%	99.2%	99.2%	99.2%
May 2020	89.4%	99.6%	99.7%	99.8%	99.8%
June 2020	95.1%	97.7%	99.8%	99.9%	99.9%
July 2020	84.1%	88.7%	89.1%	89.2%	89.3%
August 2020	81.9%	84.0%	84.0%	84.1%	84.1%
September 2020	88.4%	88.4%	88.4%	88.4%	88.4%
October 2020	88.0%	88.5%	88.6%	88.8%	88.8%
November 2020	89.5%	89.6%	89.6%	89.6%	89.7%
December 2020	88.9%	89.1%	89.1%	89.1%	89.1%
January 2021	91.9%	91.9%	91.9%	91.9%	93.4%
February 2021	93.3%	93.4%	93.5%	95.5%	100.0%
March 2021	94.1%	94.3%	96.1%	100.0%	100.0%
April 2021	96.6%	98.0%	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 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

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	98.1%	98.1%	98.1%	98.1%	98.1%
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	99.8%	99.9%	100.0%	100.0%	100.0%
September 2020	38.0%	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	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**
202001	11,099												11,099
202002	99,996	7,796											107,792
202003	29,624	118,840	15,679										164,143
202004	10,383	15,038	57,579	6,478									89,478
202005	2,878	4,757	11,814	45,526	4,173								69,148
202006	2,192	3,342	3,803	12,088	56,142	11,909							89,476
202007	1,962	1,484	1,880	2,293	11,450	58,418	4,731						82,218
202008	2,145	1,252	1,337	2,357	3,825	16,013	98,324	24,976					150,229
202009	1,239	1,246	2,687	8,326	5,492	5,791	24,456	95,215	17,974				162,426
202010	1,260	1,399	30,610	19,912	30,301	43,246	16,621	18,204	112,468	35,716			309,737
202011	567	703	14,840	9,211	5,298	4,270	4,418	6,858	16,281	103,365	27,263		193,074
202012	573	665	821	911	1,938	1,703	2,681	4,082	5,922	17,816	101,680	25,139	163,931
202101	444	396	407	332	438	883	1,361	1,586	3,074	6,866	16,045	112,003	143,835
202102	252	380	388	379	454	754	1,029	1,100	1,713	3,420	5,633	14,907	30,409
202103	188	227	338	263	431	579	640	739	1,237	2,045	3,171	4,992	14,850
202104	120	113	300	471	566	825	740	1,072	1,504	2,016	3,170	5,112	16,009
202105	188	223	175	512	712	993	1,263	1,548	2,503	2,201	2,273	2,735	15,326
202106	351	275	275	231	367	439	2,170	2,134	2,675	2,651	2,932	3,036	17,536
202107	53	74	75	32	53	171	176	232	576	586	439	355	2,822
Total	165,514	158,210	143,008	109,322	121,640	145,994	158,610	157,746	165,927	176,682	162,606	168,279	1,833,538
MM	135,164	137,775	139,636	143,664	148,764	152,561	155,888	158,866	161,907	165,195	167,875	171,506	1,838,801
PMPM	**1.225**	**1.148**	**1.024**	**0.761**	**0.818**	**0.957**	**1.017**	**0.993**	**1.025**	**1.070**	**0.969**	**0.981**	**0.999**

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	1,408												1,408
202002	14,904	443											15,347
202003	3,349	16,229	2,152										21,730
202004	1,360	2,613	11,735	771									16,479
202005	436	732	1,616	6,604	484								9,872
202006	322	493	684	1,326	9,438	1,780							14,043
202007	174	213	299	347	1,829	9,917	732						13,511
202008	113	168	220	227	596	3,309	9,962	136					14,731
202009	132	117	160	172	285	885	5,580	13,006	1,521				21,858
202010	153	149	135	117	214	510	1,006	3,157	12,866	3,241			21,548
202011	75	65	108	75	128	258	383	824	2,104	11,685	2,376		18,081
202012	73	81	107	60	300	1,708	348	477	762	2,465	10,560	1,938	18,879
202101	102	80	57	48	79	130	217	264	597	1,094	3,487	12,192	18,347
202102	102	227	641	63	127	200	190	191	253	547	848	2,745	6,134
202103	99	58	61	34	65	63	78	126	148	224	335	721	2,012
202104	35	34	67	180	175	154	126	152	190	207	295	513	2,128
202105	42	25	20	14	43	88	111	110	297	330	312	376	1,768
202106	16	23	10	12	27	53	2,384	2,268	2,598	2,504	2,461	2,403	14,759
202107	1,036	1,042	795	435	559	19	23	23	28	30	30	36	4,056
Total	23,931	22,792	18,867	10,485	14,349	19,074	21,140	20,734	21,364	22,327	20,704	20,924	236,691
MM	135,164	137,775	139,636	143,664	148,764	152,561	155,888	158,866	161,907	165,195	167,875	171,506	1,838,801
PMPM	**0.177**	**0.165**	**0.135**	**0.073**	**0.096**	**0.125**	**0.136**	**0.131**	**0.132**	**0.135**	**0.123**	**0.122**	**0.129**

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	694												694
202002	125,454	551											126,005
202003	22,419	82,242	119										104,780
202004	104	60,122	153,540	1,043									214,809
202005	13	36	5,904	118,870	842								125,665
202006	6	29	70	14,804	128,015	7,359							150,283
202007	71	57	77	70	266	123,493	1,177						125,211
202008		6	3	15	39	5,889	119,901	729					126,582
202009	4	5	4	8	6	54	20,320	41,493	768				62,662
202010	16	15	3	10	11	35	230	93,606	132,040	31,750			257,716
202011	3	2	2	2	4	5	26	68	307	107,736	19,380		127,535
202012	489		2			2	5	10	30	520	111,185	74,591	186,834
202101	14			4					4	8	80	60,762	60,872
202102							1	9	9	20	39	388	466
202103	2			2	6	14	13	11		4	1	16	69
202104	1							1			4	4	10
202105								1	1		3	2	7
202106									3	3	3	2	11
Total	149,290	143,065	159,724	134,828	129,189	136,851	141,673	135,928	133,162	140,041	130,695	135,765	1,534,446
MM	135,164	137,775	139,636	143,664	148,764	152,561	155,888	158,866	161,907	165,195	167,875	171,506	1,667,295
PMPM	**1.105**	**1.038**	**1.144**	**0.938**	**0.868**	**0.897**	**0.909**	**0.856**	**0.822**	**0.848**	**0.779**	**0.792**	**0.916**

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	1,833,538	1,833,538	100.0%	1,811,970	1,833,538	98.8%
Header Service From Date	1,833,538	1,833,538	100.0%	1,833,538	1,833,538	100.0%
Header Service To Date	1,833,538	1,833,538	100.0%	1,833,537	1,833,538	>99.9%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Detail Service From Date	3,468,657	3,468,657	100.0%	3,468,657	3,468,657	100.0%
Detail Service To Date	3,468,657	3,468,657	100.0%	3,468,656	3,468,657	>99.9%
Billing Provider NPI	1,833,538	1,833,538	100.0%	1,828,645	1,833,538	99.7%
Rendering Provider NPI	1,833,538	1,833,538	100.0%	1,828,366	1,833,538	99.7%
Servicing Provider Taxonomy Code	3,468,657	3,468,657	100.0%	3,430,820	3,468,657	98.9%
Referring Provider NPI	587,811	1,833,538	32.1%	561,273	587,811	95.5%
Primary Diagnosis Codes	1,833,538	1,833,538	100.0%	1,833,537	1,833,538	>99.9%
Secondary Diagnosis Codes	800,480	1,833,538	43.7%	1,846,108	1,846,108	100.0%
CPT/HCPCS Codes	3,468,657	3,468,657	100.0%	3,468,651	3,468,657	>99.9%
CPT/HCPCS Codes with PTP Edits	3,468,657	3,468,657	100.0%	3,466,999	3,468,657	>99.9%
Service Units	3,468,657	3,468,657	100.0%	3,468,657	3,468,657	100.0%
Service Units with MUE Edits	1,969,551	1,969,551	100.0%	1,955,987	1,969,551	99.3%
National Drug Codes	355,287	3,468,657	10.2%	354,155	355,287	99.7%
HCPCS/NDC Combination	70,981	74,178	95.7%	46,561	70,981	65.6%
MCO Received Date	3,468,657	3,468,657	100.0%	3,468,657	3,468,657	100.0%
MCO Paid Date	3,468,657	3,468,657	100.0%	3,468,657	3,468,657	100.0%
Header Paid Amount	1,833,538	1,833,538	100.0%	1,833,538	1,833,538	100.0%
Header TPL Paid Amount	53,708	1,833,538	2.9%	52,971	53,708	98.6%
Detail Paid Amount	3,468,657	3,468,657	100.0%	3,468,657	3,468,657	100.0%
Detail TPL Paid Amount	95,623	3,468,657	2.8%	95,623	95,623	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	236,691	236,691	100.0%	234,239	236,691	99.0%
Header Service From Date	236,691	236,691	100.0%	236,691	236,691	100.0%
Header Service To Date	236,691	236,691	100.0%	236,691	236,691	100.0%
Detail Service From Date	831,354	831,354	100.0%	831,354	831,354	100.0%
Detail Service To Date	831,354	831,354	100.0%	831,354	831,354	100.0%
Billing Provider NPI	236,691	236,691	100.0%	236,246	236,691	99.8%
Rendering Provider NPI	302	236,691	0.1%	300	302	99.3%
Attending Provider NPI	236,492	236,691	>99.9%	229,863	236,492	97.2%
Servicing Provider Taxonomy Code	697,794	831,354	83.9%	584,464	697,794	83.8%
Referring Provider NPI	1,295	236,691	0.5%	1,277	1,295	98.6%
Primary Diagnosis Codes	236,691	236,691	100.0%	236,691	236,691	100.0%
Secondary Diagnosis Codes	234,197	236,691	98.9%	990,136	990,136	100.0%
CPT/HCPCS Codes	668,598	831,354	80.4%	668,567	668,598	>99.9%
CPT/HCPCS Codes with PTP Edits	668,598	831,354	80.4%	668,349	668,598	>99.9%
Service Units	831,354	831,354	100.0%	831,354	831,354	100.0%
Service Units with MUE Edits	550,432	550,432	100.0%	549,076	550,432	99.8%
Primary Surgical Procedure Codes	10,049	236,691	4.2%	10,043	10,049	>99.9%
Secondary Surgical Procedure Codes	5,810	236,691	2.5%	14,163	14,171	>99.9%
Revenue Codes	831,354	831,354	100.0%	831,354	831,354	100.0%
Diagnosis-Related Groups Codes	13,336	236,691	5.6%	13,335	13,336	>99.9%
Type of Bill Codes	236,691	236,691	100.0%	236,691	236,691	100.0%
National Drug Codes	122,490	831,354	14.7%	121,628	122,490	99.3%
HCPCS/NDC Combination	96,004	96,008	>99.9%	64,198	96,004	66.9%
MCO Received Date	831,354	831,354	100.0%	831,354	831,354	100.0%
MCO Paid Date	831,354	831,354	100.0%	831,354	831,354	100.0%
Header Paid Amount	236,691	236,691	100.0%	236,691	236,691	100.0%
Header TPL Paid Amount	7,910	236,691	3.3%	7,891	7,910	99.8%
Detail Paid Amount	831,354	831,354	100.0%	831,354	831,354	100.0%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Detail TPL Paid Amount	30,442	831,354	3.7%	30,442	30,442	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	1,670,211	1,670,211	100.0%	1,649,321	1,670,211	98.7%
DOS	1,670,211	1,670,211	100.0%	1,670,211	1,670,211	100.0%
Rendering Provider NPI	1,670,211	1,670,211	100.0%	1,661,009	1,670,211	99.4%
Prescribing Provider NPI	1,670,211	1,670,211	100.0%	1,608,919	1,670,211	96.3%
National Drug Codes	1,670,211	1,670,211	100.0%	1,665,295	1,670,211	99.7%
MCO Received Date	1,670,211	1,670,211	100.0%	1,670,211	1,670,211	100.0%
MCO Paid Date	1,670,211	1,670,211	100.0%	1,670,211	1,670,211	100.0%
Header Paid Amount	1,670,211	1,670,211	100.0%	1,670,211	1,670,211	100.0%
Header TPL Paid Amount	5,295	1,670,211	0.3%	5,295	5,295	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 8 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
Medallion 4.0				
Percent of Billed	0.07%	0.06%	0	0
Line-by-Line	83.92%	79.07%	0	0
Per Diem	6.31%	3.68%	0	0
Capitation	0	0.33%	0	0
DRG	8.03%	0	0	0
Negotiated (Flat) Rate	0.23%	0.91%	0	0
Ingredient Cost (for Pharmacy)	0	0	100%	0
Other	0.42%	8.99%	0	0
Other N/A	1.02%	6.96%	0	0
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	312,478	343,910	908.6
February 2020	298,356	345,841	862.7
March 2020	261,606	348,031	751.7
April 2020	198,262	355,377	557.9
May 2020	221,408	364,511	607.4
June 2020	255,994	371,080	689.9
July 2020	276,278	376,767	733.3
August 2020	275,163	382,053	720.2
September 2020	290,959	386,995	751.8
October 2020	313,295	392,424	798.4
November 2020	283,473	396,895	714.2
December 2020	293,097	402,526	728.1

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	44,093	343,910	128.2
February 2020	41,956	345,841	121.3
March 2020	33,571	348,031	96.5
April 2020	17,063	355,377	48.0
May 2020	22,772	364,511	62.5
June 2020	29,351	371,080	79.1
July 2020	33,457	376,767	88.8
August 2020	33,684	382,053	88.2

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
September 2020	33,819	386,995	87.4
October 2020	35,540	392,424	90.6
November 2020	32,964	396,895	83.1
December 2020	33,392	402,526	83.0

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	267,477	343,910	777.8
February 2020	256,762	345,841	742.4
March 2020	274,655	348,031	789.2
April 2020	220,110	355,377	619.4
May 2020	211,404	364,511	580.0
June 2020	220,811	371,080	595.0
July 2020	226,618	376,767	601.5
August 2020	223,410	382,053	584.8
September 2020	230,488	386,995	595.6
October 2020	237,312	392,424	604.7
November 2020	219,611	396,895	553.3
December 2020	227,087	402,526	564.2

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	37,041,962	107.7	754,913	2.2
February 2020	34,985,845	101.2	744,582	2.2
March 2020	34,759,662	99.9	590,843	1.7
April 2020	27,354,263	77.0	431,996	1.2
May 2020	30,223,210	82.9	397,848	1.1
June 2020	34,834,530	93.9	471,453	1.3
July 2020	36,213,796	96.1	518,076	1.4

Month	Paid Amount	Paid Amount PMPM	TPL Amount	TPL Amount PMPM
August 2020	33,427,011	87.5	602,151	1.6
September 2020	35,317,900	91.3	631,301	1.6
October 2020	37,479,992	95.5	788,651	2.0
November 2020	33,889,430	85.4	701,646	1.8
December 2020	35,401,118	87.9	685,152	1.7

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	36,396,349	105.8	2,259,353	6.6
February 2020	34,688,113	100.3	1,890,984	5.5
March 2020	34,260,488	98.4	1,444,335	4.2
April 2020	23,755,700	66.8	817,187	2.3
May 2020	27,689,486	76.0	1,210,768	3.3
June 2020	31,783,838	85.7	1,438,203	3.9
July 2020	36,183,704	96.0	1,335,347	3.5
August 2020	35,648,141	93.3	1,562,317	4.1
September 2020	34,712,775	89.7	1,604,479	4.1
October 2020	35,413,243	90.2	1,468,857	3.7
November 2020	34,225,564	86.2	1,433,006	3.6
December 2020	35,085,496	87.2	1,562,368	3.9

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	19,108,024	55.6	430,737	1.3
February 2020	19,388,148	56.1	432,309	1.3
March 2020	23,054,763	66.2	434,595	1.2
April 2020	21,484,425	60.5	442,886	1.2
May 2020	20,636,717	56.6	393,372	1.1
June 2020	21,520,069	58.0	414,028	1.1
July 2020	22,014,682	58.4	454,458	1.2
August 2020	22,184,333	58.1	496,375	1.3
September 2020	22,482,507	58.1	503,258	1.3
October 2020	24,211,645	61.7	718,301	1.8
November 2020	23,425,525	59.0	561,227	1.4
December 2020	26,288,743	65.3	609,070	1.5

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

Table E-11—Percentage of Duplicate Encounters

Claim Type	Total Records	Number of Duplicate Records	Percent of Duplicates
Professional Encounters	6,107,864	34,346	0.6%
Institutional Encounters	1,243,004	7,490	0.6%
Pharmacy Encounters	2,816,011	140	<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

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	96.2%	98.1%	98.1%	99.1%	100.0%
February 2020	99.1%	99.4%	99.6%	100.0%	100.0%
March 2020	99.9%	99.9%	99.9%	99.9%	99.9%
April 2020	96.5%	100.0%	100.0%	100.0%	100.0%
May 2020	99.8%	99.9%	99.9%	99.9%	99.9%
June 2020	100.0%	100.0%	100.0%	100.0%	100.0%
July 2020	87.9%	98.8%	99.1%	99.2%	99.2%
August 2020	96.8%	97.7%	97.7%	97.7%	97.8%
September 2020	97.7%	97.8%	97.8%	97.8%	97.8%
October 2020	94.6%	94.6%	94.8%	94.8%	95.0%
November 2020	94.8%	94.8%	94.8%	94.8%	95.8%
December 2020	93.8%	93.9%	94.0%	95.1%	98.3%
January 2021	87.9%	88.5%	89.4%	91.1%	93.1%
February 2021	96.4%	98.0%	99.3%	99.9%	100.0%
March 2021	98.8%	99.6%	99.8%	100.0%	100.0%
April 2021	98.8%	99.9%	100.0%	100.0%	100.0%
May 2021	98.9%	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

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	99.6%	100.0%	100.0%	100.0%	100.0%
March 2020	99.3%	99.3%	99.3%	99.3%	99.3%
April 2020	99.3%	99.3%	99.3%	99.3%	99.3%
May 2020	98.6%	98.6%	98.6%	98.6%	98.6%
June 2020	98.6%	98.6%	98.6%	98.6%	98.6%
July 2020	80.1%	91.7%	91.8%	91.9%	91.9%
August 2020	87.0%	87.6%	87.6%	87.7%	87.7%
September 2020	89.3%	89.4%	89.4%	89.4%	89.4%
October 2020	75.5%	75.8%	76.0%	76.1%	76.5%
November 2020	83.4%	83.4%	83.4%	83.4%	94.6%
December 2020	83.2%	83.4%	83.5%	94.7%	99.9%
January 2021	85.9%	86.2%	91.3%	99.7%	99.9%
February 2021	86.1%	96.7%	99.3%	99.7%	100.0%
March 2021	94.1%	98.8%	99.3%	100.0%	100.0%
April 2021	95.9%	99.8%	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-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

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	98.4%	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	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	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 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**
201912	5												5
202001	50,332	5											50,337
202002	202,245	38,621											240,866
202003	47,857	227,748	44,835										320,440
202004	12,351	26,381	82,599	20,195									141,526
202005	8,757	10,041	16,588	83,166	20,946								139,498
202006	3,349	4,930	5,848	13,518	95,769	36,484							159,898
202007	1,398	1,631	1,805	3,344	9,162	81,638	17,034						116,012
202008	2,819	2,368	4,012	4,391	9,233	74,637	219,926	77,631					395,017
202009	936	1,260	44,570	77,673	89,587	55,076	20,026	148,716	86,192				524,036
202010	1,378	1,629	73,957	5,183	2,912	9,743	13,753	22,048	163,975	124,698			419,276
202011	1,684	1,403	899	1,443	1,942	2,330	4,572	6,389	14,079	137,167	82,350		254,258
202012	676	886	2,830	436	1,738	5,791	4,200	4,002	7,872	19,792	149,657	74,949	272,829
202101	2,788	3,107	1,644	1,341	1,977	2,464	3,970	5,747	4,790	12,294	24,827	169,122	234,071
202102	256	625	1,015	468	679	885	1,291	1,367	1,829	3,845	6,274	14,321	32,855
202103	203	505	1,205	789	1,008	1,608	1,889	3,198	3,898	4,441	6,179	10,889	35,812
202104	271	352	699	880	1,515	1,867	5,686	6,209	6,651	7,671	8,968	9,718	50,487
202105	330	358	315	292	667	1,181	2,504	11,035	13,329	14,671	14,351	16,381	75,414
202106	244	250	238	202	373	770	1,084	1,387	1,518	2,065	2,700	8,993	19,824
202107	3	5	11	11	17	11	4	13	10	28	33	32	178
Total	337,882	322,105	283,070	213,332	237,525	274,485	295,939	287,742	304,143	326,672	295,339	304,405	3,482,639
MM	343,910	345,841	348,031	355,377	364,511	371,080	376,767	382,053	386,995	392,424	396,895	402,526	4,466,410
PMPM	**0.982**	**0.931**	**0.813**	**0.600**	**0.652**	**0.740**	**0.785**	**0.753**	**0.786**	**0.832**	**0.744**	**0.756**	**0.781**

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	6,009												6,009
202002	29,705	4,306											34,011
202003	4,185	32,274	4,670										41,129
202004	1,859	3,008	11,375	1,828									18,070
202005	636	853	1,119	6,020	2,596								11,224
202006	407	557	612	974	15,427	5,779							23,756
202007	235	261	263	303	2,434	16,502	568						20,566
202008	455	363	417	277	1,049	5,151	20,691	6,567					34,970
202009	141	161	6,363	7,449	406	762	2,626	16,867	7,518				42,293
202010	190	147	10,680	203	269	417	1,132	1,738	17,512	9,929			42,217
202011	468	178	220	103	129	250	337	624	1,398	15,148	7,176		26,031
202012	50	55	58	64	77	144	214	288	651	1,974	16,465	6,340	26,380
202101	37	64	67	47	66	105	444	537	448	1,306	2,204	18,628	23,953
202102	46	76	55	53	74	115	168	175	203	645	685	1,319	3,614
202103	63	66	67	38	75	98	128	271	167	325	512	850	2,660
202104	74	136	223	138	378	365	6,079	6,277	6,120	6,339	5,932	6,199	38,260
202105	77	63	100	48	113	145	1,439	715	198	254	290	344	3,786
202106	43	26	46	24	31	77	136	135	150	176	196	212	1,252
202107	7	4	3	3	6	9	13	10	9	22	12	33	131
Total	44,687	42,598	36,338	17,572	23,130	29,919	33,975	34,204	34,374	36,118	33,472	33,925	400,312
MM	343,910	345,841	348,031	355,377	364,511	371,080	376,767	382,053	386,995	392,424	396,895	402,526	4,466,410
PMPM	**0.130**	**0.123**	**0.104**	**0.049**	**0.063**	**0.081**	**0.090**	**0.090**	**0.089**	**0.092**	**0.084**	**0.084**	**0.090**

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	249,534	19,163											268,697
202003	2,525	236,663	17,471										256,659
202004	226	610	256,741	45,005									302,582
202005	15,136	250	324	174,619	25,728								216,057
202006	10	14	81	410	185,216	10,191							195,922
202007	26	30	46	55	362	210,324	38,338						249,181
202008	6	5	8	17	50	201	181,892	17,423					199,602
202009	4	6	7	4	13	35	331	199,398	1,212				201,010
202010	22	37	24	29	22	55	56	724	222,591	104,245			327,805
202011		1	1	1	1	3	4	20	88	125,645	83,285		209,049
202012	1	3	1	1	1	2	4	12	28	145	129,347	122,457	252,002
202101	2	1	3	2	1	2	5	16	21	14	74	97,105	97,246
202102					10		6	5	6	14	21	114	176
202103							5,982	5,819	6,540	7,257	6,876	7,386	39,860
202104	4		3	5	7	7	17	12	7	10	13	20	105
202105			1					1	2		4	13	21
202106	8	5	5		5	5				4		2	34
202107												3	3
Total	267,504	256,788	274,716	220,148	211,416	220,825	226,635	223,430	230,495	237,334	219,620	227,100	2,816,011
MM	343,910	345,841	348,031	355,377	364,511	371,080	376,767	382,053	386,995	392,424	396,895	402,526	4,466,410
PMPM	**0.778**	**0.743**	**0.789**	**0.619**	**0.580**	**0.595**	**0.602**	**0.585**	**0.596**	**0.605**	**0.553**	**0.564**	**0.634**

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	3,482,639	3,482,639	100.0%	3,452,448	3,482,639	99.1%
Header Service From Date	3,482,639	3,482,639	100.0%	3,482,639	3,482,639	100.0%
Header Service To Date	3,482,639	3,482,639	100.0%	3,482,617	3,482,639	>99.9%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Detail Service From Date	6,107,864	6,107,864	100.0%	6,107,864	6,107,864	100.0%
Detail Service To Date	6,107,864	6,107,864	100.0%	6,107,849	6,107,864	>99.9%
Billing Provider NPI	3,482,639	3,482,639	100.0%	3,293,893	3,482,639	94.6%
Rendering Provider NPI	3,482,639	3,482,639	100.0%	3,182,765	3,482,639	91.4%
Servicing Provider Taxonomy Code	6,107,864	6,107,864	100.0%	4,068,534	6,107,864	66.6%
Referring Provider NPI	1,151,638	3,482,639	33.1%	991,396	1,151,638	86.1%
Primary Diagnosis Codes	3,482,639	3,482,639	100.0%	3,482,637	3,482,639	>99.9%
Secondary Diagnosis Codes	1,574,129	3,482,639	45.2%	3,535,793	3,535,793	100.0%
CPT/HCPCS Codes	6,107,864	6,107,864	100.0%	6,107,829	6,107,864	>99.9%
CPT/HCPCS Codes with PTP Edits	6,107,864	6,107,864	100.0%	6,106,558	6,107,864	>99.9%
Service Units	6,107,864	6,107,864	100.0%	6,107,864	6,107,864	100.0%
Service Units with MUE Edits	3,426,473	3,426,473	100.0%	3,420,230	3,426,473	99.8%
National Drug Codes	765,113	6,107,864	12.5%	761,117	765,113	99.5%
HCPCS/NDC Combination	166,358	208,826	79.7%	109,065	166,358	65.6%
MCO Received Date	6,107,864	6,107,864	100.0%	6,107,864	6,107,864	100.0%
MCO Paid Date	6,107,864	6,107,864	100.0%	6,107,864	6,107,864	100.0%
Header Paid Amount	3,482,639	3,482,639	100.0%	3,482,557	3,482,639	>99.9%
Header TPL Paid Amount	74,932	3,482,639	2.2%	71,719	74,932	95.7%
Detail Paid Amount	6,107,864	6,107,864	100.0%	6,107,864	6,107,864	100.0%
Detail TPL Paid Amount	111,948	6,107,864	1.8%	111,948	111,948	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	400,312	400,312	100.0%	396,534	400,312	99.1%
Header Service From Date	400,312	400,312	100.0%	400,312	400,312	100.0%
Header Service To Date	400,312	400,312	100.0%	400,311	400,312	>99.9%
Detail Service From Date	1,243,004	1,243,004	100.0%	1,243,004	1,243,004	100.0%
Detail Service To Date	1,243,004	1,243,004	100.0%	1,243,004	1,243,004	100.0%
Billing Provider NPI	400,312	400,312	100.0%	392,008	400,312	97.9%
Rendering Provider NPI	0	400,312	0.0%	NA	NA	NA
Attending Provider NPI	393,768	400,312	98.4%	337,453	393,768	85.7%
Servicing Provider Taxonomy Code	458,903	1,243,004	36.9%	276,077	458,903	60.2%
Referring Provider NPI	11,915	400,312	3.0%	10,165	11,915	85.3%
Primary Diagnosis Codes	400,312	400,312	100.0%	400,311	400,312	>99.9%
Secondary Diagnosis Codes	395,880	400,312	98.9%	1,616,553	1,616,558	>99.9%
CPT/HCPCS Codes	974,700	1,243,004	78.4%	974,638	974,700	>99.9%
CPT/HCPCS Codes with PTP Edits	974,700	1,243,004	78.4%	974,395	974,700	>99.9%
Service Units	1,243,004	1,243,004	100.0%	1,243,004	1,243,004	100.0%
Service Units with MUE Edits	821,098	821,098	100.0%	818,587	821,098	99.7%
Primary Surgical Procedure Codes	19,899	400,312	5.0%	19,895	19,899	>99.9%
Secondary Surgical Procedure Codes	11,076	400,312	2.8%	26,670	26,678	>99.9%
Revenue Codes	1,243,004	1,243,004	100.0%	1,243,004	1,243,004	100.0%
Diagnosis-Related Groups Codes	28,009	400,312	7.0%	26,947	28,009	96.2%
Type of Bill Codes	400,312	400,312	100.0%	400,312	400,312	100.0%
National Drug Codes	188,155	1,243,004	15.1%	182,811	188,155	97.2%
HCPCS/NDC Combination	148,299	148,448	99.9%	92,817	148,299	62.6%
MCO Received Date	1,243,004	1,243,004	100.0%	1,243,004	1,243,004	100.0%
MCO Paid Date	1,243,004	1,243,004	100.0%	1,243,004	1,243,004	100.0%
Header Paid Amount	400,312	400,312	100.0%	400,312	400,312	100.0%
Header TPL Paid Amount	11,593	400,312	2.9%	10,962	11,593	94.6%
Detail Paid Amount	1,243,004	1,243,004	100.0%	1,243,004	1,243,004	100.0%
Detail TPL Paid Amount	35,777	1,243,004	2.9%	35,777	35,777	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	2,816,011	2,816,011	100.0%	2,788,374	2,816,011	99.0%
DOS	2,816,011	2,816,011	100.0%	2,816,011	2,816,011	100.0%
Rendering Provider NPI	2,816,011	2,816,011	100.0%	2,782,167	2,816,011	98.8%
Prescribing Provider NPI	2,816,011	2,816,011	100.0%	2,263,326	2,816,011	80.4%
National Drug Codes	2,816,011	2,816,011	100.0%	2,809,587	2,816,011	99.8%
MCO Received Date	2,816,011	2,816,011	100.0%	2,816,011	2,816,011	100.0%
MCO Paid Date	2,816,011	2,816,011	100.0%	2,816,011	2,816,011	100.0%
Header Paid Amount	2,816,011	2,816,011	100.0%	2,816,011	2,816,011	100.0%
Header TPL Paid Amount	38,613	2,816,011	1.4%	38,613	38,613	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
Medallion 4.0				
Percent of Billed	0	0.11%	0	0
Line-by-Line	96.45%	99.89%	0	99.99%
Per Diem	0.24%	0	0	0.01%
DRG	2.28%	0	0	0
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)	*5.33%*	*0.63%*
Professional (Medical, Vision, NEMT, and CD/FEA)	*4.07%*	*0.25%*
Pharmacy (MRx)	*3.03%*	*0.00%*

[F-1] HSAG assumes Molina originally reported the percentage of claims that passed EPS business rules rather the percentage the 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	64,129	65,717	975.8
February 2020	61,540	66,555	924.6
March 2020	56,173	67,475	832.5
April 2020	45,445	69,262	656.1
May 2020	50,705	71,957	704.7
June 2020	60,092	73,781	814.5
July 2020	63,287	75,306	840.4
August 2020	62,709	76,495	819.8
September 2020	63,991	78,019	820.2
October 2020	67,211	79,672	843.6
November 2020	61,464	81,031	758.5
December 2020	64,576	83,246	775.7

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	11,276	65,717	171.6
February 2020	10,889	66,555	163.6
March 2020	9,271	67,475	137.4
April 2020	5,576	69,262	80.5
May 2020	7,352	71,957	102.2
June 2020	9,304	73,781	126.1
July 2020	10,287	75,306	136.6
August 2020	10,173	76,495	133.0

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
September 2020	10,145	78,019	130.0
October 2020	10,890	79,672	136.7
November 2020	9,773	81,031	120.6
December 2020	9,772	83,246	117.4

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	51,906	65,717	789.8
February 2020	48,305	66,555	725.8
March 2020	53,271	67,475	789.5
April 2020	44,683	69,262	645.1
May 2020	44,606	71,957	619.9
June 2020	48,407	73,781	656.1
July 2020	49,865	75,306	662.2
August 2020	48,894	76,495	639.2
September 2020	49,925	78,019	639.9
October 2020	44,650	79,672	560.4
November 2020	47,969	81,031	592.0
December 2020	50,277	83,246	604.0

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	7,966,230	121.2	9,488	0.1
February 2020	7,631,102	114.7	19,370	0.3
March 2020	7,546,893	111.8	28,016	0.4
April 2020	6,388,111	92.2	31,617	0.5
May 2020	7,511,076	104.4	27,771	0.4
June 2020	8,633,629	117.0	67,933	0.9
July 2020	8,685,669	115.3	109,510	1.5
August 2020	8,588,900	112.3	85,687	1.1
September 2020	8,667,760	111.1	96,010	1.2
October 2020	8,724,021	109.5	101,896	1.3
November 2020	7,859,667	97.0	103,774	1.3
December 2020	8,580,070	103.1	79,481	1.0

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	10,273,387	156.3	79,550	1.2
February 2020	9,930,388	149.2	4,434	0.1
March 2020	9,812,405	145.4	23,949	0.4
April 2020	7,617,044	110.0	2,234	0.0
May 2020	8,887,943	123.5	518	0.0
June 2020	9,251,559	125.4	2,473	0.0
July 2020	10,995,988	146.0	10,858	0.1
August 2020	12,145,512	158.8	2,094	0.0
September 2020	12,130,243	155.5	17,898	0.2
October 2020	11,795,518	148.1	8,328	0.1
November 2020	10,082,890	124.4	13,737	0.2
December 2020	11,222,834	134.8	23,758	0.3

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	5,166,665	78.6	172,262	2.6
February 2020	4,829,451	72.6	144,842	2.2
March 2020	5,847,182	86.7	156,158	2.3
April 2020	5,142,519	74.2	113,555	1.6
May 2020	5,066,283	70.4	113,709	1.6
June 2020	5,822,686	78.9	125,138	1.7
July 2020	5,711,855	75.8	160,353	2.1
August 2020	5,658,893	74.0	169,456	2.2
September 2020	6,142,239	78.7	156,315	2.0
October 2020	5,222,723	65.6	155,149	1.9
November 2020	6,119,504	75.5	130,571	1.6
December 2020	6,645,798	79.8	125,374	1.5

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

Table F-16—Percentage of Duplicate Encounters

Claim Type	Total Records	Number of Duplicate Records	Percent of Duplicates
Professional Encounters	1,707,226	51,407	3.0%
Institutional Encounters	428,713	189	<0.1%
Pharmacy Encounters	582,764	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

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	95.5%	95.5%	95.5%	95.6%	95.6%
February 2020	96.1%	96.1%	96.2%	96.3%	96.3%
March 2020	99.4%	99.6%	99.7%	99.7%	99.7%
April 2020	99.2%	99.3%	99.5%	99.5%	99.6%
May 2020	99.0%	99.3%	99.3%	99.3%	99.6%
June 2020	99.6%	99.6%	99.6%	99.8%	99.8%
July 2020	92.5%	95.0%	99.3%	99.8%	99.8%
August 2020	92.3%	99.6%	99.8%	99.8%	99.8%
September 2020	99.9%	99.9%	99.9%	99.9%	99.9%
October 2020	98.7%	99.4%	99.5%	99.6%	99.6%
November 2020	98.5%	98.8%	98.9%	98.9%	99.2%
December 2020	99.4%	99.6%	99.6%	99.8%	99.8%
January 2021	99.6%	99.6%	100.0%	100.0%	100.0%
February 2021	98.1%	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-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

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	99.9%	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	99.9%	99.9%	100.0%	100.0%	100.0%
October 2020	98.8%	99.4%	99.6%	99.6%	99.7%
November 2020	99.6%	99.7%	99.8%	99.8%	100.0%
December 2020	99.5%	99.6%	99.6%	100.0%	100.0%
January 2021	99.3%	99.3%	100.0%	100.0%	100.0%
February 2021	97.9%	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	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

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%	99.5%	99.5%	99.5%
February 2020	99.3%	99.3%	99.5%	99.5%	99.5%
March 2020	99.4%	99.4%	99.5%	99.5%	99.5%
April 2020	99.5%	99.5%	99.5%	99.5%	99.5%
May 2020	99.5%	99.5%	99.5%	99.5%	99.5%
June 2020	99.5%	99.5%	99.5%	99.5%	99.5%
July 2020	99.6%	99.6%	99.5%	99.5%	99.5%
August 2020	99.5%	99.5%	99.5%	99.5%	99.5%
September 2020	99.6%	99.6%	99.5%	99.5%	99.5%
October 2020	88.0%	88.0%	99.5%	99.5%	99.5%
November 2020	99.6%	99.6%	99.5%	99.5%	99.9%
December 2020	99.8%	99.8%	99.5%	99.9%	100.0%
January 2021	100.0%	100.0%	99.5%	99.5%	99.5%
February 2021	100.0%	100.0%	99.5%	99.5%	99.5%
March 2021	100.0%	100.0%	99.5%	99.5%	99.5%
April 2021	100.0%	100.0%	99.5%	99.5%	99.5%
May 2021	100.0%	100.0%	99.5%	99.5%	99.5%
June 2021	100.0%	100.0%	99.5%	99.5%	99.5%

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	17,525												17,525
202002	32,479	17,062											49,541
202003	9,053	37,717	11,638										58,408
202004	3,331	6,704	27,215	12,760									50,010
202005	1,894	2,329	2,968	18,707	11,607								37,505
202006	3,547	2,946	1,794	2,646	23,391	16,515							50,839
202007	617	652	597	971	2,152	21,842	20,809						47,640
202008	534	518	650	1,261	1,751	4,328	31,668	17,746					58,456
202009	2,892	482	17,529	12,806	14,643	18,964	8,598	39,383	24,910				140,207
202010	403	285	438	579	733	2,152	3,285	4,831	33,692	23,010			69,408
202011	210	255	389	418	620	864	1,233	2,087	4,589	37,649	19,567		67,881
202012	186	264	383	383	473	701	2,081	2,906	4,126	8,050	38,021	26,637	84,211
202101	447	427	437	290	377	499	994	727	1,261	2,109	4,548	33,136	45,252
202102	397	484	409	483	678	816	1,228	1,301	1,490	2,060	3,423	6,562	19,331
202103	71	132	231	255	414	641	817	955	1,249	1,698	2,163	3,725	12,351
202104	67	83	50	83	130	180	226	358	505	652	798	1,277	4,409
202105	55	64	50	45	154	257	301	358	488	613	763	1,115	4,263
202106	138	185	197	162	163	241	306	384	464	522	604	821	4,187
Total	73,846	70,589	64,975	51,849	57,286	68,000	71,546	71,036	72,774	76,363	69,887	73,273	821,424
MM	65,717	66,555	67,475	69,262	71,957	73,781	75,306	76,495	78,019	79,672	81,031	83,246	888,516
PMPM	**1.124**	**1.061**	**0.963**	**0.749**	**0.796**	**0.922**	**0.950**	**0.929**	**0.933**	**0.958**	**0.862**	**0.880**	**0.927**

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	3,471												3,471
202002	5,275	3,069											8,344
202003	956	5,677	2,863										9,496
202004	467	805	4,492	1,863									7,627
202005	476	563	918	2,486	2,047				1				6,491
202006	285	365	459	520	3,911	3,630							9,170
202007	115	124	195	282	509	3,962	443						5,630
202008	91	79	120	118	257	803	1,169	623					3,260
202009	81	86	83	114	282	435	335	1,169	994				3,579
202010	89	121	70	84	123	166	389	751	4,786	3,458			10,037
202011	39	37	50	37	52	82	5,174	4,793	2,452	5,465	2,967		21,148
202012	39	28	37	26	56	94	1,006	985	729	966	5,379	3,828	13,173
202101	28	46	30	29	56	68	174	201	252	415	704	4,437	6,440
202102	15	41	36	34	54	61	968	1,063	568	367	402	833	4,442
202103	17	28	37	39	36	56	343	365	256	193	261	465	2,096
202104	4	10	12	13	34	20	371	269	182	90	87	156	1,248
202105	4	6	5	5	20	32	38	53	50	60	54	104	431
202106	3	3	4	6	18	14	41	32	36	40	41	59	297
Total	11,455	11,088	9,411	5,656	7,455	9,423	10,451	10,304	10,306	11,054	9,895	9,882	116,380
MM	65,717	66,555	67,475	69,262	71,957	73,781	75,306	76,495	78,019	79,672	81,031	83,246	888,516
PMPM	**0.174**	**0.167**	**0.139**	**0.082**	**0.104**	**0.128**	**0.139**	**0.135**	**0.132**	**0.139**	**0.122**	**0.119**	**0.132**

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	33,532												33,532
202002	17,861	40,985											58,846
202003	138	6,935	42,248										49,321
202004	23	43	10,646	30,403									41,115
202005	11	5	36	13,950	37,122								51,124
202006	19	15	22	24	7,235	37,058							44,373
202007	8	11	9	12	35	11,116	43,937						55,128
202008	2		2	13	9	14	5,675	39,376					45,091
202009	1		1			9	19	9,255	35,515				44,800
202010	3				3	2	8	28	14,080	32,929			47,053
202011	1						1	7	17	6,789	40,024		46,839
202012								13	62	4,712	7,695	37,128	49,610
202101								1	21	30	51	13,024	13,127
202102										1	12	8	21
202103	237	201	217	183	113	117	128	102	3	2	12	14	1,329
202104	70	110	91	99	90	91	97	112	227	188	174	104	1,453
202105												1	1
202106											1		1
Total	51,906	48,305	53,272	44,684	44,607	48,407	49,865	48,894	49,925	44,651	47,969	50,279	582,764
MM	65,717	66,555	67,475	69,262	71,957	73,781	75,306	76,495	78,019	79,672	81,031	83,246	888,516
PMPM	**0.790**	**0.726**	**0.790**	**0.645**	**0.620**	**0.656**	**0.662**	**0.639**	**0.640**	**0.560**	**0.592**	**0.604**	**0.660**

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	821,424	821,424	100.0%	810,441	821,424	98.7%
Header Service From Date	821,424	821,424	100.0%	821,424	821,424	100.0%
Header Service To Date	821,424	821,424	100.0%	821,424	821,424	100.0%
Detail Service From Date	1,707,226	1,707,226	100.0%	1,707,226	1,707,226	100.0%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Detail Service To Date	1,707,226	1,707,226	100.0%	1,707,226	1,707,226	100.0%
Billing Provider NPI	821,424	821,424	100.0%	819,405	821,424	99.8%
Rendering Provider NPI	821,424	821,424	100.0%	818,090	821,424	99.6%
Servicing Provider Taxonomy Code	1,707,226	1,707,226	100.0%	1,693,584	1,707,226	99.2%
Referring Provider NPI	315,689	821,424	38.4%	299,570	315,689	94.9%
Primary Diagnosis Codes	821,424	821,424	100.0%	821,424	821,424	100.0%
Secondary Diagnosis Codes	339,404	821,424	41.3%	793,162	793,163	>99.9%
CPT/HCPCS Codes	1,707,226	1,707,226	100.0%	1,707,219	1,707,226	>99.9%
CPT/HCPCS Codes with PTP Edits	1,707,226	1,707,226	100.0%	1,706,751	1,707,226	>99.9%
Service Units	1,707,226	1,707,226	100.0%	1,707,226	1,707,226	100.0%
Service Units with MUE Edits	839,363	839,363	100.0%	832,825	839,363	99.2%
National Drug Codes	216,086	1,707,226	12.7%	214,865	216,086	99.4%
HCPCS/NDC Combination	30,569	32,233	94.8%	19,005	30,569	62.2%
MCO Received Date	1,707,226	1,707,226	100.0%	1,707,226	1,707,226	100.0%
MCO Paid Date	1,707,226	1,707,226	100.0%	1,707,226	1,707,226	100.0%
Header Paid Amount	821,424	821,424	100.0%	821,423	821,424	>99.9%
Header TPL Paid Amount	6,167	821,424	0.8%	5,956	6,167	96.6%
Detail Paid Amount	1,707,226	1,707,226	100.0%	1,707,226	1,707,226	100.0%
Detail TPL Paid Amount	9,862	1,707,226	0.6%	9,862	9,862	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	116,380	116,380	100.0%	114,879	116,380	98.7%
Header Service From Date	116,380	116,380	100.0%	116,380	116,380	100.0%
Header Service To Date	116,380	116,380	100.0%	116,379	116,380	>99.9%
Detail Service From Date	428,713	428,713	100.0%	428,713	428,713	100.0%
Detail Service To Date	428,713	428,713	100.0%	428,713	428,713	100.0%
Billing Provider NPI	116,380	116,380	100.0%	113,466	116,380	97.5%
Rendering Provider NPI	217	116,380	0.2%	217	217	100.0%
Attending Provider NPI	53,519	116,380	46.0%	53,340	53,519	99.7%
Servicing Provider Taxonomy Code	195,534	428,713	45.6%	192,127	195,534	98.3%
Referring Provider NPI	122	116,380	0.1%	111	122	91.0%
Primary Diagnosis Codes	116,380	116,380	100.0%	116,380	116,380	100.0%
Secondary Diagnosis Codes	94,513	116,380	81.2%	365,921	365,921	100.0%
CPT/HCPCS Codes	336,303	428,713	78.4%	336,296	336,303	>99.9%
CPT/HCPCS Codes with PTP Edits	336,303	428,713	78.4%	336,167	336,303	>99.9%
Service Units	428,713	428,713	100.0%	428,713	428,713	100.0%
Service Units with MUE Edits	278,953	278,953	100.0%	278,390	278,953	99.8%
Primary Surgical Procedure Codes	5,547	116,380	4.8%	5,544	5,547	>99.9%
Secondary Surgical Procedure Codes	3,123	116,380	2.7%	7,118	7,119	>99.9%
Revenue Codes	428,713	428,713	100.0%	428,713	428,713	100.0%
Diagnosis-Related Groups Codes	8,525	116,380	7.3%	8,514	8,525	99.9%
Type of Bill Codes	116,380	116,380	100.0%	116,380	116,380	100.0%
National Drug Codes	63,122	428,713	14.7%	61,397	63,122	97.3%
HCPCS/NDC Combination	47,848	47,850	>99.9%	29,845	47,848	62.4%
MCO Received Date	428,713	428,713	100.0%	428,713	428,713	100.0%
MCO Paid Date	428,713	428,713	100.0%	428,713	428,713	100.0%
Header Paid Amount	116,380	116,380	100.0%	116,380	116,380	100.0%
Header TPL Paid Amount	136	116,380	0.1%	84	136	61.8%
Detail Paid Amount	428,713	428,713	100.0%	428,713	428,713	100.0%
Detail TPL Paid Amount	481	428,713	0.1%	481	481	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	582,764	582,764	100.0%	576,219	582,764	98.9%
DOS	582,764	582,764	100.0%	582,764	582,764	100.0%
Billing Provider NPI	582,764	582,764	100.0%	577,779	582,764	99.1%
Prescribing Provider NPI	582,764	582,764	100.0%	520,494	582,764	89.3%
National Drug Codes	582,764	582,764	100.0%	581,305	582,764	99.7%
MCO Received Date	582,764	582,764	100.0%	582,764	582,764	100.0%
MCO Paid Date	582,764	582,764	100.0%	582,764	582,764	100.0%
Header Paid Amount	582,764	582,764	100.0%	582,764	582,764	100.0%
Header TPL Paid Amount	35,595	582,764	6.1%	35,595	35,595	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
Medallion 4.0				
Percent of Billed	1.4%	6.7%	—	—
Line-by-Line	0.8%	48.0%	100%	—
Per Diem	13.0%	1.0%	—	—
DRG	81.1%	—	—	—
Other (OP-EAPG)	—	42.6%	—	100%
Other (MISC)	3.7%	1.7%	—	—
Total	**100%**	**100%**	**100%**	**100%**

The symbol "—" indicates that the MCO did not submit a response for a cell.

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.

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.

[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.

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%
Pharmacy	*<.01%*	0.04%
Transportation	*<.01%*	0.93%

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
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	224,133	223,069	1,004.8
February 2020	212,094	223,679	948.2
March 2020	188,972	225,220	839.1
April 2020	145,927	230,500	633.1
May 2020	160,944	236,152	681.5
June 2020	184,069	240,086	766.7
July 2020	197,636	243,369	812.1
August 2020	190,198	245,496	774.7
September 2020	204,675	248,206	824.6
October 2020	212,609	251,580	845.1
November 2020	195,252	254,548	767.1
December 2020	201,530	258,625	779.2

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	40,475	223,069	181.4
February 2020	38,387	223,679	171.6
March 2020	31,866	225,220	141.5
April 2020	17,649	230,500	76.6
May 2020	23,917	236,152	101.3
June 2020	31,443	240,086	131.0
July 2020	35,598	243,369	146.3
August 2020	33,721	245,496	137.4

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
September 2020	34,457	248,206	138.8
October 2020	36,859	251,580	146.5
November 2020	34,252	254,548	134.6
December 2020	34,266	258,625	132.5

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	195,065	223,069	874.5
February 2020	185,545	223,679	829.5
March 2020	204,905	225,220	909.8
April 2020	167,508	230,500	726.7
May 2020	160,216	236,152	678.4
June 2020	167,714	240,086	698.6
July 2020	170,953	243,369	702.4
August 2020	163,462	245,496	665.8
September 2020	169,813	248,206	684.2
October 2020	171,240	251,580	680.7
November 2020	161,211	254,548	633.3
December 2020	166,931	258,625	645.5

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	31,425,110	140.9	529,539	2.4
February 2020	30,015,465	134.2	593,327	2.7
March 2020	29,606,738	131.5	520,820	2.3
April 2020	24,091,627	104.5	318,900	1.4
May 2020	26,635,411	112.8	407,258	1.7
June 2020	31,660,133	131.9	495,957	2.1
July 2020	29,216,430	120.0	635,681	2.6
August 2020	27,824,455	113.3	581,614	2.4
September 2020	29,314,253	118.1	537,943	2.2
October 2020	31,182,156	123.9	656,855	2.6
November 2020	28,906,635	113.6	493,776	1.9
December 2020	30,639,199	118.5	569,102	2.2

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	29,022,625	130.1	2,795,562	12.5
February 2020	26,651,429	119.2	1,754,056	7.8
March 2020	26,202,458	116.3	1,273,799	5.7
April 2020	17,723,655	76.9	1,104,057	4.8
May 2020	24,299,932	102.9	1,277,105	5.4
June 2020	28,597,767	119.1	1,474,180	6.1
July 2020	29,911,447	122.9	1,630,577	6.7
August 2020	27,341,911	111.4	1,669,195	6.8
September 2020	29,894,980	120.4	1,311,823	5.3
October 2020	28,591,408	113.6	2,001,549	8.0
November 2020	28,326,716	111.3	1,316,776	5.2
December 2020	29,709,661	114.9	1,418,413	5.5

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	15,966,951	71.6	199,243	0.9
February 2020	15,306,477	68.4	165,447	0.7
March 2020	17,967,843	79.8	194,594	0.9
April 2020	17,229,264	74.7	172,661	0.7
May 2020	16,057,060	68.0	153,612	0.7
June 2020	16,962,781	70.7	170,128	0.7
July 2020	16,590,693	68.2	166,183	0.7
August 2020	15,673,564	63.8	199,899	0.8
September 2020	17,512,841	70.6	230,914	0.9
October 2020	17,445,168	69.3	231,639	0.9
November 2020	17,526,166	68.9	184,993	0.7
December 2020	19,223,341	74.3	253,847	1.0

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

Table G-12—Percentage of Duplicate Encounters

Claim Type	Total Records	Number of Duplicate Records	Percent of Duplicates
Professional Encounters	4,471,865	36,641	0.8%
Institutional Encounters	1,348,164	907	0.1%
Pharmacy Encounters	2,086,353	249	<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

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	100.0%	100.0%	100.0%	100.0%	100.0%
February 2020	100.0%	100.0%	100.0%	100.0%	100.0%
March 2020	98.1%	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	99.9%	100.0%	100.0%	100.0%	100.0%
August 2020	99.9%	99.9%	99.9%	99.9%	99.9%
September 2020	98.1%	98.1%	98.1%	98.1%	98.1%
October 2020	98.8%	98.9%	98.9%	98.9%	98.9%
November 2020	98.8%	98.8%	98.8%	98.8%	99.2%
December 2020	98.7%	98.7%	98.7%	99.2%	100.0%
January 2021	97.9%	97.9%	98.4%	99.9%	100.0%
February 2021	98.9%	99.3%	100.0%	100.0%	100.0%
March 2021	99.7%	100.0%	100.0%	100.0%	100.0%
April 2021	99.8%	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

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	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	100.0%	100.0%	100.0%	100.0%	100.0%
November 2020	100.0%	100.0%	100.0%	100.0%	100.0%
December 2020	99.9%	99.9%	99.9%	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	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 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

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	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	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 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**
201912	121												121
202001	105,071	137										1	105,209
202002	101,950	101,214	156										203,320
202003	14,925	94,093	46,510	143									155,671
202004	6,554	16,669	54,443	47,548	172								125,386
202005	3,086	4,900	11,314	38,385	45,044	128							102,857
202006	2,188	2,590	2,668	5,250	43,377	43,302	65						99,440
202007	1,397	1,874	1,634	2,767	8,904	58,469	99,578	144					174,767
202008	1,367	1,501	55,438	4,410	3,390	10,254	81,441	86,664	123				244,588
202009	586	684	19,946	44,774	51,891	61,888	10,606	85,924	76,141	98			352,538
202010	554	677	9,738	9,881	14,260	17,098	5,594	14,105	105,766	104,761	140		282,574
202011	821	584	553	764	902	1,375	2,542	5,239	19,559	93,023	94,746	121	220,229
202012	836	1,089	390	519	672	1,214	1,461	2,508	4,942	13,201	87,943	113,387	228,162
202101	1,760	1,988	813	616	1,070	1,007	1,821	1,295	2,812	4,353	9,220	70,903	97,658
202102	134	224	428	363	416	606	842	1,048	1,659	2,441	4,261	11,025	23,447
202103	55	84	283	668	1,568	1,890	2,975	2,764	2,960	3,431	4,703	10,127	31,508
202104	58	72	188	424	578	826	3,708	3,808	4,200	4,922	6,278	7,130	32,192
202105	403	112	226	196	360	360	637	487	641	959	1,648	1,800	7,829
202106	83	70	52	60	139	290	462	477	530	747	904	1,498	5,312
202107	6	7	5	13	16	20	71	70	82	118	123	149	680
Total	241,955	228,569	204,785	156,781	172,759	198,727	211,803	204,533	219,415	228,054	209,966	216,141	2,493,488
MM	223,069	223,679	225,220	230,500	236,152	240,086	243,369	245,496	248,206	251,580	254,548	258,625	2,880,530
PMPM	**1.085**	**1.022**	**0.909**	**0.680**	**0.732**	**0.828**	**0.870**	**0.833**	**0.884**	**0.906**	**0.825**	**0.836**	**0.868**

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	18,272												18,272
202002	17,930	16,957											34,887
202003	1,728	17,095	13,870										32,693
202004	866	2,231	11,368	7,354									21,819
202005	1,214	1,253	3,888	7,813	8,758								22,926
202006	645	702	676	756	11,130	10,897							24,806
202007	229	300	350	355	1,174	16,606	14,101						33,115
202008	174	175	682	455	801	1,423	19,443	14,817					37,970
202009	66	72	863	826	1,018	1,133	1,262	16,341	12,100				33,681
202010	185	211	619	426	1,246	1,694	715	1,707	19,957	16,569			43,329
202011	92	109	128	95	185	274	350	708	1,341	17,947	15,334		36,563
202012	87	97	92	65	117	157	289	360	1,049	1,781	17,436	18,986	40,516
202101	54	66	55	39	57	96	133	287	467	833	1,176	13,569	16,832
202102	38	59	66	46	103	116	169	204	249	398	650	1,356	3,454
202103	13	20	38	33	41	65	89	121	166	209	264	654	1,713
202104	12	15	39	35	58	89	89	115	114	176	231	376	1,349
202105	7	10	10	22	27	46	71	81	101	115	114	162	766
202106	28	47	20	3	25	22	38	50	62	40	92	150	577
202107	16	10	4		3	7	12	9	11	28	11	17	128
Total	41,656	39,429	32,768	18,323	24,743	32,625	36,761	34,800	35,617	38,096	35,308	35,270	405,396
MM	223,069	223,679	225,220	230,500	236,152	240,086	243,369	245,496	248,206	251,580	254,548	258,625	2,880,530
PMPM	**0.187**	**0.176**	**0.145**	**0.079**	**0.105**	**0.136**	**0.151**	**0.142**	**0.143**	**0.151**	**0.139**	**0.136**	**0.141**

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	113,310												113,310
202002	81,180	97,786											178,966
202003	315	87,326	146,983										234,624
202004	23	57	57,615	102,240									159,935
202005	1	4	83	65,057	86,479								151,624
202006	18	7	14	85	73,515	114,475							188,114
202007	1	4	11	17	71	52,990	92,087						145,181
202008	221	370	464	104	20	63	71,182	80,055					152,479
202009	2	1	6	300	378	447	328	83,452	107,363				192,277
202010	1		5	6	5	22	1,711	96	62,516	93,637			157,999
202011			1	1	1	3	5,868	9	77	74,811	78,514		159,285
202012			1					5	12	93	80,712	110,453	191,276
202101								1	49	2,689	1,933	56,354	61,026
202102						6	5	2	5	6	37	87	148
202103	1	1	2	2		1	1		2	2	9	35	56
202104										3	3	3	9
202105							1				2	1	4
202106				1		3	5	5	3	5	10	8	40
Total	195,073	185,556	205,185	167,813	160,469	168,010	171,188	163,625	170,027	171,246	161,220	166,941	1,762,259
MM	223,069	223,679	225,220	230,500	236,152	240,086	243,369	245,496	248,206	251,580	254,548	258,625	2,398,882
PMPM	**0.874**	**0.830**	**0.911**	**0.728**	**0.680**	**0.700**	**0.703**	**0.667**	**0.685**	**0.681**	**0.633**	**0.645**	**0.728**

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	2,493,488	2,493,488	100.0%	2,470,321	2,493,488	99.1%
Header Service From Date	2,493,488	2,493,488	100.0%	2,493,488	2,493,488	100.0%
Header Service To Date	2,493,488	2,493,488	100.0%	2,490,623	2,493,488	99.9%
Detail Service From Date	4,471,865	4,471,865	100.0%	4,471,865	4,471,865	100.0%
Detail Service To Date	4,471,865	4,471,865	100.0%	4,467,765	4,471,865	>99.9%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Billing Provider NPI	2,493,488	2,493,488	100.0%	2,468,652	2,493,488	99.0%
Rendering Provider NPI	2,493,488	2,493,488	100.0%	2,480,530	2,493,488	99.5%
Servicing Provider Taxonomy Code	4,471,865	4,471,865	100.0%	3,914,615	4,471,865	87.5%
Referring Provider NPI	0	2,493,488	0.0%	NA	NA	NA
Primary Diagnosis Codes	2,493,488	2,493,488	100.0%	2,493,488	2,493,488	100.0%
Secondary Diagnosis Codes	1,078,385	2,493,488	43.2%	2,429,089	2,429,092	>99.9%
CPT/HCPCS Codes	4,471,865	4,471,865	100.0%	4,471,859	4,471,865	>99.9%
CPT/HCPCS Codes with PTP Edits	4,471,865	4,471,865	100.0%	4,469,904	4,471,865	>99.9%
Service Units	4,471,865	4,471,865	100.0%	4,471,865	4,471,865	100.0%
Service Units with MUE Edits	2,547,933	2,547,933	100.0%	2,540,993	2,547,933	99.7%
National Drug Codes	281,228	4,471,865	6.3%	281,015	281,228	>99.9%
HCPCS/NDC Combination	36,038	127,611	28.2%	26,947	36,038	74.8%
MCO Received Date	4,471,865	4,471,865	100.0%	4,471,865	4,471,865	100.0%
MCO Paid Date	4,471,865	4,471,865	100.0%	4,471,865	4,471,865	100.0%
Header Paid Amount	2,493,488	2,493,488	100.0%	2,493,355	2,493,488	>99.9%
Header TPL Paid Amount	60,714	2,493,488	2.4%	60,677	60,714	>99.9%
Detail Paid Amount	4,471,865	4,471,865	100.0%	4,471,865	4,471,865	100.0%
Detail TPL Paid Amount	97,632	4,471,865	2.2%	97,632	97,632	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	405,396	405,396	100.0%	402,266	405,396	99.2%
Header Service From Date	405,396	405,396	100.0%	405,396	405,396	100.0%
Header Service To Date	405,396	405,396	100.0%	405,396	405,396	100.0%
Detail Service From Date	1,348,164	1,348,164	100.0%	1,348,164	1,348,164	100.0%
Detail Service To Date	1,348,164	1,348,164	100.0%	1,348,164	1,348,164	100.0%
Billing Provider NPI	405,396	405,396	100.0%	405,378	405,396	>99.9%
Rendering Provider NPI	0	405,396	0.0%	NA	NA	NA
Attending Provider NPI	396,855	405,396	97.9%	396,235	396,855	99.8%
Servicing Provider Taxonomy Code	0	1,348,164	0.0%	0	0	—
Referring Provider NPI	0	405,396	0.0%	NA	NA	NA
Primary Diagnosis Codes	405,396	405,396	100.0%	405,396	405,396	100.0%
Secondary Diagnosis Codes	405,396	405,396	100.0%	1,391,765	1,391,765	100.0%
CPT/HCPCS Codes	1,115,961	1,348,164	82.8%	1,115,948	1,115,961	>99.9%
CPT/HCPCS Codes with PTP Edits	1,115,961	1,348,164	82.8%	1,115,034	1,115,961	>99.9%
Service Units	1,348,164	1,348,164	100.0%	1,348,164	1,348,164	100.0%
Service Units with MUE Edits	949,608	949,608	100.0%	947,541	949,608	99.8%
Primary Surgical Procedure Codes	16,766	405,396	4.1%	16,759	16,766	>99.9%
Secondary Surgical Procedure Codes	9,189	405,396	2.3%	21,025	21,033	>99.9%
Revenue Codes	1,348,164	1,348,164	100.0%	1,348,164	1,348,164	100.0%
Diagnosis-Related Groups Codes	20,231	405,396	5.0%	20,164	20,231	99.7%
Type of Bill Codes	405,396	405,396	100.0%	405,396	405,396	100.0%
National Drug Codes	152,070	1,348,164	11.3%	145,065	152,070	95.4%
HCPCS/NDC Combination	125,133	125,140	>99.9%	82,544	125,133	66.0%
MCO Received Date	1,348,164	1,348,164	100.0%	1,348,164	1,348,164	100.0%
MCO Paid Date	1,348,164	1,348,164	100.0%	1,348,164	1,348,164	100.0%
Header Paid Amount	405,396	405,396	100.0%	405,393	405,396	>99.9%
Header TPL Paid Amount	10,461	405,396	2.6%	2,531	10,461	24.2%
Detail Paid Amount	1,348,164	1,348,164	100.0%	1,348,164	1,348,164	100.0%
Detail TPL Paid Amount	41,568	1,348,164	3.1%	41,568	41,568	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	2,086,353	2,086,353	100.0%	2,060,440	2,086,353	98.8%
DOS	2,086,353	2,086,353	100.0%	2,086,353	2,086,353	100.0%
Rendering Provider NPI	2,086,353	2,086,353	100.0%	2,086,353	2,086,353	100.0%
Prescribing Provider NPI	2,086,353	2,086,353	100.0%	2,086,323	2,086,353	>99.9%
National Drug Codes	2,086,353	2,086,353	100.0%	2,080,849	2,086,353	99.7%
MCO Received Date	2,086,353	2,086,353	100.0%	2,086,353	2,086,353	100.0%
MCO Paid Date	2,086,353	2,086,353	100.0%	2,086,353	2,086,353	100.0%
Header Paid Amount	2,086,353	2,086,353	100.0%	2,086,353	2,086,353	100.0%
Header TPL Paid Amount	85,773	2,086,353	4.1%	85,773	85,773	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
Medallion 4.0				
Percent of Billed	32%	42%	—	N/A
Per Diem	9%	5%	—	N/A
DRG	47%	—	—	N/A
Negotiated (Flat) Rate	12%	2%	—	
Other (EAPG)	—	51%	—	N/A
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.	N/A
Total	**100%**	**100%**	**100%**	**100%**

The symbol "—" indicates that the MCO did not submit a response for a cell.

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

Measure	Description
	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. 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	95,533	106,195	899.6
February 2020	90,281	106,754	845.7
March 2020	79,245	107,822	735.0
April 2020	60,329	110,665	545.1
May 2020	68,524	114,754	597.1
June 2020	82,635	117,475	703.4
July 2020	89,734	119,792	749.1
August 2020	86,114	120,822	712.7
September 2020	90,572	122,701	738.2
October 2020	97,269	125,262	776.5
November 2020	87,285	126,857	688.1
December 2020	90,345	129,840	695.8

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	14,361	106,195	135.2
February 2020	13,808	106,754	129.3
March 2020	11,085	107,822	102.8
April 2020	6,275	110,665	56.7
May 2020	8,429	114,754	73.5
June 2020	11,315	117,475	96.3
July 2020	12,342	119,792	103.0
August 2020	11,948	120,822	98.9

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
September 2020	12,419	122,701	101.2
October 2020	12,894	125,262	102.9
November 2020	11,903	126,857	93.8
December 2020	11,874	129,840	91.5

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	79,640	106,195	749.9
February 2020	76,088	106,754	712.7
March 2020	83,467	107,822	774.1
April 2020	67,896	110,665	613.5
May 2020	66,243	114,754	577.3
June 2020	70,884	117,475	603.4
July 2020	73,680	119,792	615.1
August 2020	69,408	120,822	574.5
September 2020	70,851	122,701	577.4
October 2020	73,833	125,262	589.4
November 2020	68,148	126,857	537.2
December 2020	71,905	129,840	553.8

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	10,608,868	99.9	103,265	1.0
February 2020	10,247,760	96.0	102,883	1.0
March 2020	9,870,251	91.5	94,251	0.9
April 2020	7,798,596	70.5	81,390	0.7
May 2020	8,802,786	76.7	77,965	0.7
June 2020	10,503,540	89.4	85,677	0.7
July 2020	10,410,641	86.9	90,817	0.8
August 2020	10,243,552	84.8	83,315	0.7
September 2020	10,926,717	89.1	89,547	0.7
October 2020	11,498,182	91.8	93,325	0.7
November 2020	10,518,828	82.9	73,199	0.6
December 2020	11,154,257	85.9	70,449	0.5

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	12,398,480	116.8	613,482	5.8
February 2020	11,619,342	108.8	572,293	5.4
March 2020	10,579,625	98.1	452,387	4.2
April 2020	8,734,017	78.9	937,444	8.5
May 2020	11,387,906	99.2	753,844	6.6
June 2020	12,691,821	108.0	571,431	4.9
July 2020	13,151,130	109.8	538,890	4.5
August 2020	12,386,637	102.5	928,247	7.7
September 2020	12,415,283	101.2	323,142	2.6
October 2020	12,877,774	102.8	1,305,281	10.4
November 2020	12,106,636	95.4	515,306	4.1
December 2020	12,659,529	97.5	487,998	3.8

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	6,256,034	58.9	204,590	1.9
February 2020	6,183,293	57.9	197,240	1.8
March 2020	7,225,074	67.0	198,853	1.8
April 2020	6,946,892	62.8	207,511	1.9
May 2020	7,003,979	61.0	181,108	1.6
June 2020	7,326,437	62.4	201,465	1.7
July 2020	7,419,090	61.9	230,552	1.9
August 2020	7,186,760	59.5	152,833	1.3
September 2020	7,152,888	58.3	155,299	1.3
October 2020	7,732,578	61.7	199,612	1.6
November 2020	7,591,084	59.8	185,406	1.5
December 2020	8,169,814	62.9	181,557	1.4

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

Table H-11—Percentage of Duplicate Encounters

Claim Type	Total Records	Number of Duplicate Records	Percent of Duplicates
Professional Encounters	2,009,433	870	<0.1%
Institutional Encounters	477,269	880	0.2%
Pharmacy Encounters	872,625	19	<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

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	99.9%	100.0%	100.0%	100.0%	100.0%
April 2020	100.0%	100.0%	100.0%	100.0%	100.0%
May 2020	99.6%	99.7%	100.0%	100.0%	100.0%
June 2020	99.9%	100.0%	100.0%	100.0%	100.0%
July 2020	99.4%	99.4%	99.4%	99.4%	99.4%
August 2020	98.7%	98.7%	98.7%	98.7%	98.7%
September 2020	99.4%	99.4%	99.4%	99.4%	99.4%
October 2020	98.5%	98.8%	98.8%	98.8%	98.8%
November 2020	99.0%	99.0%	99.0%	99.0%	99.0%
December 2020	98.8%	98.8%	98.8%	98.8%	98.8%
January 2021	98.4%	98.4%	98.4%	98.4%	99.9%
February 2021	98.7%	98.7%	98.7%	99.8%	100.0%
March 2021	99.0%	99.2%	99.8%	100.0%	100.0%
April 2021	99.1%	99.9%	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-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

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	99.8%	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	95.5%	95.5%	95.5%	95.5%	95.5%
August 2020	90.0%	90.0%	90.0%	90.0%	90.0%
September 2020	87.9%	87.9%	87.9%	87.9%	87.9%
October 2020	87.8%	88.3%	88.3%	88.3%	88.3%
November 2020	87.6%	87.6%	87.6%	87.6%	87.6%
December 2020	88.5%	88.5%	88.5%	88.5%	92.7%
January 2021	90.2%	90.3%	90.3%	92.3%	100.0%
February 2021	90.1%	90.1%	92.1%	100.0%	100.0%
March 2021	90.5%	93.2%	100.0%	100.0%	100.0%
April 2021	94.3%	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

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	97.0%	97.0%	97.0%	97.0%	97.0%
February 2020	38.8%	38.8%	38.8%	38.8%	38.8%
March 2020	0.3%	0.3%	0.3%	0.3%	0.3%
April 2020	0.3%	0.3%	0.3%	0.3%	0.3%
May 2020	0.3%	0.3%	0.3%	0.3%	0.3%
June 2020	38.6%	38.6%	38.6%	38.6%	38.6%
July 2020	0.2%	0.2%	0.2%	0.2%	0.2%
August 2020	0.2%	0.2%	0.2%	0.2%	0.2%
September 2020	0.3%	0.3%	0.3%	0.3%	0.3%
October 2020	0.6%	0.6%	0.6%	0.6%	0.6%
November 2020	0.8%	0.8%	0.8%	0.8%	1.4%
December 2020	0.2%	0.2%	0.2%	0.7%	3.1%
January 2021	0.1%	0.1%	0.1%	3.0%	3.0%
February 2021	0.0%	0.0%	5.0%	5.0%	5.0%
May 2021	25.0%	25.0%	25.0%	25.0%	25.0%

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	30,229												30,229
202002	51,525	29,095											80,620
202003	7,900	48,459	14,433										70,792
202004	3,817	8,419	27,145	8,271									47,652
202005	2,740	3,719	3,901	25,822	14,110								50,292
202006	984	1,408	2,228	2,075	24,081	15,150							45,926
202007	575	779	877	1,797	3,655	30,936	35,117						73,736
202008	407	420	644	1,141	2,640	6,295	43,169	30,075					84,791
202009	281	306	30,991	21,366	24,326	28,858	5,402	43,874	23,464				178,868
202010	339	359	1,000	760	802	1,697	4,254	7,565	56,111	34,609			107,496
202011	192	257	508	597	745	1,188	1,693	3,005	6,814	51,062	28,689		94,750
202012	286	223	375	394	619	780	942	1,468	2,621	6,870	47,507	26,043	88,128
202101	225	212	162	183	223	597	761	1,001	1,808	3,545	7,291	54,825	70,833
202102	106	196	234	226	204	332	458	744	881	1,760	2,810	5,854	13,805
202103	31	47	146	198	139	233	333	401	767	1,084	1,702	3,583	8,664
202104	79	54	76	154	219	251	270	391	548	887	986	1,489	5,404
202105	31	34	39	38	215	281	295	241	436	532	650	946	3,738
202106	143	141	281	367	333	616	1,923	1,759	1,776	1,844	1,978	2,003	13,164
202107					1	9	13	10	12	30	46	36	157
Total	99,890	94,128	83,040	63,389	72,312	87,223	94,630	90,534	95,238	102,223	91,659	94,779	1,069,045
MM	106,195	106,754	107,822	110,665	114,754	117,475	119,792	120,822	122,701	125,262	126,857	129,840	1,408,939
PMPM	**0.941**	**0.882**	**0.770**	**0.573**	**0.630**	**0.742**	**0.790**	**0.749**	**0.776**	**0.816**	**0.723**	**0.730**	**0.760**

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	4,270												4,270
202002	7,698	3,822											11,520
202003	965	7,570	3,190										11,725
202004	746	1,290	6,041	1,157									9,234
202005	311	525	902	4,115	2,399								8,252
202006	135	215	274	350	4,654	2,936							8,564
202007	145	210	391	296	573	6,879	3,543						12,037
202008	81	89	108	153	353	678	5,315	2,867					9,644
202009	53	72	62	43	97	342	936	5,806	2,306				9,717
202010	47	60	60	61	106	163	519	886	6,878	3,267			12,047
202011	46	48	55	35	67	131	170	433	632	6,200	2,889		10,706
202012	36	36	49	33	57	85	123	186	422	822	5,770	2,392	10,011
202101	26	21	30	28	53	49	81	133	273	504	980	6,302	8,480
202102	13	22	26	45	92	139	146	122	243	408	482	1,011	2,749
202103	6	8	13	10	24	22	46	43	95	190	286	434	1,177
202104	4	7	24	17	29	37	64	49	70	97	119	276	793
202105	7	4	5	17	20	27	1,512	1,523	1,617	1,566	1,480	1,506	9,284
202106	3	8	3	4	10	29	67	64	64	46	65	93	456
202107	4			1	5	2	8	6	4	6	5	17	58
Total	14,596	14,007	11,233	6,365	8,539	11,519	12,530	12,118	12,604	13,106	12,076	12,031	140,724
MM	106,195	106,754	107,822	110,665	114,754	117,475	119,792	120,822	122,701	125,262	126,857	129,840	1,408,939
PMPM	**0.137**	**0.131**	**0.104**	**0.058**	**0.074**	**0.098**	**0.105**	**0.100**	**0.103**	**0.105**	**0.095**	**0.093**	**0.100**

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	60,300												60,300
202002	17,052	63,360											80,412
202003	64	10,571	67,510										78,145
202004	8	38	13,711	54,240									67,997
202005	16	13	31	11,790	50,805								62,655
202006	1	9	11	21	13,525	57,918							71,485
202007			7	18	15	11,009	56,245						67,294
202008		3	5	7	12	32	15,284	54,469					69,812
202009			1	1	1	1	15	12,878	56,757				69,654
202010					3	4	37	68	12,094	55,913			68,119
202011						3	2	4	21	15,676	57,480		73,186
202012						6	7	4	10	11	8,546	55,631	64,215
202101			1				8	9	16	13	25	14,125	14,197
202102			1			1				2	8	25	37
202103	1				1				1		3	16	22
202104	2,197	2,080	2,262	1,896	1,932	1,999	2,158	1,994	1,920	2,200	2,065	2,081	24,784
202105	23	17	20	23	27	32	29	25	38	23	26	28	311
Total	79,662	76,091	83,560	67,996	66,321	71,005	73,785	69,451	70,857	73,838	68,153	71,906	872,625
MM	106,195	106,754	107,822	110,665	114,754	117,475	119,792	120,822	122,701	125,262	126,857	129,840	1,408,939
PMPM	**0.750**	**0.713**	**0.775**	**0.614**	**0.578**	**0.604**	**0.616**	**0.575**	**0.577**	**0.589**	**0.537**	**0.554**	**0.624**

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	1,069,045	1,069,045	100.0%	1,057,221	1,069,045	98.9%
Header Service From Date	1,069,045	1,069,045	100.0%	1,069,045	1,069,045	100.0%
Header Service To Date	1,069,045	1,069,045	100.0%	1,069,045	1,069,045	100.0%
Detail Service From Date	2,009,433	2,009,433	100.0%	2,009,433	2,009,433	100.0%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Detail Service To Date	2,009,433	2,009,433	100.0%	2,009,433	2,009,433	100.0%
Billing Provider NPI	1,069,045	1,069,045	100.0%	1,067,162	1,069,045	99.8%
Rendering Provider NPI	1,069,045	1,069,045	100.0%	1,068,283	1,069,045	>99.9%
Servicing Provider Taxonomy Code	2,009,433	2,009,433	100.0%	2,000,268	2,009,433	99.5%
Referring Provider NPI	486,552	1,069,045	45.5%	477,533	486,552	98.1%
Primary Diagnosis Codes	1,069,045	1,069,045	100.0%	1,069,041	1,069,045	>99.9%
Secondary Diagnosis Codes	517,239	1,069,045	48.4%	1,169,882	1,169,886	>99.9%
CPT/HCPCS Codes	2,009,433	2,009,433	100.0%	2,009,416	2,009,433	>99.9%
CPT/HCPCS Codes with PTP Edits	2,009,433	2,009,433	100.0%	2,008,831	2,009,433	>99.9%
Service Units	2,009,433	2,009,433	100.0%	2,009,433	2,009,433	100.0%
Service Units with MUE Edits	1,217,285	1,217,285	100.0%	1,212,104	1,217,285	99.6%
National Drug Codes	229,201	2,009,433	11.4%	226,803	229,201	99.0%
HCPCS/NDC Combination	56,370	61,431	91.8%	35,642	56,370	63.2%
MCO Received Date	2,009,433	2,009,433	100.0%	2,009,433	2,009,433	100.0%
MCO Paid Date	2,009,433	2,009,433	100.0%	2,009,433	2,009,433	100.0%
Header Paid Amount	1,069,045	1,069,045	100.0%	1,069,045	1,069,045	100.0%
Header TPL Paid Amount	17,426	1,069,045	1.6%	15,099	17,426	86.6%
Detail Paid Amount	2,009,433	2,009,433	100.0%	2,009,433	2,009,433	100.0%
Detail TPL Paid Amount	24,296	2,009,433	1.2%	24,296	24,296	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	140,724	140,724	100.0%	139,009	140,724	98.8%
Header Service From Date	140,724	140,724	100.0%	140,724	140,724	100.0%
Header Service To Date	140,724	140,724	100.0%	140,724	140,724	100.0%
Detail Service From Date	477,269	477,269	100.0%	477,269	477,269	100.0%
Detail Service To Date	477,269	477,269	100.0%	477,269	477,269	100.0%
Billing Provider NPI	140,724	140,724	100.0%	140,695	140,724	>99.9%
Rendering Provider NPI	288	140,724	0.2%	287	288	99.7%
Attending Provider NPI	140,585	140,724	>99.9%	139,258	140,585	99.1%
Servicing Provider Taxonomy Code	279,109	477,269	58.5%	239,801	279,109	85.9%
Referring Provider NPI	3,001	140,724	2.1%	2,945	3,001	98.1%
Primary Diagnosis Codes	140,724	140,724	100.0%	140,724	140,724	100.0%
Secondary Diagnosis Codes	140,724	140,724	100.0%	586,355	586,355	100.0%
CPT/HCPCS Codes	357,435	477,269	74.9%	357,418	357,435	>99.9%
CPT/HCPCS Codes with PTP Edits	357,435	477,269	74.9%	357,347	357,435	>99.9%
Service Units	477,269	477,269	100.0%	477,269	477,269	100.0%
Service Units with MUE Edits	300,672	300,672	100.0%	300,255	300,672	99.9%
Primary Surgical Procedure Codes	7,052	140,724	5.0%	7,048	7,052	>99.9%
Secondary Surgical Procedure Codes	4,100	140,724	2.9%	10,328	10,330	>99.9%
Revenue Codes	477,269	477,269	100.0%	477,269	477,269	100.0%
Diagnosis-Related Groups Codes	8,983	140,724	6.4%	8,975	8,983	>99.9%
Type of Bill Codes	140,724	140,724	100.0%	140,724	140,724	100.0%
National Drug Codes	64,467	477,269	13.5%	63,423	64,467	98.4%
HCPCS/NDC Combination	51,332	51,336	>99.9%	32,536	51,332	63.4%
MCO Received Date	477,269	477,269	100.0%	477,269	477,269	100.0%
MCO Paid Date	477,269	477,269	100.0%	477,269	477,269	100.0%
Header Paid Amount	140,724	140,724	100.0%	140,724	140,724	100.0%
Header TPL Paid Amount	2,908	140,724	2.1%	2,540	2,908	87.3%
Detail Paid Amount	477,269	477,269	100.0%	477,269	477,269	100.0%
Detail TPL Paid Amount	12,605	477,269	2.6%	12,605	12,605	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	872,625	872,625	100.0%	860,457	872,625	98.6%
DOS	872,625	872,625	100.0%	872,625	872,625	100.0%
Rendering Provider NPI	872,625	872,625	100.0%	872,595	872,625	>99.9%
Prescribing Provider NPI	872,625	872,625	100.0%	872,204	872,625	>99.9%
National Drug Codes	872,625	872,625	100.0%	871,123	872,625	99.8%
MCO Received Date	872,625	872,625	100.0%	872,625	872,625	100.0%
MCO Paid Date	872,625	872,625	100.0%	872,625	872,625	100.0%
Header Paid Amount	872,625	872,625	100.0%	872,625	872,625	100.0%
Header TPL Paid Amount	51,444	872,625	5.9%	51,444	51,444	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
Medallion 4.0				
Line-by-Line	—	61.64%	99.00%	25.58%
Per Diem	5.40%	<1.00%	—	0.65%
DRG	93.60%	—	—	<1.00%
Negotiated (Flat) Rate	1.00%	—	1.00%	40.31%
Other (SNF [Resource Utilization Grouper-RUG])	—	—	—	32.46%
Other (OP-EAPG)	—	37.36%	—	—
Total	**100%**	**100%**	**100%**	**100%**

The symbol "—" indicates that the MCO did not submit a response for a cell.

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%*
Pharmacy	*MLTSS: less than 1%*	*MLTSS: less than 1%*
Kaiser Permanente	*Less than 1%*	*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	*0%*	*0%*

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 DQS 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	259,133	230,048	1,126.4
February 2020	245,598	231,372	1,061.5
March 2020	214,662	232,659	922.6
April 2020	163,020	237,177	687.3
May 2020	176,101	242,758	725.4
June 2020	200,680	246,475	814.2
July 2020	216,747	249,888	867.4
August 2020	215,366	252,504	852.9
September 2020	224,771	255,524	879.6
October 2020	239,511	258,539	926.4
November 2020	216,330	261,177	828.3
December 2020	220,773	264,836	833.6

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	32,881	230,048	142.9
February 2020	31,468	231,372	136.0
March 2020	24,809	232,659	106.6
April 2020	13,409	237,177	56.5
May 2020	18,224	242,758	75.1
June 2020	23,067	246,475	93.6
July 2020	25,817	249,888	103.3
August 2020	25,513	252,504	101.0

Month	Encounter Volume	Member Count	Encounter Volume per 1,000 MM
September 2020	26,381	255,524	103.2
October 2020	27,796	258,539	107.5
November 2020	25,642	261,177	98.2
December 2020	25,335	264,836	95.7

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	221,043	230,048	960.9
February 2020	212,015	231,372	916.3
March 2020	226,167	232,659	972.1
April 2020	183,452	237,177	773.5
May 2020	174,800	242,758	720.1
June 2020	186,088	246,475	755.0
July 2020	191,018	249,888	764.4
August 2020	185,614	252,504	735.1
September 2020	190,799	255,524	746.7
October 2020	196,936	258,539	761.7
November 2020	184,582	261,177	706.7
December 2020	190,322	264,836	718.6

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	31,356,881	136.3	211,589	0.9
February 2020	29,692,941	128.3	196,447	0.8
March 2020	27,454,907	118.0	161,251	0.7
April 2020	20,982,556	88.5	108,412	0.5
May 2020	23,521,516	96.9	154,581	0.6
June 2020	26,009,365	105.5	192,649	0.8
July 2020	26,810,303	107.3	230,073	0.9
August 2020	26,679,343	105.7	242,263	1.0
September 2020	27,649,772	108.2	251,854	1.0
October 2020	29,684,041	114.8	376,748	1.5
November 2020	26,925,562	103.1	244,974	0.9
December 2020	27,773,642	104.9	242,455	0.9

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	25,646,748	111.5	101,038	0.4
February 2020	23,385,203	101.1	29,491	0.1
March 2020	20,607,415	88.6	49,298	0.2
April 2020	15,564,412	65.6	32,233	0.1
May 2020	21,522,101	88.7	59,743	0.2
June 2020	23,378,147	94.8	134,431	0.5
July 2020	26,498,209	106.0	106,085	0.4
August 2020	24,452,644	96.8	137,277	0.5
September 2020	24,410,017	95.5	135,482	0.5
October 2020	27,553,520	106.6	146,531	0.6
November 2020	26,786,521	102.6	114,191	0.4
December 2020	23,809,848	89.9	59,120	0.2

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	17,227,366	74.9	135,279	0.6
February 2020	16,480,429	71.2	114,324	0.5
March 2020	19,235,838	82.7	126,988	0.5
April 2020	16,641,152	70.2	219,980	0.9
May 2020	15,985,504	65.8	95,751	0.4
June 2020	17,529,361	71.1	74,382	0.3
July 2020	17,957,401	71.9	233,612	0.9
August 2020	17,773,474	70.4	214,248	0.8
September 2020	18,375,899	71.9	125,300	0.5
October 2020	19,119,025	74.0	142,953	0.6
November 2020	18,090,875	69.3	135,405	0.5
December 2020	19,636,058	74.1	85,671	0.3

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

Table I-11—Percentage of Duplicate Encounters

Claim Type	Total Records	Number of Duplicate Records	Percent of Duplicates
Professional Encounters	5,473,265	9,340	0.2%
Institutional Encounters	1,518,952	4,037	0.3%
Pharmacy Encounters	2,344,327	411	<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

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	99.9%	99.9%	99.9%	100.0%	100.0%
April 2020	100.0%	100.0%	100.0%	100.0%	100.0%
May 2020	99.9%	99.9%	99.9%	99.9%	99.9%
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	99.9%	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	99.5%	99.6%	99.6%	100.0%	100.0%
April 2021	99.1%	99.2%	100.0%	100.0%	100.0%
May 2021	97.8%	100.0%	100.0%	100.0%	100.0%
June 2021	91.0%	91.0%	91.0%	91.0%	91.0%

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

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	96.9%	97.0%	97.0%	97.0%	97.0%
February 2020	97.2%	97.2%	97.2%	97.3%	97.6%
March 2020	93.7%	93.7%	94.3%	95.5%	100.0%
April 2020	87.8%	90.6%	93.4%	100.0%	100.0%
May 2020	88.6%	92.9%	100.0%	100.0%	100.0%
June 2020	91.3%	99.9%	99.9%	99.9%	99.9%
July 2020	99.9%	99.9%	99.9%	99.9%	99.9%
August 2020	99.9%	99.9%	99.9%	99.9%	99.9%
September 2020	99.9%	99.9%	99.9%	99.9%	99.9%
October 2020	99.6%	99.7%	99.7%	99.7%	99.7%
November 2020	99.5%	99.6%	99.6%	99.6%	99.8%
December 2020	99.8%	99.9%	99.9%	100.0%	100.0%
January 2021	99.7%	99.8%	99.8%	100.0%	100.0%
February 2021	98.8%	99.1%	99.3%	100.0%	100.0%
March 2021	96.8%	99.0%	99.7%	100.0%	100.0%
April 2021	92.7%	95.3%	100.0%	100.0%	100.0%
May 2021	95.8%	100.0%	100.0%	100.0%	100.0%
June 2021	12.2%	12.2%	12.2%	12.2%	12.2%

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

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	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	99.9%	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	95.4%	99.7%	99.7%	99.7%	99.7%
October 2020	99.9%	99.9%	99.9%	99.9%	99.9%
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	99.6%	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	50.0%	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	63,138												63,138
202002	146,844	55,545											202,389
202003	49,895	172,478	46,505										268,878
202004	11,658	25,195	106,807	41,022									184,682
202005	6,244	7,118	9,606	71,022	40,780								134,770
202006	1,607	2,158	4,352	9,037	78,822	33,387							129,363
202007	4,640	4,532	2,462	5,052	14,305	110,572	71,114						212,677
202008	2,671	3,486	2,354	4,838	7,021	14,063	142,405	66,343					243,181
202009	647	799	1,043	1,449	1,886	3,249	16,580	142,629	55,488				223,770
202010	1,946	1,887	52,649	34,155	39,598	50,280	7,410	21,050	157,879	44,317			411,171
202011	996	989	1,650	1,478	2,680	3,122	4,020	7,858	26,811	177,388	62,454		289,446
202012	1,196	1,317	1,099	1,170	1,716	2,550	2,326	3,234	6,818	20,779	142,624	85,650	270,479
202101	841	648	11,622	8,750	7,541	8,996	1,229	1,598	3,010	6,850	13,352	122,994	187,431
202102	1,221	1,319	1,774	1,367	1,603	1,877	1,818	2,405	3,048	4,664	6,691	15,906	43,693
202103	507	538	601	603	613	674	958	1,331	3,087	4,048	6,093	10,052	29,105
202104	353	145	258	278	333	405	463	627	965	1,627	1,974	2,813	10,241
202105	94	89	131	176	499	849	517	735	761	1,083	1,774	2,686	9,394
202106	271	121	105	110	172	335	502	720	776	899	1,310	1,796	7,117
Total	294,769	278,364	243,018	180,507	197,569	230,359	249,342	248,530	258,643	261,655	236,272	241,897	2,920,925
MM	230,048	231,372	232,659	237,177	242,758	246,475	249,888	252,504	255,524	258,539	261,177	264,836	2,962,957
PMPM	**1.281**	**1.203**	**1.045**	**0.761**	**0.814**	**0.935**	**0.998**	**0.984**	**1.012**	**1.012**	**0.905**	**0.913**	**0.989**

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**
202001	6,081												6,081
202002	20,630	7,218											27,848
202003	1,799	18,322	4,826										24,947
202004	661	1,694	10,625	2,159									15,139
202005	324	439	620	4,021	2,241								7,645
202006	101	482	529	647	6,114	1,636							9,509
202007	1,928	1,460	1,456	1,124	2,235	10,891	3,574						22,668
202008	141	222	255	565	798	1,751	12,462	5,074					21,268
202009	929	1,276	6,008	4,373	5,912	7,333	5,715	14,490	2,880				48,916
202010	172	144	180	188	309	520	926	1,925	15,047	723			20,134
202011	124	160	162	126	259	386	702	1,252	5,191	22,926	6,012		37,300
202012	157	144	159	142	229	365	417	524	1,044	2,034	16,160	7,497	28,872
202101	56	51	37	34	46	71	144	226	374	720	1,494	13,790	17,043
202102	45	77	64	54	109	122	214	263	358	575	930	1,517	4,328
202103	52	67	124	78	121	119	171	228	300	587	735	1,939	4,521
202104	18	25	26	30	36	60	73	100	135	245	229	338	1,315
202105	18	24	32	34	76	89	129	117	165	186	241	313	1,424
202106	9	9	12	13	21	41	1,613	1,623	1,341	161	177	223	5,243
Total	33,245	31,814	25,115	13,588	18,506	23,384	26,140	25,822	26,835	28,157	25,978	25,617	304,201
MM	230,048	231,372	232,659	237,177	242,758	246,475	249,888	252,504	255,524	258,539	261,177	264,836	2,962,957
PMPM	**0.145**	**0.138**	**0.108**	**0.057**	**0.076**	**0.095**	**0.105**	**0.102**	**0.105**	**0.109**	**0.099**	**0.097**	**0.103**

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	117,199												117,199
202002	103,641	147,614											251,255
202003	155	64,338	146,829										211,322
202004	27	70	79,273	99,264									178,634
202005	45	31	120	84,302	119,530								204,028
202006	1	12	34	35	55,149	110,809							166,040
202007	26	36	66	40	121	75,244	142,054						217,587
202008	1	6	40	18	127	139	48,769	121,197					170,297
202009	1	6	3	1	6	11	293	64,182	30,549				95,052
202010	3		5	8	6	21	33	262	159,341	55,836			215,515
202011	5	10	6	10	12	18	25	30	143	140,509	119,790		260,558
202012					1	1	4	4	101	389	64,768	150,880	216,148
202101	1	1	1	6	4	3	7	4	11	21	34	39,322	39,415
202102							3	4	7	30	27	82	153
202103			1	2	1	1		8	675	179	23	46	936
202104						1	1		1	2	2	20	27
202105										1		6	7
202106	6	9	6	6	11	12	10	12	20	21	16	25	154
Total	221,111	212,133	226,384	183,692	174,968	186,260	191,199	185,703	190,848	196,988	184,660	190,381	2,344,327
MM	230,048	231,372	232,659	237,177	242,758	246,475	249,888	252,504	255,524	258,539	261,177	264,836	2,962,957
PMPM	**0.961**	**0.917**	**0.973**	**0.774**	**0.721**	**0.756**	**0.765**	**0.735**	**0.747**	**0.762**	**0.707**	**0.719**	**0.795**

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	2,920,925	2,920,925	100.0%	2,895,853	2,920,925	99.1%
Header Service From Date	2,920,925	2,920,925	100.0%	2,920,925	2,920,925	100.0%
Header Service To Date	2,920,925	2,920,925	100.0%	2,920,922	2,920,925	>99.9%

	Percent Present			Percent Valid Value		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Detail Service From Date	5,473,265	5,473,265	100.0%	5,473,265	5,473,265	100.0%
Detail Service To Date	5,473,265	5,473,265	100.0%	5,473,265	5,473,265	100.0%
Billing Provider NPI	2,920,925	2,920,925	100.0%	2,918,604	2,920,925	>99.9%
Rendering Provider NPI	2,920,925	2,920,925	100.0%	2,914,581	2,920,925	99.8%
Servicing Provider Taxonomy Code	5,473,265	5,473,265	100.0%	4,614,453	5,473,265	84.3%
Referring Provider NPI	1,162,964	2,920,925	39.8%	1,144,279	1,162,964	98.4%
Primary Diagnosis Codes	2,920,925	2,920,925	100.0%	2,920,900	2,920,925	>99.9%
Secondary Diagnosis Codes	1,187,614	2,920,925	40.7%	2,599,423	2,599,473	>99.9%
CPT/HCPCS Codes	5,473,265	5,473,265	100.0%	5,473,258	5,473,265	>99.9%
CPT/HCPCS Codes with PTP Edits	5,473,265	5,473,265	100.0%	5,465,254	5,473,265	99.9%
Service Units	5,473,265	5,473,265	100.0%	5,473,265	5,473,265	100.0%
Service Units with MUE Edits	3,108,930	3,108,930	100.0%	3,090,994	3,108,930	99.4%
National Drug Codes	487,285	5,473,265	8.9%	486,725	487,285	99.9%
HCPCS/NDC Combination	62,256	138,803	44.9%	29,391	62,256	47.2%
MCO Received Date	5,473,265	5,473,265	100.0%	5,473,265	5,473,265	100.0%
MCO Paid Date	5,473,265	5,473,265	100.0%	5,473,265	5,473,265	100.0%
Header Paid Amount	2,920,925	2,920,925	100.0%	2,918,130	2,920,925	>99.9%
Header TPL Paid Amount	17,173	2,920,925	0.6%	16,745	17,173	97.5%
Detail Paid Amount	5,473,265	5,473,265	100.0%	5,473,265	5,473,265	100.0%
Detail TPL Paid Amount	26,481	5,473,265	0.5%	26,481	26,481	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	304,201	304,201	100.0%	301,960	304,201	99.3%
Header Service From Date	304,201	304,201	100.0%	304,201	304,201	100.0%
Header Service To Date	304,201	304,201	100.0%	304,201	304,201	100.0%
Detail Service From Date	1,518,952	1,518,952	100.0%	1,518,952	1,518,952	100.0%
Detail Service To Date	1,518,952	1,518,952	100.0%	1,518,952	1,518,952	100.0%
Billing Provider NPI	304,201	304,201	100.0%	304,185	304,201	>99.9%
Rendering Provider NPI	0	304,201	0.0%	NA	NA	NA
Attending Provider NPI	300,807	304,201	98.9%	299,353	300,807	99.5%
Servicing Provider Taxonomy Code	78,544	1,518,952	5.2%	65,032	78,544	82.8%
Referring Provider NPI	6,235	304,201	2.0%	6,173	6,235	99.0%
Primary Diagnosis Codes	304,201	304,201	100.0%	304,200	304,201	>99.9%
Secondary Diagnosis Codes	300,791	304,201	98.9%	1,162,845	1,162,848	>99.9%
CPT/HCPCS Codes	1,220,080	1,518,952	80.3%	1,220,051	1,220,080	>99.9%
CPT/HCPCS Codes with PTP Edits	1,220,080	1,518,952	80.3%	1,216,574	1,220,080	99.7%
Service Units	1,518,952	1,518,952	100.0%	1,518,952	1,518,952	100.0%
Service Units with MUE Edits	1,036,544	1,036,544	100.0%	1,032,746	1,036,544	99.6%
Primary Surgical Procedure Codes	14,401	304,201	4.7%	14,394	14,401	>99.9%
Secondary Surgical Procedure Codes	8,233	304,201	2.7%	19,565	19,572	>99.9%
Revenue Codes	1,518,952	1,518,952	100.0%	1,518,952	1,518,952	100.0%
Diagnosis-Related Groups Codes	2,271	304,201	0.7%	2,241	2,271	98.7%
Type of Bill Codes	304,201	304,201	100.0%	304,201	304,201	100.0%
National Drug Codes	234,954	1,518,952	15.5%	225,921	234,954	96.2%
HCPCS/NDC Combination	139,667	139,744	>99.9%	97,872	139,667	70.1%
MCO Received Date	1,518,952	1,518,952	100.0%	1,518,952	1,518,952	100.0%
MCO Paid Date	1,518,952	1,518,952	100.0%	1,518,952	1,518,952	100.0%
Header Paid Amount	304,201	304,201	100.0%	304,166	304,201	>99.9%
Header TPL Paid Amount	873	304,201	0.3%	869	873	99.5%
Detail Paid Amount	1,518,952	1,518,952	100.0%	1,518,952	1,518,952	100.0%
Detail TPL Paid Amount	5,525	1,518,952	0.4%	5,525	5,525	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	2,344,327	2,344,327	100.0%	2,319,269	2,344,327	98.9%
DOS	2,344,327	2,344,327	100.0%	2,344,327	2,344,327	100.0%
Rendering Provider NPI	2,344,327	2,344,327	100.0%	2,329,183	2,344,327	99.4%
Prescribing Provider NPI	2,344,327	2,344,327	100.0%	2,220,106	2,344,327	94.7%
National Drug Codes	2,344,327	2,344,327	100.0%	2,336,215	2,344,327	99.7%
MCO Received Date	2,344,327	2,344,327	100.0%	2,344,327	2,344,327	100.0%
MCO Paid Date	2,344,327	2,344,327	100.0%	2,344,327	2,344,327	100.0%
Header Paid Amount	2,344,327	2,344,327	100.0%	2,344,327	2,344,327	100.0%
Header TPL Paid Amount	32,247	2,344,327	1.4%	32,247	32,247	100.0%