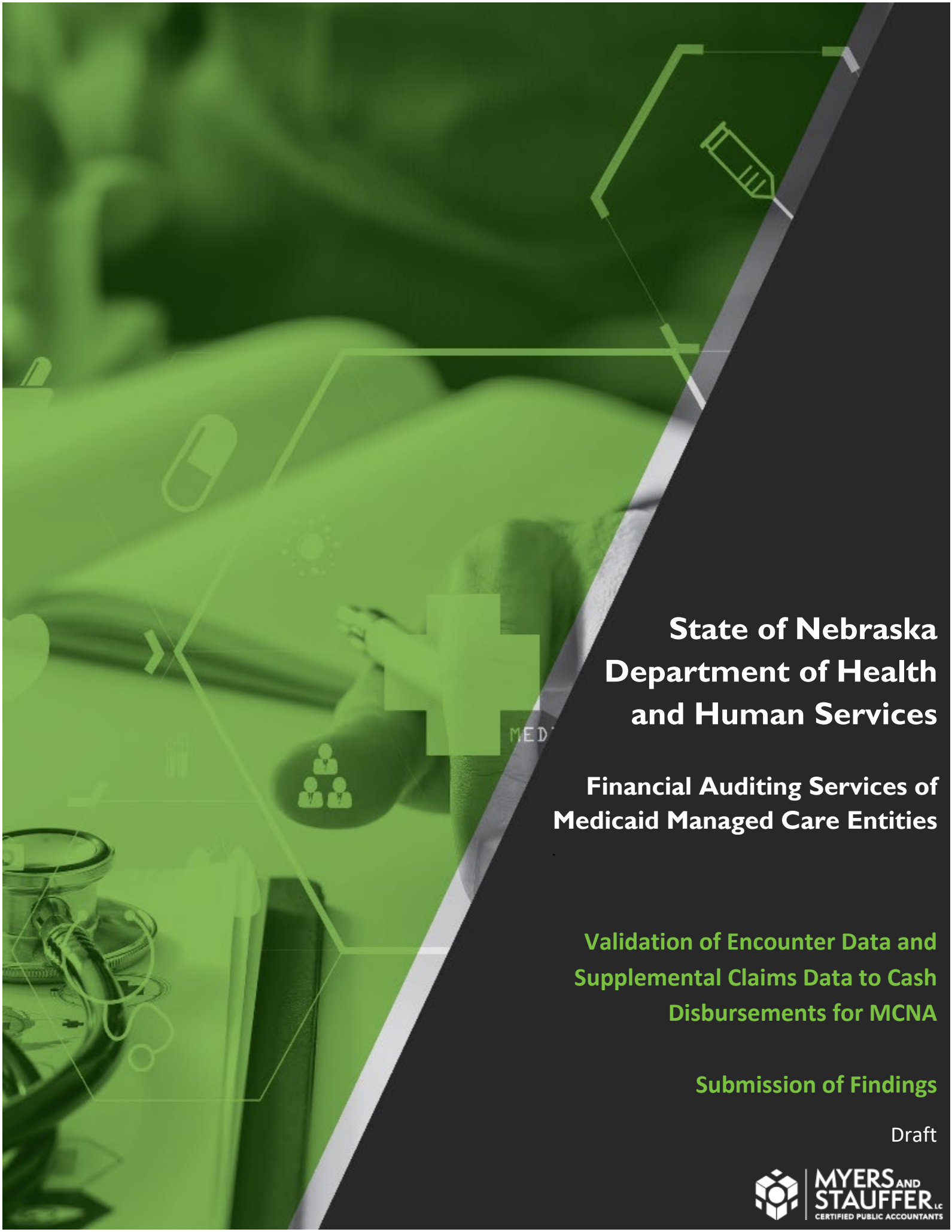

State of Nebraska Department of Health and Human Services

Financial Auditing Services of Medicaid Managed Care Entities

Validation of Encounter Data and Supplemental Claims Data to Cash Disbursements for MCNA

Submission of Findings

Draft

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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Executive Summary

The Nebraska Department of Health and Human Services (DHHS, or "State"), Division of Medicaid & Long-Term Care (MLTC) engaged Myers and Stauffer to perform an Encounter Data Validation (EDV) of MCNA's ("health plan") Cash Disbursement Journal (CDJ) to the health plan's fiscal year (FY) 2021 supplemental claims data submitted to Optumas, the actuary of record. Additional comparisons to encounter data submitted to the State by the health plan were completed. The health plan provided the following:

- A sample of two months of cash disbursement journals (CDJs), October 2020 and January 2021, which included payment dates and amounts paid by the health plan to providers.

In addition to the CDJ's provided by MCNA, Optumas provided the following:

- Supplemental claims data for fiscal year 2021 (July 1, 2020 through June 30, 2021).

A 95 percent completeness threshold was used when comparing the supplemental claims data to the CDJs submitted by the health plan.

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

Analysis indicated that the supplemental claims data provided by Optumas was supported 100 percent (based on total amounts paid) for both of the sample months tested. When comparing the total amounts paid on both the CDJs and the supplemental claims data to the encounter data from the State's data warehouse, significant variances were noted and total encounter paid amounts for the two sample months were below the 95 percent threshold, approximately 92 and 75 percent, respectively, of the CDJ total paid amounts. We recommend more in-depth analysis of the encounter data in order to thoroughly identify the root cause of the variances and that the health plan work with DHHS and HIA to resolve these issues. Also, there were instances where we were able to match an encounter to a CDJ transaction based on Medicaid ID and Billing ID; however, the paid amounts did not match. We recommend that the health plan research and respond to confirm the potential difference.

Introduction

Nebraska's Medicaid managed care program, known as Heritage Health, is the means by which most of Nebraska's Medicaid and Children's Health Insurance Program recipients receive health care services. Heritage Health combines Nebraska Medicaid's physical health, behavioral health, and pharmacy programs into a single comprehensive and coordinated program for the State's Medicaid and expansion enrollees. Heritage Health members enroll in one of three statewide health plans to receive their health care benefits.[1]

MCNA Insurance Company (MCNA or health plan) provides dental services for Medicaid and Children's Health Insurance Program (CHIP) recipients.

The State's new data warehouse, HealthInteractive (HIA), went live in November 2020 in order to house the Medicaid encounter data from the Heritage Health Plans and from MCNA, the State's dental vendor. The State is in the process of working through known issues prior to utilizing the encounter data from the HIA system for rate setting purposes. Currently, supplemental claims data provided to the actuary by each of the health plans is used as the primary source for rate setting. This supplemental claims data was the main focus of this review. Encounter data from the data warehouse was reviewed secondarily. Health plan-submitted CDJ data was compared to the supplemental claims data submitted to Optumas to determine the supplemental claims data's integrity (i.e., completeness). The supplemental claims data included final claims with dates of service occurring during fiscal year (FY) 2021 and paid through December 2021.

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

Supplemental Claims Data Extract Limitation

The supplemental claims data extract received by Myers and Stauffer from Optumas included claims paid from July 2019 through December 2021. A limitation was identified within the data and is listed below. This limitation may have impacted the results and findings of this validation.

Encounter Data Extract	
Limitations	
E-1	Data only includes final claims. This can be a limitation when comparing to sampled financial data which could contain financial transactions that were later reversed or adjusted.

[1] https://dhhs.ne.gov/Pages/Heritage-Health-Contacts.aspx

Discussion of results and observations are presented along with detailed analyses. Observations and findings are based on the information provided, and known data limitations at the time of the review. The observations and recommendations within this report provide an opportunity for the health plan to review its processes to ensure information and data submitted to the State, Optumas, or captured by the State's data warehouse is complete and accurate. The expectation is for the health plan to work with DHHS, HIA, and/or Optumas to resolve any issues noted within the supplemental data and/or encounter data.

Completeness

Completeness of the supplemental claims data is important for ensuring the accuracy of the rates being calculated. The completeness of the supplemental claims data was evaluated through comparisons to the health plan-submitted CDJs.

Cash Disbursement Journals

Myers and Stauffer received two months of CDJs (October2020 and January 2021) from the health plan. The health plan's FY 2021 supplemental claims data was reviewed to determine the completeness percentage when compared to the CDJ files from a financial perspective. The amounts reflected on the CDJ's were assumed complete and correct and served as the basis for determining the completeness of the supplemental claims data.

Figure 1, below, shows the completion percentages for the two sample months tested for FY 2021.

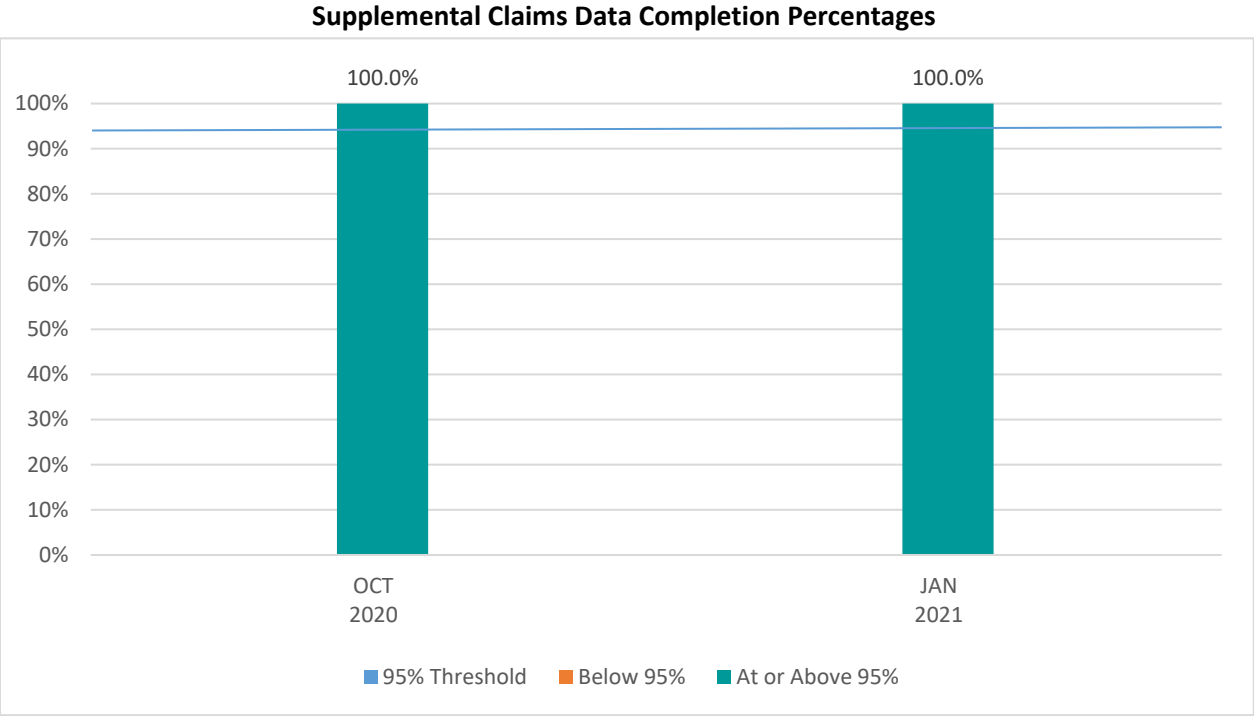

Table 1 below, shows the detail of the comparison between CDJs and supplemental claims data.

Supplemental Claims Data Completion Percentages

	October 2020	January 2021	Total
CDJ Data			
CDJ Paid Amount Total	***$3,481,181***	***$2,506,127***	***$5,987,307***
Supplemental Claims Data			
Supplemental Claims Data Paid Amount Total	$3,481,203	$2,506,127	$5,987,329
Payment Adjustments	-$22	$0	-$22
Net Supplemental Claims Data Paid Amount Total	***$3,481,181***	***$2,506,127***	***$5,987,307***
Supplemental Claims Data Completion Percentages	***100.0%***	***100.0%***	***100.0%***

**Payment adjustment represents an adjustment to the paid amount for a claim that was identified in both the CDJ and the Supplemental Claims Data.*

The analysis of the CDJs to the supplemental claims data provided by Optumas indicates that the data used for rate setting matched 100 percent to the health plan's financial records.

Comparison of CDJs to Encounter Data

An additional analysis was performed comparing the paid amounts from the CDJs to the encounter data contained in HIA. Optumas provided a copy of the encounter data they received from HIA to Myers and Stauffer for this analysis. This encounter data extract included encounters with paid dates from January 1, 2020 through May 31, 2022. The encounter data extract did not contain the health plan's Internal Control Number (ICN) and this limited our ability to match encounters directly to CDJ transactions. We confirmed with Optumas that while the encounter data they received from HIA did not include ICNs, those ICNs are included within the HIA data warehouse. The comparison between the CDJs and the encounters was, therefore, completed based on total dollars processed, grouped by Medicaid ID and Billing Provider ID, for the two sampled months (October 2020 and January 2021).

Table 2 below, shows the detail of the comparison between CDJ and the encounter data.

Encounter Data Comparison

	October 2020	January 2021	Total
CDJ Data			
CDJ Paid Amounts Total	$3,481,203	$2,506,127	$5,987,330
CDJ paid amounts not identified in encounters	$(708,574)	$(911,008)	$(1,619,582)
Total CDJ paid amounts matched to paid amounts within the encounter data	$2,772,629	$1,595,119	$4,367,748
Encounter paid amounts which were not identified in the CDJs	$413,756	$295,635	$709,391
Encounter Data			
Encounter Paid Amounts Total	$3,201,633	$2,053,731	$5,255,365
Variance between CDJ to encounters*	$(15,249)	$(162,978)	$(178,227)
Adjusted Encounters	$3,186,385	$1,890,753	$5,077,138
Net Encounters Completion Percentage	91.5%	75.4%	84.8%

**Variance represents instances where we were able to match an encounter to the CDJ using the Medicaid ID and Billing ID but the paid amounts did not match. These could potentially represent instances where a claim was paid within the sample month but later adjusted (and reflected correctly in the supplemental claims data provided to Optumas) but would require additional analysis to confirm.*

Overall, the completion percentage of the encounters based on total paid dollars for the two sampled months is 84.8 percent. It is important to note that there was more than $1.6 million included in the CDJs with Medicaid ID/Billing Provider combinations that we were not able to identify within the encounter data. Additionally, there was over $709,000 in paid amounts included in the encounters with Medicaid ID/Billing Provider combinations that we were not able to identify within the CDJ data. Because of the health plan ICN limitation mentioned above, these results are only an approximation of the completeness of the encounter data. We recommend additional in-depth analysis in order to more thoroughly reconcile the variances between data sets.

Summary of Observations and Recommendations

The table below summarizes the observations and our accompanying recommendations from the encounter data validation activities included within this report.

Observations and Recommendations		
	Observation	**Recommendation**
1	Total encounter paid amounts for the two sample months were below the 95 percent threshold, approximately 92 and 75 percent, respectively, of the CDJ total paid amounts	Recommend more in-depth analysis of the encounter data in order to thoroughly identify the root cause of the variances and the health plan should work with DHHS and HIA to resolve these issues.
2	In certain instances, encounters which were matched to the CDJ transactions based on Medicaid ID and Billing ID did not match based on paid amounts.	We recommend that the health plan be provided with examples of these encounters and ask that they research and respond to the variance to confirm accuracy.

Glossary

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

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

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

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

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

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

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

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

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

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

CFR – Code of Federal Regulations.

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

Delegated Vendor– A vendor to whom the health plan has contractually assigned responsibility for the provision and oversight of approval, payment, and administration of medical services to the Medicaid health plan's members. Also known as a subcontractor.

Department of Health and Human Services – The department that oversees services that assist the elderly, low income and those with disabilities and provide safety to abused and/or neglected children and vulnerable adults within the state of Nebraska.

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

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

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

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

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

Health Plan – A private organization that has entered into a contractual arrangement with DHHS to obtain and finance care for enrolled Medicaid members. Health plans receive a capitation or per member per month (PMPM) payment from DHHS for each enrolled member. Also referred to as Managed Care Organization (MCO), Managed Care Plan (MCP) or Managed Care Entity (MCE).

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

HealthInteractive (HIA) - Is the system of record for encounters for Nebraska Medicaid.

Heritage Health –Combines Nebraska Medicaid's physical health, behavioral health, and pharmacy programs into a single comprehensive and coordinated program for the state's Medicaid and Children's Health Insurance Program (CHIP) enrollees. Heritage Health members enroll in one of three statewide health plans to receive their health care benefits.

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

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

Medicaid and Long-Term Care (MLTC) – oversees the Nebraska Medicaid program, home and community based services, and the State Unit on Aging.

Optumas – The actuary of record for the state of Nebraska. Responsible for setting Medicaid rates for

Heritage Health program.

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

Validation – The review of information, data, and procedures to determine the extent to which encounter data is accurate, reliable, free from bias, and in accord with standards for data collection and analysis.