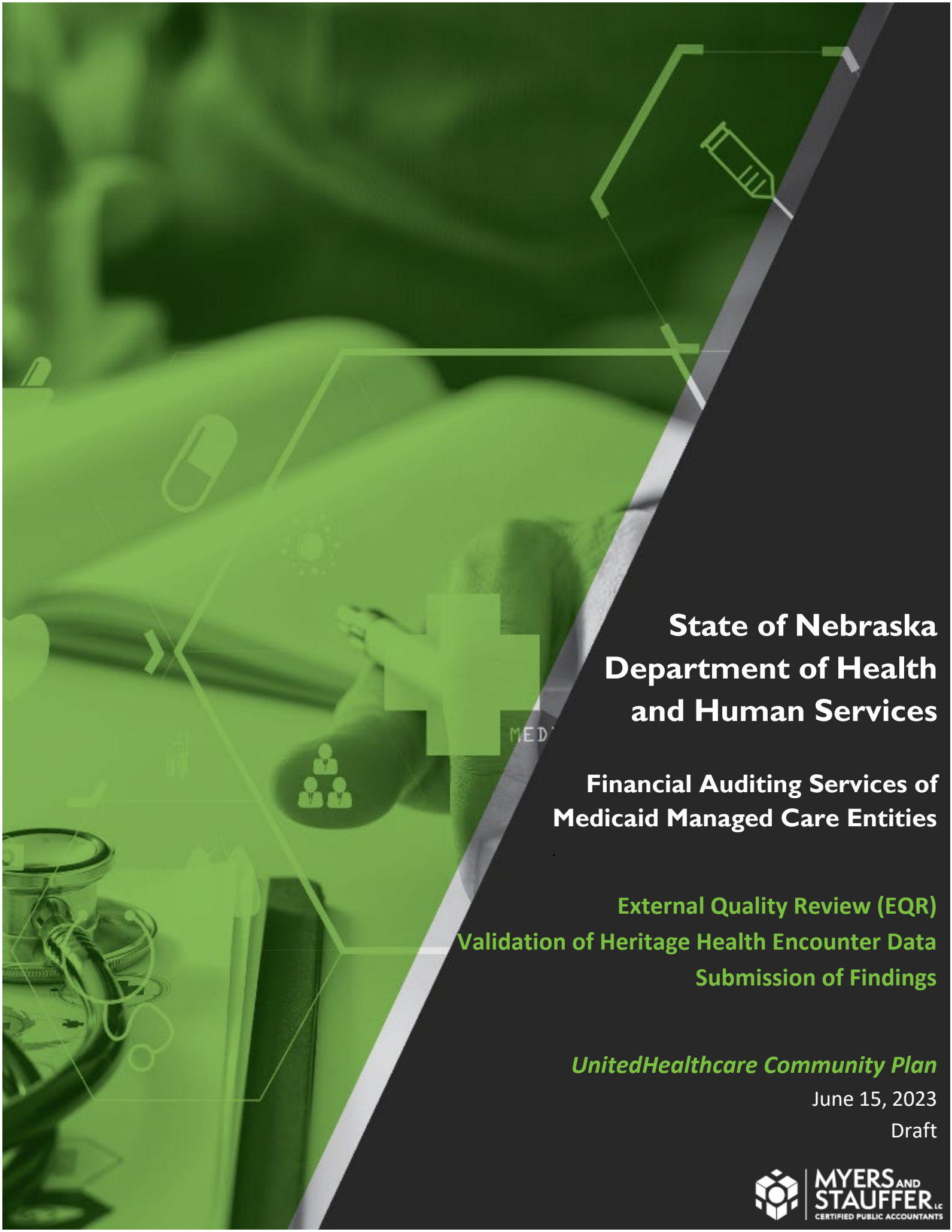

# State of Nebraska Department of Health and Human Services

## Financial Auditing Services of Medicaid Managed Care Entities

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

***UnitedHealthcare Community Plan***

June 15, 2023

Draft

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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# Executive Summary

The Nebraska Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC) engaged Myers and Stauffer to perform CMS' External Quality Review (EQR) Protocol 5, Validation of Encounter Data, to evaluate the completeness and accuracy of the supplemental claims data submitted by UnitedHealthcare Community Plan (UHC) and used for rate setting for the State's Medicaid Managed Care program, Heritage Health. The health plan's calendar year (CY) 2021 supplemental claims data submitted to Optumas, the State's actuary, was reviewed for completeness and accuracy. The health plan submitted the following for our validation procedures:

- A sample of two months of cash disbursement journals (CDJs), March 2021 and September 2021, which included payment dates and amounts paid by the health plan to providers.
- Sample claims data which included transactions with payment/adjudication dates within two selected sample months, March 2021 and September 2021.
- Medical records for review, which were randomly sampled from the supplemental claims data with dates of service occurring during CY 2021. A sample of 120 medical records was selected and sent to the health plan for retrieval and submission.

In addition to the data provided by the health plan, Optumas provided the following data:

- A copy of the supplemental claims data submitted to Optumas by the health plan for calendar year 2021, which contained all data received through May 2022.
- A copy of the encounter data Optumas received from HealthInteractive (HIA), which included encounters received and processed through May 31, 2022.

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

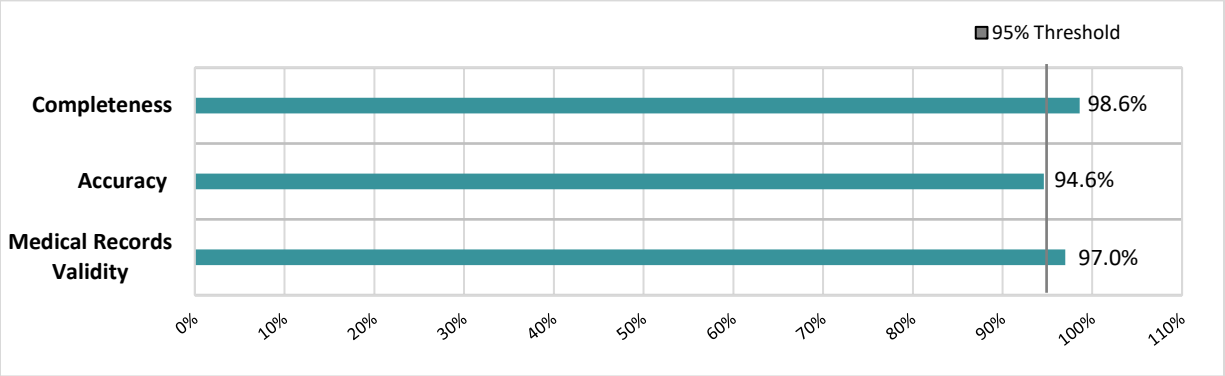
Our work was performed in accordance with the American Institute of Certified Public Accountants (AICPA) professional standards for consulting engagements. We were not engaged to, nor did we perform, an audit, examination, or review services. We express no opinion or conclusion related to the procedures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

Observations and findings are based on the information provided and known at the time of the review. The health plan should work with DHHS, HIA and/or Optumas to resolve issues noted within the supplemental claims data or the encounter data.

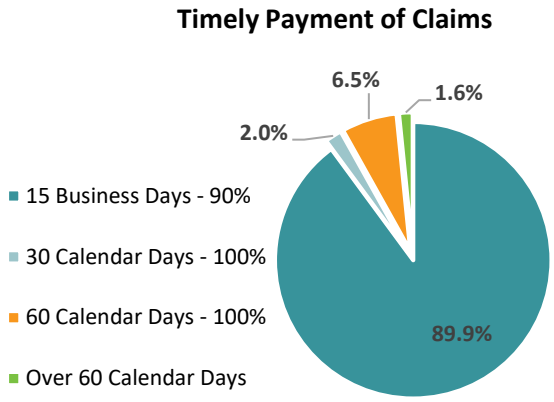
## Findings

- **Completeness:** For all claim types the supplemental claims data completion percentages met the 95 percent threshold when compared to CDJ paid amounts, claims sample paid amounts and claims sample counts. The aggregate completion percentage exceeded the 95 percent threshold (98.6 percent).

- **Accuracy:** The overall accuracy percentage was 94.6percent for all claim types and all key data elements reviewed.
- **Medical Record Validation Rates:** 103 of the medical records requested were submitted for review. Two (2) of the medical records submitted were for the incorrect dates of service resulting in 101 records (84.2 percent) being tested. The validation rate for the medical records tested exceeded the 95 percent threshold (97.0 percent).




- **Timeliness:**



# 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]

In 2016, the Centers for Medicare and Medicaid Services (CMS) established requirements for states to improve the reliability of encounter data collected from managed care health plans. Under CMS' Medicaid managed care final rule [2], states are required to conduct an independent audit of encounter data reported by each managed care health plan. CMS indicated that states could fulfill this requirement by conducting an encounter data validation assessment based on EQR Protocol 5[3]. While Protocol 5 is a voluntary protocol, CMS strongly encourages states to contract with qualified entities to implement Protocol 5 to evaluate its Medicaid encounter data and meet the audit requirement of the final rule. Protocol 5 measures the completeness and accuracy of the encounter data that has been adjudicated (i.e., paid or denied) by the health plan and submitted to state. States may be at risk for loss of federal financial participation/reimbursement if the encounter data is incomplete and/or inaccurate.

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

The State of Nebraska'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 MCNA, the state's dental vendor. The state is in the process of working through known issues prior to utilizing the data from the system for rate setting purposes. In order to calculate the 2021 capitation, supplemental claims data was provided by the health plans to Optumas for this purpose. The supplemental claims data included final claims with dates of service occurring during calendar year (CY) 2021 and paid through May 2022.

[1] https://dhhs.ne.gov/Pages/Heritage-Health-Contacts.aspx
[2] https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered
[3] 81 Fed. Reg. 27,498, 27,603 (May 6, 2016).
[4] Electronic Code of Federal Regulations: https://www.ecfr.gov/cgi-bin/text-idx?SID=888e7bb305afac68ec3793a21b77a4ba&mc=true&node=pt42.4.438&rgn=div5

The Nebraska Department of Health and Human Services (DHHS) Division of Medicaid & Long-Term Care (MLTC) engaged Myers and Stauffer LC (Myers and Stauffer) to perform Protocol 5 to evaluate the completeness and accuracy of the supplemental claims data submitted by UHC for CY 2021 for the State's Medicaid Managed Care program. CMS guidelines were followed and implemented during the review.

For a portion of the measurement period a public health emergency was in effect. On March 13, 2020, Nebraska's Governor, Pete Ricketts, declared a public health emergency (PHE)[5]. Federal and state responses to the PHE triggered social and economic disruptions, and periodically limited health care services to essential, emergency services. On June 30, 2021, Nebraska's Governor declared an end to the PHE; however, the federal PHE remained in place for the duration of the measurement period.

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

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

[5] https://dhhs.ne.gov/Pages/Gov-Ricketts-Ends-Coronavirus-State-of-Emergency.aspx

# Activity 1: Review State Requirements

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

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

Observations made from the reviews are summarized below along with recommendations for DHHS.

| Findings and Recommendations | | |
|---|---|---|
| | **Findings** | **Recommendations** |
| 1-A | Interest on claims is included in the total amount paid in health plan's submitted encounters. | DHHS should consider adding a separate encounter field for interest paid on claims. This will allow the separate consideration of interest in rate setting. |
| 1-B | Interest on claims is not reported in a separate field in the health plan's supplemental claims data submitted to Optumas. | Optumas should consider adding a separate field for interest paid on claims in the supplemental claims data request. This will help to ensure the plan identifies any interest paid on claims and allow Optumas to consider it in Rate Setting. This is currently done through a separate question within Optumas' supplemental claims data request to the plan. |
| 1-C | There is no clear guidance as to what is being attested to in the encounter level attestation segment within the health plans encounter submissions. | DHHS should consider publishing what the health plan is attesting to within the encounter segment either through enhanced language in the contract or additional detail in the encounter submission guidance. |
| 1-D | The file layout for the supplemental data for prescriber ID field is ambiguous leading some plans to submit NPI and others to submit other forms of the prescriber IDs. | Optumas should consider clarifying the data request to specify the ID type being requested to allow for consistent reporting by all plans. |

# Activity 2: Review Health Plan Capability

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

| Findings and Recommendations | |
|---|---|
| **Findings** | **Recommendations** |
| There were no findings related to our review of the health plan's capability. | |

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

# Activity 3: Analyze Electronic Encounter Data

Activity 3 determines the validity of the encounter data submitted to the State and requires verifying its completeness and accuracy. Nebraska utilizes the supplemental claims data provided to the actuary as the primary source for rate setting and this data was the primary focus of the EQR review. Encounter data from the data warehouse was reviewed secondarily. Health plan-submitted CDJs and sample claims data were compared to the supplemental claims data submitted to Optumas to determine the supplemental claims data's integrity (i.e., completeness and accuracy). Statistics and distributions were also generated on the data for validation.

The health plan contracted with third party vendors to administer its behavioral health, vision, non-emergency transportation (NEMT), and pharmacy benefits. Sample claims data was also submitted by the vendors. CDJ data for the health plan's pharmacy vendor was also separately submitted. These files were separately compared to the supplemental claims data to determine the completeness and accuracy of the data submitted to Optumas, via the health plan's delegated vendors. However, CDJ data for their related party vendors for behavioral health, vision, and NEMT were submitted with the Medical claims from the Health Plan and were evaluated as a single population.

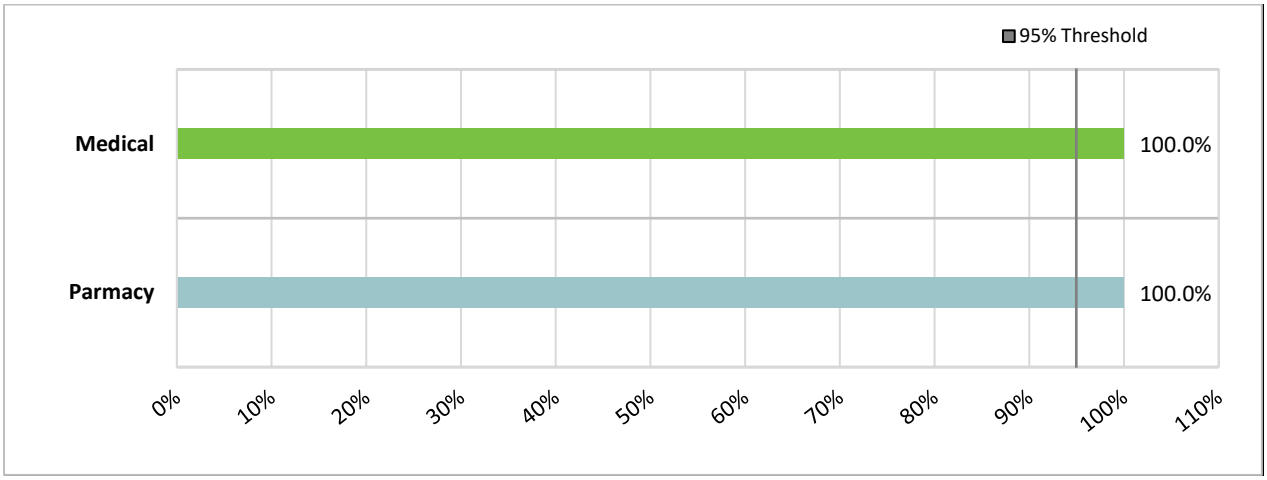
## Completeness

Completeness of the supplemental claims data is important for ensuring accurate rates can be set. The completeness of the supplemental claims data was evaluated through multiple analyses.

### Cash Disbursement Journals

Myers and Stauffer received two months of cash disbursements journals (March 2021 and September 2021) from the health plan**.** The health plan's CY 2021 supplemental claims data was reviewed to determine the completeness percent when compared to the CDJ files from a financial perspective. **Figure 1,** below, shows the completion percentages for the combination of the two sample tested for CY 2021. The medical CDJ for UHC included vision and transportation.

**Supplemental Claims Data Completion Percentages**




Detailed results can be found in Appendix A.

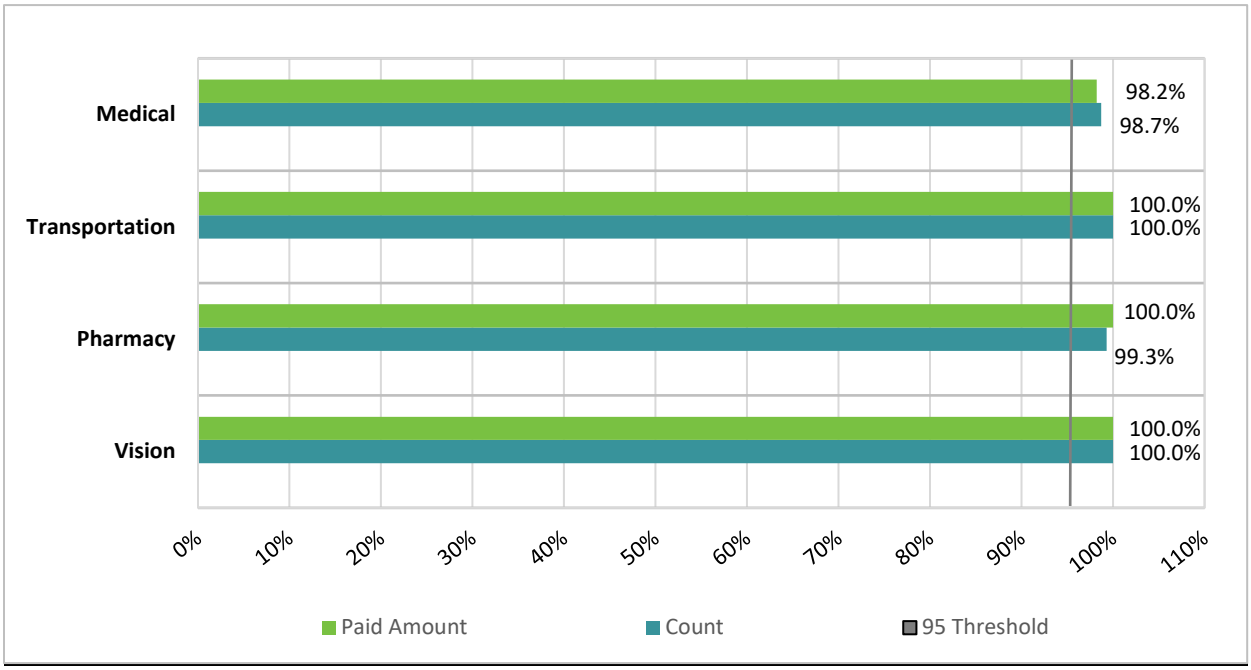
## Sample Claims

The comparison of the sample claims data to the supplemental claims data sought to ensure that all claims were included in the sample claims and/or supplemental claims data. The health plan-submitted sample claims data was traced to the supplemental claims data using data elements provided in the sample claims data. The supplemental claims data was evaluated against the sample claims data based on the following criteria:

- Sample Claim Count: The number of sample claims that were identified in the supplemental claims data.
- Sample Claim Paid Amount: Sample claim paid amounts compared to supplemental paid amounts.

**Figure 2** shows the completion percentages obtained after the identification of sample claims in the supplemental claims data and the comparison of the sample claim count and paid amounts to supplemental claims data count and paid amounts for the two sample months combined. Detailed results can be found in Appendix B.

**Supplemental Claims Data and Sample Claims Data Completion Percentages**




Completion percentages below 100 percent indicate there are records missing from the supplemental claims data. All claim types exceed the 95 percent completion threshold.

## Accuracy

For the purpose of validating supplemental claims data accuracy, certain key data elements were selected for testing. See Appendix C-1 for key data elements tested by claim type. The key data elements of the supplemental claims data traced to the sample claims data were compared to the corresponding key data

elements on the sample claim. Consistency checks on blank or null data element values were also applied. The key data elements were evaluated based on the following criteria:

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

Supplemental claims data accuracy issues were noted for Inpatient, Outpatient, and NEMT. Pharmacy issues were identified with billing/service/prescribing provider NPIs, billed charges, and paid date. Accuracy percentages by claim type are presented in **Table 1**. The key data elements evaluated and specific testing results are presented in Appendix D.

**Accuracy Percentages – Key Data Elements Analysis**

| Claim Type | Valid Values | Missing Values | Erroneous Values |
|---|---|---|---|
| Inpatient | 94.0% | 5.3% | 0.7% |
| Outpatient | 93.9% | 5.1% | 1.0% |
| Professional | 98.3% | 0.8% | 0.9% |
| Transpiration | 100% | 0.0% | 0.0% |
| Pharmacy | 88.7% | 0.0% | 11.3% |
| Vision | 99.3% | 0.5% | 0.2% |
| ***Total Average*** | ***94.6%*** | ***1.0%*** | ***4.4%*** |

## Findings and Recommendations

The findings from the completeness and accuracy analyses of the supplemental claims data are summarized below, including recommendations for the health plan.

| Findings and Recommendations | | |
|---|---|---|
| | **Findings** | **Recommendations** |
| 3-A | Finding was removed based on plan's response. | |
| 3-B | **Accuracy – Servicing Provider NPI:** *Inpatient, Outpatient, and Professional and* – A majority of the servicing provider NPIs that were identified as having accuracy issues were missing from the supplemental claims data. | The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate Servicing Provider NPI are being reported. |
| 3-C | **Accuracy – Billed Charges-** *Pharmacy* – The billed charges were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues. | The health plan should review its process for submitting supplemental claims data to Optumas to ensure billed charges are being reported accurately in the supplemental claims data. |
| 3-D | Finding was removed based on plan's response. | |

## Statistics and Distributions

To further support the supplemental claims data validation process, supplemental claims data with CY 2021 dates of service were analyzed for consistency among attributes such as member utilization and paid amounts, and timeliness of payments.

### Members, Utilization and Paid Amounts

The total number of utilized services (i.e., procedures) and total paid amounts for CY 2021 were divided by the number of unique members receiving service for the measurement period to determine average per member utilization. These numbers were derived from the supplemental claims data. Table 2 below shows the resulting average utilization and paid amounts per member. Detailed results can be found in Appendix E.

The health plan's membership represented 30.5 percent of Heritage Health's members receiving service in 2021. Average per member utilization and paid amounts for UHC were less than Heritage Health, as a whole, average per member utilization and paid amounts.

| Average Per Member Utilization and Paid Amounts by Service Type, CY 2021 | | | |
|---|---|---|---|
| | **Heritage Health** | **UHC** | **Percentage of Heritage Health** |
| **Members** | | | |

| Average Per Member Utilization and Paid Amounts by Service Type, CY 2021 | | | | | | |
|---|---|---|---|---|---|---|
| | Heritage Health | | UHC | | Percentage of Heritage Health | |
| Distinct Member Count receiving services based on supplemental claims data - CY 2021 | 369,789 | | 112,909 | | 30.5% | |
| Service Type | Average Per Member Utilization | Average Per Member Paid Amount | Average Per Member Utilization | Average Per Member Paid Amount | Percentage Variance | |
| | | | | | Count | Paid Amount |
| Ancillary | 2.0 | *$169* | 4.4 | $359 | 115.2% | 112.2% |
| Inpatient | 1.7 | *$994* | 1.6 | $1,064 | -6.4% | 7.0% |
| Non-Emergent Transportation | 0.5 | *$16* | 1.0 | $25 | 95.7% | 58.1% |
| Outpatient | 7.5 | *$1,059* | 9.3 | $1,357 | 23.7% | 28.2% |
| Pharmacy | 11.4 | *$979* | 15.5 | $1,161 | 35.6% | 18.6% |
| Primary Care | 6.8 | *$451* | 8.6 | $508 | 25.5% | 12.7% |
| Specialty | 3.7 | *$285* | 1.6 | $125 | -57.5% | -56.1% |
| Vision | 1.0 | *$32* | 1.3 | $30 | 28.8% | -6.3% |
| ***Total Health Plan Services*** | ***34.8*** | ***$3,984*** | **43.2** | **$4,629** | **24.3%** | **16.2%** |

**Table 2: Per Member Utilization and Paid Amount Statistics.** *Positive/Negative* percentage variances indicate that the health plan's PMPY counts and/or paid amounts are *greater than/less than* counts and/or paid amounts of Heritage Health's as a whole. Differences are due to rounding.

## Timeliness

### Timely Payment of Claims

This analysis measures the compliance of the health plan in paying or denying claims submitted by providers for payment. The contract between DHHS and the health plan requires that the health plan pay or deny at least 90 percent of all claims within 15 business days of receipt, 99 percent within 60 calendar

days of the date of receipt and all claims within six months of receipt[7]. **Table 3** shows the results of the analysis. Detailed results can be found in Appendix F.

| Timely Payment of Claims | | | | |
|---|---|---|---|---|
| **Claim Type** | **15 Business Days 90%** | **60 Calendar Days 99%** | **180 Calendar Days 100%** | **Average Days** |
| Inpatient | 87.9% | 93.7% | 97.8% | 21 |
| Outpatient | 95.4% | 97.7% | 99.3% | 12 |
| Professional | 80.4% | 83.8% | 96.8% | 30 |
| Vision | 93.1% | 99.5% | 99.8% | 8 |
| NEMT | 100.0% | 100.0% | 100.0% | 11 |
| Pharmacy | 100.0% | 100.0% | 100.0% | 0 |
| ***Overall Average*** | **89.9%** | **91.8%** | **98.3%** | **16** |

**Table 3: Timely Payment of Claims** measures the percentage of claims paid (adjudicated) by the health plan within the designated number of days. Percentages reflect claims with CY 2021 dates of service.

The health plan received dates and health plan paid (adjudicated) dates from the two sample claims months were used for the analysis. The number of days between these dates were used to determine the percentage of claims paid (adjudicated) by the health plan within the designated timeframes.

Overall, the health plan did not meet the any of the required levels of timeliness for the payment of claims. The plan did not meet the any of the levels of timeliness thresholds for inpatient, outpatient and professional claims. The health plan's delegated Vision vendors met the 15 business day and 60 calendar Day timeliness thresholds but did not meet the 180 calendar day timeliness thresholds. The health plan's delegated NEMT and pharmacy vendors met the all of the timeliness thresholds for transportation and pharmacy claims respectively.

## Findings and Recommendations

The findings from the timeliness analysis are presented below, including recommendations for the health plan.

[7] Contract Amendment 6 Sec IV.S.3.a

| Findings and Recommendations | | |
|---|---|---|
| | **Findings** | **Recommendations** |
| 3-E | **Timely Payment of Claims**: The plan did not meet the timeliness standards for inpatient, outpatient or professional claims. | The health plan should ensure their claims are adjudicated promptly in order to meet the timeliness requirements established within the contract between the DHHS and the health plan. |

# Activity 4: Review of Medical Records

Activity 4 provides supporting information for the findings detailed in the Activity 3 analysis of supplemental claims data. This is done by tracing certain key data elements from the supplemental claims data to the member's medical record obtained from the service provider. Supplemental claims data with dates of service during the measurement period were used as the population for the selection of sample records for review. A non-statistical[8], random sampling of 120 records was selected from the supplemental claims data for review.

The supplemental claims data records selected for review were forwarded to the health plan on November 16, 2022 for retrieval of the medical records. The notification to the health plan stated that medical records were due to Myers and Stauffer no later than January 11, 2023.

**Table 5** below summarizes the number of records requested, received, replaced or missing, and the net number of medical records tested.

| Medical Records Summary | | | | | |
|---|---|---|---|---|---|
| **Description** | **Inpatient** | **Outpatient** | **Professional** (includes Behavioral Health, Vision and NEMT) | **Pharmacy** | **Total** |
| Requested | 3 | 29 | 54 | 34 | 120 |
| Missing | 1 | 7 | 9 | 0 | 17 |
| Incorrect Record Submitted | 0 | 1 | 1 | 0 | 2 |
| Replaced | 0 | 0 | 0 | 0 | 0 |
| Medical Records Received and Tested | 2 | 21 | 44 | 34 | 101 |
| ***Percentage of Requested Records Tested*** | ***66.6%*** | ***72.4%*** | ***81.5%*** | ***100.0%*** | ***84.2%*** |

**Table 5: Medical Records Summary.** 103 of the 120 medical records requested were submitted.

## Validation

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

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

validation was segregated in the following manner:

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

Validity issues were noted with the pharmacy supplemental claims data. Prescribing Providers were unsupported in the medical record. **Table 6**, below, reflects the validation rates from the medical record key data element review. The detail analysis is included in Appendix G.

| Medical Records Validation Rates | | |
|---|---|---|
| **Data Types** | **Supported Validation Rate** | **Unsupported Validation Rate** |
| Inpatient | 100% | 0.0% |
| Outpatient | 98.5% | 1.5% |
| Professional (includes Behavioral Health, Vision and NEMT) | 97.7% | 2.3% |
| Pharmacy | 87.0% | 13.0% |
| ***Total*** | ***97.0%*** | ***3.0%*** |

**Table 6: Medical Record Validation Rates.** 101 of the 120 medical records requested were tested. Supported and unsupported determinations were for each key data element tested and not a claim level determination.

## Findings and Recommendations

The findings from the supplemental claims data testing against medical records are presented below, including recommendations for or the health plan.

| Findings and Recommendations | | |
|---|---|---|
| | **Findings** | **Recommendations** |
| 4-A | The plan was not able to provide Medical records to support 17 of 120 records requested. Additionally, the plan provided records for the wrong timeframe for 2 of the 103 records that were submitted. | The health plan should work with its providers to ensure medical records are available and submitted for the members and dates of service requested, and are submitted within the requested time frame(s). |
| 4-B | Validation rates for pharmacy claims were below the 95 percent accuracy threshold for the 101 records that were tested (87.0 percent) | The health plan should review the claims with accuracy issues and determine the root cause of missing or mismatched data then develop a plan to address the issue with adjustment to their processes. (See plan response for additional context) |

# Activity 5: Submission of Findings

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

| Findings and Recommendations | | |
|---|---|---|
| | **Findings** | **Recommendations** |
| **Activity 1 – Review State Requirements** | | |
| 1-A | Interest on claims is included in the total amount paid in health plan's submitted encounters. | DHHS should consider adding a separate encounter field for interest paid on claims. This will allow the separate consideration of interest in rate setting. |
| 1-B | Interest on claims is not reported in a separate field in the health plan's supplemental claims data submitted to Optumas. | Optumas should consider adding a separate field for interest paid on claims in the supplemental claims data request. This will help to ensure the plan identifies any interest paid on claims and allow Optumas to consider it in Rate Setting. This is currently done through a separate question within Optumas supplemental claims data request to the plan. |
| 1-C | There is no clear guidance as to what is being attested to in the encounter level attestation segment within the health plans encounter submissions. | DHHS should consider publishing what the health plan is attesting to within the encounter segment either through enhanced language in the contract or additional detail in the encounter submission guidance. |
| 1-D | The file layout for the supplemental data for prescriber ID field is ambiguous leading some plans to submit NPI and others to submit other forms of the prescriber IDs. | Optumas should consider clarifying the data request to specify the ID type being requested to allow for consistent reporting by all plans. |
| **Activity 2 – Review Health Plan Capability** | | |
| There were no findings related to our review of the health plan's policy and process. | | |
| **Activity 3 – Analyze Electronic Encounter Data** | | |
| 3-A | Finding was removed based on plan's response. | |
| 3-B | **Accuracy – Servicing Provider NPI:** *Inpatient, Outpatient, Professional and Transportation* – A majority of the servicing provider NPIs that were identified as having accuracy issues were missing from the supplemental claims data. | The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate Servicing Provider NPI are being reported. |
| 3-C | **Accuracy – Billed Charges-** *Pharmacy* – The billed charges were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues. | The health plan should review its process for submitting supplemental claims data to Optumas to ensure billed charges are being reported accurately in the supplemental claims data. |

| Findings and Recommendations | | |
|---|---|---|
| | **Findings** | **Recommendations** |
| 3-D | Finding was removed based on plan's response. | |
| 3-E | **Timely Payment of Claims**: The plan did not meet the timeliness standards or inpatient, outpatient and professional claims. | The health plan should ensure their claims process is set up to meet the timeliness requirements established within the contract between the DHHS and the health plan. |
| **Activity 4 – Review of Medical Records** | | |
| 4-A | The plan was not able to provide Medical records to support 17 of 120 records requested. Additionally, the plan provided records for the wrong timeframe for 2 of the 103 records that were submitted. | The health plan should work with its providers to ensure medical records are available and submitted for the members and dates of service requested, and are submitted within the requested time frame(s). |
| 4-B | Validation rates for pharmacy claims were below the 95 percent accuracy threshold for the 101 records that were tested (87.0 percent) | The health plan should work with its providers to ensure medical records support the submitted claims. For claims that are not supported by the medical record the health plan should conduct provider outreach to ensure future claims are appropriately billed. (See plan response for additional context) |

# 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.

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

**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.

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

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

(DCN).

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

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

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

**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.

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

**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.

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

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

**Sub-Capitated Provider** – A health care provider that is paid on a capitated or per member per month (PMPM) basis that has contracted with a health plan paid under a capitated system and shares a portion of the health plan's capitated premium.

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

# Appendices

# Appendix A: Cash Disbursement Journal (CDJ) Completeness

| | Medical | | | Pharmacy | | |
|---|---|---|---|---|---|---|
| | March 2021 | September 2021 | Total | March 2021 | September 2021 | Total |
| **CDJ Data** | | | | | | |
| CDJ Paid Amount Total | $33,738,368 | $38,627,166 | $72,365,534 | $8,241,579 | $9,067,971 | $17,309,550 |
| Reconciling Adjustment | -$3,398,781 | -$4,508,980 | -$7,907,761 | $3,273,604 | $3,476,715 | $6,750,319 |
| ***Net CDJ Data Paid Amount Total*** | ***$30,339,586*** | ***$34,118,187*** | ***$64,457,773*** | ***$11,515,183*** | ***$12,544,685*** | ***$24,059,869*** |
| **Supplemental Claims Data** | | | | | | |
| Supplemental Paid Amount Total | $37,394,649 | $38,163,562 | $75,558,211 | $11,488,799 | $12,502,390 | $23,991,190 |
| Payment Adjustments | -$7,055,062 | ($4,045,375) | -$11,100,437 | $26,384 | $42,295 | $68,679 |
| ***Net Supplemental Paid Amount Total*** | ***$30,339,586*** | ***$34,118,187*** | ***$64,457,773*** | ***$11,515,183*** | ***$12,544,685*** | ***$24,059,869*** |
| ***Supplemental Completeness Percentage*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** |

# Appendix B: Claims Sample Completeness

| Description | Medical | | | | | | Transportation | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | March 2021 | | September 2021 | | Total | | March 2021 | | September 2021 | | Total | |
| | Count | Paid Amount | Count | Paid Amount | Count | Paid Amount | Count | Paid Amount | Count | Paid Amount | Count | Paid Amount |
| **Sample Data** | | | | | | | | | | | | |
| Total Submitted Claims Sample Data | 187,848 | $42,200,508 | 179,421 | $43,036,070 | 367,269 | $85,236,579 | 3,872 | $301,414 | 4,586 | $363,207 | 8,458 | $664,622 |
| Claim Lines Not Identified in the Supplemental Claims Data | | | | | | | | | | | | |
| Entire Claim | (2,026) | ($642,129) | (2,592) | ($893,550) | (4,618) | ($1,535,679) | 0 | $0 | 0 | $0 | 0 | $0 |
| ***Matched Sample Claims*** | ***185,822*** | ***$41,558,379*** | ***176,829*** | ***$42,142,520*** | ***362,651*** | ***$83,700,900*** | ***3,872*** | ***$301,414*** | ***4,586*** | ***$363,207*** | ***8,458*** | ***$664,622*** |
| **Supplemental Claims Data** | | | | | | | | | | | | |
| Total Matched Supplemental Claims | 185,822 | $34,525,807 | 176,829 | $35,127,459 | 362,651 | $69,653,266 | 3,872 | $130,237 | 4,586 | $154,038 | 8,458 | $284,274 |
| Less Payment Adjustment | 0 | $7,032,572 | 0 | $7,015,061 | 0 | $14,047,634 | 0 | $171,178 | 0 | $209,169 | 0 | $380,347 |
| ***Net Matched Supplemental Claims*** | ***185,822*** | ***$41,558,379*** | ***176,829*** | ***$42,142,520*** | ***362,651*** | ***$83,700,900*** | ***3,872*** | ***$301,414*** | ***4,586*** | ***$363,207*** | ***8,458*** | ***$664,622*** |

| Description | Pharmacy | | | | | | Vision | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | March 2021 | | September 2021 | | Total | | March 2021 | | September 2021 | | Total | |
| | Count | Paid Amount | Count | Paid Amount | Count | Paid Amount | Count | Paid Amount | Count | Paid Amount | Count | Paid Amount |
| **Sample Data** | | | | | | | | | | | | |
| Total Submitted Claims Sample Data | 115,531 | $11,518,772 | 119,952 | $12,549,606 | 235,483 | $24,068,378 | 3,700 | $250,028 | 3,694 | $86,480 | 7,394 | $336,508 |
| Claim Lines Not Identified in the Supplemental Claims Data | | | | | | | | | | | | |
| Entire Claim | ***(725)*** | ***$0*** | ***(932)*** | ***$0*** | ***(1,657)*** | ***$0*** | ***0*** | ***$0*** | ***0*** | ***$0*** | ***0*** | ***$0*** |
| ***Matched Sample Claims*** | ***114,806*** | ***$11,518,772*** | ***119,020*** | ***$12,549,606*** | ***233,826*** | ***$24,068,378*** | ***3,700*** | ***$250,028*** | ***3,694*** | ***$86,480*** | ***7,394*** | ***$336,508*** |
| **Supplemental Claims Data** | | | | | | | | | | | | |
| Total Matched Supplemental Claims | 114,806 | $11,581,246 | 119,020 | $12,631,603 | 233,826 | $24,212,849 | 3,700 | $163,916 | 3,694 | $150,867 | 7,394 | $314,782 |
| Less Payment Adjustment | 0 | ($62,474) | 0 | ($81,997) | 0 | ($144,471) | 0 | $86,112 | 0 | ($64,387) | 0 | $21,725 |
| ***Net Matched Supplemental Claims*** | ***114,806*** | ***$11,518,772*** | ***119,020*** | ***$12,549,606*** | ***233,826*** | ***$24,068,378*** | ***3,700*** | ***$250,028*** | ***3,694*** | ***$86,480*** | ***7,394*** | ***$336,508*** |

# Appendix C: Key Data Element Tested

| Key Data Element | IP | OP | Professional | Vision | RX | NEMT |
|---|---|---|---|---|---|---|
| Bill Type (digits 1 and 2) | X | X | N/A | N/A | N/A | N/A |
| Billed Charges | X | X | X | X | X | X |
| Billing Provider NPI/Number | X | X | X | X | N/A | N/A* |
| Days Supply | N/A | N/A | N/A | N/A | X | N/A |
| Diagnosis Codes | X | X | X | X | N/A | N/A |
| Date of Service - First | X | X | X | X | N/A | X |
| Date of Service - Last | X | X | X | X | N/A | N/A |
| Fill Date | N/A | N/A | N/A | N/A | X | N/A |
| Health Plan (MCO) Paid Amount | X | X | X | X | X | X |
| Health Plan (MCO) Paid Date | X | X | X | X | X | X |
| MMIS Member Number (Medicaid ID) | X | X | X | X | X | X |
| National Drug Code (NDC) | N/A | N/A | N/A | N/A | X | N/A |
| Place of Service | N/A | N/A | X | X | | N/A |
| Prescribing Provider NPI | N/A | N/A | N/A | N/A | X | N/A |
| Procedure Code | N/A | X | X | X | N/A | X |
| Procedure Code Modifiers | N/A | X | X | X | N/A | X |
| Quantity Dispensed | N/A | N/A | N/A | N/A | X | N/A |
| Refill Number | N/A | N/A | N/A | N/A | X | N/A |
| Revenue Code | X | X | N/A | N/A | N/A | N/A |
| Service/Rendering Provider NPI / Number | X | X | X | X | N/A | N/A* |
| Surgical Procedure Codes | X | N/A | N/A | N/A | N/A | N/A |

*Servicing and Billing NPIs were not evaluated for transportation claims because of the use of atypical providers who do not have NPIs

# Appendix D: Key Data Element Matching

| Medical | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Key Data Element | March 2021 | | | | | | | September 2021 | | | | | | | Total | | | | | | | | |
| | Number of Claims Evaluated | Valid Values (Matching) | | Missing Values (Invalid) | | Erroneous Values (Non-matching/ Invalid) | | Number of Claims Evaluated | Valid Values (Matching) | | Missing Values (Invalid) | | Erroneous Values (Non-matching/ Invalid) | | Number of Claims Evaluated | Valid Values (Matching) | | Missing Values (Invalid) | | Erroneous Values (Non-matching/ Invalid) | | |
| | | Count | Percent | Count | Percent | Count | Percent | | Count | Percent | Count | Percent | Count | Percent | | Count | Percent | Count | Percent | Count | Percent | | |
| Bill Type (digits 1 and 2) | 28,970 | 28,948 | 99.9% | 2 | 0.0% | 20 | 0.1% | 35,508 | 35,486 | 99.9% | 0 | 0.0% | 22 | 0.1% | 64,478 | 64,434 | 99.9% | 2 | 0.0% | 42 | 0.1% | | |
| Billed Charges | 185,809 | 185,170 | 99.7% | 0 | 0.0% | 639 | 0.3% | 176,829 | 176,476 | 99.8% | 0 | 0.0% | 353 | 0.2% | 362,638 | 361,646 | 99.7% | 0 | 0.0% | 992 | 0.3% | | |
| Billing Provider NPI/Number | 185,809 | 185,592 | 99.9% | 0 | 0.0% | 217 | 0.1% | 176,829 | 176,564 | 99.9% | 0 | 0.0% | 265 | 0.1% | 362,638 | 362,156 | 99.9% | 0 | 0.0% | 482 | 0.1% | | |
| Diagnosis Codes | 185,809 | 185,752 | 100.0% | 0 | 0.0% | 57 | 0.0% | 176,829 | 176,794 | 100.0% | 0 | 0.0% | 35 | 0.0% | 362,638 | 362,546 | 100.0% | 0 | 0.0% | 92 | 0.0% | | |
| Date of Service - First | 185,809 | 185,786 | 100.0% | 0 | 0.0% | 23 | 0.0% | 176,829 | 176,804 | 100.0% | 0 | 0.0% | 25 | 0.0% | 362,638 | 362,590 | 100.0% | 0 | 0.0% | 48 | 0.0% | | |
| Date of Service - Last | 185,809 | 185,746 | 100.0% | 0 | 0.0% | 63 | 0.0% | 176,829 | 176,772 | 100.0% | 0 | 0.0% | 57 | 0.0% | 362,638 | 362,518 | 100.0% | 0 | 0.0% | 120 | 0.0% | | |
| Health Plan Paid Amount | 185,809 | 175,317 | 94.4% | 0 | 0.0% | 10,492 | 5.6% | 176,829 | 173,244 | 98.0% | 0 | 0.0% | 3,585 | 2.0% | 362,638 | 348,561 | 96.1% | 0 | 0.0% | 14,077 | 3.9% | | |
| MMIS Member Number (Medicaid ID) | 185,809 | 185,795 | 100.0% | 0 | 0.0% | 14 | 0.0% | 176,829 | 176,826 | 100.0% | 0 | 0.0% | 3 | 0.0% | 362,638 | 362,621 | 100.0% | 0 | 0.0% | 17 | 0.0% | | |
| Place of Service | 156,839 | 156,828 | 100.0% | 0 | 0.0% | 11 | 0.0% | 141,321 | 141,306 | 100.0% | 0 | 0.0% | 15 | 0.0% | 298,160 | 298,134 | 100.0% | 0 | 0.0% | 26 | 0.0% | | |
| Procedure Code | 184,305 | 184,085 | 99.9% | 0 | 0.0% | 220 | 0.1% | 175,093 | 174,797 | 99.8% | 0 | 0.0% | 296 | 0.2% | 359,398 | 358,882 | 99.9% | 0 | 0.0% | 516 | 0.1% | | |
| Procedure Code Modifiers | 184,305 | 184,176 | 99.9% | 0 | 0.0% | 129 | 0.1% | 175,093 | 174,951 | 99.9% | 0 | 0.0% | 142 | 0.1% | 359,398 | 359,127 | 99.9% | 0 | 0.0% | 271 | 0.1% | | |
| Revenue Code | 28,970 | 28,962 | 100.0% | 2 | 0.0% | 6 | 0.0% | 35,508 | 35,499 | 100.0% | 0 | 0.0% | 9 | 0.0% | 64,478 | 64,461 | 100.0% | 2 | 0.0% | 15 | 0.0% | | |
| Service/Rendering Provider NPI / Number | 185,809 | 130,841 | 70.4% | 43,624 | 23.5% | 11,344 | 6.1% | 176,829 | 145,554 | 82.3% | 21,790 | 12.3% | 9,485 | 5.4% | 362,638 | 276,395 | 76.2% | 65,414 | 18.0% | 20,829 | 5.7% | | |
| Surgical Procedure Codes | 1,504 | 1,496 | 99.5% | 0 | 0.0% | 8 | 0.5% | 1,736 | 1,705 | 98.2% | 0 | 0.0% | 31 | 1.8% | 3,240 | 3,201 | 98.8% | 0 | 0.0% | 39 | 1.2% | | |
| ***Total*** | ***2,071,365*** | ***2,004,494*** | ***96.8%*** | ***43,628*** | ***2.1%*** | ***23,243*** | ***1.1%*** | ***1,978,891*** | ***1,942,778*** | ***98.2%*** | ***21,790*** | ***1.1%*** | ***14,323*** | ***0.7%*** | ***4,050,256*** | ***3,947,272*** | ***97.5%*** | ***65,418*** | ***1.6%*** | ***37,566*** | ***0.9%*** | | |

**Note**: Contains Inpatient, Outpatient, and Professional

| Non-Emergent Transportation | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Key Data Element | March 2021 | | | | | | September 2021 | | | | | | Total | | | | | |
| | Valid Values (Matching) | | Missing Values (Invalid) | | Erroneous Values (Non-matching/ Invalid) | | Valid Values (Matching) | | Missing Values (Invalid) | | Erroneous Values (Non-matching/ Invalid) | | Valid Values (Matching) | | Missing Values (Invalid) | | Erroneous Values (Non-matching/ Invalid) | |
| | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent |
| Billed Charges | 3,872 | 100.0% | 0 | 0.0% | 0 | 0.0% | 4,586 | 100.0% | 0 | 0.0% | 0 | 0.0% | 8,458 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Date of Service - First | 3,872 | 100.0% | 0 | 0.0% | 0 | 0.0% | 4,586 | 100.0% | 0 | 0.0% | 0 | 0.0% | 8,458 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Health Plan Paid Amount | 3,872 | 100.0% | 0 | 0.0% | 0 | 0.0% | 4,586 | 100.0% | 0 | 0.0% | 0 | 0.0% | 8,458 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Health Plan Paid Date | 3,872 | 100.0% | 0 | 0.0% | 0 | 0.0% | 4,586 | 100.0% | 0 | 0.0% | 0 | 0.0% | 8,458 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| MMIS Member Number (Medicaid ID) | 3,872 | 100.0% | 0 | 0.0% | 0 | 0.0% | 4,586 | 100.0% | 0 | 0.0% | 0 | 0.0% | 8,458 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Procedure Code | 3,872 | 100.0% | 0 | 0.0% | 0 | 0.0% | 4,586 | 100.0% | 0 | 0.0% | 0 | 0.0% | 8,458 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Procedure Code Modifiers | 3,872 | 100.0% | N/A | | 0 | 0.0% | 4,586 | 100.0% | N/A | | 0 | 0.0% | 8,458 | 100.0% | N/A | | 0 | 0.0% |
| ***Total*** | ***27,104*** | ***100.0%*** | ***0*** | ***0.0%*** | ***0*** | ***0.0%*** | ***32,102*** | **100.0%** | ***0*** | **0.0%** | ***0*** | **0.0%** | ***59,206*** | ***100.0%*** | ***0*** | ***0.0%*** | ***0*** | ***0.0%*** |
| | | | | | | | | | | | | | | | | | | |
| Total Records in the Supplemental Claims Data | 3,872 | | | | | | 4,586 | | | | | | 8,458 | | | | | |
| Number of Key Data Element Evaluated | 7 | | | | | | 7 | | | | | | 7 | | | | | |
| Maximum Count | 27,104 | 100.0% | | | | | 32,102 | 100.0% | | | | | 59,206 | 100.0% | | | | |

| Pharmacy | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Key Data Element | March 2021 | | | | | | September 2021 | | | | | | Total | | | | | |
| | Valid Values (Matching) | | Missing Values (Invalid) | | Erroneous Values (Non-matching/ Invalid) | | Valid Values (Matching) | | Missing Values (Invalid) | | Erroneous Values (Non-matching/ Invalid) | | Valid Values (Matching) | | Missing Values (Invalid) | | Erroneous Values (Non-matching/ Invalid) | |
| | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent |
| Billed Charges | 695 | 0.6% | 0 | 0.0% | 114,111 | 99.4% | 972 | 0.8% | 0 | 0.0% | 118,048 | 99.2% | 1,667 | 0.7% | 0 | 0.0% | 232,159 | 99.3% |
| Days Supply | 114,805 | 100.0% | 0 | 0.0% | 1 | 0.0% | 119,019 | 100.0% | 0 | 0.0% | 1 | 0.0% | 233,824 | 100.0% | 0 | 0.0% | 2 | 0.0% |
| Fill Date | 114,806 | 100.0% | 0 | 0.0% | 0 | 0.0% | 119,020 | 100.0% | 0 | 0.0% | 0 | 0.0% | 233,826 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| MCO Paid Amount | 114,806 | 100.0% | 0 | 0.0% | 0 | 0.0% | 119,019 | 100.0% | 0 | 0.0% | 1 | 0.0% | 233,825 | 100.0% | 0 | 0.0% | 1 | 0.0% |
| MCO Paid Date | 112,868 | 98.3% | 0 | 0.0% | 1,938 | 1.7% | 117,066 | 98.4% | 0 | 0.0% | 1,954 | 1.6% | 229,934 | 98.3% | 0 | 0.0% | 3,892 | 1.7% |
| MMIS Member Number (Medicaid ID) | 114,798 | 100.0% | 0 | 0.0% | 8 | 0.0% | 119,010 | 100.0% | 0 | 0.0% | 10 | 0.0% | 233,808 | 100.0% | 0 | 0.0% | 18 | 0.0% |
| National Drug Code (NDC) | 114,382 | 99.6% | 0 | 0.0% | 424 | 0.4% | 118,678 | 99.7% | 0 | 0.0% | 342 | 0.3% | 233,060 | 99.7% | 0 | 0.0% | 766 | 0.3% |
| Quantity Dispensed | 114,682 | 99.9% | 0 | 0.0% | 124 | 0.1% | 118,911 | 99.9% | 0 | 0.0% | 109 | 0.1% | 233,593 | 99.9% | 0 | 0.0% | 233 | 0.1% |
| Refill Number | 114,806 | 100.0% | 0 | 0.0% | 0 | 0.0% | 119,020 | 100.0% | 0 | 0.0% | 0 | 0.0% | 233,826 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| ***Total*** | ***916,648*** | ***88.7%*** | ***0*** | ***0.0%*** | ***116,606*** | ***11.3%*** | ***950,715*** | **88.8%** | ***0*** | **0.0%** | ***120,465*** | **11.2%** | ***1,867,363*** | ***88.7%*** | ***0*** | ***0.0%*** | ***237,071*** | ***11.3%*** |
| Total Records in the Supplemental Claims Data | 114,806 | | | | | | 119,020 | | | | | | 233,826 | | | | | |
| Number of Key Data Element Evaluated | 9 | | | | | | 9 | | | | | | 9 | | | | | |
| Maximum Count | 1,033,254 | 100.0% | | | | | 1,071,180 | 100.0% | | | | | 2,104,434 | 100.0% | | | | |

| Vision | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Key Data Element | March 2021 | | | | | | September 2021 | | | | | | Total | | | | | |
| | Valid Values (Matching) | | Missing Values (Invalid) | | Erroneous Values (Non-matching/ Invalid) | | Valid Values (Matching) | | Missing Values (Invalid) | | Erroneous Values (Non-matching/ Invalid) | | Valid Values (Matching) | | Missing Values (Invalid) | | Erroneous Values (Non-matching/ Invalid) | |
| | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent |
| Billed Charges | 3,700 | 100.0% | 0 | 0.0% | 0 | 0.0% | 3,694 | 100.0% | 0 | 0.0% | 0 | 0.0% | 7,394 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Billing Provider NPI/Number | 3,679 | 99.4% | 21 | 0.6% | 0 | 0.0% | 3,650 | 98.8% | 44 | 1.2% | 0 | 0.0% | 7,329 | 99.1% | 65 | 0.9% | 0 | 0.0% |
| Diagnosis Codes | 3,700 | 100.0% | 0 | 0.0% | 0 | 0.0% | 3,694 | 100.0% | 0 | 0.0% | 0 | 0.0% | 7,394 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Date of Service - First | 3,700 | 100.0% | 0 | 0.0% | 0 | 0.0% | 3,694 | 100.0% | 0 | 0.0% | 0 | 0.0% | 7,394 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Date of Service - Last | 3,700 | 100.0% | 0 | 0.0% | 0 | 0.0% | 3,694 | 100.0% | 0 | 0.0% | 0 | 0.0% | 7,394 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Health Plan Paid Amount | 3,700 | 100.0% | 0 | 0.0% | 0 | 0.0% | 3,694 | 100.0% | 0 | 0.0% | 0 | 0.0% | 7,394 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Health Plan Paid Date | 3,700 | 100.0% | 0 | 0.0% | 0 | 0.0% | 3,694 | 100.0% | 0 | 0.0% | 0 | 0.0% | 7,394 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| MMIS Member Number (Medicaid ID) | 3,700 | 100.0% | 0 | 0.0% | 0 | 0.0% | 3,694 | 100.0% | 0 | 0.0% | 0 | 0.0% | 7,394 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Place of Service | 3,700 | 100.0% | 0 | 0.0% | 0 | 0.0% | 3,694 | 100.0% | 0 | 0.0% | 0 | 0.0% | 7,394 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Procedure Code | 3,700 | 100.0% | 0 | 0.0% | 0 | 0.0% | 3,694 | 100.0% | 0 | 0.0% | 0 | 0.0% | 7,394 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Procedure Code Modifiers | 3,509 | 94.8% | N/A | | 191 | 5.2% | 3,694 | 100.0% | N/A | | 0 | 0.0% | 7,203 | 97.4% | N/A | | 191 | 2.6% |
| Service/Rendering Provider NPI / Number | 3,389 | 91.6% | 310 | 8.4% | 1 | 0.0% | 3,650 | 98.8% | 44 | 1.2% | 0 | 0.0% | 7,039 | 95.2% | 354 | 4.8% | 1 | 0.0% |
| ***Total*** | ***43,877*** | ***98.8%*** | ***331*** | ***0.7%*** | ***192*** | ***0.4%*** | ***44,240*** | ***99.8%*** | ***88*** | ***0.2%*** | ***0*** | ***0.0%*** | ***88,117*** | ***99.3%*** | 419 | 0.5% | ***192*** | ***0.2%*** |
| | | | | | | | | | | | | | | | | | | |
| Total Records in the Supplemental Claims Data | 3,700 | | | | | | 3,694 | | | | | | 7,394 | | | | | |
| Number of Key Data Element Evaluated | 12 | | | | | | 12 | | | | | | 12 | | | | | |
| Maximum Count | 44,400 | 100.0% | | | | | 44,328 | 100.0% | | | | | 88,728 | 100.0% | | | | |

# Appendix E: Average Per Member Utilization and Paid Amounts by Service Type

| Description | Heritage Health | | | | UHC | | | | Heritage Health | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Members** | | | | | | | | | | |
| Distinct Member Count receiving services based on supplemental claims data - CY 2021 | 369,789 | | | | 112,909 | | | | 30.5% | |
| | | | | | | | | | *Percentage Variance* | |
| ***Service Type*** | ***Count*** | ***PMPY[1] Count*** | ***Paid Amount*** | ***PMPY[1] Amount*** | ***Count*** | ***PMPY[1] Count*** | ***Paid Amount*** | ***PMPY[1] Amount*** | ***Count*** | ***Amount*** |
| Ancillary | 750,773 | 2.0 | $62,525,550 | $ 169 | 493,282 | 4.4 | $40,504,591 | $ 359 | 115.2% | 112.2% |
| Inpatient | 618,960 | 1.7 | $367,549,774 | $ 994 | 176,889 | 1.6 | $120,083,074 | $ 1,064 | -6.4% | 7.0% |
| Non-Emergent Transportation | 181,764 | 0.5 | $5,954,958 | $ 16 | 108,610 | 1.0 | $2,875,401 | $ 25 | 95.7% | 58.1% |
| Outpatient | 2,784,094 | 7.5 | $391,509,493 | $ 1,059 | 1,051,759 | 9.3 | $153,245,436 | $ 1,357 | 23.7% | 28.2% |
| Pharmacy | 4,230,948 | 11.4 | $362,119,011 | $ 979 | 1,752,345 | 15.5 | $131,112,385 | $ 1,161 | 35.6% | 18.6% |
| Primary Care | 2,529,758 | 6.8 | $166,694,966 | $ 451 | 969,456 | 8.6 | $57,378,705 | $ 508 | 25.5% | 12.7% |
| Specialty | 1,385,024 | 3.7 | $105,326,121 | $ 285 | 179,702 | 1.6 | $14,132,804 | $ 125 | -57.5% | -56.1% |
| Vision | 378,797 | 1.0 | $11,697,296 | $ 32 | 148,976 | 1.3 | $3,345,834 | $ 30 | 28.8% | -6.3% |
| ***Total Services[2]*** | ***12,860,118*** | ***34.8*** | ***$1,473,377,168*** | ***$3,984*** | ***4,881,019*** | ***43.2*** | ***$522,678,230*** | ***$4,629*** | ***24.3%*** | ***16.2%*** |

[1] Paid amount divided by the average number of members receiving services.

[2] Differences are due to rounding.

# Appendix F: Timely Payment of Claims

| Claim Type | 30 Days - 90% | | 90 Days - 99% | | | 180 Days - 100% | | | Over 180 Days - 100% | | | Total Count | Average Days |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Percentage | | Percentage | | | Percentage | | | Percentage | | | |
| | *Count* | Absolute | Count | Absolute | Cumulative | Count | Absolute | Cumulative | Count | Absolute | Cumulative | | |
| Inpatient | 2,813 | 87.9% | 185 | 5.8% | 93.7% | 132 | 4.1% | 97.8% | 70 | 2.2% | 100.0% | 3,200 | 21 |
| Outpatient | 58,384 | 95.4% | 1,441 | 2.4% | 97.7% | 934 | 1.5% | 99.3% | 447 | 0.7% | 100.0% | 61,206 | 12 |
| Professional | 239,515 | 80.4% | 9,973 | 3.3% | 83.8% | 38,791 | 13.0% | 96.8% | 9,587 | 3.2% | 100.0% | 297,866 | 30 |
| Vision | 6,886 | 93.1% | 471 | 6.4% | 99.5% | 19 | 0.3% | 99.8% | 18 | 0.2% | 100.0% | 7,394 | 8 |
| NEMT | 8,456 | 100.0% | 2 | 0.0% | 100.0% | 0 | 0.0% | 100.0% | 0 | 0.0% | 100.0% | 8,458 | 11 |
| Pharmacy | 233,826 | 100.0% | 0 | 0.0% | 100.0% | 0 | 0.0% | 100.0% | 0 | 0.0% | 100.0% | 233,826 | 0 |
| ***Total*** | ***549,880*** | ***89.9%*** | ***12,072*** | ***2.0%*** | ***91.8%*** | ***39,876*** | ***6.5%*** | ***98.3%*** | ***10,122*** | ***1.7%*** | ***100.0%*** | ***611,950*** | ***16*** |

# Appendix G: Medical Records Validity Rate

| Inpatient | | | | | |
|---|---|---|---|---|---|
| | Total Elements Sampled | Supported Elements | | Unsupported Elements | |
| Key Data Element | Count | Count | Percent | Count | Percent |
| Member DOB | 2 | 2 | 100.0% | 0 | 0.0% |
| Admit Date | 2 | 2 | 100.0% | 0 | 0.0% |
| First DOS | 2 | 2 | 100.0% | 0 | 0.0% |
| Last DOS | 2 | 2 | 100.0% | 0 | 0.0% |
| Type of Bill Code | 1 | 1 | 100.0% | 0 | 0.0% |
| Revenue Code | 18 | 18 | 100.0% | 0 | 0.0% |
| DRG | 1 | 1 | 100.0% | 0 | 0.0% |
| Diagnosis Codes | 5 | 5 | 100.0% | 0 | 0.0% |
| Servicing Provider | 2 | 2 | 100.0% | 0 | 0.0% |
| Surgical Procedure Codes | 1 | 1 | 100.0% | 0 | 0.0% |
| Billing Provider | 2 | 2 | 100.0% | 0 | 0.0% |
| **Total** | **38** | **38** | **100.0%** | **0** | **0.0%** |

**Note:** 101 of the 120 medical records requested were tested.

**Note:** Two IP claims were sampled but one claim was not provided and the other was for the wrong date of service.

| Outpatient | | | | | |
|---|---|---|---|---|---|
| | Total Elements Sampled | Supported Elements | | Unsupported Elements | |
| Key Data Element | Count | Count | Percent | Count | Percent |
| Member DOB | 21 | 21 | 100.0% | 0 | 0.0% |
| First DOS | 21 | 21 | 100.0% | 0 | 0.0% |
| Last DOS | 21 | 18 | 85.7% | 3 | 14.3% |
| Type of Bill Code | 18 | 18 | 100.0% | 0 | 0.0% |
| Revenue Code | 21 | 21 | 100.0% | 0 | 0.0% |
| Procedure Code | 835 | 825 | 98.8% | 10 | 1.2% |
| Procedure Modifiers | 92 | 92 | 100.0% | 0 | 0.0% |
| Diagnosis Codes | 65 | 61 | 93.8% | 4 | 6.2% |
| Servicing Provider | 12 | 12 | 100.0% | 0 | 0.0% |
| Billing Provider | 21 | 21 | 100.0% | 0 | 0.0% |
| ***Total*** | ***1,127*** | ***1,110*** | ***98.5%*** | ***17*** | ***1.5%*** |

**Note:** 101 of the 120 medical records requested were tested.

| Professional | | | | | |
|---|---|---|---|---|---|
| | Total Elements Sampled | Supported Elements | | Unsupported Elements | |
| Key Data Element | Count | Count | Percent | Count | Percent |
| Member DOB | 44 | 41 | 93.2% | 3 | 6.8% |
| First DOS | 44 | 42 | 95.5% | 2 | 4.5% |
| Last DOS | 44 | 41 | 93.2% | 3 | 6.8% |
| Place of Service | 44 | 43 | 97.7% | 1 | 2.3% |
| Procedure Code | 275 | 275 | 100.0% | 0 | 0.0% |
| Procedure Modifiers | 154 | 154 | 100.0% | 0 | 0.0% |
| Diagnosis Codes | 89 | 81 | 91.0% | 8 | 9.0% |
| Servicing Provider | 35 | 34 | 97.1% | 1 | 2.9% |
| Billing Provider | 43 | 43 | 100.0% | 0 | 0.0% |
| ***Total*** | ***772*** | ***754*** | ***97.7%*** | ***18*** | ***2.3%*** |

**Note:** 101 of the 120 medical records requested were tested.

| Pharmacy | | | | | |
|---|---|---|---|---|---|
| | Total Elements Sampled | Supported Elements | | Unsupported Elements | |
| Key Data Element | Count | Count | Percent | Count | Percent |
| Member DOB | 34 | 33 | 97.1% | 1 | 2.9% |
| Date of Service | 34 | 33 | 97.1% | 1 | 2.9% |
| Billing Provider | 34 | 34 | 100.0% | 0 | 0.0% |
| Nation Drug Code (NDC) | 34 | 33 | 97.1% | 1 | 2.9% |
| Quantity Dispensed | 34 | 34 | 100.0% | 0 | 0.0% |
| Days Supply | 34 | 34 | 100.0% | 0 | 0.0% |
| Prescribing Provider | 27 | 0 | 0.0% | 27 | 100.0% |
| ***Total*** | ***231*** | ***201*** | ***87.0%*** | ***30*** | ***13.0%*** |

**Note:** 101 of the 120 medical records requested were tested.

# Appendix H Plan Response Letter

June 14, 2023

Kevin Buchser, CPA
Senior Manager, Meyers and Stauffer
nemce@mslc.com

RE: UHC-NE EQR Draft Report to Plan V2

Dear Mr. Buchser,

Please see the enclosed formal response from United Healthcare Community Plan of Nebraska to the above-referenced report provided by Meyers and Stauffer on May 25, 2023. Thank you for the opportunity to respond to the report. Please contact me directly with any questions.

Regards,

Sarah Khalili, JD
Compliance Officer
United Healthcare Community Plan of Nebraska

**United Healthcare Community Plan of Nebraska - Formal Response to EQR Audit Report**

| | Findings | Recommendations | MCO Response |
|---|---|---|---|
| 3-A | **Accuracy - Health Plan Paid Dates:** Inpatient,Outpatient and Professional – The dates were populated in both the claims and supplemental claims data populations but do not agree for all claims which were identifiedas having accuracy issues. | The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate paid dates are being reported. | UHC compared the sample file and the Optumas file and for all claims that are present in both files all claim paid dates matched at 100%<br><br>UHC would like to have examples of claims found to not match. |
| 3-B | **Accuracy – Servicing Provider NPI:** Inpatient, Outpatient, and Professional and – A majority of the servicing provider NPIs that were identified as having accuracy issues were missing from the supplemental claims data. | The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate Servicing Provider NPI are being reported. | UHCCP has submitted the rate setting data in a flat file to Optumas for some time now. Our main objective in this flat file dataset is to ensure that the Billing provider Medicaid ID's and NPI's are populated which gives MLTC and Optumas the insights of where actual payment was made to the billing group. Also, Optumas has not laid any specific requirements for the servicing/rendering provider information and has been satisfied with our files. If Optumas requires a change in the data file to add the servicing/rendering provider information, UHC will make the appropriate changes to provide the data.<br><br>UHC does provide the servicing/rendering provider is populated in the right loops/segments in our 837 encounter submissions to MLTC in the way the provider bills it on the claim. |
| 3-C | **Accuracy – Billed Charges**- Pharmacy – The billed charges were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues. | The health plan should review its process for submitting supplemental claims data to Optumas to ensure billed charges are being reported accurately in the supplemental claims data. | The “Billed Charges” in the pharmacy claims data are paid amounts which includes the ingredient cost, dispensing fee, and any fee paid to the PBM. The “Billed Charges” on the pharmacy claims data set should match the “Medicaid Paid Amount” in the supplemental claims data submitted to Optumas. Medicaid Paid Amounts is the expenditure of Nebraska Medicaid for the UHC Pharmacy Benefit/Coverage. |
| 3-D | **Accuracy - Prescribing Provider NPIs**- Pharmacy – The prescribing provider NPIs were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues. | The health plan should review its process for submitting supplemental claims data to Optumas to ensure prescribing provider NPIs are being reported accurately in the supplemental claims data. | Optumas has not asked UHC to provide Prescribing Provider NPI's in the rate setting extracts for Pharmacy. Their request has been solely for the Provider Medicaid ID in the "Prescribing Provider ID" field. If Myers and Stauffer is comparing Prescribing Provider NPI from the files to Provider Provider Medicaid ID in the Optumas rate extracts, the data will not match. |
| 3-E | **Timely Payment of Claims:** The plan did not meet the timeliness standards for inpatient, outpatient, or professional claims. | The health plan should ensure their claims are adjudicated promptly in or to meet the timliness requirements established within the contract between the DHHS and the health plan. | UHC submitted final claims in our data. This data would include new claims and adjusted claims. When UHC sent the adjusted claims data, the original received date was populated rather than the adjustment received date which would result in what looks like a longer turn around time because the original received date could be day or even monthly later. The adjustment received date would be the date needed to calculate the recieved to payment turn around time.<br><br>UHC would be happy to demonstrate the difference in the claims system or provide a new file. |
| 4-B | Validation rates for pharmacy claims were below the 95 percent accuracy threshold for the 101 records that were tested (87.0 percent) | The health plan should review the claims with accuracy issues and determine the root cause of missing or mismatched data then develop a plan to address the issue with adjustment to their processes. | All 27 sampled medical records for pharmacy were noted to have missing Prescribing Provider information. The prescriber information are required fields at the point of sale. Otherwise, the pharmacy claim will reject in real-time at the point of sale if prescriber information is not submitted for claims adjudication. Prescriber information in the pharmacy medical records are indicated by “Prescriber.”<br><br>The health plan reviewed the Pharmacy Medical Record Samples provided and can provide evidence the prescriber information was provided as requested. |