State of Minnesota
Department of Human Services
Encounter Data Quality Assurance Protocols

September 9, 2014
September 9, 2014

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Manager, Health Data Quality  
Health Care Research and Quality (HRQ) Division  
Minnesota Department of Human Services  
540 Cedar St.  
Saint Paul, MN 55101

Subject: Encounter Data Quality Assurance Protocols

Dear Ms. Knapp:

We appreciate the opportunity to provide services to the State of Minnesota’s (“the State”) Department of Human Services (“DHS”). This report summarizes the results of the interviews, research, and analysis performed by Deloitte Consulting LLP (“Deloitte”) regarding the establishment of quality assurance protocols for use with the State’s Medicaid managed care encounter data. Contained within this report are the following:

- A high-level overview of the project scope and findings
- A summary of the methods and approaches used to conduct the analysis
- An assessment of DHS’s current managed care contracts and data practices compared to managed care contracts and practices compiled from other states and industry sources
- A detailed description of the 10 quality assurance protocols developed based on our findings and DHS feedback
- Next steps for the implementation and prioritization of the quality assurance protocols

This report and accompanying appendices have been solely prepared for the use of DHS in support of quality assurance protocols for its Medicaid encounter data. This report and accompanying appendices should not be relied upon for any other purpose or by any other entity other than DHS.

Again, we appreciate the opportunity to provide this report. If you have questions or concerns regarding this report, please contact Steve Wander at swander@deloitte.com or (612) 397-4312 or Chris Schmidt at chrischmidt@deloitte.com or (612) 397-4697.

Sincerely,

Deloitte Consulting LLP

Steve N. Wander, Principal


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Executive Summary

Project Scope

DHS contracted with Deloitte to develop ten quality assurance protocols, with associated methods and measurements, to support DHS’s management and monitoring of the quality of data submitted by its MCOs. MCOs can apply these protocols as they adjudicate claims and create encounter data files that are submitted to DHS. The protocols are designed to provide DHS with data that is more timely, complete, accurate, and consistent.

To support these quality assurance protocols, Deloitte provides two deliverables within this report, including the following:

- **Analysis & Design** – This deliverable summarizes Deloitte’s review of current contracting terms and language between DHS and its MCOs for data submissions and related technical expectations for submissions. It also provides insights about DHS’s current contracts and published transmission companion guides based on Deloitte’s experience in other jurisdictions.

- **Develop & Deliver** – This deliverable presents ten recommended quality assurance protocols for DHS, including a written definition of each protocol, the intent of the protocol (e.g., procedural, technical), a measurement mechanism for each, and recommended next steps for implementation.

This report references these two deliverables as “DHS Current Practices and Industry Practices” and “Quality Assurance Protocols,” respectively. The following is an overview of the approach and findings for these two deliverables.

DHS Current Practices and Industry Practices

Approach

The analysis of DHS’s current practices and industry practices is the “Analysis & Design” deliverable. Deloitte developed an understanding of DHS’s current state by reviewing the State’s 2014 MCO contracts and companion guides, as well as conducting interviews with a variety of DHS personnel that work with the encounter data. Industry practices were compiled by reviewing a sample of other state MCO contracts and practices, analyzing various industry reports, and leveraging the experience of Deloitte internal resources. Deloitte identified potential enhancements in areas where current DHS practice is inconsistent with industry practices compiled from other state contracts, industry reports, and other sources.

Findings

The following findings summarize areas where DHS’s current encounter data quality assurance practices are strong and areas that could be enhanced in relation to industry practices.
Areas where DHS is Currently Strong

<table>
<thead>
<tr>
<th>Category</th>
<th>Industry Practices</th>
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</thead>
<tbody>
<tr>
<td>Staffing and Data Uses</td>
<td>• Staff a designated team to work only on handling encounter data and resolving data</td>
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<tr>
<td></td>
<td>quality issues</td>
</tr>
<tr>
<td></td>
<td>• Use encounter data to perform risk adjustment</td>
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<tr>
<td></td>
<td>• Use encounter data to perform other analyses related to financial reporting, policy</td>
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<td></td>
<td>analysis, health care research, population health, MCO profiling, provider profiling, etc.</td>
</tr>
<tr>
<td>Standards for Submitting Encounters</td>
<td>• Provide companion guides to MCOs which detail guidelines, requirements, and data</td>
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<td></td>
<td>formats for encounter submissions and resubmissions</td>
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<tr>
<td></td>
<td>• Require MCOs to submit allowed and paid amounts on all encounter records</td>
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<tr>
<td></td>
<td>• Use contract language to define timing requirements for encounter submissions and</td>
</tr>
<tr>
<td></td>
<td>resubmissions</td>
</tr>
<tr>
<td>Reduction of Data Issues</td>
<td>• Run encounter submissions through a series of automatic data edits to identify and</td>
</tr>
<tr>
<td></td>
<td>deny encounters with issues such as duplicates, missing fields, or invalid values</td>
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<tr>
<td></td>
<td>• Track and analyze the volume of encounters in total and by service category to check</td>
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<td></td>
<td>for completeness</td>
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</table>

Areas for Potential Enhancements

<table>
<thead>
<tr>
<th>Category</th>
<th>Industry Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing and Data Uses</td>
<td>• Use encounter data to set capitation rates</td>
</tr>
<tr>
<td>Standards for Submitting Encounters</td>
<td>• Require MCOs to continue to submit encounters to the state following contract</td>
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<td></td>
<td>termination for any and all services rendered during the contract period</td>
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<tr>
<td>Reduction of Data Issues</td>
<td>• Use contract language to define acceptable limits of denied and/or duplicate</td>
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<tr>
<td></td>
<td>encounters</td>
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<tr>
<td></td>
<td>• Establish encounter data submission benchmarks and compare them to submissions to</td>
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<tr>
<td></td>
<td>proactively identify potential issues with completeness and accuracy</td>
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<tr>
<td>Claim Review and Reconciliation</td>
<td>• Reconcile encounter data submissions to MCO financial reports and individual</td>
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<td></td>
<td>encounters pulled from an MCO’s claims system</td>
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<td></td>
<td>• Review encounter data submissions against provider medical records for completeness</td>
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<td></td>
<td>and accuracy</td>
</tr>
<tr>
<td></td>
<td>• Perform a review of MCO encounter data systems</td>
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<td>MCO Reporting</td>
<td>• Require MCOs to submit a certification that attests to the accuracy and completeness</td>
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<td>of encounter data, including an MCO review of provider data as appropriate</td>
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<td></td>
<td>• Require MCOs with identified deficiencies to submit a corrective action plan to the</td>
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<td></td>
<td>state</td>
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<td></td>
<td>• Require MCOs to submit a data quality assurance plan to the state which provides</td>
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<td>detailed information on MCO encounter data systems, data validation, and quality</td>
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<td>assurance processes</td>
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<td>Communication and Feedback</td>
<td>• Hold periodic meetings or on-site visits with MCOs with the goal of working</td>
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<td>collaboratively to enhance encounter data quality</td>
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<td></td>
<td>• Provide MCOs with periodic feedback/performance reports which track the MCOs’</td>
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<td></td>
<td>encounter data quality over time and compared to that of other MCOs</td>
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<tr>
<td>Financial Incentives/ Sanctions</td>
<td>• Use financial penalties/sanctions for not meeting contractual requirements and/or</td>
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<td>defined benchmarks such as: volume of denied encounters, volume of duplicates,</td>
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<td></td>
<td>timeliness of submissions, timeliness of resubmissions, failing benchmarks, and</td>
</tr>
<tr>
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<td>reconciliation variance</td>
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<td></td>
<td>• Use bonus payments to reward MCOs which submit timely or accurate encounters</td>
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Quality Assurance Protocols

Approach

The development of ten quality assurance protocols is the “Develop & Deliver” deliverable. Protocols are focused on processes, standards, quality checks, and reviews that DHS may require MCOs to implement and follow. These protocols were developed from the findings of our analysis of DHS current practices compared to industry practices and refined through conversations and feedback from members of DHS’s Encounter Data Quality Unit.

Findings

The following are the ten quality assurance protocols which were determined to be options for DHS in their effort to improve the timeliness, completeness, accuracy, and consistency of the encounter data.

Protocol 1: **Timeliness of Submissions** – A standard for the timeliness of encounter submissions which measures the percentage of encounters not submitted within the 30 calendar day time standard set by DHS. Performance will be tracked for each MCO and must be below a specified threshold, as determined by DHS.

Protocol 2: **Resubmissions** – A standard for encounter resubmissions which measures the percentage of encounters requiring resubmission that are not resubmitted or are not resubmitted within the 20 calendar day time standard set by DHS. Performance will be tracked for each MCO and must be below specified thresholds, as determined by DHS.

Protocol 3: **MCO Quality Checks Against Benchmarks** – Various performance benchmarks which the MCOs will be required to monitor and report to DHS to demonstrate compliance with the benchmark thresholds.

Protocol 4: **Duplicate Encounter Records Submitted** – A standard for duplicate encounters which measures the percentage of denials for duplicate encounters. Performance will be tracked for each MCO and must be below a specified threshold, as determined by DHS.

Protocol 5: **Rejections and Denials by DHS** – A standard for rejections and denials which measures the percentage of rejected and denied encounters. Performance will be tracked for each MCO and must be below a specified threshold, as determined by DHS.

Protocol 6: **Control Reporting and Reconciliation** – Each MCO will be responsible for reconciling both a high-level aggregate paid claims summary and individual encounter data (provided by DHS) to its internal financial reporting and systems data. Each MCO will provide DHS with a confirmation report that this has been completed, notify DHS of any discrepancies, and correct any data issues.

Protocol 7: **Claim Reviews** - MCOs will engage an independent third-party entity to perform the following two tasks: 1.) review a sample of encounters provided by DHS to provider medical records or other sources, and 2.) review a sample of encounters obtained from providers to encounters submitted to DHS.

Protocol 8: **Corrective Action Plans** – At the discretion of DHS, an MCO will submit a corrective action plan to DHS for review and approval to remedy an identified deficiency in the MCO’s encounter data submission process or a deficiency in the quality of submitted data.
Protocol 9: **Data Quality Assurance Report** – Each MCO will submit a report annually to DHS specifying its practices and processes used to ensure encounter data quality, completeness, and accuracy. DHS will review and either approve or request changes to the report and any related practices/processes.

Protocol 10: **MCO Review of Provider Data** - MCOs will be required to confirm data received from providers is complete and accurate by performing checks and certifying to specified activities on a quarterly basis. The MCOs also will be required to submit a quarterly report of control totals between the data received from providers to the data submitted to DHS.
Methods and Approach

Sources

Our approach considered a range of sources to develop a view of DHS’s current practices and identify industry practices for gathering complete, accurate, and timely encounter data. These sources referenced below formed the foundation for analyzing DHS’s current practices, identifying industry practices, and developing quality assurance protocols.

- **DHS Contracts and Materials**
  Our understanding of DHS’s current practices was developed from a review of recent contracts and materials used by and pertaining to DHS’s encounter data practices. These items included:
  - 2014 MCO Contracts
    - Families and Children
    - MSHO-MSC+
    - SNBC
  - Companion Guides
    - X12 837 Companion Guide
    - NCPDP Companion Guide
    - Remittance Advice Remark Code Guide
  - Minnesota 2012 External Quality Review Report
  - 2014 MN Medicaid Rate Development Documentation

- **Interviews with DHS Personnel**
  We conducted interviews with twenty DHS employees that work with encounter data for various purposes and at various levels, ranging from members of the Encounter Data Quality Unit to the Medicaid Director. These interviews provided key insight and feedback into the current uses of encounter data, as well as strengths and issues with the encounter data. We also discussed potential areas for improving DHS’s practices for confirming quality encounter data. Interviews included the following:
  - Don Rademacher (MMIS Systems Architect) – June 25, 2014
  - Gary Johnson (Internal Audit Manager) – June 25, 2014
• Literature Review
We performed a literature review of multiple industry sources on leading practices in encounter data process, validation, and reporting guidelines. A complete list of the sources used in our literature review can be found in the Appendix.

• Other State Contracts
We reviewed the contract language and encounter data practices of ten other states with Medicaid managed care programs in order to gain an understanding of how other states are addressing the issues of receiving quality encounter data. The Appendix includes a summary of some of the practices found within each of these states. These ten states include:
  o Arizona
  o Delaware
  o Michigan
  o New Jersey
  o Ohio
  o Oregon
  o Pennsylvania
  o Texas
  o Washington
  o Wisconsin

• Internal Deloitte Resources
We leveraged the experience of Deloitte internal resources with knowledge of encounter data quality assurance practices. These resources bring perspectives from a variety of practice backgrounds across both public sector and commercial health care including:
  o Actuarial
  o Data Analytics
  o Audit
  o Technology
  o Information Management
  o Risk Management
  o Health Plan Operations
  o Data Quality
Protocol Categories

To analyze DHS’s current practices and industry practices and develop quality assurance protocols, we categorized practices and protocols into seven different common categories. These seven categories were observed throughout our analysis and used to summarize practices and protocols within groupings of consistent themes. The following are the seven protocol categories, including how each was defined:

1. **Staffing and Data Uses**
   Standards for resource allocation to ensure quality, complete, and accurate encounter data and the potential uses of the encounter data

2. **Standards for Submitting Encounters**
   Requirements to ensure a standard process and format for encounter submissions and resubmissions

3. **Reduction of Data Issues**
   Approaches and standards to identify and limit issues with encounter data submitted by MCOs

4. **Claim Review and Reconciliation**
   Formal claim review or reconciliation methods to validate that encounter data provided by MCOs is accurate and complete

5. **MCO Reporting**
   Reports that MCOs must produce and provide to document processes, verify data, and correct deficiencies

6. **Communication and Feedback**
   Forms of communication and feedback between states and MCOs to collaboratively work to improve encounter data quality, completeness, accuracy, and timeliness

7. **Financial Incentives/Sanctions**
   Use of certain incentives such as withholds and bonuses or penalties to incent MCOs to provide quality, complete, accurate, and timely encounter data

**DHS Current State and Industry Analysis Approach**

The approach to the “Analysis & Design” deliverable was to review DHS’s current practices compared to industry practices for encounter data processing, validation, and reporting. The current state for DHS was developed by conducting interviews with DHS personnel about DHS encounter data and reviewing DHS’s current MCO contracts, companion guides, and other materials provided by DHS. After developing an understanding of DHS’s current state, we compiled an inventory of encounter data industry practices for benchmarking against current DHS practices. We defined industry practices by consolidating information from our review of a sample of other state contracts and practices, the literature review of industry reports, and our conversations with Deloitte internal subject matter experts. By comparing the DHS current state to the inventory of industry practices, we identified areas of potential enhancement for DHS. Throughout this assessment phase, we held...
weekly meetings with the Encounter Data Quality Unit at DHS to share findings and observations and gather feedback.

**Protocol Development Approach**

The approach to the “Develop & Deliver” deliverable was to combine the findings from our analysis of DHS current state and industry practices with the input from our discussions with the DHS Encounter Data Quality Unit to develop a final list of the ten highest priority quality assurance protocols. We used the potential enhancements identified during the review of DHS’s current state and industry practices to develop a comprehensive inventory of potential protocols relevant to DHS’s needs. This inventory of potential protocols was reviewed in a white-boarding session between Deloitte and several members of the DHS Encounter Data Quality Unit. The purpose of this session was to have an open and constructive discussion of thoughts and feedback about the inventory of potential protocols. Points of discussion in this session included: which protocols seemed like a good fit for DHS, which protocols seemed unnecessary for DHS, which protocols could be revised or consolidated, and which protocols might be missing from the inventory. A series of feedback discussions between Deloitte and the DHS Encounter Data Quality Unit followed this white-boarding session to refine and revise the protocol list. The result of this process was the final list of the top ten quality assurance protocols with detailed descriptions on the intent, definition, measurement, and implementation steps for each protocol. The final list of protocols focused on what DHS will require the MCOs to implement and follow in order to ensure complete, accurate, and timely encounter data.
DHS Current Practices and Industry Practices

This report section includes the findings from our analysis of DHS’s current practices and industry practices. We have structured these findings into an assessment of DHS’s current practices compared to industry practices in each of the seven protocol categories. Our assessment for each of the protocol categories includes the following areas:

- Industry practices yielded from our research, analysis, and experience
- Summary of DHS’s current state
- Potential enhancement areas based on the comparison of DHS’s current state to industry practices
- Potential action items for DHS to consider in enhancing its encounter data practices

For industry practices, we comment on the number of sampled states that employ a practice based on our review of their managed care contracts.

Assessment of Staffing and Data Uses

Industry Practices

- Staff a designated team to work only on handling encounter data and resolving data quality issues.  
  Other states with this practice: 3 of 10; Mathematica Policy Research – Encounter Data Toolkit

- Use encounter data to perform risk adjustment. This use of data should be clearly communicated to MCOs, including the implications to this use if the encounter data is not accurate or complete.  
  Other states with this practice: 3 of 10

- Use encounter data to set capitation rates. This use of data should be clearly communicated to MCOs, including the implications to this use if the encounter data is not accurate or complete.  
  Other states with this practice: 10 of 10

- Use encounter data to perform other analyses related to financial reporting, policy analysis, health care research, population health, MCO profiling, provider profiling, etc.  
  Leading industry practice

Current State

DHS has an Encounter Data Quality Unit dedicated solely to working with the encounter data that is submitted to DHS and improving the quality of the data. The State uses encounter data to perform risk adjustment and a variety of analyses and is working towards using encounter data to set capitation rates in the near future. These uses create an incentive for the MCOs to provide complete and accurate encounter data to DHS.

Potential Areas for Enhancements

Staffing and data use is a current area of strength for DHS. DHS does not use encounter data for setting capitation rates yet, but has initiated efforts to make this a reality in the near future.
Potential Action Items

- Communicate clearly to MCOs that encounter data will be used to set capitation rates beginning in a specified fiscal year.

Assessment of Standards for Submitting Encounters

Industry Practices

- Produce and provide MCOs with companion guides which clearly lay out the guidelines and requirements that MCOs must follow in submitting encounter data. These guidelines should cover areas such as file formats, data fields, submission processes, and submission timelines/frequencies.
  
  Other states with this practice: 3 of 10; Mathematica Policy Research – Encounter Data Toolkit

- Require MCOs to submit allowed and paid amounts on all encounter records.
  
  Other states with this practice: 8 of 10

- Require MCOs to submit an encounter within a specified timeframe following the date of claim adjudication.
  
  Other states with this practice: 7 of 10; Mathematica Policy Research – Encounter Data Toolkit

- Require MCOs to resubmit an encounter within a specified timeframe following the date that the MCO receives the returned encounter.
  
  Other states with this practice: 2 of 10; Mathematica Policy Research – Encounter Data Toolkit

- Require MCOs to continue to submit encounters to the state following contract termination for any and all encounters for services rendered during the contract period.
  
  Other states with this practice: 1 of 10; Mathematica Policy Research – Encounter Data Toolkit

Current State

DHS produces detailed and comprehensive companion guides which specify requirements for encounter data submission. DHS also receives the paid amount on encounter records. Additionally, DHS has timeliness standards for MCOs to submit encounters (no later than 30 calendar days after the date the MCO adjudicates the claim) and to resubmit denied encounters (no later than 20 calendar days from the date the MCO receives the file).

Potential Areas for Enhancements

DHS has established clear format and timeliness standards for encounter submission and resubmission. However, MCO sanctions for non-compliance are not strictly enforced.

Potential Action Items

- Enforce current timeliness standards for submissions and resubmissions through strong contractual incentives and/or sanctions.

- Consider implementing the following to enhance compliance with submission and timeliness standards:
  1) Set contractual thresholds for late submissions or late/absent resubmissions, and
2) Reinforce standards using financial incentives or sanctions for MCOs that do not meet contractual standards.

Related Quality Assurance Protocols: #1 Timeliness of Submissions, #2 Resubmissions

Assessment of Reduction of Data Issues

Industry Practices

- Run all encounter submissions through a series of data edits, including an edit to check for duplicate encounters and other edits to automatically flag encounters which should be rejected or denied.
  Other states with this practice: 7 of 10; Mathematica Policy Research – Encounter Data Toolkit

- Track and analyze the volume of encounters in total and by service category in order to check for completeness.
  Other states with this practice: 3 of 10; EQR Protocol 4

- Set thresholds on acceptable limits for the number or percentage of denied/pended and/or duplicate encounters which an MCO can submit.
  Other states with this practice: 3 of 10

- Establish encounter data submission benchmarks and compare them to submissions to identify issues with completeness and accuracy. Sample benchmarks include: expected encounter volume, maximum error rates for specified data fields, expected utilization per service category, etc.
  Other states with this practice: 3 of 10; Mathematica Policy Research – Encounter Data Toolkit; EQR Protocol 4

Current State

DHS runs all encounters through its Medicaid Management Information System (MMIS), which applies a series of data edits to determine if the encounter should be rejected or denied. These data edits check for items such as duplicate submissions, missing fields, inappropriate values, and others. DHS’s Encounter Data Quality Unit also performs analyses such as tracking the volume of encounters and edits to check for completeness and accuracy.

Potential Areas for Enhancements

DHS mainly relies on system data edits to identify encounters with data issues. This is a reactive solution which does not address the source of issues. DHS does not use any proactive measures such as requiring MCOs to perform specified quality checks or strongly enforcing contract sanctions to reduce the volume of data issues in MCO encounter data.

Potential Action Items

- Take a more proactive approach to reducing the volume of encounters with data issues that are submitted by MCOs.

- Consider implementing the following items in order to enhance MCO processes and reduce data issues:
  1) Establish completeness and accuracy benchmarks for encounter data which MCOs must monitor prior to submitting encounters to DHS;
2) Set thresholds for acceptable limits of denials and/or duplicate encounters in the contract; and
3) Reinforce these thresholds using financial incentives or sanctions for MCOs that do not meet standards.

Related Quality Assurance Protocols: #3 MCO Quality Checks Against Benchmarks, #4 Duplicate Encounter Records Submitted, #5 Rejections and Denials by DHS

Assessment of Claim Review and Reconciliation

Industry Practices

- Validate the completeness and accuracy of encounter submissions against financial reports and/or other similar summary reports produced by MCOs.
  *Other states with this practice: 4 of 10; Mathematica Policy Research – Encounter Data Toolkit*

- Validate the accuracy of encounter submissions against a sample/extract of encounters pulled from each MCO’s claims system.
  *Other states with this practice: 2 of 10*

- Require each MCO to reconcile both individual submitted encounters and a summary of submitted encounter paid claims totals (provided by the state) to paid claims in the MCO’s claims system and to the MCO’s financial reports.
  *Other states with this practice: 1 of 10*

- Perform a review of the MCOs’ encounter data systems. This may include an on-site visit of the MCO to perform the review.
  *Other states with this practice: 2 of 10; EQR Protocol 4*

- Validate the completeness of encounter submissions against medical records or other source data from providers.
  *Other states with this practice: 2 of 10; EQR Protocol 4*

Current State

DHS does not yet use regular, formal claim reviews or reconciliations to validate encounter data.

Potential Areas for Enhancements

Claim reviews and reconciliations are an area of opportunity which DHS can use to validate the completeness and accuracy of encounter data submitted by MCOs. Encounters pass through multiple stages from provider to MCO to DHS, which creates vulnerability of data being altered or lost. Reviews are a tool which can be used to identify these areas.

Potential Action Items

- Consider implementing the following forms of claim review and reconciliation activities:
  1) Require MCOs to reconcile both aggregate and individual encounter paid claims to reports provided by DHS;
  2) Review a sample of encounter records in DHS’s warehouse to provider medical records; and
3) Review a sample of encounter records obtained from providers to encounter records in DHS’s warehouse.

**Related Quality Assurance Protocols:** #6 Control Reporting and Reconciliation, #7 Claim Reviews

**Assessment of MCO Reporting**

**Industry Practices**

- Require MCOs to submit encounter data with a certification that attests to the accuracy and completeness of the data and is signed by a senior-level individual at the MCO in charge of encounter data (could be CEO or CFO). This may include a requirement for the MCO to review the provider data to certify its accuracy.
  
  *Other states with this practice: 7 of 10; Mathematica Policy Research – Encounter Data Toolkit*

- Require each MCO with identified deficiencies to submit a corrective action plan which establishes a plan and timing for the MCO to fix the deficiency.
  
  *Other states with this practice: 3 of 10*

- Require each MCO to submit a data completeness plan to the state which provides detailed information on the MCO's encounter data system and specific practices related to encounter data. This should include a detailed plan on the MCO's strategy for ensuring data quality, accuracy, completeness, and timeliness. Additionally, the plan should specify the MCO’s remediation practices.

  *Other states with this practice: 1 of 10*

**Current State**

DHS requires an MCO’s CEO or CFO to certify the number of claims and files provided to DHS for each submission, but does not have a reconciliation process to validate certified values. Additionally, DHS does not have contract language on certification of provider data.

**Potential Areas for Enhancements**

MCO reporting is an area of opportunity for DHS to engage MCOs in reviewing data, certifying data, correcting process and data deficiencies, and implementing strategies and plans to ensure data quality, accuracy, completeness, and timeliness.

**Potential Action Items**

- Consider implementing the following forms of MCO reports to engage MCOs and hold them accountable for the quality of encounter data submitted to DHS:

  1) Corrective action plans;
  2) Data quality assurance reports; and
  3) MCO certification of review of provider data.

**Related Quality Assurance Protocols:** #8 Corrective Action Plans, #9 Data Quality Assurance Report, #10 MCO Review of Provider Data
Assessment of Communication and Feedback

Industry Practices

- Conduct periodic meetings or on-site visits/interviews with MCOs with the goal of working collaboratively to enhance encounter data quality.
  Other states with this practice: 3 of 10; Mathematica Policy Research – Encounter Data Toolkit

- Provide MCOs with periodic feedback/performance reports which track each MCO’s encounter data quality over time and compared to that of other MCOs.
  Other states with this practice: 3 of 10

Current State

DHS holds ad hoc meetings with MCOs to discuss changes or issues in the encounter data processes.

Potential Areas for Enhancements

DHS could include MCO feedback and performance discussions/communications as a regular and structured part of its relationship with MCOs. Providing regular feedback to MCOs on encounter data performance can open the door to collaborative discussions between DHS and the MCOs to improve the quality of encounter data.

Potential Action Items

- Migrate from an ad hoc approach of communicating with MCOs to a structured approach with regular forms of feedback provided to MCOs.

- Consider implementing the following related to MCO communication and feedback:
  1) Conduct regularly scheduled meetings with MCOs to discuss encounter data quality updates and issues; and
  2) Provide the MCOs with periodic feedback/performance reports related to submitting quality encounter data.

Assessment of Financial Incentives/Sanctions

Industry Practices

- Apply financial penalties/sanctions for any one of the following contractual standards or benchmarks with which an MCO does not comply:
  a.) Volume of denied or pended encounters
  b.) Volume of duplicates
  c.) Timeliness of submitted encounters
  d.) Timeliness in resubmitting encounters
  e.) Accuracy and completeness benchmarks
  f.) Incomplete data or variance in claims reconciliation
  Other states with this practice: 3 of 10
  Other states with this practice: 1 of 10
  Other states with this practice: 3 of 10
  Other states with this practice: 2 of 10
  Other states with this practice: 3 of 10
  Other states with this practice: 5 of 10
  In Total – Other states with this practice: 9 of 10; Mathematica Policy Research – Encounter Data Toolkit

- Use withhold payments (applied to the list of contractual standards or quality checks above) for any MCO that is not in compliance.
  Other states with this practice: 2 of 10; Mathematica Policy Research – Encounter Data Toolkit
• Use bonus payments to reward MCOs which submit timely and accurate encounters.  
   *Other states with this practice: 1 of 10; Mathematica Policy Research – Encounter Data Toolkit*

**Current State**

DHS does not use any forms of financial incentives or sanctions related to encounter data denials, duplicates, accuracy, or completeness. DHS does have sanctions regarding timeliness of encounter submissions and resubmissions, but these sanctions are not strictly enforced.

**Potential Areas for Enhancements**

The use of financial incentives or sanctions is a common method that states use to enforce MCO compliance with contractual standards or protocols for encounter data. DHS can enhance its protocols and contract terms by applying financial penalties or sanctions to MCOs that are not in compliance.

**Potential Action Items**

• Consider implementing financial penalties or sanctions to any contractual term or standard for which MCO noncompliance puts the quality of encounter data at risk.
  
  – An example of a current contract standard where financial incentives could be applied is the number of days that MCOs have to submit or resubmit encounters
  
  – An example of a potential future contract standard where financial incentives could be applied is the volume of denied encounters or duplicates

*Related Quality Assurance Protocols: All Protocols (#1-10)*
**DHS Current Degree of Alignment with Industry Practices**

The table below summarizes our findings on the current degree of alignment between DHS practices and industry practices.

- **Green** = currently aligned
- **Yellow** = partially aligned
- **Red** = not aligned

<table>
<thead>
<tr>
<th>Category</th>
<th>Industry Practices</th>
<th>Alignment</th>
</tr>
</thead>
</table>
| Staffing and Data Uses           | - Staff a designated team to work only on handling encounter data and resolving data quality issues  
- Use encounter data to perform risk adjustment  
- Use encounter data to perform other analyses related to financial reporting, policy analysis, health care research, population health, MCO profiling, provider profiling, etc.  
- Use encounter data to set capitation rates                                                                                                                                                                                                                                                                                                                                 | Green     |
| Standards for Submitting Encounters | - Provide companion guides to MCOs which detail guidelines, requirements, and data formats for encounter submissions and resubmissions  
- Require MCOs to submit allowed and paid amounts on all encounter records  
- Use contract language to define timing requirements for encounter submissions and resubmissions  
- Require MCOs to continue to submit encounters to the state following contract termination for any and all services rendered during the contract period                                                                                                                                                                                                 | Green     |
| Reduction of Data Issues         | - Run encounter submissions through a series of automatic data edits to identify and deny encounters with issues such as duplicates or missing fields  
- Track and analyze the volume of encounters in total and by service category to check for completeness  
- Use contract language to define acceptable limits of denied and/or duplicate encounters  
- Establish encounter data submission benchmarks and compare them to submissions to identify issues with completeness and accuracy                                                                                                                                                                                                                                                                                                       | Yellow    |
| Claim Review and Reconciliation  | - Reconcile encounter data submissions to MCO financial reports and individual encounters pulled from an MCO’s claims system  
- Review encounter data submissions against provider medical records for completeness and accuracy  
- Perform a review of MCO encounter data systems                                                                                                                                                                                                                                                                                                                                                                        | Red       |
| MCO Reporting                     | - Require MCOs to submit a certification that attests to the accuracy and completeness of encounter data, including an MCO review of provider data as appropriate  
- Require MCOs with identified deficiencies to submit a corrective action plan to the state  
- Require MCOs to submit a data completeness plan to the state which provides detailed information on MCO encounter data systems, validation, and processes                                                                                                                                                                                                                                                      | Red       |
| Communication and Feedback        | - Hold periodic meetings or on-site visits with MCOs with the goal of working collaboratively to enhance encounter data quality  
- Provide MCOs with periodic feedback/performance reports which track the MCOs’ encounter data quality over time and compared to that of other MCOs                                                                                                                                                                                                                                                                                              | Red       |
| Financial Incentives/ Sanctions   | - Use financial penalties/sanctions for not meeting contractual requirements and/or defined benchmarks such as: volume of denied encounters, volume of duplicates, timeliness of submissions, timeliness of resubmissions, failing benchmarks, reconciliation variance  
- Use bonus payments to reward MCOs which submit timely or accurate encounters                                                                                                                                                                                                                                                                                                                                                                                   | Red       |
Quality Assurance Protocols

This section includes the ten quality assurance protocols which were developed based on the analysis of DHS current state and industry practices as well as feedback discussions with DHS. These protocols will help to ensure that DHS receives complete, accurate, and timely encounter data. Each of the protocols includes the following information:

- Intent of the protocol
- Definition of the protocol
- Measurement to use in determining compliance with the protocol
- Next steps for DHS and MCOs to take in order to implement the protocol

The table below categorizes the quality assurance protocols into the seven common categories defined during the analysis and design phase of the project.

<table>
<thead>
<tr>
<th>Category</th>
<th>Protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing and Data Uses</td>
<td>None</td>
</tr>
</tbody>
</table>
| Standards for Submitting Encounters | Protocol 1 – Timeliness of Submissions  
                                     Protocol 2 – Resubmissions                                                |
| Reduction of Data Issues        | Protocol 3 – MCO Quality Checks Against Benchmarks  
                                     Protocol 4 – Duplicate Encounter Records Submitted  
                                     Protocol 5 – Rejections and Denials by DHS                                  |
| Claim Review and Reconciliation | Protocol 6 – Control Reporting and Reconciliation  
                                     Protocol 7 – Claim Reviews                                                  |
| MCO Reporting                   | Protocol 8 – Corrective Action Plans  
                                     Protocol 9 – Data Quality Assurance Plans  
                                     Protocol 10 – MCO Review of Provider Data                                    |
| Communication and Feedback      | None                                                                     |
| Financial Incentives/Sanctions  | All Protocols (1-10)                                                     |
**Protocol 1 – Timeliness of Submissions**

The inability to receive timely encounter data is a risk to DHS’s ability to reliably use the encounter data for rate-setting, reporting, and other analytics. This protocol was selected to put greater accountability on the MCOs to comply with DHS’s timing standards for submitting encounters. Establishing an incentive/sanction will promote MCO compliance with the data submission timing already specified in the contract.

**Protocol Intent**

The purpose of this protocol is to ensure that MCOs are submitting encounters in a timely fashion.

**Protocol Definition**

At least annually but not more than semi-annually, DHS will calculate for each MCO the total number of encounter records submitted more than 30 calendar days after the date the MCO adjudicates the claim. DHS will determine a threshold for the acceptable percentage of late encounter records in relation to total encounters submitted. If the percentage of encounter records submitted later than the 30 calendar day standard is above the threshold of x%, the MCO could be considered in breach of contract and subject to a corrective action plan or financial penalty.

**Measurement**

The following standards are used to assess compliance with the timeliness of submissions protocol:

- \[
\frac{\text{Total number of encounter records submitted after 30 calendar days}}{\text{Total encounter records submitted to DHS}} < x\%
\]

- This percentage will be monitored at least annually, but not more than semi-annually, for each MCO

*Note: Threshold used in another state contract is x = 2%*

**Next Steps**

**DHS:**
1. Determine the thresholds of the measurement metrics
2. Determine how often the metric calculations will be evaluated
3. Determine the implementation timeline
4. Reach out to MCOs with protocol details
5. Calculate and track actual MCO-specific performance

**MCO:**
1. Review and enhance process for submitting timely encounters
2. Monitor measurement metrics internally

*Other states with this practice: PA*
Protocol 2 – Resubmissions

Our conversations with personnel at DHS indicated that it is a known issue that MCOs often do not resubmit claims denied by DHS. This lack of resubmitting data contributes to the encounter data being incomplete. It can also be difficult to track if an encounter has been resubmitted since MCOs may change the claim ID. This protocol was selected to provide more clarity around the encounters which MCOs are resubmitting, and which encounters are not being resubmitted. Additionally, establishing an incentive/sanction will promote compliance with the resubmission standards already in the contract.

Protocol Intent

The purpose of this protocol is to confirm that each MCO has documented processes and checks in place to ensure they are resubmitting encounter records initially denied or rejected by DHS.

Protocol Definition

Every quarter, DHS will provide each MCO a report listing all encounter records requiring resubmission for the period. The MCO will then be required to specify the encounter ID for each resubmitted record or specify a reason why the MCO believes the encounter record does not require resubmission. At that time, DHS will evaluate the following for each MCO:

1. The number of encounter records resubmitted (including records not resubmitted but justified by the MCO) as a percentage of total encounter records requiring resubmission, per DHS’s definition
2. The percentage of encounter records not resubmitted within 20 calendar days from the date the MCO receives the file

These calculations will be compared to specified thresholds as determined by DHS. If the resubmission rate or the percentage of encounter records not resubmitted within 20 calendar days is below the specified thresholds, the MCO could be considered in breach of contract and subject to a corrective action plan or financial penalty.

Measurement

The following standards are used to assess compliance with the resubmissions protocol:

- \[
\frac{\text{Total number of encounter records resubmitted}}{\text{Total encounter records requiring resubmission}} > x\%
\]
- \[
\frac{\text{Total number of encounter records not resubmitted within 20 calendar days}}{\text{Total encounter records DHS requiring resubmission}} < y\%
\]
- The above percentages will be tracked every quarter for each MCO

Note: Thresholds used in other state contracts include \( y = 0\% \) to 2%

Next Steps

DHS:
1. Determine the thresholds of the measurement metrics
2. Determine if metric calculations should be evaluated more or less frequently than quarterly
3. Determine the implementation timeline
4. Reach out to MCOs with protocol details
5. Calculate and track actual MCO-specific performance

MCO:
1. Assess capabilities to identify resubmissions and link to original submissions
2. Review and enhance process for resubmitting encounters
3. Monitor measurement metrics internally

Other states with this practice: AZ, WI
Protocol 3 – MCO Quality Checks Against Benchmarks

Currently the correction of data issues is fairly reactive as data issues not caught by MMIS edits are typically found by an individual performing detailed data analysis. Through our research of industry practices, we determined that there are a variety of quality checks that states use to monitor the completeness and accuracy of encounter submissions. The proposed quality checks can serve as proactive indicators to flag potential data issues. This protocol was selected to enhance the quality checks that are being performed by both DHS and the MCOs to help identify potential data issues proactively.

Protocol Intent

The purpose of this protocol is to provide MCOs with encounter submission benchmarks to be applied before encounters are submitted to DHS to detect possible deficiencies or errors.

Protocol Definition

DHS will produce a report of various benchmarks which MCOs will be required to monitor for their encounter submissions. Benchmarks may be refined over time by DHS. Initial benchmarks could include:

i. Minimum volume of encounter records per thousand member months, by service category
ii. Range of average paid amount per service by service category
iii. Range of paid Per Member Per Month (PMPM) by service category
iv. Volume of error records by key field

At least annually but not more than semi-annually, MCOs will be required to submit the benchmark report to DHS demonstrating that they meet the benchmark thresholds or explain why the benchmarks are not met. DHS will compare each MCO’s submitted benchmark report to its own records to check for any discrepancies in the MCO reporting. DHS will follow up with the MCO on any reporting discrepancies. The MCO will be required to explain the reason for the discrepancy and take any action needed to remedy the discrepancy. Failure to comply with any step outlined above could be considered a breach of contract and subject an MCO to a corrective action plan or financial penalty. DHS may add, delete, or modify the benchmarks being monitored and their values as necessary.

Below are examples of potential metrics which could be included as part of the quality checks.
Table 1

Table 1 is an example of metrics that could be used to assess the reasonableness of average paid PMPM, average paid amount per service, and minimum utilization. A minimum standard for utilization per 1,000 member months can be established for various service categories. Several states have this completeness check to provide assurance that MCOs are sending a minimum amount of all necessary encounter records. The average paid PMPM and paid amount per service ranges are used as a check against the overall reasonableness of the data being submitted. The paid amount per service can also be used as a check that the utilization units are being counted consistently across MCOs. The service categories can be revised based on the desired level of detail for tracking these metrics. For instance, the example below is similar to the service category level of detail found in the Ohio contract, whereas the New Jersey contract tracks metrics for more than 25 different categories. The metric values can also be adjusted over time, possibly starting with a wider acceptable range (greater standard deviation) in early years to give MCOs time to work through data issues, with the acceptable ranges narrowing over time as MCO and DHS processes become more established. Values outside acceptable ranges are proactive indicators to potential data issues or missing data. The Appendix provides additional information regarding considerations for selecting confidence intervals and appropriate standard deviations.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Paid PMPM</th>
<th>Paid Amount per Service</th>
<th>Utilization</th>
<th>Measure per 1,000 Member Months</th>
<th>Minimum Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minimum Standard</td>
<td>Maximum Standard</td>
<td>Minimum Standard</td>
<td>Maximum Standard</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td>Discharges</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td>Visits</td>
</tr>
<tr>
<td>Primary and Specialty Care</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td></td>
</tr>
<tr>
<td>Ancillary Services</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td></td>
</tr>
<tr>
<td>Personal Care Assistant (PCA)</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td>Days</td>
</tr>
<tr>
<td>Total</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td>Avg - N StDev</td>
<td>Avg + N StDev</td>
<td></td>
</tr>
</tbody>
</table>
Table 2

Table 2 is an example of thresholds that could be set up for minimum acceptable error rates (missing, null value, or invalid value) for key data fields. These types of metrics track an MCO’s compliance with accurately populating key data fields on encounter records. Certain data fields may be selected to be tracked due to their informational importance, concern of the ability for MCOs to populate appropriately, or other reasons of DHS’s choosing. This table includes examples of key data fields which may be chosen to have an individual metric, or minimum error rate. This process of tracking errors on key data fields is a practice that is found in EQR Protocol 4 and other states.

<table>
<thead>
<tr>
<th>Data Field</th>
<th>Acceptable Error Rate (Error rate must be below this %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee ID</td>
<td>X%</td>
</tr>
<tr>
<td>Provider ID</td>
<td>X%</td>
</tr>
<tr>
<td>Principal Diagnosis</td>
<td>X%</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>X%</td>
</tr>
<tr>
<td>Date of Service</td>
<td>X%</td>
</tr>
<tr>
<td>Units of Service</td>
<td>X%</td>
</tr>
<tr>
<td>Attending Physician</td>
<td>X%</td>
</tr>
<tr>
<td>Treating Provider</td>
<td>X%</td>
</tr>
<tr>
<td>Paid Amount</td>
<td>X%</td>
</tr>
<tr>
<td>Allowed Amount</td>
<td>X%</td>
</tr>
<tr>
<td>Type of Bill</td>
<td>X%</td>
</tr>
<tr>
<td>Service Location</td>
<td>X%</td>
</tr>
<tr>
<td>Type of Admission</td>
<td>X%</td>
</tr>
<tr>
<td>Source of Admission</td>
<td>X%</td>
</tr>
<tr>
<td>Patient Discharge Status</td>
<td>X%</td>
</tr>
<tr>
<td>Place of Service</td>
<td>X%</td>
</tr>
<tr>
<td>Drug NDC</td>
<td>X%</td>
</tr>
<tr>
<td>Drug Quantity</td>
<td>X%</td>
</tr>
<tr>
<td>Drug Days Supply</td>
<td>X%</td>
</tr>
<tr>
<td>Prescription Number</td>
<td>X%</td>
</tr>
</tbody>
</table>

Measurement

The following standards are used to assess compliance with the MCO quality checks against benchmarks protocol:

- Metrics from MCO encounter submissions are tracked against the thresholds/ranges in the benchmark report at least annually, but not more than semi-annually
- MCOs that fall outside of the thresholds/ranges in the benchmark report or fail to properly explain discrepancies could be considered in breach of contract and subject to a corrective action plan or financial penalty
Next Steps

DHS:
1. Develop benchmarks using historical data, including setting the thresholds and ranges of acceptability/reasonability
2. Provide benchmarks to MCOs
3. Determine the implementation timeline
4. Reach out to MCOs with protocol details
5. Calculate and track actual MCO-specific performance
6. Continue to revise and refine benchmarks in subsequent years

MCO:
1. Designate individual/team to be in charge of performing quality checks against benchmarks, submitting report to DHS, and working with DHS to address discrepancies
2. Modify systems to track and report benchmark measurements

Other states with this practice: MI, NJ, OH
Protocol 4 – Duplicate Encounter Records Submitted

The high volume of duplicate encounter records that MCOs currently submit creates an added burden of time, work, resources, and cost for DHS. DHS’s claim system currently has edits in place to flag and deny duplicates; however, not all duplicates are flagged. Reducing duplicates submitted by the MCOs could reduce costs, resources, and processing time for DHS. This protocol was selected as a proactive approach to addressing this issue by promoting change in MCO practices.

Protocol Intent

The purpose of this protocol is to reduce the number of duplicate encounter records submitted to DHS.

Protocol Definition

DHS will track the number of duplicate encounter records as a percentage of total encounter records submitted for each MCO according to DHS’s duplicate submission definition. At least annually, but not more than semi-annually, the percentage of denials for duplicate encounter records will be calculated for each MCO and must be below a specified threshold as determined by DHS. DHS will set an initial threshold at a somewhat liberal level, which may be adjusted to be more conservative in future years at DHS’s discretion. If the duplicate encounter rate is not below the specified threshold, the MCO could be considered in breach of contract and subject to a corrective action plan or financial penalty.

Measurement

The following standards are used to assess compliance with the duplicate encounter record protocol:

- \[
\frac{\text{Total number of duplicate encounter records}}{\text{Total number of encounter records submitted}} < x\%
\]
- The above percentage will be tracked for each MCO at least annually but not more than semi-annually

*Note: Thresholds used in other state contracts include \( x = 2\% \) to \( 10\% \)*

Next Steps

**DHS:**
1. Finalize the appropriate denominator (i.e., \% of total encounters or total enrollee months)
2. Finalize the initial duplicate threshold
3. Finalize the measurement period (i.e., per submission, monthly, quarterly, etc.)
4. Determine implementation timeline
5. Reach out to MCOs with protocol details
6. Calculate and track actual MCO-specific performance
7. Continue to track and revise acceptable duplicate threshold over time

**MCO:**
1. Review and enhance controls to prevent submitting duplicates
2. Monitor measurement metrics internally

*Other states with this practice: NJ, OR*
Protocol 5 – Rejection and Denials by DHS

The high volume of encounters rejected and denied by DHS creates an added burden of time and work for DHS. DHS currently takes a reactive approach to handling the issue of errors on encounters that MCOs submit to DHS. The DHS claims system has rules and edits in place to reject and deny encounter records for a variety of reasons. Often these claims may not be resubmitted by the MCOs, which reduces the completeness of the encounter data. This protocol was selected as a proactive approach to addressing this issue by promoting change in MCO practices. Establishing an incentive/sanction with this protocol is expected to incent the MCOs to improve the quality of the encounter data being sent to DHS.

Protocol Intent

The purpose of this protocol is to reduce the number of submitted encounters which are rejected or denied by DHS.

Protocol Definition

DHS will track the number of encounter records rejected and denied by DHS as a percentage of total encounter records submitted by each MCO. Every quarter, the percentage of encounter records rejected and denied by DHS must be below a specified threshold as determined by DHS. DHS will set an initial threshold at a somewhat liberal level which may be adjusted to be more conservative in future quarters at DHS’s discretion. If the rejection and denial rate is not below the specified threshold, the MCO could be considered in breach of contract and subject to a corrective action plan or financial penalty.

Measurement

The following standards are used to assess compliance with the rejections and denials protocol:

- \[ \frac{\text{Total number of rejected and denied encounter records}}{\text{Total number of encounter records submitted}} < x\% \]
- The above percentage will be tracked every quarter for each MCO

Note: Thresholds used in other state contracts include \( x = 2\% \) to 10\% in aggregate for two states and up to 34\% for specific claim types for another state

Next Steps

DHS:
1. Determine acceptable rejection and denial threshold
2. Determine if metric calculations should be evaluated more or less frequently than quarterly
3. Determine implementation timeline
4. Reach out to MCOs with protocol details
5. Calculate and track actual MCO-specific performance
6. Continue to track and revise acceptable rejection and denial threshold over time

MCO:
1. Review and enhance controls to ensure data elements in encounters are accurate
2. Monitor measurement metrics internally

Other states with this practice: NJ, OH, OR
Protocol 6 – Control Reporting and Reconciliation

A number of different states use various approaches and sources to reconcile the encounter data being submitted by MCOs. This protocol was selected as a way to help DHS verify the completeness and accuracy of the encounter data being submitted by each MCO. DHS will provide each MCO with aggregated and claim-level data. The MCOs will be required to reconcile this data to their financials and data in their data warehouse. Any discrepancies will be identified and communicated to DHS, and MCOs will use the information to improve encounter data quality. This protocol establishes a proactive approach to identifying data problems.

Protocol Intent

The purpose of this protocol is to verify the completeness and accuracy of the encounter data by requiring MCOs to validate encounter submissions in aggregate and at the detailed encounter records level.

Protocol Definition

At least annually, DHS will provide each MCO with the following two items produced from the encounter submissions received by DHS from the MCO during the calendar year:

1. A high-level report summarizing the aggregate paid amount by program for each high-level service category
2. The raw data for each individual encounter record submitted (line and header), including the status of each line and whether it contributed to the report totals noted above

The MCO will be required to reconcile this report and data to its own internal financial reporting and system data. A confirmation report that this has been completed and a summary of any discrepancies will be reported back to DHS within “x” calendar days. DHS will work with each MCO to help reconcile and remedy the discrepancies. Any outstanding unexplained variance in excess of “y%” of the aggregate and service category paid dollars for all encounter records or “z%” of the line-level paid dollars on individual encounter records, or failure to perform a timely reconciliation, could be considered a breach of contract and subject to a corrective action plan or financial penalty.

Measurement

The following standards are used to assess compliance with the control reporting and reconciliation protocol:

- Reconciliation will be performed at least at the close of each calendar year
- MCOs must respond with the reconciliation results no later than “x” calendar days after receiving the aggregate encounter records report and individual raw claim data
- MCOs must not have more than a “y%” unexplained variance in the aggregate paid amount for all encounter records in aggregate and by service category
- MCOs must not have more than a “z%” unexplained variance in the line-level paid dollars on individual encounter records

Note: Thresholds used in other state contracts include y = 1% to 2%

Next Steps

DHS:
1. Determine the frequency of reporting and the amount of time the MCO will have to perform reconciliation
2. Determine variance thresholds
3. Develop samples of aggregate encounter records report and individual raw data
4. Provide MCOs with the aggregate encounter records report and individual raw data for the prior calendar year to aid MCOs in developing their internal reconciliation processes
5. Reach out to MCOs with protocol details
6. Track and evaluate MCO responses
7. Determine the implementation timeline

MCO:
1. Designate individual/team to be in charge of reconciliation
2. Create processes to perform reconciliation
3. Monitor measurement metrics internally

*Other states with this practice: WA*
Protocol 7 – Claim Reviews

Encounter data passes through multiple stages and processes from the time it is coded and sent by a provider to the time it is populated in the DHS data warehouse. These multiple stages and processes make the data susceptible to losses or alterations. The claim reviews will be conducted by an independent third party and will be a way to review the details of a statistically valid sample of claims to confirm the data being sent by the provider matches the data being stored in the DHS data warehouse. Any discrepancies will be identified and communicated to all parties, with resulting information used to improve encounter data quality. This protocol was selected as a way to verify encounter data between the source (the provider) and the end user (DHS). The Appendix provides additional information regarding the selection of a statistically valid sample size.

Protocol Intent

The purpose of this protocol is to have two-way reviews of the completeness and accuracy of encounter records being submitted to DHS.

Protocol Definition

Each MCO is required to engage an independent third-party. The third party will perform the following two types of claim reviews once every two years:

1. Review a sample of encounter records provided by DHS and compare to provider medical records or other source
2. Review a sample of encounter records obtained from providers and compare to encounter records submitted to DHS

For both reviews, an error rate will be calculated from the sample. An error rate of greater than “x%” could be considered a breach of contract and subject to a corrective action plan or financial penalty. Each review will be based on a statistically valid sample of no less than 200 records. DHS will have discretion on the size of the sample to be used in each review.

Measurement

The following standards are used to assess compliance with the claim reviews protocol:

- Error Rate = $\frac{\text{Number of encounter records with at least one error}}{\text{Total number of encounter records from sample}}$
- Error rate in the review of the DHS supplied encounter sample must be < x%
- Error rate in the review of the provider encounter record sample must be < y%

Note: Thresholds used in another state contract includes x and y = 5%

Next Steps

DHS:
1. Determine if review should be completed more or less frequently
2. Determine an appropriate sampling process and volume of records to review
3. Determine what defines an error (i.e., missing data, incorrect data, etc.)
4. Determine an acceptable error rate threshold
5. Hold meetings with MCOs to explain this protocol
6. Determine the implementation timeline
7. Track and evaluate MCO compliance and review findings

MCO:
1. Designate individual/team to prepare for reviews and work with the third-party as needed
2. Contract with a an independent third-party entity

Other states with this practice: AZ, TX
Protocol 8 – Corrective Action Plans

A common theme in industry practices is the importance of engaging MCOs as active participants in the process of making changes to correct issues and ensure higher quality data. Several states require an MCO to submit and follow a corrective action plan outlining how an identified data issue will be resolved. This protocol was selected as a way to make MCOs accountable for developing and executing changes to correct data issues.

Protocol Intent

The purpose of this protocol is to develop clear and actionable plans to correct deficiencies in MCO encounter data submission processes and improve data quality.

Protocol Definition

Upon identification of a deficiency in an MCO’s encounter data submission process or the quality of submitted data, DHS may require an MCO to submit a corrective action plan. Upon receipt of request for a corrective action plan, the MCO will have “x” days to submit a corrective action plan for review and approval. The corrective action plan must contain the following information:

i. Reason(s) for the corrective action plan;
ii. Effective date of the corrective action plan;
iii. Detailed work plan for the resolution of the area(s) of concern; and
iv. Timeframe for the resolution of area(s) of concern

Failure to submit a corrective action plan within the required timeframe or continued deficiency following the timeframe for resolution indicated in the corrective action plan could be considered a breach of contract and subject to a financial penalty.

Measurement

The following standards are used to assess compliance with the corrective action plans protocol:

- MCOs must submit a corrective action plan no later than “x” days after receiving the request for a corrective action plan
- MCOs must correct the deficiency within the timeframe for resolution indicated in the corrective action plan

Next Steps

DHS:
1. Determine the amount of time the MCOs will have to submit a corrective action plan, which may vary based on complexity of issue
2. Hold meetings with MCOs to explain this protocol, including a list of examples of possible deficiencies. Provide sample corrective action plans, as appropriate
3. Determine the implementation timeline
4. Reach out to MCOs with protocol details
5. Track and evaluate MCO compliance, as necessary

MCO:
1. Designate individual/team to be in charge of corrective action plans
2. Draft template for corrective action plan

Other states with this practice: MI, OR, PA
Protocol 9 – Data Quality Assurance Report

Through our conversations with personnel at DHS, it was noted that there is a lack of clarity at DHS regarding the processes and quality checks which the MCOs are using to ensure quality encounter data. Another state requires each MCO to submit a report outlining their data validation and quality assurance processes. This protocol was selected as a way to provide this clarity through a documented report.

Protocol Intent

The purpose of this protocol is to ensure that MCOs have documented processes and checks in place to ensure quality encounter data is being provided.

Protocol Definition

Each MCO will submit a report annually to DHS specifying its practices and processes used to ensure encounter data quality, completeness, and accuracy. The purpose of the report will be for each MCO to:

i. Demonstrate that all claims and encounters submitted to the MCO by health care providers are submitted accurately and timely as encounters to DHS;
ii. Demonstrate that encounters denied by DHS are resolved and/or resubmitted;
iii. Evaluate health care provider compliance with contractual reporting requirements, and
iv. Demonstrate the MCO has processes in place to act on information from the monitoring program and take appropriate action to ensure full compliance with encounter data reporting to DHS

The report will provide information on, but not limited to:

i. Overview of processing encounter data submissions;
ii. Adjudication edits;
iii. Data validation checks;
iv. Audits;
v. Data remediation process;
vi. Compliance processes;
vii. Any use of supplemental data to capture service use;
viii. Standard reports created; and
ix. Data certification

DHS will review and either approve or request changes to the report and any related practices/processes. The MCO will update the report on an annual basis documenting any changes to existing practices or processes that occurred throughout the year. Failure to submit or update the report in accordance with the parameters prescribed by DHS could be considered a breach of contract and subject to a financial penalty.

Measurement

The following standards are used to assess compliance with the data quality assurance report protocol:

- First Report: MCO must submit a report
- Future Reports: MCO must revise the report to address any changes that occurred throughout the previous year
Next Steps

DHS:
1. Define the parameters of the report
2. Determine implementation timeline
3. Reach out to MCOs with protocol details
4. Track and evaluate MCO compliance

MCO:
1. Designate individual/team to be in charge of development and maintenance of data quality assurance reports
2. Draft template for report

Other states with this practice: PA
Protocol 10 – MCO Review of Provider Data

Encounter data passes through multiple stages and processes from the time it is coded and sent by a provider to the time it is populated in the DHS data warehouse. These multiple stages and processes make the data susceptible to losses or alterations. This requires an MCO to conduct reviews of the data being sent by the providers and certify to the State that they are conducting these reviews. This protocol was selected as a way to make the MCOs more accountable for the completeness and accuracy of the encounter data which is being submitted by ensuring the data they receive from the providers is complete and accurate.

Protocol Intent

The purpose of this protocol is to require MCOs to review and check the data received from providers for completeness and accuracy.

Protocol Definition

MCOs are required to ensure that data received from providers is complete and accurate by:

i. Verifying the accuracy and timeliness of reported data;
ii. Screening the data for completeness, logic, and consistency; and
iii. Collecting service information in standardized formats.

MCOs will continually perform these checks and are required to certify these activities with DHS on a quarterly basis. In addition, MCOs will provide DHS with a quarterly report that compares control totals from data coming in from providers with data submitted to DHS. Failure to perform and certify adequate checks or submit the report in accordance with the parameters prescribed by DHS could be considered a breach of contract and subject to a financial penalty.

Measurement

The following standards are used to assess compliance with the MCO review of provider data protocol:

• MCOs must certify their review of provider data with DHS on a quarterly basis
• MCO must provide a quarterly report to DHS comparing control totals from provider data with the MCO data submissions to DHS

Next Steps

DHS:
1. Determine what is included in certification
2. Determine if certification should be provided more or less frequently
3. Communicate the protocol to MCOs
4. Determine implementation timeline
5. Reach out to MCOs with protocol details
6. Track and evaluate MCO compliance and MCO findings

MCO:
1. Designate individual/team to be in charge of reviewing provider data
2. Establish and implement the checks and activities needed to perform an acceptable review
3. Draft template for certification and report

Other states with this practice: NJ, OR
Conclusions and Next Steps

The findings and suggestions in this report are designed to help DHS improve the timeliness, completeness, and accuracy of its encounter data. It is DHS’s discretion to select quality assurance protocols to implement and how they choose to implement them. This report section provides a sample timeline for the frequency of protocol measurement and a sample implementation prioritization for the ten quality assurance protocols.

Frequency of Protocol Measurement

The following lists the ten quality assurance protocols and the potential frequency for protocol measurement to monitor MCO compliance. Frequency can be modified as needed over time.

<table>
<thead>
<tr>
<th>Frequency of Measurement</th>
<th>Protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly</td>
<td>Protocol 2 – Resubmissions</td>
</tr>
<tr>
<td></td>
<td>Protocol 5 – Rejections and Denials by DHS</td>
</tr>
<tr>
<td></td>
<td>Protocol 10 – MCO Review of Provider Data</td>
</tr>
<tr>
<td>At Least Annually</td>
<td>Protocol 1 – Timeliness of Submissions</td>
</tr>
<tr>
<td></td>
<td>Protocol 3 – MCO Quality Checks Against Benchmarks</td>
</tr>
<tr>
<td></td>
<td>Protocol 4 – Duplicate Encounter Records Submitted</td>
</tr>
<tr>
<td></td>
<td>Protocol 6 – Control Reporting and Reconciliation</td>
</tr>
<tr>
<td></td>
<td>Protocol 9 – Data Quality Assurance Report</td>
</tr>
<tr>
<td>Bi-Annually</td>
<td>Protocol 7 – Claim Reviews</td>
</tr>
<tr>
<td>As-Needed</td>
<td>Protocol 8 – Corrective Action Plan</td>
</tr>
</tbody>
</table>

Sample Implementation Prioritization

The following is a sample implementation prioritization for the timing and frequency of the ten quality assurance protocols. Protocols are grouped by prioritization for near-term (immediate), mid-term, or long-term implementation.

Near Term (Immediate):

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Target Start Date</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action Plan</td>
<td>Q4 2014</td>
<td>As needed</td>
</tr>
<tr>
<td>Resubmissions</td>
<td>Q4 2014</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Rejections and Denials by DHS</td>
<td>Q4 2014</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Duplicate Encounter Records Submitted</td>
<td>Q4 2014</td>
<td>At least annually, but not more than semi-annually</td>
</tr>
<tr>
<td>Timeliness of Submissions</td>
<td>Q4 2014</td>
<td>At least annually, but not more than semi-annually</td>
</tr>
</tbody>
</table>
Mid-Term:

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Target Start Date</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO Review of Provider Data</td>
<td>Q1 2015</td>
<td>Quarterly</td>
</tr>
<tr>
<td>MCO Quality Checks Against Benchmarks</td>
<td>Q1 2015</td>
<td>At least annually, but not more than semi-annually</td>
</tr>
<tr>
<td>Control Reporting and Reconciliation</td>
<td>Q1 2015</td>
<td>Annually</td>
</tr>
<tr>
<td>Data Quality Assurance Report</td>
<td>Q1 2015</td>
<td>Annually</td>
</tr>
</tbody>
</table>

Long-Term:

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Target Start Date</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Reviews</td>
<td>Q1 2016</td>
<td>Once every two years</td>
</tr>
</tbody>
</table>

The following graphic provides a visual illustration of the sample implementation timeline just described.
Sample Implementation:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td><strong>Near-Term (Immediate)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective Action Plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resubmissions</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Rejections and Denials by DHS</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Duplicate Encounter Records</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Submitted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timeliness of Submissions</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td><strong>Mid-Term</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCO Review of Provider Data</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>MCO Quality Checks against</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Benchmarks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Reporting and</td>
<td>★</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reconciliation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Quality Assurance Report</td>
<td>★</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Long-Term</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim Reviews</td>
<td>★</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

★ Occurrence ★ Possible Occurrence ➔ Continually Occurring
Appendix – Benchmark Standards

Confidence Levels for Benchmark Standards

In setting the appropriate benchmark standards in the benchmark report, the following are the number of standard deviations which apply to two-sided (i.e. range standard) and one-sided (i.e. minimum standard) confidence levels.

<table>
<thead>
<tr>
<th>Range Standard - two-sided</th>
<th>N Standard Deviations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence Level</td>
<td></td>
</tr>
<tr>
<td>68.27%</td>
<td>1.0000</td>
</tr>
<tr>
<td>90%</td>
<td>1.6449</td>
</tr>
<tr>
<td>95%</td>
<td>1.9600</td>
</tr>
<tr>
<td>95.45%</td>
<td>2.0000</td>
</tr>
<tr>
<td>99%</td>
<td>2.5758</td>
</tr>
<tr>
<td>99.73%</td>
<td>3.0000</td>
</tr>
</tbody>
</table>

Two-Sided Confidence Level interpretation – “If the benchmark is set at the average plus or minus 1.6449 standard deviations then the observed average from encounter submissions would be expected to be within this range 90% of the time.”

<table>
<thead>
<tr>
<th>Minimum Standard - one-sided</th>
<th>N Standard Deviations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence Level</td>
<td></td>
</tr>
<tr>
<td>84.13%</td>
<td>1.0000</td>
</tr>
<tr>
<td>90%</td>
<td>1.2816</td>
</tr>
<tr>
<td>95%</td>
<td>1.6449</td>
</tr>
<tr>
<td>97.72</td>
<td>2.0000</td>
</tr>
<tr>
<td>99%</td>
<td>2.3263</td>
</tr>
<tr>
<td>99.87%</td>
<td>3.0000</td>
</tr>
</tbody>
</table>

One-Sided Confidence Level interpretation – “If the benchmark is set at the average minus 1.2816 standard deviations then the observed average from encounter submissions would be expected to be higher than this standard 90% of the time.”
The parameters in these tables hold true under the following assumptions:

- Underlying distributions of Paid PMPM, Paid Amount per Service, and Utilization are approximately normal
- Size of both the baseline data used to set the benchmarks and the sample of encounters being compared to the benchmarks are large enough to be considered statistically significant
- Distribution of baseline data is reflective of expectation for submitted encounters (i.e., expect to have same mean and variance)
Appendix – Claim Review Sampling

Sample Size Determination

The following sample size determination approach is used for estimating a population proportion from a finite population. These formulas are applicable to determining the sample size for a claim review, as demonstrated below.

Situation: The error rate, or proportion of encounters identified as having an error, for the total encounters submitted for a specified time period is to be determined from reviewing a randomly drawn sample of the encounters. How many encounters must be included in the sample to determine that the true error rate is within +/- X% of the observed error rate from the sample with Y% confidence?

Parameters:

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>p</td>
<td>expected maximum proportion, or error rate (proportion of encounters identified as having an error)</td>
</tr>
<tr>
<td>Z</td>
<td>Z-score associated with the chosen confidence level (90% = 1.645, 95% = 1.96, 99% = 2.576)</td>
</tr>
<tr>
<td>c</td>
<td>size of chosen confidence interval (one-side, expressed as decimal), or degree of reliability</td>
</tr>
<tr>
<td>N</td>
<td>population, or total number of encounters</td>
</tr>
<tr>
<td>SS</td>
<td>sample size for an infinite population</td>
</tr>
<tr>
<td>SS*</td>
<td>sample size adjusted for finite population, or sample size for number of encounters to be reviewed</td>
</tr>
</tbody>
</table>

Formulas:

\[ SS = \frac{Z^2 \times p \times (1 - p)}{c^2} \]

\[ SS* = \frac{SS}{1 + \frac{(SS - 1)}{N}} \]

Note: CMS guideline for Payment Error Rate Measurement (PERM) Report is a 95% confidence level with +/- 3% reliability when performing a claim sampling. We apply this assumption for the confidence level in the sample size approach described above for claim reviews.

Sample Size Determination – Example

The following is an example of how a sample size would be determined in a given scenario of 100,000 submitted encounters using the CMS guidelines for Payment Error Rate Measurement (PERM) Report of a 95% confidence level with +/- 3% reliability and an assumption of 5% expected error rate.
Parameters Values:

\[ p = .05 \]
\[ Z = 1.96 \]
\[ c = .03 \]
\[ N = 100,000 \]

Solve:

\[
SS = \frac{Z^2 \cdot p \cdot (1 - p)}{c^2} \quad SS = \frac{1.96^2 \cdot .05 \cdot (1 - .05)}{0.03^2} \quad SS = \quad 203
\]

\[
SS^* = \frac{SS}{1 + \frac{(SS - 1)}{N}} \quad SS^* = \frac{203}{1 + \frac{(203 - 1)}{100,000}} \quad SS^* = \quad 203
\]

Solution: A sample of 203 randomly selected encounters from the population of 100,000 encounters will yield an error rate within 3% of the true population error rate with 95% confidence.

Sample Size Based on MCO Size

The following is an example of sample sizes for each MCO using the methodology detailed above and data provided by DHS on the actual number of encounters submitted for each MCO during the period of 1/1/2013 to 12/31/2013.

<table>
<thead>
<tr>
<th>MCO</th>
<th>Expected Maximum Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5%</td>
</tr>
<tr>
<td>Blue Plus</td>
<td>203</td>
</tr>
<tr>
<td>HealthPartners</td>
<td>203</td>
</tr>
<tr>
<td>Hennepin Health</td>
<td>203</td>
</tr>
<tr>
<td>Itasca Medical Care</td>
<td>203</td>
</tr>
<tr>
<td>Medica</td>
<td>203</td>
</tr>
<tr>
<td>MHP</td>
<td>203</td>
</tr>
<tr>
<td>PrimeWest</td>
<td>203</td>
</tr>
<tr>
<td>South Country Health Alliance</td>
<td>203</td>
</tr>
<tr>
<td>UCare</td>
<td>203</td>
</tr>
</tbody>
</table>

The calculated sample size is not very sensitive to differences in the number of encounters between MCOs at the high volume of encounters seen in the above example.
## Appendix – Contract Language Examples

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Source</th>
<th>Contract Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resubmissions</td>
<td>WI Contract</td>
<td>“If the HMO fails to correct an error to the encounter record within the time frame specified, the Department may assess liquidated damages of $5 per erred encounter record per month until the error has been corrected. The liquidated damage amount will be deducted from the HMO’s capitation payment. When applied, these liquidated damages will be calculated and assessed on a monthly basis.”</td>
</tr>
</tbody>
</table>
| Timeliness of Submissions    | PA Contract  | “With the exception of pharmacy encounters, all MCO approved encounters and those specified MCO denied encounters must be approved in PROMISe by the last day of the third month following the month of initial MCO adjudication. Pharmacy encounters must be submitted and approved in PROMISe within 30 days following the MCO adjudication. During the sixth months following the month of the initial PROMISe adjudication, the encounters will be analyzed for timely submission of encounters.  
  
o  Failure to achieve PROMISe approved/paid status for 98% of all MCO paid/approved and specified MCO denied encounters by the last day of the third month following initial MCO adjudication may result in a penalty.  
o  Any encounter corrected or initially submitted after the last day of the third month following initial MCO adjudication may be subject to a penalty.”                                                                                                                                                                                                                                                                                                                                                         |
| Quality Checks and Benchmarks| OH Contract  | “ABD Adult Data Quality Standards:  
The ABD adult data quality standards for the encounter data volume measure are listed in Table 2 below. The utilization rate for each service category listed in Table 2 must be equal to or greater than the associated standard established for each service category in Table 2. The standard for the Ancillary Services service category for dates of service on or after July 1, 2009 has been updated in response to simplification and streamlining of the SFY 2012 methodology for this measure.  
Table 2. ABD Adult Standards – Encounter Data Volume:  

<table>
<thead>
<tr>
<th>Category</th>
<th>Measure per 1,000 EIM</th>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>Discharges</td>
<td>22.0</td>
<td>General/surgical care, excluding newborns and mental health and chemical dependency services</td>
</tr>
<tr>
<td>Emergency Department</td>
<td></td>
<td>135.0</td>
<td>Includes physician and hospital emergency department encounters</td>
</tr>
<tr>
<td>Dental</td>
<td>Visits</td>
<td>28.1</td>
<td>Non-institutional and hospital dental visits</td>
</tr>
<tr>
<td>Vision</td>
<td></td>
<td>19.2</td>
<td>Non-institutional and hospital outpatient optometry and ophthalmology visits</td>
</tr>
<tr>
<td>Primary and Specialist Care</td>
<td></td>
<td>452.0</td>
<td>Physician/practitioner and hospital outpatient visits</td>
</tr>
<tr>
<td>Ancillary Services</td>
<td></td>
<td>239.0</td>
<td>Ancillary visits</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Service</td>
<td>75.5</td>
<td>Inpatient and outpatient behavioral encounters</td>
</tr>
<tr>
<td>Pharmacy*</td>
<td>Prescriptions</td>
<td>4260.4</td>
<td>Prescribed drugs</td>
</tr>
</tbody>
</table>
| Duplicates                    | NJ Contract           | “For the period beginning July 1, 2011, minimum encounter data submission accuracy and completeness is measured by, but not limited to:  
  
  3. a duplicate encounter submission rate not greater than 2% each month;”                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
Rejections and Denials

NJ Contract

“For the period beginning July 1, 2011, minimum encounter data submission accuracy and completeness is measured by, but not limited to:

1. an encounter denial rate of less than 2% (excluding HMO capitation detail records, HMO-denied encounters, duplicate encounters, non-correctable denied encounters determined at the discretion of DMAHS, and other encounters at the request of the contractor and approved by DMAHS) for each HIPAA transaction type, for each month;”

Reconciliation

WA Contract

“The Contractor must validate the accuracy and completeness of all encounter data compared to the year-to-date general ledger of paid claims.

Within sixty (60) days of the end of each calendar quarter, the Contractor shall provide aggregate totals of all encounters submitted during that quarter, and shall reconcile the cumulative encounter data submitted for the quarter and contract year with the year-to-date general ledger paid claims. The Contractor shall provide justification for any discrepancies.

The reconciliation of the encounter data for the first calendar quarter of 2014 that is performed according to the timeline in subsection 5.11.6.1 will be done to test the reconciliation process and to identify discrepancies that would prevent release of the amounts withheld for that quarter to the Contractor. The Contractor will have until the completion of the second reconciliation process of the first calendar quarter of encounter data to correct the discrepancies found through the initial reconciliation of the first quarter encounter data.

Following the quarterly reconciliation process for the second calendar quarter of 2014, if the discrepancy between the submitted paid encounter data and the general ledger paid claims for the first two calendar quarters of 2014 cannot be justified for reasons other than encounter data quality and completeness, and that discrepancy is more than one percent (1%) of the anticipated amount to reconcile to the general ledger amounts, HCA will notify the Contractor and will retain the amounts withheld from the monthly premium payments for the first two calendar quarters of 2014.

Following the quarterly reconciliation process for the third and fourth calendar quarters of 2014, if the discrepancy between the submitted paid encounter data and the general ledger paid claims for the quarter being reconciled cannot be justified for reasons other than encounter data quality and completeness, and that discrepancy is more than one percent (1%) of the anticipated amount to reconcile to the general ledger amounts, HCA will notify the Contractor and will retain the amounts withheld from the monthly premium payments for the prior calendar quarter.

The release of amounts withheld shall apply only to the calendar months being reconciled as part of that quarter’s reconciliation process. Failure to demonstrate that the encounter data submitted within required timing reconciles to the general ledger amounts within one percent (1%) per the processes included in subsections 5.11.6.1 through 5.11.6.4 of this Contract will result in loss of the amounts withheld for the quarter(s).”

Claim Reviews

AZ Contract

“Per CMS requirements, AHCCCS will conduct encounter validation studies of the Contractor’s encounter submissions. These studies may result in sanctions of the Contractor and/or require a corrective action plan for noncompliance with related encounter submission requirements.

The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with the Contractor’s submitted encounter data. Any and all covered services may be validated as part of these studies. The criteria used in encounter validation studies may include timeliness, correctness and omission of encounters.”

TX Contract

“Encounter Data will be validated by chart review of a random sample of Texas Health Steps eligible enrollees against monthly Encounter Data reported by the MCO. HHSC or its designee will conduct chart reviews to validate that all screens are performed when due and as reported, and that reported data is accurate and timely. Substantial deviation between reported and charted Encounter Data could result in the MCO and/or Network Providers being investigated for potential Fraud, Abuse, or Waste without notice to the MCO or the Provider.”
<table>
<thead>
<tr>
<th><strong>Corrective Action Plans</strong></th>
<th><strong>OR Contract</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>“Upon identification of areas of deficiency the Contractor shall require of the subcontractor, a Contractor approved Corrective Action Plan, as defined in Exhibit A of this Contract. The Corrective Action Plan shall provide the following information:</td>
<td></td>
</tr>
<tr>
<td>a. Reason(s) for the Corrective Action Plan;</td>
<td></td>
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<td>b. Effective date of the Corrective Action Plan;</td>
<td></td>
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<tr>
<td>c. Required resolution of the area(s) of concern; and</td>
<td></td>
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<tr>
<td>d. Intended remedies short of termination should the subcontractor not come into compliance within the required timeframe.”</td>
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<tr>
<th><strong>Data Quality Assurance Reports</strong></th>
<th><strong>PA Contract</strong></th>
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</thead>
<tbody>
<tr>
<td>“The PH-MCO must have a data completeness monitoring program in place that:</td>
<td></td>
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<tr>
<td>i. Demonstrates that all Claims and Encounters submitted to the PH-MCO by the Health Care Providers, including Subcontractors, are submitted accurately and timely as Encounters to the Department. In addition, demonstrates that denied Encounters are resolved and/or resubmitted;</td>
<td></td>
</tr>
<tr>
<td>ii. Evaluates Health Care Provider and Subcontractor compliance with contractual reporting requirements; and</td>
<td></td>
</tr>
<tr>
<td>iii. Demonstrates the PH-MCO has processes in place to act on the information from the monitoring program and takes appropriate action to ensure full compliance with Encounter Data reporting to the Department.</td>
<td></td>
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<tr>
<td>The PH-MCO must submit an annual Data Completeness Plan for review and approval. This Data Completeness Plan must include the three elements listed above.”</td>
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<tr>
<th><strong>Review of Provider Data</strong></th>
<th><strong>NJ Contract</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>“The Contractor shall ensure that data received from providers is accurate and complete by:</td>
<td></td>
</tr>
<tr>
<td>1. Verifying the accuracy and timeliness of reported data;</td>
<td></td>
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<tr>
<td>2. Screening the data for completeness, logic, and consistency; and</td>
<td></td>
</tr>
<tr>
<td>3. Collecting service information in standardized formats”</td>
<td></td>
</tr>
</tbody>
</table>
# Appendix – Other State Practices

## Arizona

<table>
<thead>
<tr>
<th>Category</th>
<th>Practice</th>
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<tbody>
<tr>
<td><strong>Staffing and Data Uses</strong></td>
<td>• The state staffs a team dedicated solely to working with encounter data, which includes an actuary&lt;br&gt;• The state holds joint meetings of operational data and finance staff every other month to conduct a comprehensive evaluation of each MCO; encounter data is a recurring agenda item for these meetings&lt;br&gt;• The state uses encounter data for the following activities: evaluate MCO performance, develop/evaluate capitation rates, pay reinsurance to the MCO, and process reconciliations and risk adjustments</td>
</tr>
<tr>
<td><strong>Standards for Submitting Encounters</strong></td>
<td>• MCOs are required to submit paid amounts on all encounters&lt;br&gt;• MCOs are required to submit encounter data no later than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the MCO, whichever date is later&lt;br&gt;• MCOs are required to submit pharmacy encounter data no later than 30 days after the end of the quarter in which the pharmaceutical item was dispensed&lt;br&gt;• The state produces an Encounter Data Manual for the MCOs which includes information on: the purpose of collecting encounter data, encounter reporting deadlines, encounter data file processing, AHCCCS validation procedures, reference file record layouts and coding formats</td>
</tr>
<tr>
<td><strong>Reduction of Data Issues</strong></td>
<td>• The state’s actuary analyzes 3-5 years of encounter data to track trends in payments that can be used to identify potential gaps or inconsistencies in the encounter data&lt;br&gt;• The state runs all encounters through a series of front-end validation edits with checks for populated key fields, and checks for duplicate</td>
</tr>
<tr>
<td><strong>Claim Review and Reconciliation</strong></td>
<td>• MCOs are required to have an internal ongoing claims audit function which verifies that provider contracts are loaded correctly and that payments are accurate against provider contract terms&lt;br&gt;• MCOs are required to submit financial statements to the state which are used to reconcile the encounter data for completeness&lt;br&gt;• The state performs an annual Encounter Data Validation Omission Study, which compares recorded utilization information from a medical record or other source with the MCO’s submitted encounter data&lt;br&gt;• MCOs are required to maintain and submit logs for all overridden or voided encounters, which the state audits to ensure the override/void was an appropriate action</td>
</tr>
<tr>
<td><strong>MCO Reporting</strong></td>
<td>• MCOs are required to provide attestation that the services listed on encounters were actually rendered&lt;br&gt;• MCOs required to submit the following three reports each quarter:&lt;br&gt;1) Finalized Claims Report - Summarizes the number of claims and plan paid amounts finalized by the MCO and subsequently submitted as encounters to AHCCCS for the reporting timeframe&lt;br&gt;2) Override Log - A list of CRNs (Claim Record Numbers), for encounters overridden in PMMIS by the MCO including a detailed reason for the override&lt;br&gt;3) Void Log - A list of CRNs for encounters voided by the MCO including a detailed reason for the void</td>
</tr>
<tr>
<td><strong>Financial Incentives/ Sanctions</strong></td>
<td>• Financial sanctions are applied to MCOs based on their omission rate calculated from the Encounter Data Validation Omission Study&lt;br&gt;• Financial sanctions are applied to MCOs for failing timeliness thresholds for correcting pended claims</td>
</tr>
</tbody>
</table>
## Delaware

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<tr>
<th>Category</th>
<th>Practice</th>
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</table>
| **Staffing and Data Uses** | • The state uses an independent actuarial firm to help with encounter data validation  
• The state uses encounter data for the following activities: evaluate MCO performance, capitation rate-setting, and risk adjustment |
| **Standards for Submitting Encounters** | • MCOs are required to submit paid amounts on all encounters  
• MCOs are required to submit encounter data within 240 days of the date of service and no later than 75 calendar days after the encounters are processed |
<table>
<thead>
<tr>
<th>Category</th>
<th>Practice</th>
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</table>
| **Staffing and Data Uses**     | • The state contracts with an independent actuarial firm who uses the state’s encounter data to perform tasks such as: capitation rate-setting, budget forecasting, and data quality evaluation/validation  
  • The state uses encounter data for the following activities: rate calculations, DRG calculations, and risk score calculations |
| **Standards for Submitting Encounters** | • MCOs are required to submit paid amounts on all encounters  
  • The state produces companion guides, which provide the MCOs with specific guidance on how to format and submit encounters |
| **Reduction of Data Issues**   | • The state releases and tracks annual performance measurement standards for encounter data quality and compares MCO performance to the standards  
  • The state’s actuary performs quality checks of the submitted encounter data by comparing the data to national experience and the experience of other MCOs to evaluate the reasonability and credibility of the encounter data  
  • The state monitors and develops reports on the volume of encounter claims and payments by service type for each MCO to check the reasonability of the data submissions  
  • The state has implemented a series of data quality edits which reject encounters that do not meet the state's standard reporting requirements |
| **MCO Reporting**              | • MCOs that are not meeting performance standards for encounter data may be required to implement a corrective action plan |
| **Communication and Feedback** | • The state provides each MCO with an annual report of the MCO's performance measurement, which includes encounter data quality standards and compares the plan's performance over time, to that of other plans, and to industry standards  
  • MCOs are required to participate in regular data quality assessments, which are conducted as an ongoing component of on-site activities to monitor encounter data quality |
| **Financial Incentives/ Sanctions** | • Financial sanctions/penalties of varying degree may be imposed against MCOs if remedial actions and improvement plans do not resolve issues for MCOs that are not meeting encounter data standards  
  • The state may terminate an MCO’s contract if financial sanctions are ineffective in resolving issues |
New Jersey

<table>
<thead>
<tr>
<th>Category</th>
<th>Practice</th>
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<tbody>
<tr>
<td>Staffing and Data Uses</td>
<td>• The state has an encounter data monitoring unit which is dedicated solely to working with encounter data. The unit includes a programmer with experience providing technical assistance, an expert in contract language with experience working with contractors, and a data analyst/supervisor with detailed knowledge of claims and encounter data&lt;br&gt;• The state uses encounter data for the following activities: evaluate MCO performance and capitation rate-setting</td>
</tr>
<tr>
<td>Standards for Submitting Encounters</td>
<td>• MCOs are required to submit paid amounts on all encounters&lt;br&gt;• MCOs are required to resubmit encounters within 90 days of receipt of the Remittance Advice&lt;br&gt;• MCOs are required to continue to submit encounters on services rendered during the contract period following contract termination&lt;br&gt;• MCOs are required to maintain two years of active history of adjudicated claims and encounter data for verifying duplicates, checking service limitations, and supporting historical reporting&lt;br&gt;• MCOs are required to submit Capitation Detail Records for each provider and enrollee combination for each time period in which a capitation payment is made to the provider</td>
</tr>
<tr>
<td>Reduction of Data Issues</td>
<td>• MCOs are required to develop incentives to encourage sub-capitated providers and subcontractors to report complete and accurate encounter data&lt;br&gt;• The state uses data editing processes to determine whether data meets contractually specified benchmarks and conducts internal analysis to validate the quality of the data&lt;br&gt;• The state has approximately 29 encounter data completeness benchmarks which measure utilization for certain specified categories of service&lt;br&gt;• The state has benchmarks for acceptable percentages of denied encounters and duplicate encounters (2%)</td>
</tr>
<tr>
<td>Claim Review and Reconciliation</td>
<td>• The state reconciles paid amounts on submitted encounter records against lag reports which are produced and submitted by the MCOs (variance cannot exceed 2%)</td>
</tr>
<tr>
<td>MCO Reporting</td>
<td>• MCOs are required to ensure the data received from providers is accurate and complete by: verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats</td>
</tr>
<tr>
<td>Communication and Feedback</td>
<td>• The state provides MCOs with monthly reports which track denial rates, duplication rates, monthly performance against benchmarks, and historical performance against benchmarks&lt;br&gt;• The state requires subcontractors to participate in any meetings related to encounter data requirements</td>
</tr>
<tr>
<td>Financial Incentives/ Sanctions</td>
<td>• Financial penalties/sanctions (referred to as &quot;liquidated damages&quot; in the contract ) may be applied to MCOs for any of the following situations related to encounter data: failing to meet any of the completeness benchmarks, exceeding the denied encounters benchmark, exceeding the duplicate encounters benchmark, or exceeding the paid claims reconciliation variance&lt;br&gt;• Withholds are also used as another form of incentive in the place of &quot;liquidated damages&quot;</td>
</tr>
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## Ohio

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<thead>
<tr>
<th>Category</th>
<th>Practice</th>
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</thead>
<tbody>
<tr>
<td><strong>Staffing and Data Uses</strong></td>
<td>- The state uses encounter data for the following activities: MCO performance evaluation, quality reporting, risk adjustment, and capitation rate-setting</td>
</tr>
<tr>
<td><strong>Standards for Submitting Encounters</strong></td>
<td>- MCOs are required to resubmit encounters no later than 35 days after the end of the month in which the claims were paid</td>
</tr>
</tbody>
</table>
| **Reduction of Data Issues**  | - The state tracks the acceptance rate (or rate of encounters submitted to the state and accepted) for MCOs that have had Medicaid membership for one year or less and compares this to a benchmarks for minimum allowable acceptance rate  
  - The state tracks the percentage of rejected encounters by file type for each MCO and compares this to a benchmark for maximum allowable rejected encounters  
  - The state tracks the volume of encounters by service type and population type for each MCO and compares this to benchmarks for completeness and accuracy |
| **Claim Review and Reconciliation** | - The state may perform a review of the MCO's information system capabilities                                                          |
| **MCO Reporting**             | - MCOs are required to submit encounter data with an accompanying signed certification                                                   |
| **Financial Incentives/Sanctions** | - The state uses a series of progressive penalties which are assessed to MCOs which do not meet quality standards for either volume checks, rejected encounters, or acceptance rate  
  - Penalties used by the state for MCOs not meeting compliance include sanction advisories, monetary sanctions, and new member freezes |
### Oregon

<table>
<thead>
<tr>
<th>Category</th>
<th>Practice</th>
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</thead>
</table>
| **Staffing and Data Uses**        | • The state has an encounter data team of research analysts dedicated full-time to working with encounter data  
• The state also has an actuary that works with the encounter data  
• The state uses encounter data for the following activities: evaluate MCO performance and capitation rate-setting |
| **Standards for Submitting Encounters** | • MCOs are required to submit paid amounts on all encounters  
• MCOs are required to submit all pharmacy encounter data within 60 days of date of service and must submit at least 50% of all other encounter claim types monthly, with all encounter data being submitted within 180 days of date of service |
| **Reduction of Data Issues**      | • The state runs all encounters through data edits in its MMIS (fewer edits than FFS), which checks data elements such as procedure and diagnosis codes  
• The state uses a subset of FFS data to perform comparison analyses with the encounter data, in order to check for reasonability and validation  
• The state’s actuary analyzes encounters to track PMPM by service category as a check for data completeness and accuracy  
• The state tracks the percentage of pended encounters for each MCO and compares this to thresholds for allowable limits set by the state |
| **Claim Review and Reconciliation** | • The state produces a weekly submission report that lists all encounters submitted (produced from MMIS) and reconciles this report against the Submission Certification form submitted by each MCO, the results of this reconciliation are sent to each MCO |
| **MCO Reporting**                | • MCOs are required to ensure claims data received from providers (either directly or through a third-party submitter) is accurate, truthful, and complete  
• The state uses corrective action plans for MCOs that exceed pended encounter thresholds |
| **Financial Incentives/Sanctions** | • Financial penalties are applied to MCOs that continue to exceed pended encounter thresholds following the implementation of a corrective action plan |
Pennsylvania

<table>
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<tr>
<th>Category</th>
<th>Practice</th>
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<tbody>
<tr>
<td><strong>Staffing and Data Uses</strong></td>
<td>• The state uses encounter data for the following activities: evaluate MCO performance, capitation rate-setting, and risk adjustment</td>
</tr>
</tbody>
</table>
| **Standards for Submitting Encounters** | • MCOs are required to submit paid amounts on all encounters  
• All MCO approved encounters and those specified MCO denied encounters must be approved in PROMISe (the state’s system) by the last day of the third month following the month of initial MCO adjudication  
• Pharmacy encounters must be submitted and approved in PROMISe within 30 days following the MCO adjudication |
| **Reduction of Data Issues**   | • The state monitors the timeliness of encounter submissions against acceptable thresholds  
• The state monitors the completeness and accuracy of encounter submissions against acceptable thresholds                                                                 |
| **Claim Review and Reconciliation** | • The state uses a comprehensive survey to obtain information from each plan about its encounter data systems and follows up with an on-site visit every two years to check on the survey’s accuracy and see how the system works in practice  
• The state performs either annual or semi-annual audits on a sample of claims from the MCO’s claims/services history data base to validate against the encounter information submitted to the state for completeness and accuracy |
| **MCO Reporting**              | • MCOs are required to have data completeness monitoring program and submit an annual Data Completeness Plan to the state  
• MCOs are required to submit a corrective action plan to the state to fix areas of noncompliance upon the state’s request                                                                                      |
<p>| <strong>Communication and Feedback</strong> | • MCOs are required to assist the state in the validation of encounter data by making available medical records and claims data as requested                                                                                   |
| <strong>Financial Incentives/Sanctions</strong> | • Financial penalties are applied to MCOs which do not meet acceptable thresholds for either timeliness of encounter submissions or variance in the audit sample                                                                 |</p>
<table>
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<tr>
<th>Category</th>
<th>Practice</th>
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</thead>
<tbody>
<tr>
<td><strong>Staffing and Data Uses</strong></td>
<td>• The state uses encounter data for the following activities: evaluate MCO performance and capitation rate-setting</td>
</tr>
</tbody>
</table>
| **Standards for Submitting Encounters** | • MCOs are required to submit paid amounts on all encounters  
• MCOs are required to submit encounter data no later than the 30th calendar day after the last day of the month in which the claim adjudicated  
• MCOs are required to submit pharmacy encounter data no later than 25 calendar days after the date of adjudication |
| **Reduction of Data Issues** | • The state has implemented a series of data edits which automatically reject encounters that do not meet the standard reporting requirements upon initial submission |
| **Claim Review and Reconciliation** | • A quarterly report which reconciles the year-to-date paid claims reported in the MCO financial statements to the appropriate paid dollars reported in the state encounter data warehouse  
• The state uses chart reviews to validate encounter data |
| **MCO Reporting** | • MCOs are required to certify the encounter data in writing with an Encounter Data Certification Report |
| **Communication and Feedback** | • The state produces annual quality of care reports from the encounter data which are shared with the MCOs |
| **Financial Incentives/ Sanctions** | • Financial penalties may be assessed against the MCO for either late encounter submissions or variance in excess of 2% on the quarterly encounter reconciliation report |
### Washington

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<tr>
<th>Category</th>
<th>Practice</th>
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</thead>
<tbody>
<tr>
<td><strong>Staffing and Data Uses</strong></td>
<td>- The state uses encounter data for the following activities: evaluate MCO performance, risk adjustment, and capitation rate-setting</td>
</tr>
</tbody>
</table>
| **Standards for Submitting Encounters** | - MCOs are required to submit paid amounts on all encounters  
- MCOs are required to submit encounter data no later than 30 calendar days from the end of the month in which the MCO paid the financial liability                                                                                                                                                                                                          |
| **Reduction of Data Issues**  | - The state’s MMIS system shadow-prices encounter data according to FFS rules  
- The state’s actuary receives utilization data from the MCOs and compares this against the submitted encounter data as a validation check  
- The state runs all encounter submissions through a series of automated data edits                                                                                                                                                                                                                                         |
| **Claim Review and Reconciliation** | - MCOs must validate the accuracy and completeness of all encounter data compared to the year-to-date general ledger of paid claims                                                                                                                                                                                                                                             |
| **MCO Reporting**             | - MCOs must certify the accuracy and completeness of all encounter data with each file upload                                                                                                                                                                                                                                           |
| **Financial Incentives/ Sanctions** | - The state uses service-based enhanced payments to plans, which are extra payments triggered by meeting thresholds for the submission of certain timely encounter data records  
- The state uses withhold payments which are based on the discrepancy of paid claims in the MCOs reconciliation of encounter data with general ledger paid claims                                                                                                                                 |
### Wisconsin

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<tr>
<th>Category</th>
<th>Practice</th>
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</thead>
<tbody>
<tr>
<td><strong>Staffing and Data Uses</strong></td>
<td>The state uses encounter data for the following activities: capitation rate-setting</td>
</tr>
</tbody>
</table>
| **Standards for Submitting Encounters** | The state produces an Encounter Data User Manual which provides the MCOs with details and examples of the format, requirements, and guidelines which the MCO must comply with in submitting encounter data to the state  
MCOs are required to have the system capability to correct an error to the encounter record within 90 days of notification from the state |
| **Reduction of Data Issues**  | The state runs all encounter submissions through a series of automated data edits                                                                                                                          |
| **Claim Review and Reconciliation** | The state conducts data validity and completeness audits during the contract period, of which at least one audit will include a review of the MCO's encounter data system and logic |
| **MCO Reporting**             | MCOs are required to provide a signed certification to attest that the submitted encounter data is accurate, complete, and truthful to the best of the signor's knowledge                                                   |
| **Communication and Feedback** | MCOs must have assigned staff to participate in HMO encounter technical workgroup meetings periodically scheduled by the state, in which the MCO and the states collaboratively work towards enhancing data submission protocols and improving the accuracy and completeness of the data |
| **Financial Incentives/ Sanctions** | Financial penalties are applied to MCOs per erred encounter record that is not corrected within 90 days                                                                                           |
Appendix – Sources

1. Payment Error Rate Measurement (PERM) Manual
   Centers for Medicare & Medicaid Services

2. Medicaid Managed Care Encounter Data: Collection and Use
   Department of Health and Human Services: Office of Inspector General

3. Collecting, Using, and Reporting Medicaid Encounter Data: A Primer for States
   Mathematica Policy Research

4. Encounter Data Toolkit
   Mathematica Policy Research

5. Introduction to Protocols; Protocol 4 – Validate Encounter Data; Protocol 4 Attachment A; Protocol 4 – Attachment B
   Quality of Care External Quality Review (EQR)

Arizona

6. AHCCCS 2014 Acute Care Contract
   Arizona Health Care Cost Containment System

7. AHCCCS Data Validation Technical Document
   Arizona Health Care Cost Containment System

8. AHCCCS Encounter Manual
   Arizona Health Care Cost Containment System

Michigan

9. Comprehensive Health Care Program for the Michigan Department of Community Health
   Michigan Department of Community Health

10. Medicaid Health Plan Encounter Quality Initiative Frequently Asked Questions
    Michigan Department of Community Health
    http://www.michigan.gov/documents/mdch/Encounter_Quality_Initiative_FAQs_5-12_386113_7.pdf
Minnesota
11. **2014 MCO Model Contracts**  
Minnesota Department of Human Services  

12. **NCPDP Companion Guide**  
Minnesota Department of Human Services  
[https://edocs.dhs.state.mn.us/lfsrerver/Public/DHS-6761A-ENG](https://edocs.dhs.state.mn.us/lfsrerver/Public/DHS-6761A-ENG)

13. **Remittance Advice Remark Code Guide**  
Minnesota Department of Human Services  
[https://edocs.dhs.state.mn.us/lfsrerver/Public/DHS-6761B-ENG](https://edocs.dhs.state.mn.us/lfsrerver/Public/DHS-6761B-ENG)

14. **X12 837 Companion Guide**  
Minnesota Department of Human Services  
[https://edocs.dhs.state.mn.us/lfsrerver/Public/DHS-6761-ENG](https://edocs.dhs.state.mn.us/lfsrerver/Public/DHS-6761-ENG)

New Jersey
15. **Contract Between State of New Jersey Department of Human Services Division of Medical Assistance and Health Services and Contractor**  
State of New Jersey Department of Human Services Division of Medical Assistance and Health Services  

Ohio
16. **Medicaid Managed Care Provider Agreement**  
Ohio Department of Medicaid  
[http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/2013-03-01-ProviderAgreementAmendment-2014-01-01.pdf](http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/2013-03-01-ProviderAgreementAmendment-2014-01-01.pdf)

Oregon
17. **Encounter Data Submission Requirements of Coordinated Care Organizations to Provide Care for Medical Assistance Recipients**  
Oregon Health Authority Division of Medical Assistance Programs  

18. **Encounter Data Submission Guidelines**  
Oregon Health Authority Division of Medical Assistance Programs  

19. **Health Plan Services Contract**  
Oregon Health Authority Division of Medical Assistance Programs  

Pennsylvania
20. **HealthChoices Agreement**  
Pennsylvania Department of Public Welfare Office of Medical Assistance Programs  

21. **HealthChoices Agreement Exhibits**  
Pennsylvania Department of Public Welfare Office of Medical Assistance Programs
Texas
22. *Uniform Managed Care Terms & Conditions*
Texas Health & Human Services Commission
[https://www.hhsc.state.tx.us/medicaid/managed-care/UniformManagedCareContract.pdf](https://www.hhsc.state.tx.us/medicaid/managed-care/UniformManagedCareContract.pdf)

23. *Uniform Managed Care Manual – Consolidated Deliverables Matrix*
Texas Health & Human Services Commission
[http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp5/030112/5-0.pdf](http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp5/030112/5-0.pdf)

Washington
24. *Washington Apple Health Managed Care Contract*
Washington State Health Care Authority

Wisconsin
25. *Contract for BadgerCare Plus and/or Medicaid SSI*
Wisconsin Department of Health Services

26. *Encounter Data Submission User Guide*
Wisconsin Department of Health Services