Oregon Health Authority
Health Services Division

Calendar Year 2020 Encounter Data Validation Report

February 2021

Table of Contents

Overview

Pursuant to 42 Code of Federal Regulations (CFR) §438.242, Oregon Health Authority (OHA) must ensure that each of its coordinated care organizations (CCOs) maintains a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment. OHA must also review and validate encounter data collected, maintained, and submitted by the CCOs to ensure that these data are a complete and accurate representation of the services provided to its Medicaid members. Accurate and complete encounter data are critical to the success of a managed care program; submission of high-quality encounter data can accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

OHA had previously addressed the federal requirements to review and validate encounter data collected, maintained, and submitted by the CCOs via a comprehensive Information Systems Capabilities Assessment (ISCA), which was conducted every two years. In 2019, Health Services Advisory Group, Inc. (HSAG) examined the results from the 2018 comprehensive ISCA, 2019 Readiness Review (RR) Health Information Systems evaluations, and the 2019 performance measure validation (PMV) activity conducted with OHA. Based on these efforts and in working with OHA, it was determined that the comprehensive ISCA could be streamlined and that OHA could work toward an encounter data validation (EDV) process to ensure that the data are a complete and accurate representation of the services provided to members, as required for validation. HSAG also recognized that implementing a strong EDV process can be complicated and recommended that it be conducted as a sequential and collaborative process incorporating CCO accountability for claims validation.

In alignment with the Centers for Medicare & Medicaid Services (CMS) protocol[1-1] for validating encounter data, during calendar year (CY) 2020, OHA contracted HSAG to conduct an EDV focused assessment, based in part on streamlining the current ISCA. The evaluation included an evaluation of the CCOs' processes for collecting, maintaining, and submitting encounter data to OHA. The evaluation provided information on the strengths and limitations of the CCOs' information systems in promoting and maintaining quality encounter data. Similarly, HSAG also evaluated OHA's processes for collecting and managing the CCO-submitted encounter data.

The goal of the CY 2020 EDV study is to examine the extent to which OHA and the CCOs have appropriate system documentation and the infrastructure to produce, process, and monitor encounter

---

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html. Accessed on: Dec 28, 2020.

data. Table 1-1 lists the CCOs that were included in this study. The remainder of this section describes the methodology for the CY 2020 EDV study.

Table 1-1—List of Coordinated Care Organizations (CCOs)

CCO Plan Name	Acronym
Advanced Health	AH
AllCare CCO, Inc.	AllCare
Cascade Health Alliance, LLC	CHA
Columbia Pacific CCO, LLC	CPCCO
Eastern Oregon CCO, LLC	EOCCO
Health Share of Oregon	HSO
InterCommunity Health Network	IHN
Jackson Care Connect	JCC
PacificSource Community Solutions–Central Oregon	PSCS-CO
PacificSource Community Solutions–Columbia Gorge	PSCS-CG
PacificSource Community Solutions–Lane County	PSCS-Lane
PacificSource Community Solutions–Marion Polk	PSCS-MP
Trillium Community Health Plan, Inc.	TCHP
Umpqua Health Alliance, LLC	UHA
Yamhill Community Care Organization	YCCO

Methodology

HSAG conducted an EDV focused assessment to define how each participant in the encounter data process collects and processes encounter data such that the flow of the data from the CCOs to OHA is understood. The assessment was key to understanding whether information systems (IS) infrastructures are likely to produce complete and accurate encounter data. To ensure the collection of critical information, HSAG employed a three-stage assessment process that included a document review, development and fielding of a customized encounter data questionnaire, and follow-up interviews with key OHA and CCO staff members.

Stage 1—Document Review

HSAG initiated the EDV activity with a thorough desk review of existing documents related to encounter data initiatives/validation activities currently put forth by OHA. HSAG worked with OHA to obtain all documentation related to the processing of OHA and CCO data including, but not necessarily limited to, data dictionaries, IS schema, processing diagrams, file/table layouts, full encounter system edit/audit, encounter data re-adjudication processing cycle, sample rejection reports, and encounter data

submission requirements and standards. The information obtained from this review provided the necessary context for refinement in developing the targeted questionnaire to address specific topics of interest for OHA.

Additionally, HSAG reviewed and assessed previous ISCAs, RRs, and PMV findings that may be incorporated in the development of a customized questionnaire.

Stage 2—Development and Fielding of Customized Questionnaire

In order to gain an overall understanding of the CCOs' internal data processing, HSAG developed a customized questionnaire to gather information regarding each organization's information systems and data processing procedures. Based in part on the ISCA, the questionnaire was designed to identify current processes and procedures that impact encounter data processing, as well as other identified areas of interest. The questionnaire also gathered information on the claims adjudication processes in use by the CCOs, including claim validation processes. Where applicable, the questionnaire also included a review of supplemental documentation regarding other data systems, including enrollment and providers. The list below outlines the questionnaire domains for the CCOs.

- Encounter Data Sources and Systems
- Data Exchange Policies and Procedures
- Management of Encounter Data: Collection, Storage, and Processing
- Encounter Data Quality Monitoring and Reporting

The OHA questionnaire had similar domains; however, it focused on OHA's data exchange with the CCOs.

Stage 3—Key Staff Follow-up

After receiving and reviewing the completed questionnaires from OHA and the CCOs, HSAG conducted further follow-up communications via emails with key OHA and CCO information technology (IT) personnel, as necessary, to clarify any questions from the questionnaire responses.

In summary, the focused IS and data processing reviews allowed HSAG to document current processes and develop a thematic process map identifying critical points that impacted the submission of quality encounter data. From this review, HSAG provided actionable recommendations based on the existing encounter data systems.

Study Limitations

Information from OHA's and the CCOs' questionnaire responses was self-reported, and HSAG did not validate the responses for accuracy.

Representatives from all 15 CCOs completed OHA-approved questionnaires supplied by HSAG. HSAG identified follow-up questions based on the CCOs' original questionnaire responses, and the CCOs responded to these CCO-specific questions. To support their questionnaire responses, the CCOs submitted a wide range of documents with varying formats and levels of detail. OHA also completed its questionnaire.

It is important to note that **HSO** delegates to various plan partners, which are responsible for submitting claims directly to OHA. As such, each of **HSO**'s plan partners provided individual responses to the majority of the questions and supplied supporting documentation. **HSO**'s plan partners include CareOregon, Kaiser Permanente (Kaiser), Legacy Health—PacificSource (Legacy Health), Oregon Health & Science University (OHSU) Health Services, and Providence Health Assurance (Providence). Conversely, PacificSource Community Solutions (PSCS) is the Medicaid line of business for PacificSource Health Plans, serving CCO members through **PSCS-CO**, **PSCS-CG**, **PSCS-Lane**, and **PSCS-MP**. Since these four CCOs fall under PSCS and have the same encounter systems and processes, each of these CCOs' questionnaire responses, along with supporting documentation, are identical. Similarly, **CPCCO** and **JCC** are CCO subsidiaries of CareOregon; as such, both **CPCCO** and **JCC**, in having the same encounter systems and processes, have identical questionnaire responses and supporting documentation.

Findings and summaries of the questionnaire responses from OHA and the CCOs are presented in appendices C through R.

Encounter Data Sources and Systems

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

Figure 2-1 shows the primary transaction paths between each process agent (indicated by the solid line) and the data transfer feedback loops (indicated by the dotted lines).

Figure 2-1—Claims/Encounter Data Path From Origin Through Submission to OHA
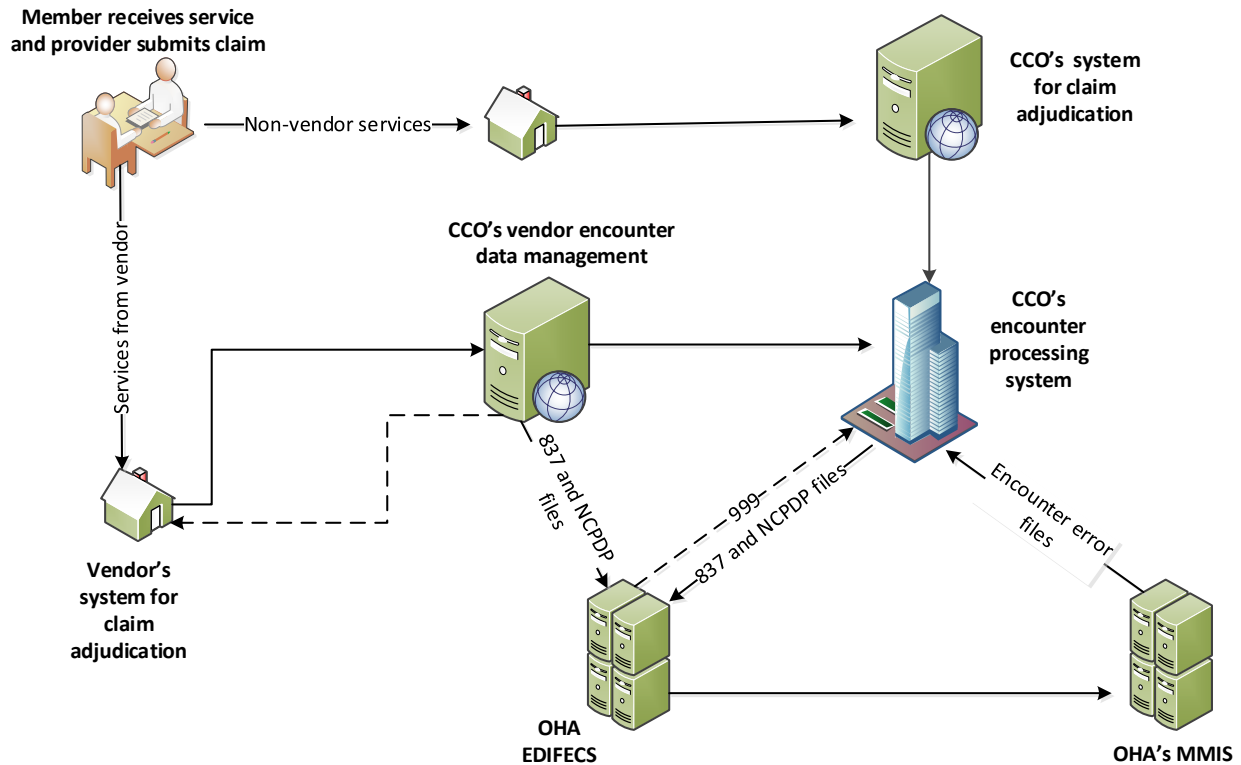
As shown in Figure 2-1, the claims/encounter process begins when a member receives a health care service from a provider; the providers then usually submit claims electronically or via paper to a clearinghouse responsible for aggregating and formatting claims for submission to the claim processor, although they may also submit the claims directly to the CCO for claims processing. Next, the claim is processed, and the data are submitted to the CCO's encounter data system. If the claim was processed by a third party, that vendor submits the claim information to the CCO through its encounter data system. The CCO or its vendor is responsible for ensuring that encounter data are accurate, complete, and formatted correctly for submission to OHA, using 837 Professional (837P), 837 Dental (837D), 837 Institutional (837I), or National Council for Prescription Drug Programs (NCPDP) D.0 files.

Depending on how providers and vendors submit data to the CCO, these data files may be passed directly to OHA, or the vendor may submit the data to OHA on behalf of the CCO (i.e., pass-through arrangements). Once the CCO submits the 837P/D/I and NCPDP files to OHA, OHA provides the CCO with 999, 835, and claim count validation (CCV) response files for the data submission. The CCO or its vendor reviews the response files and resubmits data, if needed. If the rejected data were originally provided to the CCO by a vendor, the CCO requires the vendor to correct the data and resubmit the files to the CCO.

This framework contains extensive opportunities for variation at nearly every stage based on the CCO's contractual arrangements with health care providers and provider networks, other CCOs, and trading

partners (e.g., vendors for claims preprocessing and/or processing, or provision of selected services). Each CCO in this study follows a unique encounter data process, and the remainder of this section focuses on aspects of the CCOs' encounter data processes with consideration to topics that may result in incomplete or inaccurate data submission to OHA.

Information Systems Infrastructure

While OHA receives 837P, 837D, 837I, and NCPDP files directly from the CCOs, these files may have been generated initially by the CCO and/or its subcontractors in a different format. Table 2-1 shows the source and format of data receipt among the 15 CCOs.

Table 2-1—Source of Data Receipt and Format Received by CCO

CCO	Data by Vendor/Subcontractor/Plan Partners	Format
AH	Dental (Advantage Dental Services, LLC [ADS]); pharmacy (MedImpact); professional and institutional (providers or delegates)	Dental: 837D Pharmacy: NCPDP Professional and institutional: paper or electronic
AllCare	Dental (Performance Health Technology [PH TECH]); pharmacy (MedImpact); professional and institutional (electronic: Availity clearinghouse, paper claims: JMS Associates uses a proprietary process to create an electronic 837P/I)	Dental: 837D Pharmacy: NCPDP Professional and institutional: paper or electronic
CHA	Dental (clearinghouse); pharmacy (MedImpact); professional and institutional (electronic: clearinghouse, paper claims: Quantum Choice)	Dental: 837D Pharmacy: NCPDP Professional and institutional: paper and electronic
CPCCO	Dental (ADS, CareOregon, ODS Community Dental [ODS], Willamette Dental); pharmacy (OptumRx); transportation (Ecolane); professional and institutional (in-house QNXT claim processing system); vision (Vision Service Plan [VSP])	Dental: 837D, CareOregon (dental claims are from in-house QNXT claim processing system) Pharmacy: NCPDP Professional and institutional: 837P/I
EOCCO	Dental (ADS, ODS); pharmacy (MedImpact); behavioral health (PH TECH, Greater Oregon Behavioral Health, Inc. [GOBHI], Moda Health); transportation (GOBHI); professional and institutional (Moda Health)	Dental: 837D Pharmacy: NCPDP Behavioral Health: 837P Transportation: 837P Professional and institutional: 837P/I
HSO	Plan partners: CareOregon, Kaiser, Legacy Health, OHSU Health Services, and Providence CareOregon, Legacy Health, and Providence provided a description of data receipt	Dental: 837D Pharmacy: NCPDP or flat files from CareOregon's pharmacy benefit manager (PBM), Catamaran

CCO	Data by Vendor/Subcontractor/Plan Partners	Format
		Professional and institutional: 837P/I or paper claims
IHN	Dental (ADS, Capital Dental Care (Capitol), Willamette, and MODA); pharmacy (OptumRx); transportation (Redline); professional and institutional (EDI trading partners: Payor Connections, Change Health, TriZetto, CHCI, and Office Ally)	Dental: 837D Pharmacy: NCPDP Transportation: 837P Professional and institutional: Electronic through EDI trading partners, paper claims scanned through **IHN**'s internal scanning process
JCC	Dental (ADS, Capitol, ODS, and Willamette); pharmacy (Catamaran); transportation (Ecolane); Vision (VSP); professional and institutional (in-house QNXT claim processing system)	Dental: 837D Pharmacy: NCPDP Transportation: 837P Vision: 837P Professional and Institutional: 837P/I
PSCS-CO	Dental (ADS, Capitol, and ODS); pharmacy (CVS Caremark); transportation (LogistiCare and RideSource); professional and institutional (clearinghouse and EDI gateway)	Dental: 837D Pharmacy: NCPDP Transportation: 837P Professional and institutional: 837P/I
PSCS-CG	Dental (ADS, Capitol, and ODS); pharmacy (CVS Caremark); transportation (LogistiCare and RideSource); professional and institutional (clearinghouse and EDI gateway)	Dental: 837D Pharmacy: NCPDP Transportation: 837P Professional and institutional: 837P/I
PSCS-Lane	Dental (ADS, Capitol, and ODS); pharmacy (CVS Caremark); transportation (LogistiCare and RideSource); professional and institutional (clearinghouse and EDI gateway)	Dental: 837D Pharmacy: NCPDP Transportation: 837P Professional and institutional: 837P/I
PSCS-MP	Dental (ADS, Capitol, and ODS); pharmacy (CVS Caremark); transportation (LogistiCare and RideSource); professional and institutional (clearinghouse and EDI gateway)	Dental: 837D Pharmacy: NCPDP Transportation: 837P Professional and institutional: 837P/I
TCHP	Dental (Advantage, Capitol, and ODS); pharmacy (CVS—Envolve Pharmacy); transportation (Medical Transportation Management [MTM]), Vision (Envolve Vision);	Dental: 837D Pharmacy: NCPDP Transportation: 837P Vision: 837P

CCO	Data by Vendor/Subcontractor/Plan Partners	Format
	professional and institutional (Centene's AMISYS claims processing)	Professional and institutional: 837P/I and paper claims
UHA	Dental (ADS and PH TECH), pharmacy (MedImpact), professional and institutional (PH TECH)	Dental: 837D Pharmacy: NCPDP Professional and institutional: 837P/I
YCCO	Dental (PH TECH), pharmacy (SS&C Technologies [SS&C]), professional and institutional (PH TECH)	Dental: 837D Pharmacy: For point-of-service claims submitted by retail pharmacies, SS&C formats to NCPDP Professional and institutional: 837P/I and paper claims

Claims/Encounter Data Flow

All CCOs except **AH**, **AllCare**, **HSO** (Legacy Health), and **IHN** indicated that they submit paid, denied, voided, and adjusted encounters to OHA. **AH** noted that it submits all claims except those for which it did not "reject liability," defined by OHA's code of "PI" (e.g., duplication, ineligibility), or crossover skilled nursing facility (SNF) claims for which therapy claims may be billed directly to **AH** and subsequently encountered. Similar to **AH**, both **AllCare** and **IHN** noted that they do not submit duplicate claims, claims and encounters with inactive providers or providers under investigation for fraud and abuse, or claims associated with ineligible members. All of **HSO**'s plan partners responded that they submit paid, denied, voided, and adjusted encounters to OHA. However, Legacy Health indicated that it does not submit 1) void claims, unless specifically requested by OHA, 2) claims that are denied in full and have invalid codes, 3) claims that have been denied for members not enrolled, or 4) duplicate claims.

Table 2-2 shows the type of modifications or reformatting of claims/encounter data, if any, performed by the CCOs to accommodate OHA's encounter data submission standards. Six of the CCOs did not modify or reformat their claims/encounter data, while two CCOs indicated that the formatting was performed to meet 837 specifications and OHA guidelines with no changes or modifications to the data in its claims system. Seven of the CCOs responded that in order to accommodate OHA's encounter data submission standards, they make some modifications or reformatting of claims/encounter data prior to submitting them to OHA. Table 2-2 also contains a description of how each CCO submits adjusted encounters to OHA after original encounters have been submitted. In general, the CCOs follow OHA's rules—they send a void record for the previously submitted encounter, then send a new initial encounter representing the corrected claim information; or, the CCOs submit an adjustment encounter for a previously submitted encounter with an adjustment indicator code and an internal control number (ICN) for the previously submitted encounter.

Table 2-2—Modification for Original Encounters and Submission for Adjusted Encounters

CCO	Modifications Made to Accommodate OHA's Encounter Data Submission Standards	CCO's Process for Transmitting Adjusted Encounters to OHA That Have Been Submitted Previously
AH	Examples of modifications: • Deleting value codes submitted on paper that are not X12 compliant. • Padding revenue codes with zero. • Patient control number replaced with internal claim number. • Taxonomy codes are mapped to providers as needed. • Duplicate ICD-10-CM diagnosis and procedure codes are removed. • Diagnosis-related group (DRG) payments on the first line are moved to the claim header. • Standalone EKG/radiology provider National Provider Identifier (NPI) replaced with clinic NPI.	An encounter data extract (which includes claims processed or reprocessed that week) is generated and uploaded to VisibilEDI, **AH**'s claims processing system. VisibilEDI submits the reprocessed claim as an original if not previously accepted by OHA. For claims that have been previously accepted, VisibilEDI will void the original encounter with a frequency code of "8" or replace the original encounter with a frequency code of "7" as needed.
AllCare	• Due to limitations on the number of transactions, the encounter data extract process requires intervention during data extraction. • Limits on the number of days to submit a file and the specific order of the claim adjustment reason codes.	For a claim that has been reversed, **AllCare** voids the original ICN associated with the claim, in the Medicaid Management Information System (MMIS) portal, after a full claim/encounter reversal is processed in the **AllCare** CCO core claims system.
CHA	No modifications.	All encounter claims that are negated or refunded and reprocessed are submitted as either a corrected claim or a void to the State. Negated claims are pulled through the normal encounter data pull process. If a claim is negated and a new claim is processed to replace original claim, the original void claim will be submitted first prior to the new reprocessed claims so it will not deny as a duplicate in the State encounter claim process and allow the new reprocessed claim to pay and reflect the correct claim data and outcome.
CPCCO	Fields are formatted to meet the 837 specifications and OHA guidelines. **CPCCO** does not make any material changes to data in its claims system.	According to OHA rules, when a correction pertains to certain key fields (e.g., member, claim form type), CCO sends a void record for the previously submitted encounter. Then, it sends a new initial encounter representing the corrected claim information. For all other

CCO	Modifications Made to Accommodate OHA's Encounter Data Submission Standards	CCO's Process for Transmitting Adjusted Encounters to OHA That Have Been Submitted Previously
		corrections, the CCO submits an adjustment encounter for a previously submitted encounter.
EOCCO	No modifications.	The CCO submits any adjustments through the standard 837, and it does not submit any adjustment encounters for duplicates, nonspecific diagnosis denials, or voids. For dental encounters, Advantage sends adjustments using the adjustment indicator processing code, while ODS will notify OHA by submitting an encounter data certification and validation report form. The CCO's pharmacy does not currently submit adjustments.
HSO	CareOregon and Kaiser do not modify their claims data, but fields are formatted to meet the 837 specifications and OHA guidelines. Since PacificSource (as the integrated data system [IDS] contracted by **HSO**) has the same data processing system as PSCS-CO, PSCS-CG, PSCS-Lane, and PSCS-MP, the list of modifications applied, are identical to the modifications listed in the PSCS-CO, PSCS-CG, PSCS-Lane, and PSCS-MP sections below. OHSU Health Services noted a pharmacy encounter file modification where it limits each B1 and B2 file to no more than 5,000 records and divides files based on plan code. Providence did not modify or reformat its claims/encounter data to accommodate OHA's encounter data submission standards.	CareOregon: According to OHA rules, when a correction pertains to certain key fields (e.g., member, claim form type), the CCO sends a void record for the previously submitted encounter. Then, it sends a new initial encounter representing the corrected claim information. For all other corrections, the CCO submits an adjustment encounter for a previously submitted encounter. For Behavioral Health (PH TECH), adjusted claims are submitted using the same process as a new claim, but instead a frequency code of "7" is used, and an ICN is included. Per Kaiser, when an encounter is pended and must be corrected but cannot be resolved via the automated process described above, a manual encounter adjustment form with remediated information for the encounter(s) in question is sent to the **HSO** encounter team, which then manually updates the encounter(s) in MMIS. For OHSU Health Services, since PacificSource (as the IDS for **HSO**) has the same data processing system as PSCS-CO, PSCS-CG, PSCS-Lane, and PSCS-MP, the description of the process for transmitting adjusted encounters is described in the PSCS-CO, PSCS-CG, PSCS-Lane, and PSCS-MP sections below.

CCO	Modifications Made to Accommodate OHA's Encounter Data Submission Standards	CCO's Process for Transmitting Adjusted Encounters to OHA That Have Been Submitted Previously
		Pharmacy claim adjustments are submitted in the encounter file when a pharmacy reverses a previously paid claim or resubmits a previously paid claim for information update. The adjustments are submitted as reversals, then submitted as a new billing, with an updated field for internal tracking. Providence submits adjusted encounters by attaching the previously submitted ICN to the adjusted encounter. Adjusted pharmacy claims are handled in MMIS.
IHN	No modifications.	Adjusted encounters are submitted via the standard claim submission process on an 837.
JCC	Fields are formatted to meet the 837 specifications and OHA guidelines. **JCC** does not make any material changes to data in its claims system.	According to OHA rules, when a correction pertains to certain key fields (e.g., member, claim form type), CCO sends a void record for the previously submitted encounter. Then, it sends a new initial encounter representing the corrected claim information. For all other corrections, the CCO submits an adjustment encounter for a previously submitted encounter.
PSCS-CO **PSCS-CG** **PSCS-Lane** **PSCS-MP**	Modifications and/or reformatting: • A process to roll up revenue code 250 service line in Facets, to prevent duplicate edits. • For different National Drug Code (NDC) codes on lines with duplicate Healthcare Common Procedure Coding System (HCPCS) codes, a 59 modifier is added to ensure MMIS does not deny the "duplicate." • PacificSource updates billing provider information billed on claims for Federally Qualified Health Centers (FQHCs) that have multiple locations. • PacificSource removes "duplicate" inpatient ICD-10-CM procedure codes performed on different dates of service	PacificSource works its *Failed Adjustment* report to ensure that the information in its system matches MMIS. The process for submitting adjustments is as follows: • In Facets, the original claim ends in "00." When a claim is adjusted in PacificSource's system, a "new" claim is created ending in "01." • Every week, all adjudicated claims are extracted and loaded into the Edifecs Encounter Module. • The adjusted claim/encounter ("01") overrides the original ("00") in the Encounter Module and takes the ICN from the original ("00") claim for the REF F8 segment in the adjusted claim. • Encounters are batched and pulled into electronic data file and submit to the State.

CCO	Modifications Made to Accommodate OHA's Encounter Data Submission Standards	CCO's Process for Transmitting Adjusted Encounters to OHA That Have Been Submitted Previously
	• PacificSource removes the "Onset Illness Injury" date from professional encounters if it is the same as the date of service. • PacificSource has a system limitation where encounters for members who have three payers error out, which had to be modified in order for claims to be submitted. • PacificSource removes the service facility NPI if a provider bills with a service facility NPI and address that are the same as the billing provider NPI. • If a provider bills zero units and/or zero dollars, a value of one unit and/or $0.01 is added for encounter purposes.	• The encounters are loaded to the State system, and the "01" claim finds the "00" claim in MMIS by using the ICN from the REF*F8 segment.
TCHP	No modifications.	The CCO references the claim reference number (CRN) of the previously submitted claim in the REF*F8 segment of the latest version of the claim as a replacement (void if approved by OHA).
UHA	No modifications.	Adjusted claims are submitted using the same process as a new claim, but instead use a frequency code of "7" and an ICN is included.
YCCO	No modifications.	Adjusted claims are submitted using the same process as a new claim, but instead use a frequency code of "7" and an ICN is included.

Based on OHA's questionnaire response, all CCOs and/or the CCOs' subcontractors submit dental, professional, and institutional encounters in the 837D, 837P, and 837I format, respectively, via Edifecs translator editing prior to reaching MMIS. MMIS then edits after acceptance, wherein the Edifecs translator editing rejects claims that do not meet compliance requirements of the transactions and validity of code sets. Each week, MMIS produces a submission report that lists all encounters submitted; an OHA encounter data liaison reconciles the report with the submission certification form submitted by each plan. OHA then sends the results of the reconciliation as a CCV to the plan's claims contact. Four times daily, the EDI system audits all claims received to ensure that they conform to program policy; creates an electronic remittance advice 835(which lists all encounter claims paid, denied, or denied requiring correction); and delivers the 835 to Oregon MMIS Trading Partner mailboxes. OHA also sends a weekly status file that identifies encounter claims with a pended status. Additionally, OHA provides files or feedback to CCOs submitting through a technical acknowledgement (TA1) (if the file is fully rejected) or a 999 response acknowledging receipt of the file. Following processing, the CCO receives an 835 and several other reports (e.g., status file, error reports, etc.) regarding processing of

data received. Of note, MMIS processes all claims in real time, but the actual financial cycle occurs weekly. All encounter claims are available for review on the Web portal in real time.

Collection, Use, and Submission of Provider Data

OHA uses the information from fee-for-service (FFS) providers (which CCOs use) received from the Provider Enrollment Unit (PEU) team. For CCO-only providers, the CCO requests enrollment through the Web portal following their credentialing. The provider enrollment specialist then checks all exclusions, tax ID number, license, etc., and processes the enrollment request. The validation and revalidation of provider data is a manual process, where a full revalidation of enrollment is performed once every five years. Encounter data submitted by the CCOs are checked to determine if the providers on the claim are actively enrolled into MMIS for the date(s) of service.

All CCOs and their respective subcontractors collect and maintain their respective CCO provider data. Initial provider data are captured through the provider application/credentialing/contracting process. The vendors or CCOs conduct ongoing maintenance of the provider data. For example, **EOCCO** requires providers to submit changes by using a provider roster and/or emailing or calling **EOCCO** to report changes, and the roster is run through a comparison tool to identify changes that need to be made.

All CCOs indicated that they verify whether the provider information on the claims/encounters matches the CCOs' provider data. The CCOs noted that claims are pended within their systems for review prior to processing when resolving data discrepancies. The CCOs responded with their individual processes for linking provider data to claims and encounters.

When submitting provider data to OHA, all CCOs, except for **AH**, make no modifications to their provider data. **AH** noted, however, that generally, provider information does not require modification to comply with OHA's provider data submission requirements. One exception is that for some providers (typically facilities), VisibilEDI maintains a taxonomy crosswalk that allows encounters to be associated with the appropriate Oregon Medicaid ID. To resolve providers that may be assigned multiple IDs by OHA, VisibilEDI will submit the appropriate taxonomy to OHA based on the type of claim (Professional or Institutional).

Collection, Use, and Submission of Enrollment Data

In its questionnaire response, OHA indicated that Medicaid individual and eligibility data are captured and stored in the Oregon Eligibility (ONE) system. The ONE system Worker Portal and Applicant Portal have various on-screen and backend validation functionalities to prevent missing or incongruent information. The ONE system also triggers electronic verification interfaces as the user navigates through data collection; if client-attested information is discrepant with verification sources, applicants are requested to provide verification. Once validation is complete and eligibility is determined, Medicaid enrollments are captured and validated in the Systems of Record and Maintenance for Member Eligibility and Enrollment database. MMIS receives information from these systems, where the feed/file is validated for layout compliance; however, the content of each Medicaid eligibility and enrollment

record is assumed to be accurate. Subject matter experts representing MMIS, the Office of Business Information Services, the Claims and Encounter Unit, the Delivery Systems Support Unit, Medicaid/CHIP eligibility policy, and Client Enrollment Services work closely with OHA's partners from Deloitte, the contractor with whom Oregon is working on development and maintenance of the ONE system. This collaboration includes system data matching, analysis of anomalies and discrepancies, and end-to-end planning and testing for system code and data fixes when needed. Daily, OHA sends the X12 834 files to the CCOs with any changes from the previous day. Once a month, an audit file of full enrollment records is sent for reconciliation. OHA receives daily updates from source systems and weekly auto-assignment changes as well.

All CCOs and their respective subcontractors collect and maintain their respective CCO enrollment data. As described previously, all enrollment data come directly from OHA in the form of an X12 834 enrollment file daily. In general, the CCOs download and process the 834 enrollment files into their core systems. The CCOs also transmit the enrollment files to their subcontractors, and similarly, the subcontractors load the data into their claims systems. The CCOs also describe in their responses that the information regarding the enrollment, such as addition, termination, and reinstatement records, are processed and verified against MMIS, and any discrepancies are reviewed and resolved, or the claims will not be submitted as an encounter to OHA. The CCOs also use the monthly audit file to ensure that member information is updated and that no discrepancies exit.

Data Exchange Policies and Procedures

The CCOs' encounter data implementation process begins with reviewing contractual requirements and data submission requirements, such as companion guides and OHA-specific edits. In general, all CCOs prepare their file submissions based on OHA's guidelines.

Table 2-3 shows a list of policy and procedure documents, as well as the encounter data flow documents that were submitted by each CCO to HSAG as supporting documentation with the completed questionnaires. The policy and procedure documents show that the CCOs employ encounter file generation and review processes that have been tailored to meet OHA's encounter submission contractual requirements and specifications.

Table 2-3—Encounter Data Work Flow and Policy and Procedure Supporting Documents

CCO	Encounter Data Work Flow and Policy and Procedure Documents
AH	• Encounter Data Policies and Procedures – Signed • Encounter Data Submission & Monitoring Process Flow
AllCare	• Weekly Encounter Data Submission Log • Weekly Encounter Data Submission Report • Sample CCO Claims and Encounters Completeness Monitoring • CLM-ALCR-0049 Encounter Data Validation Policy • AllCare Health Medicaid Medical Encounter Data Flow Diagram • AllCare Health Medicaid Dental Encounter Data Flow Diagram • AllCare Health Medicaid Pharmacy Encounter Data Flow Diagram

CCO	Encounter Data Work Flow and Policy and Procedure Documents
CHA	• Encounter Claims That Reject State Translator Process • Encounter Data Pend Process • Encounter Data Submission (Non-Pharmacy) Process • Pharmacy Encounter Data Submission and Control Total Process • Working Encounter 835 File Process • Working Encounter Status File Process
CPCCO	• CPCCO Encounter Data Submission Policy and Procedure • Columbia Pacific Encounter Data Reconciliation • Columbia Pacific Pharmacy Encounter Data Reconciliation • CPCCO VSP Encounter Data Reconciliation
EOCCO	• EOCCO Encounter Data Policy • EOCCO Encounters Data Workflow V3.2
HSO	• Health Share-CareOregon Encounter Submission Policy and Procedure • Medicaid Encounter Data Policy • OHSU Health Services Encounter Data Policy • OHSU-IDS Medical Data Flow V1.2 • CL 10.0 OHP Medical Encounter Data • Note: 1) Providence also provider a description of the pharmacy encounter data submission policy and procedure and 2)Kaiser did not include a policy and procedure supporting documentation, but included a description of the encounter data process
IHN	• RE-15 IHN Encounter Data Management Policy • SP3.5.3 _DCO Encounter Data Management • RE-65 Pharmacy Encounter Data Management
JCC	• JCC Encounter Data Submission Policy and Procedure • Jackson Care Connect Encounter Data Reconciliation • Jackson Care Connect Pharmacy Encounter Data Reconciliation • JCC VSP Encounter Data Reconciliation.
PSCS-CO **PSCS-CG** **PSCS-Lane** **PSCS-MP**	• Medicaid Encounter Data Policy • Note: 1) PacificSource provided description of the encounter data submission process and 2) • MedicaidEDV2020 document containing a screen print of the daily number reports
TCHP	• Trillium Community Health Plan Encounters Policy and Procedures
UHA	• CA1 – Health Information System Management • CA2 – Encounter Data Submission and Validation • Internally Processed Encounter Data Submission Process • Encounter Only Submission Process Map
YCCO	• Internally Processed Encounter Data Submission Process • Encounter Only Submission Process Map

Management of Encounter Data: Collection, Storage, and Processing

The OHA-approved questionnaire elements in this section focused primarily on the CCOs' collection of payment-related data.

Pricing Methodology

Table 2-4 shows the CCOs' pricing methodology for outpatient, inpatient, and pharmacy encounters. Since the encounter data submission does not include a payment methodology field, some variation in pricing methodology exists among the CCOs. For outpatient encounters, nearly all of the CCOs use percent billed methodology as one of their claim payment strategies. While this methodology is used by almost all CCOs for outpatient encounters, other methods such as line by line, fee schedule, capitated, and CMS Outpatient Prospective Payment System (OPPS) rules are also employed by various CCOs. For inpatient encounters, nearly all CCOs use the DRG or percent billed methodology for pricing. Almost all CCOs employ similar claims payment strategies for pharmacy claims, where in general, CCOs use negotiated rates (based on ingredient costs and administrative/dispensing fees) methodology to price pharmacy claims.

Table 2-4—Pricing Methodology

CCO	Outpatient	Inpatient	Pharmacy
AH	- Line by line - Per diem - Percent of billed - Capitation	- DRG - Percent of billed - Capitation	Contract rates based on ingredient costs and administrative/dispensing fees
AllCare	- DRG - Percent of billed	- DRG - Percent of billed	Negotiated rates based on percentage of medication cost plus a flat fill rate
CHA	- Line by line - Percent of billed	- DRG - Percent of billed	Negotiated rates based on ingredient cost and dispensing fee
CPCCO	- Ambulatory payment classifications (APCs) - Fee schedule - Percent of charge	- DRG - Percent of charge - Per diem	- For specialty and brand drugs—negotiated rates - For generic drugs—maximum allowable cost (MAC) list used for all pharmacies or usual and customary (U&C) price, whichever is lower
EOCCO	- Case rate - COB - Fee schedule - OPPS - Per diem - Percent of charge	- Case rate - COB - DRG - Per diem - Percent of charge	Negotiated rates based on ingredient cost and discounts according to the participating pharmacy's contract with the pharmacy benefit manager (PBM)

CCO	Outpatient	Inpatient	Pharmacy
HSO	• CareOregon: APC, fee schedule, percent of charge • Kaiser: OPPS, percent of billed, contracted bill • Legacy Health: 80% of CMS, percent of invoice, percent of billed, per member per month (PMPM), capitation, Patient Centered Primary Care Home (PCPCH), or behavioral health integration (BHI) • OHSU Health Services: Percent of billed, per diem, fee schedule, OPPS, subcapitation, or coordination of benefits (COB) • Providence: OPPS or contracted rate	• CareOregon: DRG, percent of charge, per diem • Kaiser: Inpatient Prospective Payment System (IPPS), DRG, Percent of billed • Legacy Health: DRG, percent of OHA rates • OHSU Health Services: DRG, percent of billed, per diem, COB, case rate • Providence: Percent of Medicare DRG, contracted allowable	• CareOregon: negotiated rate, MAC list, or U&C. • Kaiser: national prescription drug fee schedule. • Legacy Health: negotiated rate or U&C • OHSU Health Services: contracted discounted rate • Providence: negotiated rate
IHN	• OPPS • Fee schedules (Medicaid, custom, or DMEPOS [durable medical equipment, prosthetics, orthotics, and supplies]) • Contract rates • Capitation	• IPPS • DRG • Critical Access Hospital (CAH) payment methodology	• Negotiated rates
JCC	• APC • Fee schedule • Percent of charge	• DRG • Percent of charge • Per diem	• For specialty and brand drugs: negotiated rates • For generic drugs: MAC list used for all pharmacies or U&C, whichever is lower
PSCS-CO **PSCS-CG** **PSCS-Lane** **PSCS-MP**	• 80 percent of CMS • Fee for service • Percent of OHA, invoice, or billed • PMPM • Capitation • PCPH (tier and tier plus program) • Behavioral health integration	• DRG • Percent of OHA rates	• Negotiated rates • U&C

CCO	Outpatient	Inpatient	Pharmacy
TCHP	• Percent of Medicare (OPPS) • Percent of billed	• Per diem • Percent of CMS DRG (IPPS) • Percent of billed charge	Percent of claims dollars per: • Pharmacy type: drug pricing • Retail brand and percent discount off average wholesale price (AWP) • Specialty brand percent discount off AWP • Mail order percent discount off AWP • Vaccines 100 percent pass-through
UHA	• Percent of billed • Percent of Medicare (OPPS) • Subcapitated	• Percent of billed • Percent of Medicare DRG (IPPS) • Subcapitated	• Contracted rates based on ingredient costs and administrative or dispensing fees
YCCO	• Percent of billed • CMS OPPS rules • Capitated	• Percent of billed • CMS DRG IPPS pricing rules	• Negotiated rates

CCOs were asked if there are any services submitted to the CCO under bundle-payment structures. Three CCOs (**CHA**, **IHN**, and **TCHP**) noted that there are no services submitted under bundle-payment structures. All other CCOs indicated that there are services submitted under bundle-payment structures and described the services as follows:

- **AH**: The bundle-payments are either a result of National Correct Coding Initiative (NCCI) edits or services performed within the global period of another procedure. Prenatal care is also generally bundled into the maternity package.

- **AllCare**: The bundle-payment methodology is used through IPPS and OPPS.

- **CPCCO**, **EOCCO**, **JCC**, and **YCCO**: Global maternity services are the only claims that are considered as a bundled-payment.

- **HSO**: CareOregon and OHSU Health Services noted that only maternity services are under a bundle-payment structure, while Kaiser does not have any such services. Legacy Health considers services as a bundle-payment structure based on DRG, labor and delivery, and APCs, while Providence considers transplant and maternity services as bundle-payments.

- **PSCS-CO**, **PSCS-CG**, **PSCS-Lane**, **PSCS-MP**: Services submitted under bundle-payment structures include inpatient claims that are paid based on the DRG, labor and delivery from the professional claims, and outpatient claims that are classified under APCs.

- **UHA**: The types of services submitted under bundle-payment structures include APCs, maternity, OPPS, IPPS, and case rates for hospitalists.

Third Party Liability (TPL)

All CCOs collect TPL data for their managed care members, although information is processed at different points in their adjudication processes. TPL management is described for each CCO below:

- **AH**: **AH** created a dedicated email address to facilitate the collection of TPL data (i.e., either to report additional insurance or to report situations where a third party may be liable). The information is stored within the core claims adjudication system and reported to the health information group. Additionally, providers frequently submit an explanation of benefits (EOB) for primary payers. Lastly, the 834 files from OHA contain information on TPL or COB. **AH** is the payer of last resort.

- **AllCare**: Other insurance data are collected by means of an attached EOB with the claim/encounter or by primary information as indicated on the CMS 1500 or UB04. **AllCare** claims support services reviews the member in its core system to determine if it has the information regarding the other insurance or third party TPL listed; if not, the information will be updated. Claims/encounters are then processed based on the presented documentation as secondary. If documentation supporting other insurance is presented with no payment from the other insurer, the claim/encounter is denied until all appeals have been exhausted. **AllCare** is the payer of last resort.

- **CHA**: **CHA** collects TPL data from various sources, including the 834 eligibility file, the 837 claims file, paper claims, member contact, provider or billing office contacts, the Reliance data collection system, MMIS, and its PBM. **CHA** runs daily reports on every 834 and 837 file that is loaded into Plexis and validated against the member record to ensure **CHA** has the primary insurance loaded with accurate effective dates. Claims with TPL are processed with the TPL payment at each service line. Other insurance is stored at the member record level and at the claim detail level. Once a member is identified as having other insurance, it is validated and added to the member record. Claim history is pulled to identify any claims that were not processed in coordination with the primary payer; these claims would be negated and denied for needing prime explanation of benefits.

- **CPCCO** and **JCC**: Any employee, subcontractor, provider, intern, or volunteer that becomes aware of other insurance coverages collects all initial data about the coverage and forwards it to the CCO for investigation. The CCO follows the pay and pursue (also known as pay and chase) methodology for accidents due to the need for timely medical services and payments. The CCO pays claims where TPL may not yet be resolved, and the CCO's subrogation vendor will work to recover these payments for which another person or entity may be responsible. If the subrogation vendor's investigation determines another person or entity was responsible for the accident, the subrogation vendor will work with the member, member's attorney, and providers to resolve the TPL.

- **EOCCO**: To collect other insurance and TPL data, **EOCCO** staff members use the COB information provided by OHA to look for other coverage. **EOCCO** uses a vendor that scrubs the payment files to search for claims paid as primary for other coverage, and when found, claims are corrected in the system. ADS collects other insurance information from the member, while ODS uses the claim form to collect other insurance information, where providers are required to collect and submit all TPL data, on the 837 files. If claims are received with TPL payment information, **EOCCO** processes the claim as secondary. **EOCCO** stores all TPL allowed and paid amounts in its processing record of a claim. **EOCCO** also captures and stores other carriers' allowed and paid

amounts and submits them as part of the encounter to OHA, regardless of whether payment is made by **EOCCO**.

- **HSO**: **HSO**'s plan partners collect TPL and other insurance data through various sources, including employees, subcontractors, providers, contacting members by phone or in person, member claims, COB information from OHA, and internal reports.

- **IHN**: Other insurance, TPL, and COB information are collected through a variety of methodologies. Claims requiring COB or TPL manual processing are routed via Facets to the appropriate COB or TPL claims analyst for verification and processing. **IHN** also sends out an annual other coverage questionnaire to check on any possible changes in members' coverage. All responses are tracked and maintained in **IHN**'s claims processing system, Facets. Additionally, providers are required to submit both COB and TPL data with their claims. When processing claims where there is another carrier considered primary for **IHN**'s members, **IHN** coordinates benefits in-house at the time of claim adjudication; its system has the ability to adjudicate using the other plan's allowable amounts, tracks member cost share on both plans, accommodates multiple COB plan types, and tracks other coverage eligibility changes. For TPL claims, to investigate information received on a claim or correspondence, **IHN** follows the deny and pursue methodology.

- **PSCS-CO**, **PSCS-CG**, **PSCS-Lane**, **PSCS-MP**: Other insurance coverage is collected and tracked through various sources, including member applications (through which enrollment information is received electronically from OHA), member phone calls, provider calls, member claims that come in from providers, internal reports that match names and dates of birth of members for review by an analyst to verify if the member is the same and would be double covered on any PacificSource plan, and from the subcontractor (i.e., Optum). **PSCS** uses Transaction Manager to verify the accuracy of electronic claim source data (including Medicare crossover and other third-party claims information), and the hard copy of a submitted claim to verify the accuracy of submitted paper claims. All payment information is stored in Facets. **PSCS** stores primary payment information in its system within the Medicaid secondary claim. Encounters are sent to OHA with primary payment information (e.g., Medicare paid has other adjustment (OA) value of 23) and an allowable adjustment reason code of 45 for any remaining balance over Medicaid allowable that **PSCS** does not pay.

- **TCHP**: TPL data are collected from OHA's daily 834 file, a vendor biweekly other insurance coverage (OIC) file, Utilization Management, providers, member telecommunication, and claims data. Claims with TPL data are first identified through preadjudication and placed into AMISYS, where COB calculations are built into a configuration in processing the primary payment and allowing for **TCHP** to pay secondary. If the system is unable to finalize, the claim will pend for manual review and processing will be completed manually following the State COB guidelines for payment. If a claim is denied requesting a primary insurance EOB, the provider will resubmit, allowing for the claim be reprocessed as secondary.

- **UHA**: **UHA** requires its subcontractors to collect TPL data. **UHA** uses a robust Third Party Recovery (TPR) Department through which other insurance is collected and then stored in the claims adjudication database. **UHA** pulls the 834 COB information from the Third-Party Administrator's (TPA's) secure FTP. The 834 COB information is processed, and any case not reflecting an effective date is considered a new investigation. Claims received with a COB record are pended for manual

review of member notes and the requirement of COB. The accuracy of the COB information in all **UHA** secondary payer claims (including Medicare crossover) is determined by the claims analyst and pended for manual adjudication and/or review. The COB data are stored in the claim, as they are used to adjudicate the claim for payment.

- **YCCO**: **YCCO** uses PH TECH as its subcontracted vendor to collect TPL data. Information is gathered from the 834 file, member and provider phone calls, attorney case notification, and claims payments with primary payment noted. PH TECH also uses Health Management Systems (HMS), which recovers payment from primary payers that were never billed, recoups payment for **YCCO**, and shares the primary payer information with PH TECH. Information such as effective dates, termination dates, etc., is gathered by enrollment staff members and loaded into Community Integration Manager (CIM) in order for the claims to be paid in the required order or denied if other coverage is present. These data are exported to the PBM, where prescriptions are also paid in the proper order using all available primary insurance first.

Management of Encounter Data Submitted to OHA

OHA's MMIS team collaborates with its EDI vendor, Edifecs, to collect and process all X12 transaction files as well as the NCPDP D.0 national standard transaction. All Medicaid encounter claims are put through translator edits to determine validity of the data and to verify that transactions meet the X12 formatting standards prior to delivering encounter data to OHA's MMIS. OHA notes that there are several processes that transfer data from the main MMIS database into the Decision Support, Surveillance and Utilization Review (DSSUR) system. Each of the processes have different purposes and schedules:

- Weekend cycles to refresh the database warehouse with the most current information from MMIS, including adjudicated claims, capitation payments, and other financial transactions
- Daily eligibility extracts

There are also additional processes that transfer data from the MMIS and DSSUR databases into the Management and Administrative Reporting (MAR) database, where each of the processes has different purposes and schedules:

- Transformed Medicaid Statistical Information System (T-MSIS) Monthly cycle, which transfers data from DSSUR to the MAR database
- Monthly MAR cycle, which transfers data from DSSUR and MMIS to the MAR database

Edifecs and MMIS have edits in place to ensure required fields such as member ID and provider ID are provided for a record to be processed. Additionally, there are system reports that are created to review duplicates (based on MMIS edits), which are communicated and reviewed with each impacted CCO. For missing encounters, OHA noted in its response that it has created a system tracker that reviews every file received in the translator and shows whether the files were fully successful, partially successful, or a full fail. CCOs are required to provide an explanation of what occurred when there is an out-of-balance file and to track the correction through to completion.

When processing CCOs' encounter data submissions, OHA noted that it does not modify or reformat any data elements.

Encounter Data Quality Monitoring and Reporting

According to the OHA-approved CCO questionnaire elements, CCO responses in this section addressed the following concepts:

1. Monitoring the accuracy and completeness of claims and encounter data received from providers and vendors
2. Monitoring the status of encounter data submitted to OHA

Monitoring Metrics for Encounter Data From Vendors/Subcontractors

To submit accurate, complete, and timely encounter data to OHA, CCOs must ensure oversight of data submitted by their vendors or subcontractors. Therefore, the CCOs responded to the questionnaires with descriptions of how they monitor completeness, accuracy, and timeliness of claims and encounter data submitted by their vendors or subcontractors. In addition to the business rule edits and Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance checks executed by their claims processing systems, the CCOs conduct the following activities:

- **AH**: For completeness, while ADS does not submit claims to **AH** for payment, it provides **AH** with copies of the 837 files submitted to OHA; **AH** parses these files into a database, and utilization is analyzed quarterly. All other vendors submit claims directly to **AH**, and they are reviewed and adjudicated as part of the weekly claims payment cycle. Additionally, as part of the Post Payment Integrity policy and procedure, **AH** uses a standardized scoring tool, the Chart Audit Review Form, for all claims/audit documentation review to verify the appropriateness of service(s) provided to members and the accuracy of billing/coding for reimbursement. For timeliness, MedImpact and ADS submit encounters to **AH** every two weeks and weekly, respectively.

- **AllCare**: To ensure the completeness of claims/encounter data, PH TECH monitors daily claim imports, as well as the source, the count, and rejected claims/encounters based on multiple internal reports. **AllCare** also conducts annual dental care organization (DCO) audits based on claims that are pulled randomly from PH TECH and reviewed against dental data. For MedImpact, **AllCare** performs a full program audit each year to ensure that MedImpact is meeting contract expectations. Timeliness is monitored based on review of the daily timely claims monitoring report.

- **CHA**: To monitor encounter data accuracy and completeness, **CHA** validates the claim count and amount billed based on the State submission tracker and the CCV reports. **CHA** also contracts with Pareto, which compares a claims file extract from the claim system with the NCPDP response files. For timeliness, **CHA** monitors its PBM's payment cycles, where the PBM pays biweekly. **CHA** also monitors the new reporting in the NCPDP response file to ensure that its pharmacy claims are being reported 45 days from the paid date.

- **CPCCO** and **JCC**: To monitor completeness of encounter data submitted by a vendor or subcontractor, the CCOs compare the all payer all claims (APAC)-formatted claim file against the 837s received from their subcontractors, while for accuracy, the CCOs review OHA's weekly claim data issue reports, which identify duplicate encounters, provider enrollment issues, and mismatched claim data, with its subcontractors, including a request for resolution. For timeliness, CCO monitors the 45 Days from Date of Adjudication Report, issued by OHA monthly, for the count/threshold of CCO claims submitted outside 45 days from date of adjudication.

- **EOCCO**: To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **EOCCO** staff members (from various divisions) review all aspects of the encounter data to ensure they meet contractual obligations. **EOCCO** uses a monthly tracking sheet, which includes information such as claim type, submitter, number of encounters submitted, date of submission, and dollar amount of each submission. The monthly tracking sheet is used to monitor the encounters sent to the Health Systems Division, which reconciles, and verifies that **EOCCO** encounters are being sent, received, and submitted to comply with contractual requirements.

- **HSO**: **HSO** uses two methods to determine the completeness of encounter submission: 1) using the unencountered claim report, which identifies risk assuming entity (RAE) claims that have not been encountered to OHA, and 2) evaluating each monthly submission (claims, members, payments) against the most recent verified submissions to ensure that no unexpected shifts have occurred. CareOregon compares the APAC formatted claim file against 837 files received from its subcontractors. For accuracy, **HSO** uses the files each RAE submitted to OHA for validation and reporting and reconciles to OHA's CCV. CareOregon reviews the weekly claim data issue reports that identify duplicate encounter data records. To ensure timeliness, **HSO** uses OHA's pended encounter report to monitor whether encounter data are being submitted timely for adjudication, while CareOregon issues a 45 days from date of adjudication report to monitor the count and threshold of CCO claims submitted outside 45 days from adjudication.

- **IHN**: **IHN**'s dental encounter data submission completeness is ensured by routinely monitoring weekly submission counts and State acceptance rates by identifying any gaps or anomalies. **IHN**'s encounter data specialists monitor the validity of the pharmacy encounter data submitted by its PBM (Optum), by requiring that the PBM submit attestations that the data are complete and accurate.

  IHN's dental encounter data submission accuracy is ensured by routinely monitoring weekly submission counts and state acceptance rates, as well as any EDI translator rejections or MMIS pends. If more than 5 percent of dental 837s are rejected in the EDI translator, a formal response is required from the DCO. **IHN** also performs a quarterly EDV audit for dental data against chart records. For pharmacy claims accuracy is ensured by routinely monitoring the weekly submission counts and State acceptance rates by identifying any gaps or anomalies.

  IHN's dental encounter data submission timeliness is ensured by routinely monitoring the weekly submission counts to ensure the 837 files are submitted at least biweekly. Additional completeness, accuracy, and timeliness monitoring of the dental encounter submission is performed through oversight and monitoring of DCOs' policies. To ensure that the pharmacy encounter data submission is timely, the PBM must submit at least 50 percent of all pharmacy claims received and adjudicated by **IHN** during that calendar month.

- **PSCS-CO**, **PSCS-CG**, **PSCS-Lane**, and **PSCS-MP**: For completeness, PacificSource uses the claim verification form (CVF) with claim counts and billed amounts received from all subcontractors when they submit their encounters to PacificSource, while for accuracy, PacificSource uses the pharmacy rejected encounter report as well as the pended encounters report received from OHA. For timeliness, PacificSource maintains internal reporting that supplies the percentage of encounters submitted within 45 days after adjudication for any given week. PacificSource also reviews reports received from the DCOs with monthly trends to determine if the service claims met various metric criteria. To monitor its PBM's timeliness in submitting the pharmacy encounter data, PacificSource uses the OHA report that supplies the number of encounters received within a specific time frame.

- **TCHP**: To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **TCHP** indicated that its subcontracted vendors that receive and adjudicate claims from providers on behalf of OHA programs are contractually obligated to submit encounter data to **TCHP** in accordance with OHA requirements.

- **UHA**: To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **UHA** reviews data submission and utilization trends. Additionally, accuracy is determined by prospective audits in the form of adjudication edits applied to claims to ensure processing in accordance with specified guidelines. Accuracy and completeness are also determined by chart audit to ensure that diagnosis codes and procedure codes billed on a claim are complete and accurate. **UHA** uses the payment date and the stated date of receipt to calculate the timeliness of claim submissions.

- **YCCO**: **YCCO** receives copies of all 837 files that are submitted to OHA for monitoring of completeness. For pharmacy claims, a weekly retrospective comparison is performed to ensure that all paid claims are included in the pharmacy encounter data files. Encounter data accuracy and timeliness are monitored through transparency reports and service level agreement reporting, as well as the CCO's EDV process. For pharmacy, all claims and billed amounts in the encounter file are tallied when submitted to OHA.

Monitoring Metrics for Encounter Data From Providers

The completeness and accuracy of claims data submitted from providers and clearinghouses are generally verified through data validation checks that are incorporated into the CCOs and/or their vendors'/subcontractors' processes. These validation checks verify that claims data are not missing values for vital fields and that missing values are reasonable (e.g., valid ICD-10-CM diagnosis codes or valid NPI values). Additionally, these checks verify HIPAA compliance and that claims data meet OHA's specifications for 837D/P/I or NCPDP D.0 transactions.

- **AH**: Beyond the normal claims review process that occurs weekly prior to payment, **AH** engages in postpayment activities to monitor the accuracy of claims and encounter data. It sends a monthly survey letter to a random sampling of members based on claims data to verify that services were performed. Additionally, a random sampling of charts is requested from providers/vendors for auditing purposes. **AH** monitors completeness through the Low and Zero Paid Claim Monitoring

Dashboard and general utilization monitoring across the network to ensure that weekly submissions are in line with expectations from both a payment and volume perspective. For timeliness, **AH** imposes timely filing requirements on providers to ensure that claims are submitted timely, and claims submitted untimely are generally denied.

- **AllCare**: To further assess claims accuracy, **AllCare** performs audits by comparing chart documentation to the submitted encounters and claims. **AllCare** also engages with Moss Adams to perform annual audits of **AllCare**'s claim pricing and processing accuracy that ties back to contract language. Completeness of claims and encounter data is monitored by a monthly report measuring the volume of claims submitted by each contracted vendor. For timeliness, **AllCare** reviews the Daily Timely Claims Monitoring report to ensure that each claim met the criteria specified in the report.

- **CHA**: In addition to the validation checks that are routinely conducted, **CHA** also verifies the accuracy of claims and encounter data through provider audits by comparing chart documentation to the submitted claims and encounters. **CHA** also sends a letter to its members to ensure that members received the services that the provider is billing **CHA** for. For completeness, **CHA** has developed an internal policy and procedure document that establishes standards to ensure that all claims are received; the expected number of claims/encounter is calculated based on the number of claims received in the past. Lastly, for timeliness, **CHA** uses the completeness of claims monitoring report. If the report shows that **CHA**'s number of submitted claim is lower than normal, it would request that the report to be drilled down to the vendor level to see which providers are not submitting claims.

- **CPCCO** and **JCC**: The CCOs have policies and procedures in place to monitor the accuracy, completeness, and timeliness of claims and encounter data submitted by providers. For accuracy and completeness, if claims are submitted with missing, incomplete, or invalid fields, QNXT denies the claims and generates a message that will be communicated on the provider's remittance advice. Encounter data are also monitored for accuracy through various reporting methods. Timeliness of claims data is assessed based on timely filing expectations as outlined in the provider handbook and contracts.

- **EOCCO**: To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by providers, **EOCCO** follows a process in which it identifies, monitors, reports, resolves, and adjusts or rejects encounters. In monitoring the encounter data, **EOCCO** staff members (from various divisions) review all aspects of the encounter data to ensure they meet contractual obligations. **EOCCO** uses a monthly tracking sheet, which includes information such as claim type, submitter, number of encounters submitted, the date of submission, and dollar amount of each submission. The monthly tracking sheet is used to monitor the encounters sent to the Health Systems Division, reconcile, and verify that **EOCCO**'s encounters are being sent, received, and submitted to comply with contractual requirements.

- **HSO**: **HSO**'s plan partners monitor accuracy and completeness through various methods, such as checking for missing or invalid fields, monitoring rejections and pends based on reports, weekly monitoring of encounter volume trends, and chart reviews. Timeliness of claims data is assessed based on timely filing expectations as stipulated in the provider handbook and contracts; timeliness is calculated based on the claim date of service and the date it was received.

- **IHN**: Aside from routine HIPAA compliance requirements verification, through both its EDI clearinghouse and Facets, **IHN** uses Optum Clinical Edit System (CES) for coding validation, where incomplete claims are returned to providers for correction and resubmission. Claims are monitored for accuracy through a weekly claims audit, a random monthly audit, and focused audits. Additionally**, IHN**'s encounter data team also maintains dashboards that focus on encounter data completeness, inaccuracies, and timeliness.

- **PSCS-CO**, **PSCS-CG**, **PSCS-Lane**, and **PSCS-MP**: To monitor accuracy and completeness, PacificSource routinely conducts a provider audit, which includes a review of clinical documentation within the provider record against submitted claims and encounter data. PacificSource also uses an internal State-provided reporting mechanism to monitor accuracy, completeness, and timeliness.

- **TCHP**: **TCHP** generates monthly lag reports to track its overall completeness by both a claim's date of service and the claim's adjudication date. **TCHP** has also developed a report and dashboard to track and monitor accuracy and timeliness. The dashboard includes information such as paid claims, target quantity, claims submitted, claims not submitted with time expired and time remaining, and timely percentage.

- **UHA**: **UHA** monitors its claims and encounter data completeness, accuracy, and timeliness with prospective payment/adjudication edits and retrospective payment audits. The completeness, accuracy, and timeliness of encounter data submitted by providers is determined by reviewing various reports.

- **YCCO**: To ensure accuracy, completeness, and timeliness of data submitted by the providers, **YCCO** uses consistent and reliable data sources from its data warehouse tables, an analytic performance tracking system, and performance measure chart review.

Monitoring Metrics for Encounter Data From CCOs to OHA

All CCOs have processes both to track encounters sent to OHA and then process the response files back from OHA so that CCOs can monitor the rejections/pends and handle the corrections and resubmissions, if necessary. All CCOs process the following files:

- 999—Used to determine if a file was received and accepted into OHA's EDI translator
- 835—Claims payment/remittance file, used to ensure what was submitted, and if it was successfully processed by OHA
- Status file—Used to determine pended claims and ensure that the pended claims are corrected
- NCPDP response file—Used to identify issues with the NCPDP file submission

Although OHA does not actively track encounter rejection rates, CCOs do assess and report the average percentage of rejected encounters, as shown in Table 2-5. In general, average rejection rates for claims either rejected by OHA's EDI translator or by OHA's MMIS are less than 1 percent, with a few exceptions.

Table 2-5—Encounter Rejection Rates by CCOs

CCO	Average Rejection Rate for Encounters That Were Rejected by OHA's EDI Translator	Average Rejection Rate that Passed OHA's EDI Translator but Rejected by OHA's MMIS
AH	0.1525%	0.1859%
AllCare	<1.0%	<1.5%
CHA	1.1%	0.17%
CPCCO	0.05%	0.2%
EOCCO	3.86%	0.46%
HSO	CareOregon: 0.02% Kaiser: 0.0% Legacy Health: 0.001% OHSU Health Services: 0.064% and <0.3% for pharmacy Providence: 0.27% and <1.0% for pharmacy	CareOregon: 0.11% Kaiser: <0.1% Legacy Health: 0.02% OHSU Health Services: 0.985% Providence: 0.79%
IHN	1.6755%	0.285%
JCC	0.02%	0.04%
PSCS-CO	0.06%	0.03%
PSCS-CG	0.02%	0.01%
PSCS-Lane	0.02%	0.50%
PSCS-MP	0.08%	0.21%
TCHP	<0.5%	<1.0%
UHA	Not provided	0.05%
YCCO	<1.0%	0.13%

In response to describing how the encounter data system and data warehouse are used, the CCOs noted the following:

- **AH**: The analytics department uses the encounter data for quality reporting, decision support, contract evaluation, value-based payment design/rate-setting, financial analysis, State-mandated reporting, and other reporting tasks.

- **AllCare**: Generation of claims- and encounter-based reports for tracking, monitoring, and identifying trends, anomalies, and member-specific needs. Examples include: alternative payment models (APMs), gaps in care, rate setting, APAC-related reports, internal monitoring, case management, social determinants of health (SDoH) monitoring, provider dashboards, validation of encounter data, and provider activity trends and anomalies.

- **CHA**: CHA's encounter data system is used in various capacities, internally as well as externally. Some examples include:

- Internal: value-based payment and rate setting for capitation, quality metrics, medical and case management, and provider network management.
- External: predictive analytics, risk adjustment, health information exchange, member outreach, and health information.

- **CPCCO** and **JCC**: The CCOs' encounter data are used in various capacities such as calculating clinical quality measure performances, including CCO incentive measures, Healthcare Effectiveness Data and Information Set (HEDIS)[2-1] reporting, and CCO value-based payment models. These measures are used internally and shared externally with network partners. Encounter data are also used to calculate the total cost of care and medical loss ratios for CCO shared-risk contracts, understand patterns of member utilization, identify diagnoses for members for risk stratification, etc. Additionally, the CCOs' data warehouse and encounter data are also used to support rate-setting, financial reporting verification, and reconciliations.

- **EOCCO**: The CCO's encounter data are not used for any secondary purposes. The encounter data system/process/files represent a data "spur" from the CCO's core systems. According to **EOCCO**, all other reporting and analysis comes out of the core system.

- **HSO**: Per CareOregon, the CCO's encounter data are used in various capacities such as calculating clinical quality measure performance, including CCO incentive measures, HEDIS reporting, and CCO value-based payment models. These measures are used internally and shared externally with network partners. Encounter data are also used to calculate the total cost of care and medical loss ratios for CCO shared-risk contracts, understand patterns of member utilization, identify diagnosis for members for risk stratification, etc. **HSO** also uses the encounter data to support rate-setting, calculate leading indicators for CCO metrics, utilization and financial monitoring, and metrics for strategic initiatives.

- **IHN**: **IHN** uses the data in its encounter data system for quality, capitation analysis, rate-setting, and other managerial reporting. **IHN** uses dental and non-emergency medical transportation (NEMT) encounters for oversight and monitoring purposes. NEMT encounters are also used for budget analysis.

- **PSCS-CO**, **PSCS-CG**, **PSCS-Lane**, and **PSCS-MP**: Encounter data are used in analytics and external customer and internal financial reporting. Some examples of such reporting/analytics include but are not limited to:
    - HEDIS and Quality Incentive Measures (QIM) calculations and gap reporting.
    - Care and case Management reporting.
    - Utilization and experience reporting.
    - Provider contract-level and line-of-business level performance and financial reporting.
    - Rate-setting.
    - MLR reporting.
    - Risk stratification algorithms for population assessment and programs.

[2-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- – Condition program identification algorithms for program identification.
- – Provider efficiency algorithm tools related to cost, use, and provider data sharing.
- – Condition prevalence algorithms for population assessment and program identification, among other uses.
- – Value-based payment settlement arrangements.

- **TCHP**: **TCHP**'s Encounter Business Operations team uses the encounter data to produce accuracy, timeliness, and completeness dashboards. The encounter data are also used as a tool to correct and resubmit encounter rejects and pends. Additionally, the encounter data are used by the rate setting and risk adjustment teams.

- **UHA**: The encounter data are used for rate setting, CCO quality metric monitoring; utilization management; fraud, waste, and abuse monitoring; value-based payment modeling; contract development; budgeting trends; continuity of care; cost management; and other functions.

- **YCCO**: Encounter data are used for a variety of functions. Examples include financial/budgetary analysis; provider performance on quality measures; validation of value-based contracting agreements; provider fraud, waste, and abuse detection and investigation; analysis of service coverage; and utilization management.

Monitoring Metrics From OHA

To evaluate the quality of CCO monthly encounter submission, OHA's Claim and Encounter Data Services Unit (CEDSU) uses various receipt and validity editing that is reviewed and reported. OHA ensures the accuracy and completeness of encounter data by using MMIS edits, historical data, and error reports. The metrics used are based on contract requirements, where the contract requires certain percentage associated with certain errors. OHA also noted that it has reports that monitor each requirement in the contract and follows the contractual requirements for submission to be able to enforce any corrective action.

To monitor the timeliness of encounter data submitted by the CCOs, OHA uses the contract requirement that no more than 5 percent of encounter data can be sent more than 45 days past the date of adjudication for a service month. Timeliness monitoring is conducted weekly by the liaison within CEDSU. However, OHA does not have performance standards, beyond what is described in the CCO contract requirements, in place regarding submission, accuracy, and timeliness of encounter data.

Additionally, CCOs are required to submit a report detailing the number and dollar amount submitted as part of the encounter data submission activities. If the report information does not match what was processed, research and response is required by the CCO. Pended encounter claims sent to the CCOs are also required to be corrected by the CCOs and are monitored to ensure correction within the 63 days allowed in the contract.

Internal and External Challenges

CCOs were asked about challenges they face or anticipate when submitting encounter data to OHA, and responses varied among the CCOs across different topics (e.g., the encounter data submission process and specific data issues). Table 2-6 lists the challenges, both internally and externally, faced by the CCOs.

All CCOs identified at least one challenge, either internal or external, in submitting encounter data to OHA, with provider-related issues, volume of submission constraints, and EDI or MMIS edit rules being mentioned most frequently. Responses from the CCOs suggested that while providers may have registered with OHA's system, the State provider mapping methods (e.g., does not take into account providers with multiple IDs) and provider updates may still potentially result in CCOs being denied for failing to meet submission requirements. CCOs also stated that the 5,000 records per transmission limitation created additional steps that are cumbersome in preparing the encounter data to be submitted to OHA. Additionally, some CCOs indicated that although error files were received from OHA after submission, explanations of these errors do not appear to be clear or adequate to allow them to effectively research submission failures. Some CCOs noted that a list of edits is not available.

Table 2-6—Internal and Challenges Faced by CCOs

CCO	Internal Challenges	External Challenges
AH	• The current claims processing system does not have native support for electronic secondary/tertiary claims.	• OHA's MMIS rules, where Medicare crossover encounters may be denied, rejected, or pended due to OHA's billing requirements not aligning with CMS. • OHA's translator rejecting duplicate ICD-10-CM procedure codes. • OHA issuing multiple provider enrollment to individual providers, and MMIS does not always associate claims with the correct enrollment. • OHA does not have provider types for all providers (e.g., standalone EKG/radiology). • Providers are required to submit 100 percent of encounters, but it is very challenging to monitor completeness.
AllCare	• Allocating resources to CCO submission with the date and time limitations set.	• Lack of documented processes surrounding encounter submission. For example, rules regarding the order in which adjustment codes must be submitted. • Limitations on the number of records in a transaction. • OHA's inability to accept industry standard edits. • Limited window in which submission may occur.

CCO	Internal Challenges	External Challenges
CHA	• None.	• If too many COB claims are submitted for the same member in one file, the claim fails the translator.
CPCCO	• Managing the submission of files to OHA; on occasion, submissions are made more than once, as it is unclear whether the file has already been submitted.	• The CCO struggles to keep pace with changing encounter edits and critical error reasons. There is also a lack of transparency in terms of OHA's criteria for determining clean and unclean encounters. • The CCO also struggles with OHA's system constraints (i.e., limitations on the number of records in a transaction).
EOCCO	• Ensuring appropriate exceptions are in place to prevent 999 rejects.	• OHA EDI translator; the CCO noted a change in requirements that would allow CCOs to deny claims for missing elements rather than being rejected, which is a manual process. • Limitations on the volume of submissions. • Incorrect billing provider due to EDI specifications. • When correcting pended encounters in MMIS, it not always clear what caused the pend or how to resolve it without guidance.
HSO	• Managing the submission of files to OHA; on occasion, submissions are made more than once, as it is unclear whether the file has already been submitted. • **HSO** finds it cumbersome to send data to OHA due to the State's use of a dated system. Additionally, it is not ideal to submit documents (e.g., the questionnaire and supporting documentation) via email. • Provider setup to match OHA's requirements.	• Limiting files to 5,000 records per submission is cumbersome. • CareOregon struggles to keep pace with changing encounter edits and critical error reasons. There is also a lack of transparency in terms of OHA's criteria for determining clean and unclean encounters. • A variety of routine technical and coordination challenges such as password resets and lack of key pair authentication. • Provider enrollment requirements differ between FFS and encounter-only. • Untimely updates to procedure codes, modifiers, and diagnosis codes in MMIS processing. • NCPDP rejections specific to NDC codes. • OHA EDI translator; the CCO noted a change in requirements that would allow CCOs to deny claims for missing elements rather than being rejected, which is a manual process. • Incorrect billing provider due to EDI specifications.

CCO	Internal Challenges	External Challenges
		• When correcting pended encounters in MMIS, it not always clear what caused the pend or how to resolve it without guidance
IHN	• It is challenging to obtain the provider information necessary to register out-of-state providers with Medicaid.	• None.
JCC	• Same as **CPCCO**.	• Same as **CPCCO**.
PSCS-CO **PSCS-CG** **PSCS-Lane** **PSCS-MP**	• Matching CCO provider setup across multiple lines of business to meet OHA's requirements. • Maintenance of provider data quality relevant to encounter submissions.	• Provider enrollment differs between FFS and encounter-only. • MMIS provider matching contains duplicate records, causing CCOs' encounters to pend. • MMIS does not acknowledge the different NDCs within medical encounters, specifically when HCPCS codes are the same. • Claims search in MMIS is time consuming. • Untimely additions of new CPT codes, modifiers, and revenue codes in MMIS. • Challenges with the Drug Rebate Program and NCPDP rejections.
TCHP	• None. **TCHP** Appreciates the responsiveness and help received from OHA's encounter team.	• None. **TCHP** indicated that the MMIS portal is user friendly and great tool for the CCOs.
UHA	• None.	• OHA does not have mapping or edits from its EDI translator available for CCOs to use as a tool. • Some errors sent to CCOs are not easily defined.
YCCO	• None.	• OHA does not have mapping or edits from its EDI translator available for CCOs to use as a tool. • Some errors sent to CCOs are not easily defined. • If an encounter file is inadvertently submitted twice, there is no option to back the file out of the system.

Based on the questionnaire responses, the CCOs and/or their delegates provided information demonstrating their capacity to collect, process, and transmit to OHA claims and encounter data meeting established quality specifications. Although each CCO employs different strategies to facilitate accurate and timely encounter data submission, each CCO described the centrality of its encounter data systems and data warehouse to its ability to develop adaptable data review processes that can promptly respond to quality issues identified by OHA. All CCOs described the role of internal personnel and departments, software systems, and/or external vendors/delegates employed for activities such as claims adjudication, provider and member information verification, and management of TPL information. When necessary, the CCOs described the systems/vendor oversight and data remediation activities that they have in place to ensure the completeness and accuracy of data submitted to them or processed on their behalf.

While OHA offers the CCOs substantial autonomy regarding the development and management of their encounter data systems, it does require CCOs to submit complete and accurate encounter data in a timely manner. OHA's Edifecs translator was designed to review encounter transmissions for noncompliance with the X12 standard guidelines, as well as the validity of code sets. However, the EDI translator does not have mappings or edits available for the CCOs to use as a tool to help reduce rejection rates. Additionally, the limitation on the number of records for each transaction that the CCOs are allowed poses challenges in their encounter data submission, since additional steps have to be taken to comply with the number of record constraints. Once encounters pass OHA's EDI translator, MMIS then reviews them for OHA's data element-specific completeness and accuracy specifications. The CCOs cited examples that they perceived as MMIS' limitations to review some aspects of data quality that poses challenges to the CCOs. Some examples cited include 1) OHA issues multiple provider enrollments, resulting in MMIS not always associating claims with the correct enrollment, 2) MMIS provider matching contains duplicate records, causing CCOs' encounters to pend, 3) provider enrollment requirements differ between FFS and encounter-only, and 4) MMIS does not acknowledge the different NDCs within medical encounters, specifically for services having the same HCPCS code. While HSAG was not able to validate the CCO-reported limitations, OHA did note that not all of the identified limitations were accurate.

Medical records are considered the "gold standard" for documenting Medicaid members' access to and quality of services. Consequently, the information within the claims/encounters associated with the member should reflect information documented in member's medical records. Therefore, to ensure accuracy and completeness of claims/encounter data, medical/chart reviews should be conducted to verify the appropriateness of service(s) provided to members, as well as to verify the accuracy of coding and billing associated with the services. Based on information provided by the CCOs, there appears to be a lack of validation via chart/medical record reviews by some CCOs or by OHA.

CCOs are contractually responsible for all of their respective encounter data, including delegate encounter data. Based on information provided by the CCOs, some CCO delegates are submitting encounters directly to OHA. This minimizes CCO accountability for delegate encounters in that validation is not conducted at the CCO level prior to the encounters being submitted to OHA, and it

limits the ability of CCOs to oversee delegate encounter errors and rejections. In addition, allowing CCO delegates to submit encounters directly to OHA places the onus on OHA to manage data agreements with each delegate.

The CCOs expressed appreciation with regard to the resources OHA provides, such as facilitating monthly contractor meetings, and the numerous reports provided by OHA's encounter liaison. Additionally, the CCOs find that the MMIS portal is a useful tool, although one CCO did indicate that the claims search in MMIS is time consuming.

Recommendations

Based on its review, HSAG recommends the following for OHA to strengthen its encounter data quality:

- HSAG recommends that OHA consider developing and distributing a comprehensive list of operational edits associated with the error categories identified in the feedback/response files. Some CCOs indicated that resubmission of rejected encounters by the CCO is challenging when reasons for the rejection are not clearly detailed. Distributing an updated, comprehensive list describing the nature of the errors and providing technical assistance sessions would allow the CCOs to 1) have a better understanding of which claim-related elements are important in their encounter submission process, and 2) conduct their own investigations in a more efficient manner.

- HSAG recommends that OHA work with the CCOs to determine the data submission requirements pertaining to provider mapping. State provider mapping was identified by the CCOs as one of their challenges to the submission of complete and timely encounters to OHA. Based on OHA's questionnaire response, it appears that MMIS is adjudicating both claims and encounters submitted by the plans, based on the FFS provider enrollment. Accurate provider information is paramount in processing claims; therefore, OHA may want to consider strengthening its contractual requirements with the CCOs regarding provision of oversight activities in this area, allowing the CCOs to identify any potential issues related to provider data when claims/encounters are received in their systems. This approach would minimize any provider data anomalies noted at the very end of the CCOs' encounter submission process and allow the CCOs to work with their contracted providers to ensure information is provided accurately when the claims are first submitted to the CCOs.

- While several CCOs demonstrated that chart review is one of the validations conducted to ensure accuracy and completeness, some CCOs did not indicate such activities were being conducted. As such, HSAG recommends that OHA consider requiring all CCOs to conduct a standardized validation of encounter data using medical record reviews. To facilitate this process:
  - Develop an annual process to assess the CCOs' data validation capacity and capabilities among encounters submitted to OHA, as well as to ensure the CCOs' accountability for claims and encounter data validation.
  - Establish validation guidelines including medical records for use by the CCOs in conducting their internal validation. The guidelines may assist with improving the quality of encounter data submitted by the CCOs to OHA and may include, but be not limited to, record sampling,

reporting requirements, and the file format to guide the CCOs in conducting their internal validation.

– Conduct evaluations of CCO annual validation activities, providing feedback to CCOs and corrective actions when appropriate.

• HSAG recommends that OHA conduct a medical record review of all CCOs by selecting a random sample of cases based on specific encounter types or service categories. These cases may coincide with the cases the CCOs use to conduct chart/medical record reviews, which would reduce the CCOs' burden in procuring chart/medical records for OHA's review.

• HSAG recommends that OHA require CCOs to collect, validate, and submit all encounter data on behalf of their delegates, holding the CCOs accountable for delegate encounter completeness, accuracy, and timeliness.

This section contains the blank questionnaire sent to OHA for the focused information systems review.

CY 2020 Encounter Data Validation Questionnaire for OHA

Introduction

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, the Oregon Health Authority (OHA) requires its Coordinated Care Organizations (CCOs) to submit high-quality encounter data. OHA relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During calendar year (CY) 2020, OHA contracted with Health Services Advisory Group, Inc. (HSAG) to conduct an encounter data validation (EDV) study. The goal of the study is to determine the extent to which OHA and the CCOs have appropriate system documentation and the infrastructure to produce, process, and monitor encounter data. The study will include an evaluation of the CCOs' processes for collecting, maintaining, and submitting encounter data to OHA and on the strengths and limitations of the CCOs' information systems in promoting and maintaining quality encounter data. Similarly, HSAG will also evaluate OHA's processes for collecting and managing the CCO-submitted encounter data. In alignment with the CMS EQR Protocol 5 Validation of Encounter Data[1], HSAG has developed the following EDV focused questionnaire, based in part on a streamlining of OHA's most recent Information Systems Capabilities Assessment (ISCA), to gather information regarding each CCO's information systems and data processing procedures. This review will enable HSAG to understand how various systems interact to determine whether such interactions have an impact on the CCOs' ability to submit complete, reasonable, and accurate data.

While a separate questionnaire has been developed to survey the CCOs, this document describes the OHA questionnaire. Table 1 lists the CCOs that will be included in this study.

Table 1—List of Coordinated Care Organizations (CCOs)

CCO Plan Name	Acronym
Advanced Health	AH
AllCare CCO, Inc.	AllCare
Cascade Health Alliance, LLC	CHA
Columbia Pacific CCO, LLC	CPCCO
Eastern Oregon CCO	EOCCO
Health Share of Oregon	HSO

---

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

—Final Copy—

CCO Plan Name	Acronym
InterCommunity Health Network	IHN
Jackson Care Connect	JCC
PacificSource Community Solutions–Central Oregon	PSCS-CO
PacificSource Community Solutions–Columbia Gorge	PSCS-CG
PacificSource Community Solutions–Lane County	PSCS-LC
PacificSource Community Solutions–Marion Polk	PSCS-MP
Trillium Community Health Plan, Inc.	TCHP
Umpqua Health Alliance, LLC	UHA
Yamhill Community Care Organization	YCCO

General Instructions

HSAG developed the following questionnaire to gather both general information and specific procedures for data processing, personnel, and data acquisition capabilities. The questionnaire has been developed based on HSAG's understanding of the encounter data submission process and is divided into the following four domains:

Section A: *Encounter Data Sources and Systems*

Section B: *Data Exchange Policies and Procedures*

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

Section D: *Encounter Data Quality Monitoring and Reporting*

All sections of the following questionnaire must be completed, with comprehensive responses to each question. If different staff members within OHA are responsible for different aspects of the processes, please distribute multiple copies of the questionnaire and ensure that each group provides answers to the applicable questions in each section.

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

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

Submission of Questionnaire and Documentation

1. OHA should upload the completed questionnaire and supporting documentation electronically to HSAG's Secure Access File Exchange (SAFE) site, https://safe.hsag.com/ in OHA's folder and project subfolder labeled: **EDV/From OHA**

2. Please contact Ivan Kuletz via e-mail at ikuletz@hsag.com or Crystal Brown at cbrown@hsag.com for assistance with access to the HSAG SAFE site.

3. HSAG requests that OHA upload the completed questionnaire, and any attachments, to HSAG's SAFE site no later than **September 25, 2020**. Upon completion of upload, please notify HSAG via e-mail at ebuyong@hsag.com.

CY 2020 Encounter Data Validation—OHA Focused Questionnaire

Section A: Encounter Data Sources and Systems

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

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

1. Are there any updates to your data system/data warehouse (process flows and system architecture) used to import, process, and store encounter data submitted by the CCOs beyond what has been described in the Encounter Data Companion Guides and Encounter Submission Guidelines? Please include any supporting documentation available including, but not limited to, information system schemas, processing diagrams, and file/table layouts. If your data system differs within an encounter type (e.g., medical, vision, pharmacy), provide separate updates for each encounter type and scenario.

   Below, please note the filename(s) of any documentation attached associated with applicable list(s) or flowchart(s).

   (Please note that for file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to this question.)

   ```



   ```

2. For each key source of encounter data, provide a description of the encounters received from each CCO (including its subcontractors), and the frequency of receipt. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

CCO Name (*Acronym*)	Data Source[1]	Description of Data Received	Frequency[2]
CCO A	*Pharmacy*	*Files are submitted using the NCPDP D.0 format.*	*Weekly*
Advanced Health (*AH*)	Institutional		
	Professional		
	Pharmacy		
	Oral Health		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe[3]*)		
AllCare CCO, Inc. (*AllCare*)	Institutional		
	Professional		
	Pharmacy		
	Oral Health		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe[3]*)		
Cascade Health Alliance, LLC (*CHA*)	Institutional		
	Professional		
	Pharmacy		
	Oral Health		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe[3]*)		
Columbia Pacific CCO, LLC (*CPCCO*)	Institutional		
	Professional		
	Pharmacy		
	Oral Health		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe[3]*)		
	Institutional		
	Professional		

EDV QUESTIONNAIRE FOR OHA

CCO Name (*Acronym*)	Data Source[1]	Description of Data Received	Frequency[2]
Eastern Oregon CCO (*EOCCO*)	Pharmacy		
	Oral Health		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe[3]*)		
Health Share of Oregon (*HSO*)	Institutional		
	Professional		
	Pharmacy		
	Oral Health		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe[3]*)		
InterCommunity Health Network (*IHN*)	Institutional		
	Professional		
	Pharmacy		
	Oral Health		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe[3]*)		
Jackson Care Connect (*JCC*)	Institutional		
	Professional		
	Pharmacy		
	Oral Health		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe[3]*)		
PacificSource Community Solutions– Central Oregon (*PSCS-CO*)	Institutional		
	Professional		
	Pharmacy		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe[3]*)		
PacificSource Community Solutions–	Institutional		
	Professional		
	Pharmacy		

—Final Copy—

CCO Name (Acronym)	Data Source[1]	Description of Data Received	Frequency[2]
Columbia Georgia (*PSCS-CG*)	Oral Health		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe*[3])		
PacificSource Community Solutions–Lane County (*PSCS-LC*)	Institutional		
	Professional		
	Pharmacy		
	Oral Health		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe*[3])		
PacificSource Community Solutions–Marion Polk (*PSCS-MP*)	Institutional		
	Professional		
	Pharmacy		
	Oral Health		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe*[3])		
Trillium Community Health Plan, Inc. (*TCHP*)	Institutional		
	Professional		
	Pharmacy		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe*[3])		
Umpqua Health Alliance, LLC (*UHA*)	Institutional		
	Professional		
	Pharmacy		
	Oral Health		
	Behavioral Health		
	Vision		
	Transportation		
	Other (*list and describe*[3])		
Yamhill Community Care	Institutional		
	Professional		
	Pharmacy		
	Oral Health		

—Final Copy—

EDV QUESTIONNAIRE FOR OHA

CCO Name (Acronym)	Data Source[1]	Description of Data Received	Frequency[2]
Organization (YCCO)	Behavioral Health		
	Vision		
	Transportation		
	Other (list and describe[3])		

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

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

[3] Examples include hotel stay, non-medical transportation, etc.

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

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

4. Does OHA run incoming encounters through system/processing edits, prior to accepting/loading the data to its system?

☐ Yes
☐ No (If NO, skip to Question 5)

If YES, describe all system/processing edits that impact the acceptance of encounters. Attach any relevant documentation that illustrates these procedures.

(Please note that for file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to this question.)

HSAG HEALTH SERVICES ADVISORY GROUP

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

6. Does OHA provide any type of response file or feedback beyond what is described in the Encounter Submission Guidelines to the CCOs submitting the encounters?

    ☐ Yes
    ☐ No (If NO, skip to Question 7)

    If YES, please describe the process used to provide feedback to the CCOs including any process flows and report layouts.

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

    ☐ Yes
    ☐ No (If NO, skip to Question 8)

    If YES, describe how encounters are ultimately merged into a single encounter data platform. Include a data flow diagram, if needed.

    (Please note that for file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to this question.)

8. Please describe the process used by the CCOs to resubmit updated, modified, or corrected encounters, beyond what is described in the Encounter Submission Guidelines. How are updated records flagged in OHA's system? Are the original encounters stored in the encounter data system or deleted? Provide any documentation or policies and procedures related to the resubmission of encounter files or records.

   (Please note that for file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to this question.)

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

9. Using a list or data flow diagram, outline the path OHA's provider data follow from collection to maintenance.

10. Please describe OHA's procedures for overseeing and ensuring the completeness and accuracy of provider data.

11. Describe the process for linking provider data to encounters including any procedures for reconciling differences between data submitted on the encounter and OHA's provider data.

12. Describe how OHA uses provider data submitted by the CCOs to conduct evaluations on the encounter data, if applicable.

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

13. Using a list or data flow diagram, outline the path OHA's Medicaid enrollment data follow from collection to maintenance.

14. Describe OHA's procedures for overseeing and ensuring the completeness and accuracy of Medicaid enrollment data.

15. How often is Medicaid enrollment information updated for OHA and the CCOs?

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

Section B: Data Exchange Policies and Procedures

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

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

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

   (Please note that for file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to this question.)

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

   (Please note that for file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to this question.)

3. Describe how the loss of Medicaid encounters and other related data is prevented when systems fail. How frequently are system back-ups performed? Where are back-up data stored? How and how often are the back-ups tested to make sure the back-ups are functional?

4. How is Medicaid data corruption prevented due to a system failure or program error? Describe the controls used to ensure all data entered into the system are fully accounted for (e.g., batch control sheets)?

5. Does OHA have a process in place to ensure that updates to the State's requirements for data submission are implemented and communicated to each CCO?

☐ Yes
☐ No (If NO, skip to Section C)

If YES, please describe the process and provide any documentation, if available.

(Please note that for file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to this question.)

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

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

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

1. Please attach a flowchart outlining the structure of your complete management information systems highlighting all internal and external data inputs and processes (i.e., claims files, encounter files, ASC X12, NCPDP, etc.). Provide any documentation regarding data integration policies and procedures.

   (Please note that for file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to this question.)

2. For each database described in Question 1, please identify any processes in place that modify the data as it moves from one database to another.

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

   a. How many different data sources are merged together to create reports?

   b. What control processes are in place to ensure data merges are accurate and complete?

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

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

5. Do your current system documentation and file layouts clearly delineate derived and non-derived data fields?

    ☐ Yes
    ☐ No (If NO, skip to Question 6)

    If YES, please describe the fields that are derived and the point in the encounter data process at which they are created.

6. Describe policies and procedures used to identify duplicate or missing records in the CCOs' regular (i.e., monthly, weekly, or daily) encounter submissions. If identified, how are the affected records processed and what information is returned to the CCOs?

7. During the processing of the CCOs' encounter data submissions, does OHA modify or reformat any data elements?

    ☐ Yes
    ☐ No (If NO, skip to Section D)

    If YES, describe the modifications or reformatting using specific data field names and specific examples (e.g., zeros are added to the beginning of values in any specific field to pad the results to a length of a specific number of characters).

8. Is any code and/or field mapping performed during data processing?

☐ Yes
☐ No (If NO, skip to Section D)

If YES, explain the mapping processes and provide reference table(s) and/or source of the reference table(s), as appropriate. How often are each of the reference table(s) updated? Monthly, quarterly, annually, never, etc.?

HSAG HEALTH SERVICES ADVISORY GROUP

Section D: Encounter Data Quality Monitoring and Reporting

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

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

1. Does OHA have monitoring metrics in place to evaluate the quality of CCO monthly encounter submissions?

   ☐ Yes
   ☐ No (If NO, skip to Question 2)

   If YES, please describe the evaluation metrics including defined error thresholds and standards, if available.

2. How does OHA monitor and ensure the accuracy and completeness of encounter data submitted by the CCOs?

3. How does OHA monitor the timeliness of encounter data submitted by the CCOs?

—Final Copy—

Oregon Health Authority: Encounter Data Validation
State of Oregon

Page 17
OR2020_EDV_Questionnaire_OHA_F1_0920

Oregon Health Authority 2020 Encounter Data Validation Report
State of Oregon

Page A-18
OR2020_EDV_Report_F1_0221

4. Does OHA have performance standards, beyond what is described in the CCO contract requirements, in place regarding the submission, accuracy, and timeliness of encounter data?

☐ Yes
☐ No (If NO, skip to Question 5)

If YES, provide documentation of the performance standards and describe how the performance standards are communicated to the CCOs.

(Please note that for file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to this question.)

5. Are the CCOs required to submit reports (e.g., monthly reconciliation reports) on encounter data submission activities (e.g., submission statistics) to OHA?

☐ Yes
☐ No (If NO, skip to Question 6)

If YES, please describe the reporting process and submit a recent example of these reports for each CCO and other applicable documents.

(Please note that for file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to this question.)

6. Besides those files noted in the Encounter Submission Guidelines, does OHA use other files to provide feedback to the CCOs on their submissions?

☐ Yes
☐ No

If YES, please describe the files used to provide feedback to the CCOs.

(Please note that for file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to this question.)

—Final Copy—

7. What is the average percentage of encounters (by CCO) submitted to OHA that get rejected by OHA? *Note: The table can be expanded if additional rows or columns are required.*

CCO Plan Name (*Acronym*)	Professional	Institutional	Pharmacy	TOTAL
Advanced Health (*AH*)				
AllCare CCO, Inc. (AllCare)				
Cascade Health Alliance, LLC (*CHA*)				
Columbia Pacific CCO, LLC (*CPCCO*)				
Eastern Oregon CCO (*EOCCO*)				
Health Share of Oregon (*HSO*)				
InterCommunity Health Network (*IHN*)				
Jackson Care Connect (*JCC*)				
PacificSource Community Solutions–Central Oregon (*PSCS-CO*)				
PacificSource Community Solutions–Columbia Gorge (*PSCS-CG*)				
PacificSource Community Solutions–Lane County (*PSCS-LC*)				
PacificSource Community Solutions–Marion Polk (*PSCS-MP*)				
Trillium Community Health Plan, Inc. (*TCHP*)				
Umpqua Health Alliance, LLC (*UHA*)				
Yamhill Community Care Organization (*YCCO*)				

—Final Copy—

8. Describe how data in OHA's encounter data system/data warehouse <u>are</u> used (e.g., rate-setting, HEDIS reporting, etc.)

9. Does OHA collect capitated encounters (e.g., encounters submitted by the CCOs' capitated providers/provider groups) from its CCOs?

    ☐ Yes (If YES, skip to Question 10)
    ☐ No (If NO, the survey has ended)

10. What are OHA's requirements for submitting pricing information on capitated encounters?

11. Does OHA monitor capitated encounters for unallowable services?

    ☐ Yes
    ☐ No

    If YES, describe the type of reporting that is available.

    If NO, does OHA maintain a list of allowable/unallowable services? If OHA maintains a list of allowable/unallowable services, please provide supporting document(s).

    (Please note that for file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to this question.)

This section contains the blank questionnaire sent to the CCOs for the focused information systems review.

CY 2020 Encounter Data Validation Questionnaire for CCOs

Introduction

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, the Oregon Health Authority (OHA) requires its Coordinated Care Organizations (CCOs) to submit high-quality encounter data. OHA relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During calendar year (CY) 2020, OHA contracted with Health Services Advisory Group, Inc. (HSAG) to conduct an encounter data validation (EDV) study. The goal of the study is to determine the extent to which OHA and the CCOs have appropriate system documentation and the infrastructure to produce, process, and monitor encounter data. The study will include an evaluation of the CCOs' processes for collecting, maintaining, and submitting encounter data to OHA and on the strengths and limitations of the CCOs' information systems in promoting and maintaining quality encounter data. Similarly, HSAG will also evaluate OHA's processes for collecting and managing the CCO-submitted encounter data. In alignment with the CMS EQR Protocol 5 Validation of Encounter Data[1], HSAG has developed the following EDV focused questionnaire, based in part on a streamlining of OHA's most recent Information Systems Capabilities Assessment (ISCA), to gather information regarding each CCO's information systems and data processing procedures.

Table 1 lists the CCOs that will be included in this study. HSAG has outlined instructions below on how to complete the EDV focused questionnaire for the CY 2020 EDV study.

Table 1—List of Coordinated Care Organizations (CCOs)

CCO Plan Name	Acronym
Advanced Health	AH
AllCare CCO, Inc.	AllCare
Cascade Health Alliance, LLC	CHA
Columbia Pacific CCO, LLC	CPCCO
Eastern Oregon CCO	EOCCO
Health Share of Oregon	HSO
InterCommunity Health Network	IHN
Jackson Care Connect	JCC

---

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

CCO Plan Name	Acronym
PacificSource Community Solutions–Central Oregon	PSCS-CO
PacificSource Community Solutions–Columbia Gorge	PSCS-CG
PacificSource Community Solutions–Lane County	PSCS-LC
PacificSource Community Solutions–Marion Polk	PSCS-MP
Trillium Community Health Plan, Inc.	TCHP
Umpqua Health Alliance, LLC	UHA
Yamhill Community Care Organization	YCCO

General Instructions

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

Section A: *Encounter Data Sources and Systems*

Section B: *Data Exchange Policies and Procedures*

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

Section D: *Encounter Data Quality Monitoring and Reporting*

Each participating CCO must complete all sections of the following questionnaire, providing comprehensive answers to the questions and attach supporting documentation (e.g., policies and procedures, data layouts, data flow diagrams, sample reports, sample data, etc.), where applicable. If a CCO uses the same data system for multiple clients or lines of business, please limit responses to specific procedures related to the processing of OHA claims and encounters. If different staff members within a CCO are responsible for different aspects of the processes, please distribute multiple copies of the questionnaire and ensure that each group provides answers to the applicable questions in each section. **Responses do not need to be merged into a single final version; sending multiple sections and documents is acceptable.**

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

Submission of Questionnaire and Documentation

Each CCO should upload the completed questionnaire and supporting documentation to the CCO.MCODeliverableReports@dhsoha.state.or.us email no later than **September 25, 2020**.

CY 2020 Encounter Data Validation—CCO Focused Questionnaire

Section A: Encounter Data Sources and Systems

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

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

1. Using a list or data flow diagram, outline the path your CCO's encounter data follow from the time a member receives a service(s) until the encounter is processed by OHA. If the data path differs by or within a claim type (e.g., medical, vision, pharmacy), provide a separate list or data flow diagram for each claim type and scenario. Be sure to identify any subcontractors responsible for processing the data and the associated processes with the subcontractors.

   Below, please note the filename(s) of any documentation attached associated with applicable list(s) or flowchart(s).

2. For each key source of data (i.e., all data your CCO receives that are included in encounter data submissions), provide a description of the files received, the frequency of receipt, and the approximate data volume associated with that source. If data are provided to your CCO by a vendor or third-party, please note the name of the vendor in the "Description of Data Received" column. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Source[1]	Description of Data Received	Frequency[2]	Approximate Data Volume
Pharmacy	*We receive point of service claims submitted by retail pharmacies from our vendor, Express Scripts. Files are submitted using the NCPDP D.0 format.*	*Weekly*	*100,000 unique claims per week*
Inpatient			
Outpatient			
Home and Community Based Services (HCBS)			
Laboratory			
Long Term Care			
Pharmacy			
Oral Health			
Physician			
Transportation			
Vision			
Behavioral Health			
Other (*list and describe*[3])			

[1] These sources represent direct claims/encounters submissions from the rendering provider to your CCO or vendor.

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

[3] Examples include hotel stay, non-medical transportation, etc.

3. Does your CCO modify or reformat its claims/encounter data to accommodate OHA's encounter data submission standards? If a vendor prepares the encounter data submission for your CCO, please answer this question on behalf of the vendor.

☐ Yes
☐ No (If NO, skip to Question 4)

If YES, describe the modifications or reformatting using specific data field names and specific examples (e.g., zeros are added to the beginning of values in the Provider ID field to pad the results to a standard length of characters). Please clarify if modifications or reformatting were applied to both your CCO's claims and encounter data. If not, please describe the differences in the process applied to each type of data.

[ ]

4. Are any of the data submitted to OHA extracted from another entity's claims/encounter data system/data warehouse?

☐ Yes
☐ No (If NO, skip to Question 5)

If YES, describe the data system from which encounters are extracted from and submitted to OHA, including how this system aligns with your CCO's data warehouse. Include a data flow diagram, if needed.

[ ]

5. Does your CCO submit all types of claims/encounters to OHA—e.g., paid, denied, voided, and adjusted claims?

☐ Yes (If YES, skip to Question 6)
☐ No

If NO, describe which claims/encounters are not submitted to OHA.

[ ]

—Final Copy—

6. Does your CCO <u>not</u> submit certain types of payments made on behalf of the Medicaid population and/or certain types of services rendered to the Medicaid population as encounters?

☐ Yes
☐ No (If NO, skip to Question 7)

If YES, please describe each type of payment made or service rendered for which encounters are not submitted to OHA.

```

```

7. Describe your CCO's process for transmitting adjusted encounters to OHA that have previously been submitted. If your CCO does not submit adjustments to OHA, describe why these encounters are not submitted. Please also describe the process by which your CCO determines whether an encounter will or will not be submitted as an adjustment to OHA.

```

```

8. For claims that are processed internally, describe the types of validation performed, the percentage of validated claims, and the types of claims validated (e.g., pended, paper, and auto-adjudicated).

Type of Claims Validated	Description of Validation Performed	Percentage of Claims Validated

9. Prior to claims being adjudicated for payment processing, are any code and/or field mapping performed during data processing and validation?

☐ Yes
☐ No (If NO, skip to Question 10)

If YES, explain the mapping processes and provide reference table(s) and/or source of the reference table(s), including those maintained by your CCO's vendors, as appropriate. How often are each of the reference table(s) updated (e.g., monthly, quarterly, annually, never, etc.)?

```

```

10. Are any code and/or field mapping performed during data processing for submission to the OHA?

☐ Yes
☐ No (If NO, skip to Question 11)

If YES, explain the mapping processes and provide reference table(s) and/or sources of the reference table(s), including those maintained by your CCO's vendors, as appropriate. How often are each of the reference table(s) updated? Monthly, quarterly, annually, never, etc.?

[ ]

11. Are any outside vendors or contractors used to complete adjudication including, but not limited to, bill auditors, peer or medical reviews, bill "re-pricing" for carved out benefits, or other?

☐ Yes
☐ No (If NO, skip to Question 12)

If YES, please describe how these data are incorporated into your CCO's data. Please also include the process by which you ensure or verify accuracy and completeness of the data.

[ ]

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

12. Is provider data collected and maintained by your CCO or a subcontracted vendor?

☐ By the CCO
☐ By a subcontracted vendor (Proceed to Question 13)

If by the CCO, please include a list or data flow diagram to outline the path your CCO's provider data follow from receipt to maintenance. (Skip to Question 15)

[ ]

13. Describe the vendor's responsibilities in collecting and maintaining the provider data and your CCO's procedures for overseeing and ensuring the quality of provider data processed by the vendor.

[ ]

14. Using a list or data flow diagram, outline the path your CCO's provider data follows from collection to maintenance. Please include the processes associated with the provider network from your subcontracted vendor.

15. Describe the process for linking provider data to claims and encounters, including any procedures for reconciling differences between data submitted on the claim/encounter and your CCO's provider data. If this function is managed by a subcontracted vendor, describe the vendor's responsibilities and your CCO's oversight of the process.

16. Does your CCO's provider data require modification in order to comply with OHA's provider data submission requirements?

    ☐ Yes
    ☐ No (If NO, skip to Question 17)

    If YES, describe the modifications, including examples as needed.

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

17. Is enrollment data maintained by your CCO or a subcontracted vendor?

    ☐ By the CCO
    ☐ By a subcontracted vendor (Proceed to Question 18)

    If by the CCO, please include a list or data flow diagram to outline the path your CCO's enrollment data follow from receipt to maintenance. (Skip to Question 20)

18. Describe the vendor's responsibilities in maintaining the enrollment data and your CCO's procedures for overseeing and ensuring the quality of enrollment data processed by the vendor.

—Final Copy—

19. Using a list or data flow diagram, outline the path your CCO's enrollment data follow from receipt to maintenance. Please include the processes between your CCO and your subcontracted vendor.

20. Describe the process for linking enrollment data to claims and encounters, including any procedures for reconciling differences between data submitted on the claim/encounter and your CCO's enrollment data. If this function is managed by a subcontracted vendor, describe the vendor's responsibilities and your CCO's oversight of the process.

EDV QUESTIONNAIRE FOR CCOs

Section B: Data Exchange Policies and Procedures

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

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

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

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

Point of Contact	Description of Data Submission Responsibility

—Final Copy—

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

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

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

1. How are outpatient claims paid (e.g., percent of billed, line-by-line, case rate, etc.)? If different methods exist, list by percentage of claim dollars for each payment type. Describe how each of these payment arrangements are reflected in the encounter data submissions. If outpatient visits are paid for through sub-capitated arrangements, please describe how your CCO determines the paid amount submitted to OHA.

2. How are inpatient claims paid (e.g., DRG, APR-DRG, per diem, percent of billed, etc.)? If different methods exist, list by percentage of claim dollars for each payment type. Describe how each of these payment arrangements is reflected in the encounter data submissions.

3. How are your CCO's pharmacy claims paid (e.g., based on a negotiated rate, ingredient cost, etc.)? If different methods exist, list by percentage of claim dollars for each payment type. Describe how each of these payment arrangements is reflected in the data submissions.

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

EDV QUESTIONNAIRE FOR CCOs

5. How is other insurance data collected? Are subcontracted vendors required to collect third party liability (TPL) data?

6. How are claims processed with TPL, including if other insurance is submitted after initial claim processing? Also, describe the TPL processes for your CCO's vendor data.

7. What source data is used to verify the accuracy of the Medicare crossover and other third-party claims information? Where does your CCO store payment information and the source data? Please describe any differences, if any, in processes between Medicare crossover claims and other third-party claims and how this information is populated onto encounters submitted to OHA.

8. If your CCO is not responsible to pay for a service due to payment from a primary carrier, how is the zero-pay claim reflected in the encounter data?

9. Are zero-pay claims for sub-capitated providers processed and submitted to OHA? If so, describe how the completeness and accuracy of the claims are assessed.

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

Section D: Encounter Data Quality Monitoring and Reporting

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

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

1. If encounter data are provided to your CCO by a vendor, third-party, or a subcontractor, how do you monitor completeness of encounter data submitted by your vendor(s)? Please include metrics in place or a description on how you monitor the volume you should receive versus the volume that you receive. If regular reports are used, submit a recent report example.

2. If encounter data are provided to your CCO by a vendor, third-party, or a subcontractor, how do you monitor the accuracy of encounter data submitted by your vendor(s)? Please include metrics in place or a description on how accuracy is being evaluated. If regular reports are used, submit a recent report example.

3. If encounter data are provided to your CCO by a vendor, third-party or a subcontractor, how do you monitor the timeliness of encounter data submitted by your vendor(s)? If regular reports are used, submit a recent report example.

4. Does your CCO have monitoring metrics in place to evaluate the quality of your encounter data submissions?

   ☐ Yes (If YES, please describe the evaluation metrics)
   ☐ No (If NO, please describe how you ensure the quality of your encounter data submissions)

5. How does your CCO monitor the accuracy of claims and encounter data submitted by your providers? If regular reports are used, submit a recent report example.

6. How does your CCO monitor the completeness of claims and encounter data submitted by your providers? If regular reports are used, submit a recent report example.

7. How does your CCO monitor the timeliness of claims and encounter data submitted by your providers? If regular reports are used, submit a recent report example.

8. Does your CCO have a process to monitor the status of encounter data submitted to OHA?

   ☐ Yes
   ☐ No (If NO, skip to Question 9)

   If YES, describe the monitoring and reporting mechanisms, including pertinent supporting policies, procedures, and sample reports (e.g., claims volume reports).

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

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

—Final Copy—

10. What is the average percentage of encounters submitted to OHA that get rejected by OHA's Electronic Data Interchange (EDI) translator?

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

12. What is the average percentage of encounters submitted to OHA that pass OHA's EDI translator but are pended by OHA's Medicaid Management Information System (MMIS)?

13. Describe your CCO's process for reconciling files pended by MMIS, including key policies and procedures for the identification, correction, and subsequent resubmission of pended encounters to OHA.

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

15. What internal challenges do you face in submitting encounter data to OHA?

16. What external challenges do you face in submitting encounter data to OHA? For example, are there challenges with OHA's EDI translator or the MMIS.

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

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

Attestation Statement

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

_____   _____

Signature of CEO or responsible individual   Date

_____

Print name and title

This section summarizes the findings from **OHA**'s questionnaire responses.

Encounter Data Sources and Systems

The list below summarizes OHA's encounter data process:

- OHA processes Medicaid claims through an automated claims processing system, the Medicaid Management Information System (MMIS). OHA uses this system to process claims.

- All CCOs and/or the CCOs' subcontractors submit dental encounters in the 837D format, professional encounters in the 837P format, and institutional encounters in the 837I format via Edifecs translator editing prior to reaching MMIS, where MMIS performs additional edits to the encounter after EDI acceptance. The Edifecs translator editing would reject claims that do not meet the compliance requirements of the transactions and validity of code sets.

- Each week, MMIS produces a submission report that lists all encounter claims submitted. The OHA encounter data liaison reconciles the report with the submission certification form submitted by each plan. OHA sends the results of the reconciliation as a claim count validation to each CCO's identified claims contact.

- Four times daily, the system audits all claims received since the last cycle to ensure that they conform to program policy. Every weekend, a payment cycle runs, which finalizes all claims processed during the previous week and creates the electronic remittance advice (835). The 835 lists all encounter claims paid, denied, or denied requiring correction. The 835 is delivered the Monday after this cycle to Oregon MMIS trading partner mailboxes.

- OHA also sends a weekly status file that identifies which encounter claims remain in a Denied Must Correct (DMC, or "pended") status. This file reports only historical DMC claims that have been in that status for at least a week.

- Additionally, OHA provides files or feedback to CCOs' submitters through a technical acknowledgement (TA1) (if the file is fully rejected) or a 999 response acknowledging receipt of the file. Following processing, the CCO receives an 835 and several other reports (e.g., status file, error reports, etc.) regarding processing of data.

- MMIS processes all claims in real time, but the actual financial cycle occurs weekly. All encounter claims are available for review on the Web portal in real time.

For provider data, OHA uses the information from the FFS providers (which the CCOs use), received from Todd Howard and the Provider Enrollment Unit (PEU) team. For CCO-only providers, the CCO would request enrollment through the Web portal following their credentialing. The provider enrollment specialist then checks all exclusions, tax ID number, license, etc., and processes the enrollment request. Full revalidation of enrollment is performed once every five years. The validation and revalidation of provider data is a manual process, where the encounter-only process follows the same reviews as the

regular FFS provider review process. Encounter data submitted by the CCOs are checked to determine if the providers on the claim are actively enrolled into MMIS for the date(s) of service.

The Medicaid individual and eligibility data are captured and stored in the Oregon Eligibility (ONE) system. The ONE system Worker Portal and Applicant Portal have various on-screen and back-end validation functionalities to prevent missing or incongruent information. The ONE system also triggers electronic verification interfaces as the user navigates through data collection; where client-attested information is discrepant with verification sources, applicants are requested to provide verification. Once validation is complete and eligibility is determined, Medicaid enrollments are captured and validated by the Systems of Record and Maintenance for Member Eligibility and Enrollment database. MMIS receives information from these systems via data feeds/files. Each feed/file is validated for layout compliance; however, the content of each Medicaid eligibility and enrollment record is assumed to be accurate. Subject matter experts representing MMIS, the Office of Business Information Services, the Claims and Encounter Unit, the Delivery Systems Support Unit, Medicaid/CHIP eligibility policy, and Client Enrollment Services work closely with OHA's partners from Deloitte—the contractor with whom Oregon is working on development and maintenance of the ONE system. This cross-functionality collaboration includes system data matching, analysis of anomalies and discrepancies, and end-to-end planning and testing for system code- and data-fixes, when needed. Daily, OHA sends the 834 files to the CCOs with any changes from the previous day. Once a month, an audit file of full enrollment records is sent for reconciliation. OHA receives daily updates from source systems and weekly auto-assignment changes as well.

Data Exchange Policies and Procedures

OHA has developed data exchange policies and procedures for the CCOs through CCO contracts, 837D/I/P and NCPDP guidelines, and an encounter data instruction guide. The CCO contracts contain contractual requirements for encounter data submissions, such as what and when to submit. The companion guides and encounter submission instruction guide list the file specifications for standard HIPAA transactions and OHA-specific requirements. OHA describes in its response that the CCOs submit all encounter data using the X12 and the NCPDP D.0 national standard transactions. Additionally, the CCOs are able make adjustments on the MMIS Web portal.

In response to OHA's policy regarding Medicaid encounter audits, OHA noted that encounter claims are put through translator edits before reaching MMIS and various MMIS edits to determine validity of the data. However, per OHA in its response, for a postprocessing audit, the audit process would have to be referred to another unit within OHA.

OHA's encounter and claims data are not lost in the event of a system failure, due to continuous back-ups, ongoing disaster recovery (DR) replication, and high availability hardware architecture. Incremental backups are performed daily, and full backups are performed weekly. Additionally, a comprehensive disaster recovery drill is conducted annually. OHA also noted that backups are tested when lower environments are refreshed:

- The electronic data interchange (EDI) environment is refreshed weekly
- The user acceptance testing (UAT) environment is refreshed once a year
- The IE and performance environments are updated per State request.

Additionally, the DR backups are validated yearly during the DR drill.

The storage area network (SAN) replication prevents corruption of data in the event of hardware failure. In the event of full system failure, the DR is available with Medicaid data that are continuously replicated.

To ensure all data entered into the system are fully accounted for, OHA noted that received batches are archived in the system and can be accessed as needed, where each process generates processing logs that are viewed regularly. If data were identified as corrupted during any of these processes, the data are reviewed for corruption errors and compliance prior to restarting the process.

To ensure that updates to the State's requirements for data submission are implemented and communicated to each CCO, OHA noted that it has a multi-pronged approach for communication, including CCO leadership meetings and All Plan System Technical (APST). Additionally, OHA indicated in its response that documents are updated and testing is performed, which includes sharing information with the CCOs on outbound changes and receiving test files from the CCOs on inbound changes.

Management of Encounter Data: Collection, Storage, and Processing

Figure C-1 below, provided by OHA, shows the flowchart outlining the structure of its complete MMIS.

Figure C-1—Medicaid and MMIS Overview Flow Chart
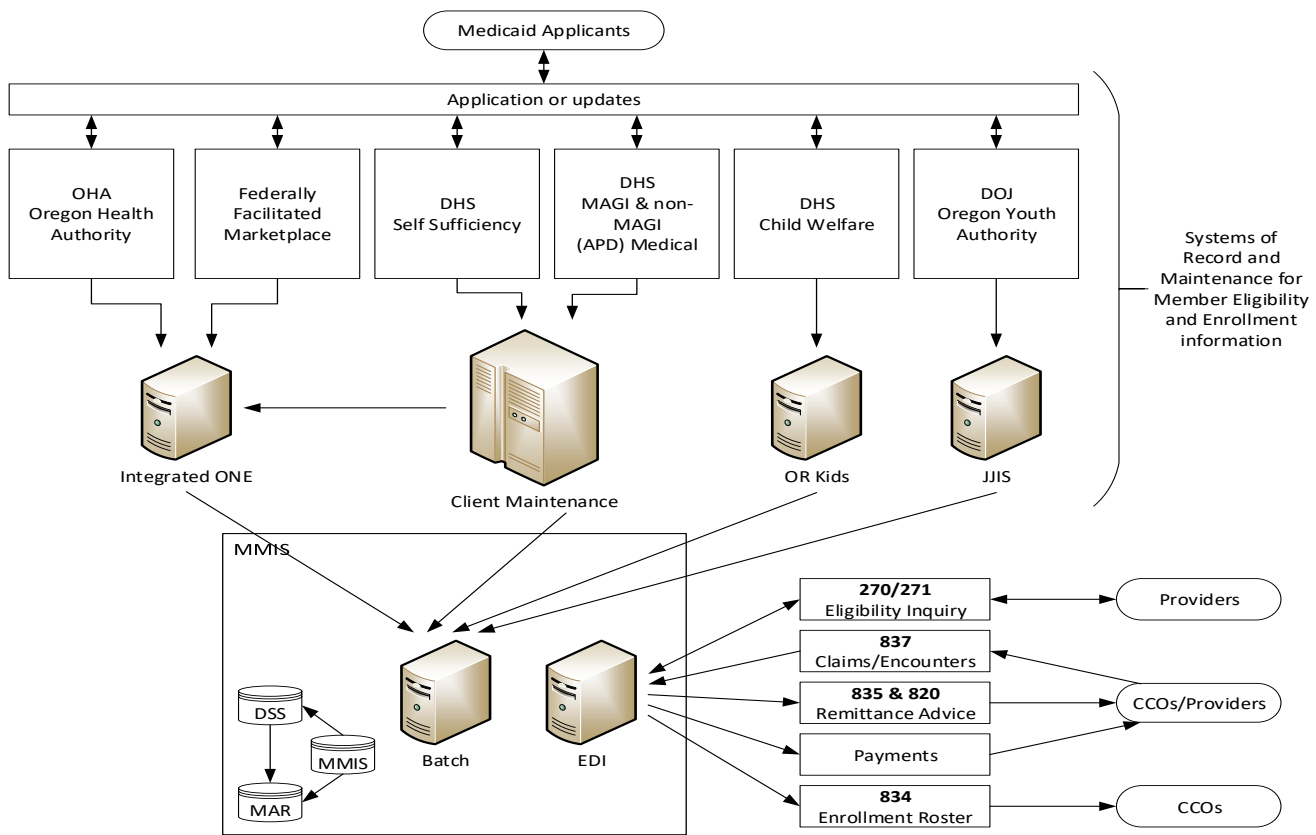
Per OHA's response, from the MMIS perspective, the MMIS data are stored within the MMIS database, where the MMIS database is the source of the Delivery System Subunit (DSS) database information. Additionally, the sources of the Management and Administrative Reporting (MAR) database are the MMIS and DSS databases.

OHA notes that there are several processes that transfer data from the main MMIS database into the Decision Support, Surveillance and Utilization Review (DSSUR) system. Each of the processes has different purposes and schedules:

- Weekend cycles to refresh the database warehouse with the most current information from MMIS; information that includes adjudicated claims, capitation payments, and other financial transactions.
- Daily eligibility extracts.

There are also additional processes that transfer data from the MMIS and DSSUR databases into the MAR database, with each of the processes having different purposes and schedules:

- T-MSIS monthly cycle, which transfers data from DSSUR to MAR database.
- Monthly MAR cycle, which transfers data from DSSUR and MMIS to the MAR database.

Edifecs and MMIS have edits in place to ensure that required fields such as member ID and provider ID are provided for a record to be processed. Additionally, there are system reports that are created to review duplicates (based on MMIS edits), which are communicated and reviewed with each impacted CCO. For missing encounters, OHA noted in its response that it has created a system tracker that reviews every file received by the translator and shows whether the files were fully successful, partially successful, or a full fail. CCOs are required to provide an explanation of what occurred when there is an out-of-balance file and to track the correction through to completion.

Of note, when processing CCOs' encounter data submissions, OHA noted that it does not modify or reformat any data elements.

Encounter Data Quality Monitoring and Reporting

To evaluate the quality of CCO monthly encounter submissions, OHA's Claims and Encounter Data Services Unit (CEDSU) team noted in its response that it has various receipt and validity editing that is reviewed and reported. OHA ensures the accuracy and completeness of encounter data by using the MMIS edits, historical data, and error reports. The metrics used are based on contract requirements, which specify a certain percentage associated with certain errors. OHA also noted that it has reports that monitor each requirement in the contract and follows the contractual requirements for submission to be able to enforce any corrective action.

To monitor the timeliness of encounter data submitted by the CCOs, OHA uses the contract requirement that no more than 5 percent of encounter data can be sent more than 45 days past the date of adjudication for a service month. Timeliness monitoring is conducted weekly by the liaison within CEDSU. However, OHA noted that it does not have performance standards, beyond what is described in the CCO contract requirements, in place regarding submission, accuracy, and timeliness of encounter data.

In its response, OHA noted that CCOs are required to submit a report detailing the number and dollar amount of encounter submitted as part of the encounter data submission activities. If the information in the report does not match what was processed, research and response is required by the CCO. Pended encounter claims sent to the CCOs are also required to be corrected by the CCOs and are monitored to ensure correction within the 63 days allowed in the contract.

While encounters submitted to OHA that get rejected by OHA are sent to the CCOs, OHA does not track the number of encounters within the file.

For encounters submitted by CCOs' capitated providers/provider groups, OHA requires the CCOs to report the amount they paid or report the reason for nonpayment. While OHA does not monitor capitated encounters for unallowable services, DXC provided a process in maintaining this list:

- HCPCS codes are loaded quarterly, and OHA policy determines if codes (services) would be open for coverage. This configuration is maintained in the Benefits Configuration reference panels within MMIS.
- CCOs may decide to pay for services that the plan configuration would not allow. However, State policy permits encounters to include such services. A functionality in MMIS can be enabled so that encounters with unallowable services are denied.

Data in OHA's encounter data system are used in various capacity, such as rate setting; HEDIS reporting; quality metrics; and reviews on accuracy, completeness, and timeliness, etc.

Recommendations

Based on its review, HSAG recommends the following for **OHA** to strengthen its encounter data quality:

- HSAG recommends that OHA consider developing and distributing a comprehensive list of operational edits associated with the error categories identified in the feedback/response files. Some CCOs indicated that resubmission of rejected encounters by the CCO is challenging when reasons for the rejection are not clearly detailed. Distributing an updated, comprehensive list describing the nature of the errors and providing technical assistance sessions allows the CCOs to 1) have a better understanding of which claim-related elements are important in their encounter submission process, and 2) conduct their own investigations in a more efficient manner.
- HSAG recommends that OHA work with the CCOs to determine the data submission requirements pertaining to provider mapping. State provider mapping was identified by the CCOs as one of their challenges to the submission of complete and timely encounters to OHA. Based on OHA's questionnaire response, it appears that MMIS is adjudicating both claims and encounters submitted by the plans, based on the FFS provider enrollment. While accurate provider information is paramount in processing claims, such verification and validation responsibilities should reside with the CCOs, with OHA acting as an oversight entity to ensure that the CCOs are collecting and processing accurate provider information. OHA may want to consider strengthening its contractual requirements with the CCOs regarding provision of oversight activities in this area, allowing the CCOs to identify any potential issues related to provider data when claims/encounters are received in their systems. This approach would minimize any provider data anomalies noted at the very end of the CCOs' encounter submission process and allow the CCOs to work with their contracted providers to ensure information is provided accurately when the claims are first submitted to the CCOs.

  Alternatively, OHA may want to consider a managed care provider management system, where credentialing verifications would be completed electronically in an automated fashion, with final approval remaining as a manual task by staff. All existing providers would be sent registration information and asked to register in this system, while new providers would begin with an application and upload required documents. Once verified and approved, they would receive

provider IDs. Daily file updates could be generated and sent to the CCOs to use for encounter verification prior to submission.

- While several CCOs demonstrated that chart review is one of the validations conducted to ensure accuracy and completeness, some CCOs did not indicate such activities were being conducted. As such, HSAG recommends that OHA consider requiring all CCOs to conduct a standardized validation of encounter data using medical record reviews. To facilitate this process:
    - Develop an annual process to assess the CCOs' data validation capacity and capabilities among encounters submitted to OHA, as well as to ensure the CCOs' accountability for claims and encounter data validation.
    - Establish validation guidelines for use by the CCOs in conducting their internal validation. The guidelines may assist with improving the quality of encounter data submitted by the CCOs to OHA and may include, but not limited to, the file format and reporting requirements to guide the CCOs in conducting their internal validation.
    - Results from these reviews may be submitted to OHA for use in its ongoing data monitoring.

This section summarizes the findings from Advanced Health's (**AH**'s) questionnaire responses.

Encounter Data Sources and Systems

For professional and institutional claims, **AH** receives claims directly from its providers or delegates via paper or electronic claims. Pharmacy claims and dental claims are processed by its vendors MedImpact and ADS, respectively. All paper claims are received by Workers Compensation (WC)-EDI via mail, and paper claim sent directly to **AH** in error are forwarded to WC-EDI via mail. All paper claims are date stamped upon receipt and scanned with optical character recognition (OCR) software by WC-EDI; images are retained for viewing via WCEDI's online portal. Scanned claims are then converted to HIPAA 5010 compliant Accredited Standards Committee (ASC) X12 837 files via OCR and submitted to **AH** for electronic claims processing. Electronic claims are submitted to TriZetto Payer Solutions (clearinghouse) in the HIPAA 5010 compliant ASCX12 837 file format. **AH** may also receive "crossover" claims directly from CMS. All electronic claims are received by VisibilEDI (gateway) and forwarded to **AH** for processing and adjudication. **AH** noted that it does not accept faxed claims and any unsolicited claims received via fax are securely destroyed.

Table D-1 shows **AH**'s format and submission frequency of pharmacy, dental, and other encounters received.

Table D-1—Format and Submission Frequency for Pharmacy, Dental, and Other[1] Encounters

	Pharmacy	**Dental**	**Other[1]**
Data Receipt	MedImpact	ADS	From providers or delegates
Format	NCPDP	837D	837P, 837I, and paper
Frequency	Biweekly	Weekly	Daily
Approximate Volume	9,163	1,050	1,815

[1] Includes professional, institutional, behavioral health, vision, and transportation encounters

- **AH** noted that for claims that are processed internally, 100 percent of the claims are auto adjudicated or manually reviewed at the time of adjudication and manually reviewed using various reports prior to payment.

- **AH** sends encounter data to VisibilEDI in the form of 837 claims data files that contain payment and adjudication information for all claims (except pharmacy claims and those submitted by ADS), which **AH** processes in-house. ADS also submits its encounters to VisibilEDI.

- The VisibilEDI portal identifies potential errors and pre-pend encounters for review. Non-pended encounters are then submitted to OHA, while pended encounters are corrected in either the claims adjudication system or the VisibilEDI portal as needed.

- **AH** noted that whenever possible, encounter data are submitted to OHA in the same way they were received. However, some data modifications are necessary, such as:
  – Deleting value codes submitted with zero padded on paper that are not X12 compliant.
  – Revenue codes starting with zero are padded to 4 characters.
  – Patient control numbers are replaced with internal claim numbers.
  – Taxonomy codes are mapped to providers as needed.
  – Duplicate diagnosis codes and ICD-10-CM procedure codes are removed.
  – DRG payments on the first line are moved to the claim header.
  – Standalone EKG/radiology provider National Provider Identifier (NPI) is replaced with clinic NPI to be encounterable.

- As noted previously, ADS maintains its own claims processing system; however, the encounters are submitted to VisibilEDI for submission to OHA. Additionally, pharmacy encounters are submitted to **AH** by MedImpact and subsequently uploaded to OHA. Of note, while outside vendors or contractors are generally not used to complete adjudication, **AH** noted that it has an arrangement for two transplant members through Optum, which provides access to a transplant provider. The provider sends the claims to Optum, which then prices them accordingly at the negotiated rate and forwards the claims to **AH** for manual entry and payment.

- In response to whether **AH** submits all types of encounters to OHA, **AH** noted that it submits all claims for which it did not "reject liability," defined by OHA using the Adjustment Group Code "PI." According to **AH**, most "PI" denials are submitted; however, VisibilEDI dropped the following "PI" claims denials that are not submitted to OHA:
  – Claims denied for duplication
  – Claims denied for ineligibility
  – Claims denied as bill correct carrier

  Additionally, crossover SNF claims paid by Medicare are not submitted to OHA, while therapy claims that may be billed directly to **AH** are subsequently encountered and submitted to OHA.

- In handling adjusted encounters that have been previously submitted, **AH** noted that every week following the claims run, a weekly encounter data extract is generated and uploaded to VisibilEDI, which includes all claims processed or reprocessed that week. **AH**'s claims analysts reprocess finalized claims as necessary within the claims processing system. These reprocessed adjustments are then subsequently submitted to VisibilEDI via the weekly encounter data export. VisibilEDI then submits the reprocessed claim as an original if not previously accepted by OHA. VisibilEDI will drop a voided claim if the original was not previously accepted by OHA. For claims that have been previously accepted, VisibilEDI will void the original encounter with a frequency code of "8" or replace the original encounter with a frequency code of "7" as needed.

- **AH** collects, stores, and maintains its provider data. Its current system requires that provider information be configured in the system prior to claims submission. Contracted providers are configured at the time of contracting and credentialing. For noncontracting providers, **AH** provides forms and instructions on its website to instruct and encourage providers to complete the setup process prior to submitting claims. Claims that are submitted prior to provider setup may be rejected.

When possible, the business process specialist may be able to validate that the provider has a valid Oregon Medicaid ID and use OHA's provider directory file, along with the information on the claim, to configure the provider. Claims are linked to the appropriate provider record based on the NPI.

- Per **AH** response, generally, the provider information does not require modification to comply with OHA's provider data submission requirements. One exception is that for some providers (typically facilities) VisibilEDI maintains a Taxonomy Crosswalk that allows the encounter to be associated with the appropriate Oregon Medicaid ID. Providers may be assigned multiple IDs by OHA, and these IDs are limited in scope. OHA's encounter data system does not always map to the appropriate ID for a given provider based on the service type; as a result, the encounters may be pended in MMIS. To resolve this issue, VisibilEDI will submit the appropriate taxonomy to OHA based on the type of claim (professional or institutional).

- **AH** internally manages member enrollment and updates member information based on enrollment data, which come directly from OHA in the form of ASCX12 834 enrollment files. **AH** does not make independent determinations regarding eligibility. MMIS is the source of truth for all discrepancies.
    - OHA generates and distributes the 834 files daily for each plan type: CCOA (physical, dental and mental health), CCOB (physical and mental health), CCOE (mental health only), and CCOG (mental and dental health). These files are downloaded daily and processed into the core system. First, eligibility files are processed into a staging and archival database. Next, individual addition (021), termination (024), and reinstatement (025) records are processed and compared against the enrollment data in the claims adjudication system. A proprietary file is then generated containing addition and termination records as appropriate. This file is then loaded into the claims adjudication system. Errors are compared against MMIS and any discrepancies are resolved.
    - Monthly, OHA provides an audit-file 834 comprised solely of audit (030) records for members who are eligible on the first of the month. **AH** processes this file to ensure that all member demographics are updated and that no discrepancies exist.
    - **AH** also generates enrollment files for its pharmacy benefit manager (PBM) (MedImpact), as well at its after-hours nurse call center (SteriCycle) based on the daily and monthly 834 files from OHA.
    - **AH** passes through the 834 files it receives from OHA to ADS, as well as Bay Cities Brokerage (NEMT vendor).
    - For all other providers, **AH** maintains a Web portal with real-time eligibility lookup.

Data Exchange Policies and Procedures

AH has internally developed policies and procedures aimed at collecting, translating, storing, and transmitting encounter data that meet OHA's submission specifications. **AH** submits encounters on a weekly cycle. Following the weekly claims payment run, claims "paid" or adjusted during the week are extracted and transmitted to VisibilEDI for submission to OHA. VisibilEDI may flag encounters that do not comport with OHA's encounter data rules. These are known as pre-pends. The systems coordinator

will work with VisibilEDI and internal claims processing staff members to resolve these pre-pends. The business process specialist resolves pended encounters within MMIS.

ADS submits encounters directly to VisibilEDI on behalf of **AH** and follows similar processes, correcting encounters in the VisibilEDI portal or MMIS as needed.

NCPDP files are submitted to OHA every two weeks. MedImpact provides **AH** with NCPDP files for submission to OHA. These files are parsed to ensure that individual members are associated with the appropriate health plan (CCOA, CCOB) prior to submission; the files are then submitted directly by **AH**.

Management of Encounter Data: Collection, Storage, and Processing

Table D-2 shows **AH**'s pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table D-2—Pricing Methodology for AH

Outpatient[1]	Inpatient[2]	Pharmacy
- Line by line: 13% - Per diem: 1% - Percent of billed: 43% - Capitation: 44%	- DRG: 39% - Percent of Billed: 8% - Capitation: 53%	- Based on contracted rates, ingredient costs, and administrative/dispensing fees - Actual amount that the member pays for the claim is reflected in the first instance of the COB segment (Segment 05) for all Oregon Encounters, which in NCPDP D.0/1.2 is field 431-DV

[1] The paid amount on the encounter reflects the actual amount paid on the claim at the time of adjudication. For example, a capitated claim would have a payment amount of zero dollars and claim adjustment reason code (CARC) 24 adjustment. A percentage of a billed claim would have a payment value equal to the appropriate contacted percentage, and a CARC 45 adjustment for the balance (write off).

[2] As with the outpatient payment methodologies, the paid amount on the inpatient encounter reflects the actual amount paid on the claim at the time of adjudication.

- In response to whether there are any services submitted to **AH** under bundle-payment structures, **AH** noted that the bundle-payments are typically the result of NCCI edits, or services performed within the global period of another procedure. Prenatal care is also generally bundled into the maternity package. As such, bundled payments are adjusted with appropriate claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs), and are submitted as zero-paid encounter data.

- **AH** created a dedicated email address to facilitate the collection of TPL data. Providers, vendors, and internal staff members are encouraged to send a message to specific email addresses to report additional insurance or to report situations where a third party may be liable (e.g., motor vehicle accident, workers' compensation, etc.). This information is stored within the core claims adjudication system and reported to the health information group. Additionally, providers frequently submit an EOB for primary payers for which **AH** may or may not have been previously aware of.

The 834 files from OHA contain information on TPL or coordination of benefits (COB). Subcontracted providers and vendors are required to collect and report TPL information.

AH is the payer of last resort. The result of the prior payer is indicated on the claim by the presence of CARC 23. If TPL is identified after a payment has been issued, the original payment would be recouped. As noted previously, Advance Health processes all claims for all vendors internally, with the exception of ADS and MedImpact, and therefore directly ensures that TPL rules are enforced for most encounters.

- Medicare crossover claims are received directly from CMS and are therefore generally considered to be valid. Anomalous claims may require additional chart review. Primary payment information is stored in the VisibilEDI portal and reviewed by claims analysts at the time of adjudication. There are no significant differences between Medicare crossover claims and other third-party claims. The primary-payer allowable is compared against Advance Health's allowable to determine the lowest value. Adjustments are then applied to the claim line items to reduce the payment accordingly. CARC 23 will reflect the amount paid by the prior payer and will be a value between 0 and 100 percent of the prior payer's allowed amount. In the event that the prior payer's allowable is less than **AH**'s allowable, CARC 45 will be used to reflect the difference. The remaining balance may be paid FFS or be adjusted further with CARC 24 to indicate that the service was capitated. In either case, the amount paid on the encounter reflects the actual amount paid for that claim (which would be zero for capitated services).

- **AH** noted that zero-pay claims for subcapitated providers are processed and submitted to OHA. This ensures completeness and accuracy by monitoring the Low and Zero Paid Claim Monitoring Dashboard. This dashboard tracks the volume of low and zero-paid claims received by providers. The dashboard is reviewed by a compliance officer who determines if there are any inconsistencies. Inconsistencies are investigated and **AH** will work with providers and vendors to resolve issues, if appropriate.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, in addition to reviewing reports generated, (such as claim status report, claim error report, etc.) as well as not issuing payments for claims deemed incomplete due to missing or inaccurate data elements, **AH** conducts the following activities:

- Completeness:
    - While ADS does not submit claims to **AH** for payment, it provides **AH** with copies of the 837 files that are submitted to VisibilEDI (and subsequently to OHA) as encounter data. These files are parsed into a database and utilization is analyzed quarterly. The 835 response files from OHA contain data for both **AH** and ADS submissions.
    - All other vendors submit claims directly to **AH**, which are reviewed and adjudicated as part of the weekly claims payment cycle. Vendors (including ADS) are given a claims/audit pull list to submit documentation for a specific quarterly time frame.

- Accuracy:
    - As part of the Post Payment Integrity policy and procedure; **AH** uses a standardized scoring tool (Chart Audit and Review Form) for all claims/audit documentation review to verify the appropriateness of service(s) provided to members and accuracy of billing/coding for reimbursement.
- Timeliness:
    - As noted previously, with the exception of ADS and MedImpact, all encounters are submitted to **AH** as unpaid claims and processed through the core claims adjudication system. As such, they are subject to timely filing requirements, and volume is monitored weekly.
    - MedImpact submits encounters to **AH** every two weeks. Should MedImpact fail to provide the biweekly NCPDP file, the director of health information systems would contact MedImpact immediately.
    - ADS provides weekly parallel encounter data files to **AH** and VisibilEDI consistently. If a lapse in submission is observed, the director of health information systems contacts ADS immediately.

To monitor the completeness, accuracy, and timeliness of the encounter data submitted by its providers, **AH** conducts the following activities:

- Completeness:
    - In addition to the aforementioned Low and Zero Paid Claim Monitoring Dashboard and general utilization monitoring across the network, an analysis of each week's claim run is performed on a billing-provider level to ensure that weekly submissions are in line with expectations from both a payment and volume perspective.
- Accuracy:
    - Beyond the normal claims review process that occurs weekly prior to payment, **AH** engages in postpayment activities to monitor the accuracy of claims and encounter data. A monthly survey letter is sent to a random sampling of members based on claims data to verify that services were performed. Additionally, as previously mentioned, a random sampling of charts is requested from providers/vendors for auditing purposes.
- Timeliness:
    - **AH** imposes timely filing requirements on providers to ensure that claims are submitted timely. Claims submitted untimely are generally denied. Note that as part of the response to coronavirus disease 2019 (COVID-19), **AH** temporarily waived timely filing for all claims submitted within 12 months of the date of service. The 120-day timely filing rules were reinstated as of September 1, 2020.

AH also has processes in place to monitor the status of encounter data submitted to OHA. In addition, **AH** has monitoring metrics in place to evaluate the quality of its encounter data submissions. **AH** performs a review of encounter data submissions by comparing internal data with the actuarial datasets provided by OHA annually (or more frequently if data are available). **AH** is currently working toward greater reconciliation of the 835 provided by OHA to the original claims stored within the adjudication system/database. Beyond just determining if a claim was successfully encountered, this will allow for

more real-time assessment of the fidelity of encounter data within MMIS to ensure that no payment elements were lost in translation.

AH also processes the 999 response files, the 835 file, the National Council for Prescription Drug Programs (NCPDP) response file, and the status file received from OHA so that it can monitor the rejection and errors, and process the corrections and resubmissions, if necessary.

At the time of the questionnaire submission, **AH** noted that it had submitted 518,065 encounters since January 1, 2020, and had 790 (i.e., 0.1525 percent) of those encounters rejected by OHA's EDI translator. VisibilEDI monitors the rejected submissions and will correct errors and resubmit as necessary. Additionally, **AH** processes all response files distributed by OHA and stores the internal control number (ICN) numbers assigned by OHA within a database that associates the encounter to **AH**'s internal claim number. This allows for **AH** to easily monitor the disposition of each claim. Any unencountered claims are reviewed jointly by VisibilEDI and **AH** during their weekly meetings where resolutions were discussed.

Among the 518,065 encounters submitted since January 1, 2020, 963 (i.e., 0.186 percent) were pended by OHA's MMIS. OHA produces the "status file" every week, which indicates pended claims within MMIS. This file is parsed and loaded into a database every Monday morning, and a report is generated. The business process specialist reviews the report, makes corrections in MMIS as necessary, and works with claims staff members to reprocess claims as necessary. Pended encounters for ADS are sent to ADS for correction in MMIS.

In response to describing how the encounter data system and data warehouse were used, **AH** noted that its Analytics Department uses encounter data for quality reporting, decision support, contract evaluation, value-based payment design/rate-setting, financial analysis, State-mandated reporting, and other reporting tasks.

AH noted the following challenges faced in submitting encounter data to OHA:

- Internal challenges:
  - **AH** noted that it had overcome numerous challenges in recent years mainly due to moving away from its previous antiquated encounter data software (Dakota Data) to the VisibilEDI platform. This has allowed a much greater degree of insight and oversight of the encounter data submission process. Additionally, **AH** has greatly increased its ability to internally process response files (835, NCP, 999, Status, etc.) to allow for greater reporting and reconciliation. However, **AH** indicated that one remaining internal challenge is that **AH**'s current claims processing system does not have native support for electronic secondary/tertiary claims. **AH** noted that it implemented a workaround with the VisibilEDI portal while it waits for the implementation of a new claims processing system in the coming months.

- External challenges:
  - **AH** noted challenges related to OHA/MMIS rules. For example, Medicare crossover encounters may be denied, rejected, or pended by OHA because OHA's billing requirements are not aligned with CMS, such as SNF consolidated billing rules, yet the OARs state that CCOs are responsible

for copays and deductibles, even for services covered by Medicare but not necessarily covered by OHA.

– OHA's translator rejects duplicate ICD-10-CM procedure codes, which is allowed by X12.

– OHA issues multiple provider enrollments to individual providers, and MMIS does not always associate the claim with the correct enrollment.

– OHA does not have provider types for all providers (e.g., standalone EKG/radiology). **AH** indicated that OHA's solution is to have the facility bill with the medical director's NPI as the rendering provider. However, the facility refuses to do so, stating that it would be fraudulent.

– **AH** noted that providers are required to submit 100 percent of encounters to **AH**, but it is very challenging to monitor the level of completeness. Additionally, practice management systems are not generally designed to submit claims when no balance exists (e.g., secondary claims that have been satisfied by the primary payer).

AH noted in its response that while **AH** appreciates the resources OHA provides, such as facilitating monthly contractor meetings and the numerous reports provided by **AH**'s encounter data liaison, **AH** would appreciate additional support in the following areas:

- Greater clarity regarding MMIS edits (i.e., principal diagnosis edits and National Drug Code (NDC) requirements).

- More guidance on how OHA's actuarial services unit would like **AH** to reflect capitated claims.

- Additional resources for interpreting the 835 and MMIS adjustments.

At the time of questionnaire submission, **AH** noted that it is in the process of implementing a new claims processing system within the coming months. One key feature of this new system is that it will process secondary claims natively. It will also natively export 837 files to VisibilEDI, which will remove the need to extract claims.

Recommendations

Based on its review, HSAG recommends the following for **AH** to strengthen its encounter data quality:

- **AH** acknowledged that at the time of questionnaire submission, its claims processing system did not have native support for electronic secondary/tertiary claims. Therefore, HSAG encourages **AH** to pursue this capability to enhance its claims/encounter data processing efficiency.

- **AH** noted that it finds it challenging to monitor the level of completeness when providers are required to submit 100 percent of encounter to **AH**, while systems are not designed to submit claims when secondary claims have not been satisfied by the primary payer. HSAG recommends that **AH** add more metrics to actively monitor encounter data completeness, for example, by reviewing volume by service month, which would add a dimension to current completeness metrics through highlighting abnormally high (e.g., due to duplicates) or low (e.g., due to submission lags or incomplete data) volumes once trends have been established.

This section summarizes the findings from AllCare CCO, Inc.'s (**AllCare**'s) questionnaire responses.

Encounter Data Sources and Systems

Providers and other contracted entities typically submit professional (including physician, home- and community-based services (HCBS), laboratory, transportation, vision, behavioral health, and non-NEMT) and institutional (including inpatient, outpatient, and long-term care) claims or encounters through a clearinghouse (Availity Clearinghouse), which then transmits electronic 837P or 837I files to **AllCare**. For paper claim forms, these documents are scanned and sent using secure file transfer protocol (FTP) to JMS Associates. JMS Associates then uses proprietary processes to create an electronic 837P and 837I files which are returned to **AllCare**.

AllCare contracts with MedImpact to perform pharmacy contracting, benefit management, and claim/encounter processing. Pharmacies provide MedImpact with claims and encounters data, which MedImpact formats into NCPDP file format and provides to **AllCare**, along with additional encounter details in a proprietary file layout. Once pharmacy encounters are received by **AllCare**, they are submitted in NCPDP formatted files to OHA.

Dental contracting and claim and encounter processing are delegated to PH TECH, which is also an authorized submitter for **AllCare**'s dental encounters. After dental claims and encounters are processed, PH TECH submits dental claim and encounter files directly to OHA on **AllCare**'s behalf. A complete database copy, along with a copy of all submission and response files, is supplied by PH TECH to **AllCare** on a weekly basis to support additional reporting and extraction needs.

Table E-1—Format and Submission Frequency for Professional[1], Institutional[2], Pharmacy, and Dental Encounters

	Professional[1]	Institutional[2]	Pharmacy	Dental
Data Receipt	Electronic claims: Availity Clearinghouse Paper claims: JMS Associates	Electronic claims: Availity Clearinghouse Paper claims: JMS Associates	MedImpact	PH TECH
Format	837P	837I	NCPDP	837D
Frequency	Weekly	Weekly	Twice a month	Weekly
Approximate Volume	Varies	Varies	17,892	4,438

[1] Includes physician, (HCBS, laboratory, transportation, vision, behavioral health, and NEMT

[2] Includes inpatient, outpatient, and long-term care

- In response to whether **AllCare** modify or reformat its claims and encounter data to accommodate OHA's encounter data submission, **AllCare** noted that there are limitations to the number of transactions (i.e., 5,000 per transaction set), which requires intervention during the encounter data extraction process. Additionally, there are some limits on the days **AllCare** can submit files to OHA and the specific order of the claim adjustment reason codes.

- **AllCare** indicated that it does submit all types of claims/encounters to OHA. **AllCare**'s IT team is working on mapping the ICN, assigned by OHA, to each claim/encounter within **AllCare**'s core claim system. Once in place, **AllCare** noted that it will allow direct and accurate submission of voided or reversed claims/encounters presenting with the associated OHA's ICN for the original claim/encounter.

- In response to whether a CCO did <u>not</u> submit certain types of payments made on behalf of the Medicaid population and/or certain types of services rendered to the Medicaid population as encounters, **AllCare** noted that there are some opportunities for encounter submission for those services that fall under health related services (HRS) or SDoH, which are reported on the **AllCare** Exhibit L financial submission. **AllCare** has the ability to support nontraditional encounters in its core claims system, and many of these services have closely related HCPCS or Current Procedural Terminology (CPT) codes that could be used for encounter submission, but at this time there is no code set or outline from OHA to support encounters for all types of nontraditional providers and services.

- According to **AllCare**, the current process of transmitting adjusted encounters to OHA that have previously been submitted is a manual process performed by the claims department data specialist. Claims/encounters that have been reversed are identified on a weekly monitoring report, where the corresponding ICNs are provided to the claims department data specialist. To maintain financial integrity with OHA, **AllCare** voids the corresponding ICNs in the State's online systems. Reports are also generated that identify claims/encounters that did not pass through the OHA transponder to the OHA MMIS. Each of those claims is reviewed to ensure that it was appropriately omitted from claims and encounter data submission. While the process is currently manual, **AllCare** noted that its IT team is working on mapping the ICN to each claim/encounter within its core claims system to allow direct and accurate submission of voided or reversed claims/encounters of the associated ICN to the original claim/encounter.

- For claims that are processed internally, **AllCare** performs the following validation activities:
  - Professional and institutional (prepayment): To validate internal adjudication rules, **AllCare** performs an analysis for claims/encounters that may require additional review to ensure rules were applied correctly. The analysis is conducted on approximately 50 percent of live claims/encounters.
  - Professional and institutional (prepayment): Each business day, several monitoring reports on claims rules and adjudication processes undergo peer review and are reviewed by the claims department supervisor and seasoned claims analysts. The reviews involve 10 percent of the claims/encounters.
  - Professional and institutional (at time of receipt): Each business day, the in-load of 100 percent of claims that originated electronically or by way of paper are validated by the claims support

services team. Each in-load from each trading partner is tracked to ensure counts of claims and encounters are validated.

- **AllCare** noted in its response that prior to claims being adjudicated for payment processing, no code and/or field mapping are performed during data processing and validation. However, during data processing for submission to OHA, **AllCare** maps place of service 85 (Critical Access Hospital [CAH]) to code 22 (on-campus outpatient hospital). Additionally, NEMT rides and medication assisted therapy services are updated with an 'XE' (separate encounter) modifier to ensure they are not handled as duplicate when a member has multiple rides in a single day as a result of OHA not accepting industry standard edits on transportation claims.

- As noted previously, **AllCare** contracts with its DCOs and dental subcontractors to adjudicate dental claims and submit encounters, where one DCO contracts with PH TECH to adjudicate its claims and encounters, and the remaining contracted DCOs adjudicate their own claims and submit the 837D EDI files weekly to **AllCare**'s third party vendor, PH TECH, to incorporate into its proprietary system. **AllCare** receives email notification from the DCOs with information once completed, signed verification and attestation forms, and an encounter submission report.

  As also noted previously, MedImpact adjudicates point-of-service pharmacy encounters on behalf of **AllCare**. MedImpact provides both adjudicated (monthly) and nonadjudicated (daily) claims from MedImpact by way of a proprietary type 54 file daily, which **AllCare** audits annually or biannually and monitors regularly.

- **AllCare** collects, stores, and maintains provider data using IntelliSoft software. During the claim administrator processing step to link provider data to claims and encounters, the provider is looked up in the core claim system based on a combination of several field such as provider NPI, vendor NPI, vendor tax ID, and date of service to find a unique provider record. If no unique provider record is found based on the combinations of these fields, data are submitted for manual review. **AllCare** noted that when submitting provider data to OHA, it made no modifications to its provider data to comply with OHA's provider data submission requirements.

- **AllCare** reported that it maintains the member enrollment data in a core claims processing system, Citra EZ-CAP (EZ-CAP), after retrieving the eligibility file in an 834 format from OHA. During the claim administrator processing step to link member data to claims and encounters, the members are first verified and looked up in EZ-CAP based on a combination of several fields such as date of birth, last name, first name, patient ID, date of service, etc., to find a unique member record. The date of birth and member ID from the X12 file are matched with the EZ-CAP patient ID, while the date of service from the X12 file is matched with the member eligibility date. A member of the support service team reviews those claims and encounters that are rejected and verifies that the edit is correct. The claim or encounter is sent electronically back to the trading partner/clearinghouse, which then passes that rejection back to the submitting provider.

Data Exchange Policies and Procedures

AllCare imports medical claims and encounters received through its clearinghouse (Availity) and paper claims processed by its third-party vendor, JMS Associates, into its core claim processing system, EZ-CAP, using the Citra EZ-NET user interface. Once medical claims and encounters are imported into EZ-CAP, they are adjudicated using **AllCare**'s auto-adjudication rules or manually adjudicated by the claims department staff. Next, during the claims payment cycle, checks, explanation of payments (EOP), and 835 files are distributed back to providers either by mail or through the appropriate clearinghouse. The medical claims and encounters are then compiled into 837P and 837I claim/encounter files appropriately and submitted to OHA on a weekly basis using a secure FTP connection to OHA's servers.

As noted previously, **AllCare** DCOs and dental subcontractors send claims/encounters for submission, which is delegated to PH TECH. PH TECH is also an authorized submitter for **AllCare** dental encounters. After dental claims/encounters are processed and loaded into Community Integration Manager (CIM), PH TECH's proprietary system, PH TECH prepares an 837D extract and submits dental claim/encounter files directly to OHA on **AllCare**'s behalf. A complete database copy, along with a copy of all submission and response files, is supplied to **AllCare** by PH TECH weekly to support additional reporting and extraction needs. Monitoring of PH TECH's data is accomplished through reviewing daily claims/encounter imports by the submitting DCO or dental subcontractor, validation counts of accepted and rejected claims/encounters, multiple internal monitoring reports, and data from PH TECH directly.

AllCare contracts with MedImpact to perform pharmacy contracting, benefit management, and claims/encounter processing. MedImpact formats claims and encounter data from pharmacies into an NCPDP file and provides this file to **AllCare** along with additional pharmacy encounter details in a proprietary file layout. **AllCare** then submits the NCPDP formatted file to OHA. **AllCare** staff members monitor member claims/encounters to ensure the accuracy of the claims/encounters and conduct weekly calls with MedImpact to review all current projects and troubleshoot any challenges that have come up.

Management of Encounter Data: Collection, Storage, and Processing

AllCare contracts with both DRG (acute care) Hospitals and Type A/B Hospitals. All DRG acute care hospitals are paid at a percentage of CMS OPPS/IPPS, while Type A/B Hospitals are paid at a percentage of billed charges based on the OHA published Type A/B Hospital Reimbursement. Contracted Type A/B hospitals can have a variance of the percentage determined by contract, but the methodology remains the same.

CMS OPPS pricing for acute care hospitals is presented on the CMS identified line with the payable CPT/HCPCS code, while other net zero paid line items are listed as zero net pay. Both net zero pay lines and paid lines are submitted for encounter purposes. The payment amount for the DRG acute care hospital for inpatient claims is presented in encounter data submissions on the room and board line (i.e., revenue codes 010X–021X).

Type A/B hospital payment methodology is a percentage of each billed line, so payment is reflected on encounter data per line item.

Table E-2 shows **AllCare**'s pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table E-2—Pricing Methodology for AllCare

Outpatient	Inpatient	Pharmacy
• DRG: 85% • Percentage of billed line: 15%	• DRG: 96% • Percentage of billed line: 4%	• **AllCare** negotiates rates with MedImpact every three years during contract renewal with an additional annual adjustment based on market rate changes • Rates are based on a percentage of medication cost plus a flat fill rate • In 2019, 91.9 percent of medications dispensed were generic and 8.1 percent were classified as brand

- In response to whether there are any services submitted under bundle-payment structures, **AllCare** noted that its contract team is currently working with its actuarial analyst and APM manager to develop bundle service agreements that benefit the CCO but maintain fairness with its provider community. At the time of the questionnaire submission, **AllCare** is only using the bundle-payment methodology through IPPS and OPPS.

- **AllCare** noted that other insurance data are collected by means of an attached EOB with the claim/encounter or by primary information as indicated on the CMS 1500 or UB04, where the information is reviewed by each business day. **AllCare**'s claims support services reviews the member information in **AllCare**'s core system to determine if **AllCare** has the information regarding the other insurance or TPL listed. If not listed in **AllCare**'s core system, a copy of the presenting documentation is sent to the Member Services Department to notify OHA/Health Insurance Group (HIG) of the other insurance for that member, and the **AllCare** core system is updated to indicate COB /TPL. Claims and/or encounters are then processed based on the presenting documentation as secondary. If documentation supporting other insurance is presented with no payment from the other insurer, the claim/encounter is denied until all appeals have been exhausted. By law, **AllCare** is the payer of last resort.

- For services that **AllCare** is not responsible for due to payment from a primary carrier, **AllCare** reviews the zero-pay claim and determines if payment applies to a line on the claim. During the adjudication process, the claim line items are adjusted to reflect the primary payer payment along with an industry standard CARC 23. Those encounters or claims for which there is no secondary payment by **AllCare**, the adjustment 23 code with a net zero payment is presented in the encounter data. The zero-pay claims for subcapitated providers are processed and submitted to OHA. The completeness and accuracy of these claims are assessed through chart reviews performed on an annual basis.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **AllCare** conducts the following activities:

- Completeness
  - For PH TECH, **AllCare** monitors daily claims imports, the source, count, and rejected claims/encounters based on multiple internal monitoring reports and data from PH TECH. **AllCare** also conducts annual DCO audits based on claims that are pulled randomly from PH TECH and reviewed against dental records.
  - For MedImpact, **AllCare** performs a full program audit each year to ensure that MedImpact is meeting contract expectations. Particular attention is paid to the coding and benefit departments.
- Accuracy
  - Regular auditing of the chart notes and documentation to verify the claim and encounter is the primary means of determining accuracy at the provider and vendor level.
- Timeliness
  - Claims analysts review the daily timely claims monitoring report and determine if the claim/encounter met the time frame for adjudication or if the claim presented no supporting information for timeliness.

To monitor the completeness, accuracy, and timeliness of the encounter data submitted by its providers, **AllCare** conducts the following activities:

- Completeness
  - **AllCare** monitors completeness of claims and encounter data by means of a monthly report measuring the volume of claims submitted by each contracted vendor. The monthly claims and encounters completeness monitoring report presents the monthly average volume over the last 12 months, and in the event that the number of claims submitted for a single vendor in the month is 15 percent or more below the monthly average for that vendor, the vendor is contacted to verify that all claims have been submitted.
- Accuracy
  - **AllCare** performs audits that review accuracy by verifying submitted claims and encounters against chart documentation. **AllCare** also engages Moss Adams to perform annual audits of **AllCare**'s claims pricing and processing accuracy that ties back to contract language, referenced in CMS resource-based relative value scale (RBRVS) tables or CMS flat rate tables.
- Timeliness
  - Similar to monitoring **AllCare**'s its vendors, claims analysts review the daily timely claims monitoring report and determine if the claim/encounter met the time frame for adjudication or if the claim presented no supporting information for timeliness.

To monitor the status of encounter data submitted to OHA, **AllCare** uses the 999 response files from OHA and stored in its network file system to compare against **AllCare**'s 837 claims and encounter submission files. The comparison identifies those claims/encounters that were rejected at the OHA EDI translator. Additionally, **AllCare** stores the 835 file in its network files system, where the data within the file are used to reconcile actuarial activities and to extract the ICN to reference back to the submitted claim/encounter. The OHA encounter status report is also stored in **AllCare**'s network file system and transformed into a readable format.

At the time of the questionnaire submission, **AllCare** noted that on average it has less than one percent of encounters rejected by OHA's EDI translator, and less than 1.5 percent of encounters pass OHA's EDI translator but are pended by OHA's MMIS. There are processes as well as policies and procedures in place for reconciling files rejected by OHA's EDI translator and files pended by MMIS.

In describing how the encounter data system and data warehouse are used, **AllCare** noted the following examples: APMs, gaps in care, rate setting, internal monitoring, reporting case management, SDoH monitoring, provider dashboards, validation of encounter data, trends, and anomalies in provider submission activities.

AllCare noted the following challenges faced in submitting encounter data to OHA:
- Internal challenges:
  - While **AllCare** has a very capable development department, it faced challenges in allocating resources to CCO submissions with the date and time limitations set. When submissions need to occur as a result of correcting errors, but the internal request to the development department is outside of the acceptance window for OHA submissions, staffs have to reschedule the completion of their work as it cannot be done at the time that it is being addressed. Removal of the limitations on submission windows would facilitate timely encounter data transmission and allow for greater flexibility with regard to error corrections.
- External challenges:
  - **AllCare** noted there is a lack of a documented process around encounter submission. Rules regarding the order in which adjustment codes must be submitted, limitations on the number of records in a transaction, and the inability to accept industry standard edits create challenges for submission because **AllCare**'s core claims systems do not natively support these rule. Without an explicitly documented guide, **AllCare** is not able to work with a vendor to submit these rules as requirements and make the process fully automated. The current documentation does not provide a change log and therefore development staff members cannot determine if older requirements are still valid and simply missing from the documentation or if they no longer apply.
  - Additionally, having a limited window in which submission may occur creates challenges with internal resource scheduling and limits when responses requiring correction may be made.

AllCare noted the following processes or additional resources and support from OHA that would be helpful in overcoming the aforementioned challenges:

- An all-inclusive submission guideline for encounters, where if CCOs followed it as documented, would produce no rejections on the EDI translator except for internal issues.
- Better alignment with the Technical Report Type 3 (TR3) HIPAA definitions for 837 EDI files, eliminating arbitrary restrictions such as record counts and ordering of adjustment codes.
- Allow for submissions to occur on any date and time.
- Provide real-time ICNs for claims and encounter submissions received in the EDI translator in a response file.
- Weekly provider active and inactive data supplied in a text file and published to the ASU mailbox in a consistent format.

Recommendations

Based on its review, HSAG recommends the following for **AllCare** to strengthen its encounter data quality:

- **AllCare** noted challenges in allocating resources due to the date and time limitations that were set for encounter data submission. HSAG recommends that **AllCare** consider adding more metrics to actively monitor encounter data accuracy, completeness, and timeliness before submitting files to OHA. For example, **AllCare** can enhance monitoring metrics for encounter timeliness based on the lag days between dates of service and dates when encounters are received by **AllCare**. This metric will help **AllCare** estimate the resources that need to be allocated, once trends have been established, to ensure timely encounter data submission.

This section summarizes the findings from Cascade Health Alliance, LLC's (**CHA**'s) questionnaire responses.

Encounter Data Sources and Systems

CHA receives professional (including physician, laboratory, transportation, vision, behavioral health, NEMT, etc.); institutional (including inpatient, outpatient, etc.); and dental claims or encounters through a clearinghouse, which then transmits an electronic 837P, 837I, or 837D file to **CHA**. For paper claim forms, these documents are sent to Quantum Choice to be processed and ultimately to create an electronic 837P, 837I, or 837D file. **CHA** provided a data flow diagram; however, HSAG was not able to determine the entity that provided dental encounters.

CHA contracts with MedImpact to perform pharmacy contracting, benefit management, and claims/encounter processing. Pharmacies provide MedImpact with claims and encounter data, which MedImpact formats into an NCPDP file and provides to **CHA**. Once pharmacy encounters are received by **CHA**, they are submitted in NCPDP formatted files to OHA.

Table F-1—Format and Submission Frequency for Professional[1], Institutional[2], Pharmacy, and Dental Encounters

	Professional[1]	**Institutional[2]**	**Pharmacy**	**Dental**
Data Receipt	Electronic claims: Clearinghouse Paper claims: Quantum Choice	Electronic claims: Clearinghouse Paper claims: Quantum Choice	MedImpact	Electronic claims: Clearinghouse
Format	837P	837I	NCPDP	837D
Frequency	Each business day	Each business day	Biweekly	Each business day
Approximate Volume	Varies	Varies	5,281	51

[1] Includes physician, laboratory, transportation, vision, behavioral health, NEMT, etc.
[2] Includes inpatient, outpatient, and long-term care

- When submitting encounter data to OHA, **CHA** noted that it does not modify or reformat its claims/encounter data to accommodate OHA's encounter submission standards.

- **CHA** indicated in its response that it submits all types of encounters (i.e., paid, denied, voided, and adjusted) to OHA. **CHA** also noted that it does not pass withhold and risk pool settlements or quality, HRS, or flexible spending dollars as encounters.

- In handling adjusted encounters that have been previously submitted, **CHA** noted that claims/encounters that are negated or refunded are processed and submitted as either a corrected claim or a void to OHA. Negated claims are pulled through the normal encounter data pull process.

If a claim is negated and a new claim is processed to replace the original claim, the original voided claim will be submitted first prior to the new reprocessed claim. This ensures that it will not be denied as a duplicate in the OHA encounter claim process and will allow the new reprocessed claim to be paid and reflect the correct claim data and outcome.

- For claims that are processed internally, Table F-2 shows the types of claims validated, a description of validation performed, and the percentage of claims validated.

Table F-2—Claims Validated, Validation Performed, and Percentage of Claims Validated

Type of Claims Validated	Description of Validation Performed	Percentage of Claims Validated
All claim types	All procedure codes and diagnosis codes are validated to ensure they are active on the date of service, missing, or incomplete; bundled code or diagnosis code sequence is missing; ensure modifier codes, place of service, and ICD-10-CM procedure codes are valid.	100%
All claim types	Random claim samples are pulled by practice office/vendor for service validation or charting	1% or minimum of five claims, depending on claim volume for practice office/vendor
All claim types	Random claim samples are pulled by member and provider for service validation at the member level	45 letters per month are sent to the member
All claim types	Member enrollment; active provider, vendors are linked to provider; missing TPL payment information if member has COB on member record; missing member COB if TPL payment being reported on a claim.	100%

- Prior to claims being adjudicated for payment processing, **CHA** does not map any codes or fields during the data processing and validation process. Similarly, codes and/or fields are not mapped during data processing for submission to OHA.

- With regard to the use of outside vendors or contractors for claim adjudication, **CHA** noted that Medicare ambulatory payment classification (APC) priced hospital claims, and Medicare DRG claims are priced by Payer Compass. When the claim is being adjudicated, the call out to the pricing software prices the claim and brings the contract amount back in to the claim along with the Medicare price methodology report, which is archived at the claim level for reference and auditing purposes.

- **CHA** collects, stores, and maintains its provider data. Claims are loaded into claims system if the provider is not enrolled or active, or if the vendor is not enrolled or linked to the provider the claims system will load the claim but pend the claim and populate the provider and vendor information in the claim. Analysts verify whether the vendor or provider is enrolled and active with OHA's provider number, and if verified, the claim will be pended so that a provider enrollment specialist can validate the provider or vendor information. Once investigation is complete and records have

been updated, the claim is released back to the analyst to complete adjudication. If the provider or vendor does not have an active OHA provider number, the analyst will deny the claim and mail the 3108 and 3974 enrollment forms along with a copy of the claim to the billing provider, requesting the form to be filled out in order to process the claim. **CHA**'s provider data do not require modification in order to comply with OHA's provider data submission requirements.

- **CHA** contracted Plexis Healthcare Systems, Inc. in the import process of the 834 X12 files into the Quantum Choice (QC) database. The 834 import is used to maintain the member, enrollment, and eligibility records in QC and keep the records synchronized with OHA. **CHA** provided a data flow diagram outlining the path **CHA**'s enrollment data follow from receipt to maintenance. Claims loaded into the claims system will automatically link the member record and the member's enrollment record to the coverage for the service date on the claim. If the member information does not match the information on the claim, the claim will be identified as pend, populate the member information if the member is in the system, or it will load all the member information on the claim in the missing information data field if the member is not found in the system. The claim will pend for analyst investigation or if it needs to be reported to enrollment for further investigation.

Data Exchange Policies and Procedures

For both nonpharmacy and pharmacy claims, **CHA** has internally developed policies and procedures aimed at collecting, translating, storing, and transmitting encounter data that meet OHA's submission specifications.

CHA generates the nonpharmacy encounter claims in the first week following the first Claims Department payment cycle that occurs biweekly. Claims are pulled by paid date, where the date pulled is the last paid date of the previous month and the first paid date of the current month to ensure that all current paid claims are sent to the State. If the month has more than two payment cycles, the extra payment cycle needs to be accounted for to ensure all claims are submitted. All encounter claims are submitted the first week following the claims department payment cycle and no later than the last full work week within the current month. The submission week cannot cross over into the next month. **CHA** ensures that it has submitted its paid claims within the current month. All encounter claims must be submitted within 45 days from the date of service and not exceeding 180 days from the date of service.

The 837D, I, and P reports that are generate per file are used to complete the State claims verification form (CVF) files to report the total claim count and billed charge per file. The 999 files are read into the system to validate receipt and to identify the claims that failed the State translator; those claims will be removed from the total reported in the 837D, I, and P reports.

Completed CVF forms are reviewed and signed by the director of claims prior to submission. All CVF files are used to balance OHA's claim count validation (CCV) that will be provided the following week. Any discrepancies in balancing are reviewed by the director of claims and the encounter data analyst. Verification acknowledgement form (VAF) is then submitted to OHA within 14 business days of receipt of the CCV and out-of-balance notification from OHA.

CHA generates the pharmacy encounter claims **CHA** receives in the first week following the first payment cycle that occurs bimonthly. All pharmacy encounters should be submitted the first week following the first payment cycle and no later than the last full work week within the current month. The submission week cannot cross over into the next month. **CHA** must ensure that it has submitted its paid claims within the current month. The claim files must represent pharmacy claims within 45 days of the date of service.

Prior to submitting the NCPDP file to OHA, the encounter data analyst pulls the TSV file and compares the claim and billed totals from the TSV. **CHA** monitors the control totals passed with each payment invoice generated by MedImpact to the NCPDP payment cycle claim files received. If there is a discrepancy in the TSV totals and the MedImpact invoice, it is reported to the Data Analytics Department via email for an audit trail so **CHA** can follow up weekly until resolved.

The Data Analytics Department runs a claim report out of the PBM vendor reporting software that pulls each point of sale paid pharmacy claim by member per payment cycle. This report is used to compare against the NCPDP file for the same payment cycle to identify the missing claims that are not being reported in the NCPDP file. The missing claims are reported to MedImpact for further investigation to ensure all pharmacy claims are being accounted for and submitted to OHA. MedImpact needs to provide the NCPDP file name in which the missing claims are being reported in for follow-up validation.

The TSV reports generated and submitted with each NCPDP file are used to report the total claims and billed dollars on the CVF forms submitted to OHA. NCPDP response files are read into the system to validate receipt and to identify the claims that failed OHA's translator, and those claims are removed from the total reported in the NCPDP file report.

Completed CVF forms are reviewed and signed by the director of claims prior to submission. All CVF forms are used to balance OHA's CCV that will be provided the following week. Any discrepancies in balancing are reviewed by the director of claims and the encounter data analyst. A VAF is submitted to OHA within 14 business days of receipt of the CCV and out-of-balance notification from OHA.

Management of Encounter Data: Collection, Storage, and Processing

Table F-3 shows **CHA**'s pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table F-3—Pricing Methodology for CHA

Outpatient[1]	Inpatient[2]	Pharmacy[3]
• Line by line (percentage of claim dollars based on net): 94% • Percentage of billed (percentage of claim dollars based on net): 6%	• DRG (percentage of claims dollars based on net): 98% • Percentage of billed (percentage of claims dollars based on net): 2%	Based on negotiated rates, ingredient cost, and dispensing fee.

[1] All these payment arrangements are reflected in the encounter data submission at the detail service charge line
[2] The DRG payment is reflected in the encounter data submission at the claim header, while the percentage of billed payments is reflected in the encounter data submission at the detail service charge line
[3] The amount **CHA** pays is reflected in the first instance of the COB segment (i.e., Segment 05) for its encounter, and in NCPDP D.0 is in field 432-DV

- **CHA** indicated that there are no services submitted to **CHA** under bundle-payment structures.
- With regard to collecting other insurance data, **CHA** indicated that these data are collected at the claim level and member level. **CHA** collects TPL data from various sources: the 834 eligibility files from the OHA, the 837 claims files, paper claims, member contact, provider or billing office contacts, the Reliance data collection system, Epic, MMIS, and its PBM. **CHA** runs daily reports on every 834 and 837 file that is loaded into Plexis, and these files are validated against the member record to ensure **CHA** has the primary insurance loaded with accurate effective dates. Any records that are not in **CHA**'s system are verified by **CHA**'s COB/TPL staff and loaded into the system. Reverification of effective dates is also completed to ensure **CHA** does not deny claims for other insurance that is no longer active. Data are then reported to HIG, and the claims refund analyst reviews claim history to determine if any claim needs to be reversed and denied for primary remittance.
- Claims with TPL are processed with the TPL payment at each service line. Other insurance is stored at the member record level and can also come in at the claim detail level. Once a member is identified as having other insurance, it is validated and added to the member record. Claim history is pulled to identify any claims that were not processed in coordination with the primary payer; these claims would be negated and denied for needing primary explanation of benefits.
- To ensure accuracy of Medicare crossover and other third-party claims, all primary payer sources are first added to the member record with effective dates and reported to the OHA HIG unit. The source data on the primary payer are also stored at the claim level in a COB data table. There is no difference in how **CHA** stores the Medicare or TPL payment source data. Medicare or TPL information on claims are populated at the line detail. The payer ID, name, insurance type, and claim filing indicator are all reported at the encounter header, and the primary payment is reported at the line detail on each encounter claim submitted to OHA.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **CHA** conducts the following activities:

- Completeness:
  - **CHA** validates the claim count and amount billed based on each of the State submission trackers and the CCV reports. The process **CHA** has in place is to monitor control totals passed with each payment invoice to the NCPDP payment cycle claim files received. If there is a discrepancy, the Data Analytic Department will be notified to run a claim report off the vendor reporting software that will pull each claim paid by member per payment cycle to identify the missing claims that are not being reported in the NCPDP file.
  - **CHA** also contracts with a data integrity solution overview company, Pareto, that compares a claims file extract from the vendor claim system with NCPDP response files and reports on any discrepancies.

- Accuracy:
  - **CHA** noted it uses the same process as above to monitor encounter data accuracy.
- Timeliness:
  - **CHA** monitors the timeliness by its PBM payment cycles, where the PBM pays biweekly. As such, **CHA** knows to watch for and pull the NCPDP files for each payment cycle. **CHA** also monitors the new reporting in the NCPDP response file to ensure its pharmacy claims are being reported 45 days from the paid date.

To monitor the completeness, accuracy, and timeliness of the encounter data submitted by its providers, **CHA** conducts the following activities:

- Completeness:
  - **CHA** has developed an internal policy and procedure document that establishes standards to ensure that all claims are received, where the expected number of claims/encounter data is calculated based on the number of claims received in the past.
- Accuracy:
  - **CHA** performs the following accuracy audits at the time the claim is adjudicated:
    o Code validation for valid codes for date of service
    o Bundled and unbundled services
    o Valid diagnosis coding for date of service
    o If diagnosis is appropriate as a primary diagnosis or if diagnosis is not coded at the highest specificity
    o Valid modifiers,
    o Valid place of service
    o Diagnosis sequence is reported at service line
    o **CHA** validates by conducting provider audits at the chart level to what the provider is billing and for risk adjustment coding.
  - **CHA** performs member service letter validation to ensure the member received the service the provider is billing **CHA** for.
  - **CHA** also monitors that it gets all claims for **CHA** members by monitoring the completeness of its claims submitted to **CHA** by providers.
- Timeliness:
  - **CHA** uses the completeness of claims monitoring report; if the report shows that if **CHA**'s number of submitted claims is lower than normal, **CHA** would request that the report to be drilled down to the vendor level to see which providers are not submitting claims.

To evaluate the quality of its encounter data submission, **CHA** contracts with Pareto to compare suspected risk with submitted encounter files to find possible gaps. The accuracy of regulatory encounter submissions is also evaluated by comparing the following three data points: **CHA**'s internal system data (medical claims, pharmacy claims, and enrollment) and OHA's 834, 837, NCPDP, and 835

files. Data degradation issues may occur at each stage in the process (e.g., a medical claim may have never been submitted in an 837 file). Pareto's clustering algorithm pinpoints the underlying root cause of these issues and groups them together to help focus and prioritize remediation and submission of missing encounter data.

CHA indicated that it monitors the encounter data status based on the 999 reports, 835 reports, CCV, and the submission tracking sheets. In its response, CHA included the processes and reports used to complete each process.

At the time of the questionnaire submission, CHA noted that on average, 1.1 percent of encounters get rejected by OHA's EDI)translator, and 0.17 percent of encounters pass OHA's EDI translator but are pended by OHA's MMIS. To reconcile files pended by MMIS, CHA works with the OHA status file within 14 days from receipt of the file and no later than 63 days. Pending claims are worked on and sent as a "7" if correctable and "8" if the claim needs to be negated as it is not correctable.

Data in CHA's encounter data system are used in various capacities internally and externally. Some examples include:

- Internal: value-based payment and rate setting for capitation, quality metrics, medical and case management, and provider network management
- External: predictive analytics, risk adjustment, health information exchange, member outreach, and health information

CHA noted it currently does not face any internal challenges in submitting encounter data to OHA. However, CHA indicated that if it submits too many COB claims on the same member in one file, they fail the translator and report out on the 999. Therefore, CHA has to resubmit in another claim file with no issues. In response to processes or additional resources and support from OHA that would be most helpful in overcoming challenges with successfully submitting encounter data to OHA, CHA noted if and when OHA puts in new edits or pends, OHA could provide the CCO with the source or coding rules. CHA does not have any upcoming changes to its encounter submission process that would impact the answers provided at the time of questionnaire submission.

Recommendations

Based on its review, HSAG recommends the following for CHA to strengthen its encounter data quality:

- In ensuring completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, CHA noted that it validates only at the file submission level where it validates the claim count and amount billed based on the State submission tracker and the CCV reports. CHA should consider adding more metrics to actively monitor encounter data completeness and accuracy before submitting files to OHA. For example, a review of encounter volume by service month would add a useful dimension to current completeness metrics through highlighting abnormally high (e.g., due to duplicate records) or low (e.g., due to submission lag or incomplete data) volumes, once trends have been established.

This section summarizes the findings from Columbia Pacific CCO, LLC's (**CPCCO**'s) questionnaire responses.

Encounter Data Sources and Systems

Professional, institutional, and dental 837 files and NCPDP files are submitted by the risk assuming entities (RAEs) directly to OHA via secure FTP, with a copy of each to **CPCCO**. OHA responds directly to each RAE with a 999 and NCPDP response per file. OHA sends a weekly CCV to **CPCCO**. If the CCV is not balanced, **CPCCO** submits a VAF to OHA. OHA submits weekly 835 remittance and status files to **CPCCO**. OHA submits a quarterly ASU file to **CPCCO**. **CPCCO** parses the files using a special CLM01 partner indicator and original 837 submission matching logic. RAEs then submit a balance report to **CPCCO** by Tuesday of each week for submission the week prior. This report includes 999 rejections and expected claims not included in the 835. Pharmacy encounters are submitted to **CPCCO** by its PBM, OptumRx, daily. These pharmacy encounters are bundled and submitted by **CPCCO** to OHA weekly. Vision service plan (VSP) must submit encounter data at least once per calendar month. The data must represent at least 50 percent of all the encounters received and adjudicated by the contractor during that month. An email is generated when VSP claims are received into the **CPCCO** data warehouse and includes the process date and count of VSP claims received.

Table G-1 shows **CPCCO**'s format and submission frequency of the pharmacy, dental, and other encounters received.

Table G-1—Format and Submission Frequency for Professional[1], Institutional[2], Transportation, Pharmacy, Dental, and Vision Encounters

	Professional[1]	Institutional[2]	Pharmacy	Transportation	Dental	Vision
Data Receipt	Claims from in-house QNXT claims processing system	Claims from in-house QNXT claims processing system	OptumRx	Ecolane	Advantage, ODS, Willamette Dental, CareOregon	VSP
Format	837P	837I	Flat Files	837P	837D	837P
Frequency	Daily	Daily	Daily	Daily	Daily	Monthly
Approximate Volume	Varies	Varies	750	157.9	Monthly: Advantage: 378 CareOregon: 509 ODS: 855 Willamette: 227	158

[1] Includes physician, HCBS, laboratory, and behavioral health
[2] Includes inpatient, outpatient, and long-term care

- When submitting claims/encounter data to OHA, **CPCCO** noted that all fields are formatted to meet 837 specifications and OHA guidelines. **CPCCO** does not make any material changes to the data that are in its claims system. When new edits are implemented, **CPCCO** adds those edits to the front end of its claims system to ensure that incoming claims meet OHS requirements.

- **CPCCO**'s subcontracted PBM and DCOs are also direct submitters of encounter data to OHA. These organizations include ADS, Capitol Dental, ODS, Willamette Dental, and OptumRx. These organizations submit encounter data no less frequently than monthly, and with each submission they make to OHA, they also provide the CCO with a notification of their submission and an 837 file copy of that submission. Additionally, VSP submits encounters via 837 files to **CPCCO** and it includes the files with its in-house claims submissions to OHA. These 837 copies are incorporated into **CPCCO**'s data warehouse.

- **CPCCO** indicated that it submits all types of claims/encounters (e.g., paid, denied, voided, and adjusted) to OHA. However, encounters are not submitted for incentive payments. **CPCCO** noted that the adjusted encounters that have previously been submitted are transmitted to OHA as an adjustment if the claim is adjusted in its claims system. According to OHA rules, if certain key fields (e.g., member, claim form type) are changed, then **CPCCO** submits the adjustment as a delete and then as a new claim.

- For claims processed internally, **CPCCO** validates all claim types via monthly claims auditing conducted by claims supervisors and training specialists. Internal audits are also conducted by compliance. Audits include all claim types (e.g., manually adjudicated and auto-adjudicated claims). These audits are performed to assess the financial, procedural, and payment accuracy of claims. **CPCCO** indicated that approximately 0.02 percent of claims are validated.

- Prior to claims being adjudicated for payment processing, **CPCCO** performs code and/or field mapping during data processing and validation. **CPCCO** uses a rules-based claims system, QNXT, that provides hundreds of editing functions to ensure automation and accuracy. QNXT edits and the fully integrated Optum Claims Edit System (CES) validate elements of a claim to ensure claim information submitted by the provider is accurate. The system uses reference tables loaded with diagnosis codes and necessary procedural codes (e.g., CPT, HCPCS, modifiers, ICD-10-CM, procedural classification system (PCS), health insurance prospective payment system (HIPPS), DRG, home health resource group (HHRG), etc.) with data files purchased from Optum or data provided by CMS or national coding sources. Additionally, Micro-Dyn Medical Systems' DRG grouper, DRG pricer, APC grouper, and ASC pricer are fully integrated with **CPCCO**'s claims system. The system edits to ensure all elements are present and valid in order to accurately price the claims. Coding and editing tables are updated with the most current information as soon as possible. Updates are handled as a high priority to prevent payment delays. CES Knowledgebase updates are released and installed quarterly. Other coding systems are dependent on their frequency; for example, CPT, HCPCS, ICD-10, DRG, and APC updates are released and imported annually. In the case of unexpected off-cycle releases, such as those experienced with the COVID-19 public health emergency in 2020, updates may be made manually for the sake of timeliness. Provider data are stored in the QNXT core system and QNXT edits the claims to ensure the provider data submitted by the provider match a provider record in the claims system in order to process for payment.

Additionally, **CPCCO** compares each attending, referring, ordering, billing, and rendering provider NPI on active claims to the weekly OHA provider file to ensure active enrollment exists prior to claim adjudication. **CPCCO** does not perform code and/or field mapping during data processing for submission to OHA.

- **CPCCO** uses outside vendors for prepayment and postpayment reviews, although the claim is adjudicated by **CPCCO**'s internal staff based on the medical record or itemized bill decision.

  – **CPCCO** conducts a comprehensive prepayment review, which allows for reimbursement to health care providers for a "clean claim." A clean claim is one that is free of defects and improprieties and contains all information necessary for adjudication on its merits before tendering payment. The health care provider must provide the required documentation at the time the claim is submitted, otherwise the claim will be denied for missing documentation for the service/item. For claims submitted with the appropriate documentation, **CPCCO** will conduct its review using national guidelines and analyze the claims to tender payment for properly billed charges. Once the review is complete and a determination is made that a coding and/or payment adjustment is applicable, the health care provider will receive the appropriate claim adjudication, a coding correction to the service line item billed, a disallowance of the applicable amount of the service line item billed, and a remittance advice (RA) with an explanation and/or reason code(s) for the finding(s).

  – **CPCCO** conducts postpayment utilization reviews of health care providers' records related to services rendered to **CPCCO** members. This process helps ensure that providers follow nationally accepted coding practices and are paid at the correct allowance. **CPCCO** may perform on-site or off-site desk reviews based on the preference of the health care provider. For off-site reviews, the health care provider must provide the required documentation within 30 days of receipt of the request. In the event the requested documentation is not received timely, the applicable claim(s) may be considered overpaid and recovered initially. Upon completion of the postpayment review, if underpayment is identified, the health care provider may be asked to resubmit a corrected claim to receive additional reimbursement. **CPCCO** identifies and recovers overpayments as mandated by federal and state laws and regulations. If overpayment is identified, **CPCCO** may be required to conduct a review that exceeds one year.

- Provider data are managed directly by **CPCCO**'s subcontracted DCOs, VSP, and PBMs: ADS, Capitol Dental, ODS, Willamette Dental, VSP, and OptumRx. **CPCCO** receives the subcontractor provider files via the weekly all payer all claims (APAC) file process. Provider data addition, change, and termination notices are received from:

  – Credentialing applications received from contracted organizations.
  – Provider information form (PIF).
  – Monthly provider rosters received from contracted organizations to which **CPCCO** delegated credentialing.
  – An external-facing email address used to collect change notifications from contracted organizations (providerupdates@careoregon.org).
  – Claims pending for missing provider or contract information.

Each data set collected has a predefined turnaround time. At initial entry, and then monthly, provider data in the core QNXT system are compared to National Plan and Provider Enumeration System (NPPES) for deactivated NPIs, the OHA weekly provider file, the CMS preclusion list, the Medicare opt-out list, and the Office of Inspector General (OIG) exclusion list.

- When collecting provider data, **CPCCO** checks QNXT to verify if the provider, group, or facility is present. If the provider is present, the claim/contract/notice is checked for contracting and credentialing information. If contracting and credentialing information is present, the provider is set up in the system as a participating provider. If the provider is not present, it is set up as "nonpar." If the provider is not present in QNXT, the provider is screened against various systems (e.g., NPPES, OIG, OHA provider file, license or registration board). If the provider is located, it is added to the QNXT system with no restrictions. If the provider is not located, it is added to the QNXT system with restrictions. The provider team runs weekly troubleshooting processes to identify license or eligibility issues by running Medicare opt-out, OIG, and preclusion list screenings against existing provider. Additionally, every new provider is audited, and current claims are compared to the OHA provider file to prevent incorrect claims payment or denial due to enrollment changes.

- When linking provider data to claims and encounters, claims with missing or mismatched provider data are pended within **CPCCO**'s core QNXT system prepayment. Provider data specialists review the submitted claim data and either update the core system to reflect a valid change or deny the claim for incorrect billing or enrollment. Encounters are populated with the provider NPIs as they appear in the claim EDI data as processed in the core QNXT system. Encounters that pend with incorrect provider data require troubleshooting between the Provider Data team and the OHA Provider Enrollment team. If a discrepancy is found between provider data in a file and OHA's provider file, encounters are sent back for recouping by **CPCCO**'s claims examiners or enrollment with OHA is updated to address the discrepancy. **CPCCO**'s provider data do not require modification in order to comply with OHA's provider data submission requirements.

- **CPCCO**'s enrollment data are maintained by the CCO. When linking enrollment data to the claims and encounters, each submitter receives the daily 834 enrollment updates. The submitter then matches incoming claims to the enrollment using the Medicaid ID. Claims are rejected if they do not match an active enrollment. If a member is retroactively disenrolled prior to encounter data submission, **CPCCO** does not submit the claim as an encounter to OHA.

Data Exchange Policies and Procedures

Encounter data files are submitted at least once per month by each submitter, including **CPCCO**. The 837 and NCPDP files are sent directly to OHA, and a copy is sent to **CPCCO** from the other submitters. Each encounter file is reported to OHA on a Certification and Validation Report Form (CVF/H2) within 24 hours of the submission, and the other submitters notify **CPCCO** when their submissions have been made. These notifications include the file name(s), claim counts, total billed amounts, and submission date. **CPCCO** keeps detailed accounting of each file to balance out each week's total submissions against the CCV report from OHA. Any out-of-balance amounts are reported back to OHA on a Claim Count Verification Acknowledgement and Action (VAF/H3) form within 10 business days from receipt of the report.

CPCCO is responsible for the data validation, testing, and fielding of encounter issues and questions from the other submitters. Weekly and monthly reports from OHA are processed, parsed out, and sent securely to each of the submitters to review and correct their own data. **CPCCO** monitors all of the reports to ensure that they are processed within the related time frames and follows up with the submitters and OHA as needed.

Management of Encounter Data: Collection, Storage, and Processing

Table G-2 shows **CPCCO**'s pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table G-2—Pricing Methodology for CPCCO

Outpatient	Inpatient	Pharmacy
• APC :18.5% • Fee schedule :7.4% • Percent of charge :74.0%	• DRG :55.5% • Percent of charge :40.09% • Per diem :4.5%	For specialty and brand drugs, pharmacy claims are paid using OptumRx's negotiated rate with each pharmacy, chain, or pharmacy services administrative organization (PSAO), or usual and customary (U&C), whichever is lower. For generic drugs, the same maximum allowable cost (MAC) list used for all pharmacies or U&C, whichever is lower.

- In response to whether there are any services submitted to **CPCCO** under bundle-payment structures, **CPCCO** noted that it follows the standard FFS process for billing for outpatient maternity services, but does not have a broader bundle in place that incorporates hospital or other ancillary services including imaging, delivery, and immediate postpartum care. **CPCCO** does not have bundle-payment structures in place for any other services.

- With regard to collecting other insurance data, any employee, subcontractor, provider, intern, or volunteer who becomes aware of other health insurance coverage or other nongroup health insurance coverage (e.g., liability, no-fault, workers' compensation) must collect all initial data about the coverage and forward it to **CPCCO** for investigation.

- When processing claims with TPL, **CPCCO** follows a pay and pursue (also known as pay and chase) methodology for accidents due to the need for timely medical services and payments. **CPCCO** pays claims where TPL may not yet be resolved, and **CPCCO**'s subrogation vendor works to recover these payments when another person or entity may be responsible. If the subrogation vendor's investigation determines another person or entity was responsible for the accident, the subrogation vendor will work with the member, member's attorney, and providers to resolve the TPL.

- To verify accuracy of Medicare crossover and other third-party claims information, **CPCCO** receives the Medicare crossover claims for members covered by **CPCCO**, based on the eligibility

reported by OHA, from the CMS Benefits Coordination & Recovery Center. **CPCCO** accepts and processes 837 claim files from EDI vendors and directly from CMS.

- If **CPCCO** is not responsible for a service due to payment from a primary carrier, **CPCCO** processes the claim as a standard COB secondary claim. If there is no remaining/outstanding balance to pay on the secondary (**CPCCO**) side, the claim is processed to pay at zero dollars and is submitted through the typical encounter data submission process. Audits are conducted by claims supervisors and training specialists on all claim types (e.g., manually adjudicated and auto-adjudicated claims) to assess the financial, procedural, and payment accuracy of the claims. Encounter data are also subject to periodic internal audits for completeness. Additionally, encounter data are subject to scrubbing done postpayment via pends in MMIS by OHA, and via the Actuarial Services Unit at OHA, which issues biannual clean/nonclean assessments of encounter data sets.

Encounter Data Quality Monitoring and Reporting

- To monitor completeness of encounter data submitted by a vendor or subcontractor, **CPCCO** compares the APAC-formatted claim file against the 837s received from its subcontractors. The APAC-formatted claim file is considered a full reporting of claims payment history. This report is distributed to all subcontracted encounter data submitters. Additionally, **CPCCO** encounter data coordinators track all submissions made by submitters as reported and monitor for trends.

- To monitor accuracy of encounter data submitted by a vendor or subcontractor, **CPCCO** reviews OHA's weekly Claim Data Issue Reports, which identify duplicate encounters, provider enrollment issues, and mismatched claim data, with its subcontractors, including a request for resolution. **CPCCO** actively parses and monitors the weekly pend status file from OHA and monitors the timely resolution by all subcontractors.

- To monitor timeliness of encounter data submitted by a vendor or subcontractor, **CPCCO** monitors the 45 Days from Date of Adjudication Report, issued by OHA monthly, for the count/threshold of **CPCCO** claims submitted outside 45 days from the date of adjudication. If an issue with a subcontractor is identified, **CPCCO** reaches out to the subcontractor. The monthly APAC-formatted claim files comparison, used to monitor completeness, alerts **CPCCO** to whether claims are being encountered timely or not at all. **CPCCO**'s subcontractors receive and respond to these reports monthly.

- To evaluate the quality of encounter data, **CPCCO** processes and monitors the following reports issued by OHA:
  - Duplicate Report
  - Claim Data Issue Reports
  - Enrollment Clean-up Report
  - Deceased Client Report

  CPCCO addresses issues identified in a pre-scrub process that omits claims from submission as encounters until the errors are resolved. These claims are worked monthly focusing on both claim data issues and provider data clean-up, as needed. Any encounters rejected on the 999 response file from OHSA are addressed on a monthly basis.

- **CPCCO** has policies and procedures in place to monitor the accuracy, completeness, and timeliness of claims and encounter data submitted by providers.
  - Accuracy and completeness: For claims submitted with missing, incomplete, or invalid fields, QNXT will generate a rule that denies the claim line and generates a message that will be communicated on the provider's remittance advice. Similarly, encounter data are monitored for accuracy using various reporting methods. Claims paid are submitted as encounters and monitored for acceptance.
  - Timeliness: Providers receive timely filing expectations through a provider handbook and contracts. Claims processed as paid or denied for timely filing are reflected as such in the encounter data submitted.
- **CPCCO** monitors the status of encounter data using a comparison between the 837 submitted encounters compared to the 835 receipt from OHA. Additionally, the Pend Status report is monitored to ensure maximum acceptance of encounter data and CPCCO works to resolve all issues preventing acceptance, including provider enrollment, claims processing, and formatting issues.
- **CPCCO** uses the following transaction response files to support encounter data submission activities:
  - 999 files: The submitting entity receives these directly from OHA. Each entity is responsible for logging errors and resubmitting corrected claims. **CPCCO** monitors overall completeness of submissions by comparing encounter data to flat file data.
  - 835 files: **CPCCO** parses the 835s and sends individual 835 files to each submitter. These are used to record ICNs of accepted claims, for use when claims need to be adjusted or reversed. **CPCCO** retains all 835 data in SQL tables.
  - Pend status files: **CPCCO** parses the 835s and sends individualized files to each submitter. Each submitter uses them to identify and correct claims. **CPCCO** retains the master list of pends and monitors outstanding pends with all submitters to make sure they are corrected.
  - NCPDP response files: **CPCCO** stores all responses to identify which pharmacy claims were rejected. Issues with provider enrollment are investigated by **CPCCO**; other issues originate with the PBM. Rejected claims are resubmitted periodically to make sure they are corrected whenever possible.
- To reconcile files rejected by OHA's EDI translator, **CPCCO** monitors and addresses encounters rejected in the 999 using an on-demand report to identify and correct impacted encounters. This report is worked quarterly, with **CPCCO** investing most of its efforts on a pre-scrub reporting process whereby encounters that fail the translator are identified and addressed prior to submission as encounters. **CPCCO** noted that an average of 0.05 percent of encounters submitted to OHA get rejected by OHA's EDI translator.
- An average of 0.20 percent of **CPCCO**'s encounters that pass OHA's EDI translator are pended by OHA's MMIS. Pend Status files are loaded into CareOregon Web Apps (COWA) each week, and staff prioritizes corrections by date and withhold month. **CPCCO** reviews the claims and claim images in QNXT to determine if adjustments are required. If an adjustment is required, the claim is sent to the Claims Department weekly to correct in the claims system and resubmit as an adjustment. Provider issues are sent to the Provider Data team to resolve, either through configuration changes or

enrollments to avoid further pended claims. **CPCCO** monitors subcontractors' pended encounters for volume spikes or pends within 10 days of the correction date. When either occurs, **CPCCO** reaches out to the encounter data contacts to ask if they need assistance. If assistance is needed, **CPCCO** requests they complete a pend correction form, explaining what needs to be corrected and how, and the encounters are adjusted manually in MMIS.

- Data in **CPCCO**'s encounter data system are used to calculate clinical quality measure performance, including incentive measures, HEDIS reporting, and value-based payment models. In addition to performance measurement, encounter data are used to:
    – Calculate the total cost of care and loss ratios.
    – Understand patterns of member utilization.
    – Segment the population according to utilization and demographics.
    – Monitor engagement of membership.
    – Identify diagnoses of members for risk stratification.
    – Identify members with gaps in care.
    – Support rate setting.

CPCCO noted the following challenges faced in submitting encounter data to OHA:

- Internal challenges:
    – **CPCCO** faces challenges managing the submission of files to OHA. Occasionally, submissions are made more than once because it is unclear whether the file has already been submitted. Therefore, OHA will processes the submission twice. **CPCCO** would like to see controls in place to prevent OHA from accepting the same file more than once.
- External challenges:
    – **CPCCO** struggles to keep pace with OHA's changing encounter data edits and critical error reasons. Often, these changes result in large configuration projects and there is a lack of transparency in terms of OHA's criteria for determining clean and nonclean encounters.
    – **CPCCO** also struggles with OHA's system constraints. OHA cannot handle sizable volumes, which can result in encounters being held. This in turn causes out-of-balance amounts for multiple weeks following the instance of held files.

CPCCO noted the following processes or additional resources and support from OHA that would be helpful in overcoming the aforementioned challenges:

- Providing the resource data or crosswalk for new edits and critical error reasons when OHA implements changes so **CPCCO** can configure its system appropriately to match OHA's criteria.
- Knowing exactly which list of codes OHA requires an NDC on encounters.
- Reviewing a published list of valid primary diagnosis codes.
- Allowing a standard amount of time for new edits and critical error reasons, that includes a published guideline, to accompany a rule change.

- Liaison consistency across CCOs. **CPCCO** often receives different answers or instructions on encounter data from its different OHA liaisons.

At the time of questionnaire submission, **CPCCO** noted it would be working to reconfigure its system to meet three new edits proposed to be implemented on November 1, 2020. These edits could impact pend volumes if changes are not made in time or accurately aligned with OHA's currently unpublished source data.

Recommendations

Based on its review, HSAG recommends the following for **CPCCO** to strengthen its encounter data quality:

- In describing its methods for ensuring completeness and accuracy of its encounter data submission, **CPCCO** did not demonstrate that chart review was one of the validations conducted. HSAG recommends that **CPCCO** consider conducting validation of encounter data based on medical record reviews by comparing medical record documentation (i.e., diagnosis codes and procedure codes) against the submitted encounter data for a sample of records. Results from these reviews can be used as part of **CPCCO**'s ongoing data monitoring.

This section summarizes the findings from Eastern Oregon's (**EOCCO**'s) questionnaire responses.

Encounter Data Sources and Systems

EOCCO receives professional and institutional (including inpatient and outpatient) encounters from Moda through 837 files, which then transmits electronic 837P, 837I, or 837D files to **EOCCO**.

EOCCO contracts with MedImpact to perform pharmacy contracting, benefit management, and claim/encounter processing. Pharmacies provide MedImpact with claims and encounter data, which MedImpact formats into NCPDP files and provides to **EOCCO**. Once pharmacy encounters are received by **EOCCO**, they are submitted in NCPDP formatted files to OHA.

Table H-1 shows **EOCCO**'s format and submission frequency for professional, institutional, pharmacy, dental, and other encounters received.

Table H-1—Format and Submission Frequency for Professional, Institutional[1], Pharmacy, and Dental Encounters

	Professional	Institutional[1]	Pharmacy	Transportation	Dental	Behavioral Health
Data Receipt	Moda	Moda	MedImpact	GOBHI	Advantage, ODS	PH TECH/GOBHI, Moda
Format	837P	837I	NCPDP	837P	837D	837P
Frequency	Biweekly	Biweekly	Biweekly	Biweekly	Advantage: Weekly ODS: Biweekly	Bi-weekly
Approximate Volume	27,561	Varies	11,063	6,540	Advantage: 1,726 ODS: 752	PH TECH/GOBHI: 5,169 Moda: 8,663

[1] Includes inpatient and outpatient

- **EOCCO** does not modify or reformat its claims or encounter data to accommodate OHA's encounter data submission standards. ADS extracts and submits claims to OHA on behalf of **EOCCO**. Claims are aggregated from various sources, processed in Dental Edge, and then sent in 837D batches to CCOs and OHA. **EOCCO** receives copies of the 837s and processes them into the CRUX database. This database is used by actuarial services for data warehousing purposes. Similarly, **EOCCO** encounter data are generated from its PBM's core system.

- **EOCCO** submits all types of claims/encounters (e.g., paid, denied, voided, and adjusted) to OHA. When submitting adjusted encounters to OHA that have previously been submitted, **EOCCO**

submits adjustments through the standard 837. However, **EOCCO** does not submit any adjustment encounters for duplicates, nonspecific diagnosis denials, or voids. Similarly, **EOCCO**'s pharmacy does not currently submit adjustments. ADS adjustments are indicated in the 837 files using the adjustment indicator processing code. All adjusted claims are then submitted to OHA. For adjusted claims processed by ODS, ODS will notify OHA by submitting an Encounter Data Certification and Validation report form. Any claims that were submitted and not encountered due to an error are the only ones that require an adjustment and notification to OHA. Otherwise, claims are accepted by OHA when submitted.

- For claims that are processed internally, **EOCCO** performs the following validation activities on 100 percent of its claims:
  - Paper claims: The majority of paper claims received are sent to a vendor that captures the details from the paper claim form, turning the information into an electronic transaction that is returned to Moda on a nightly basis. A small percentage of paper claims are electronically logged into **EOCCO**'s claims system by internal employees. Claims are matched to the correct member and provider and subjected to system and clinical edits. All providers who are entered into **EOCCO**'s system are validated against the NPPES system, applicable providers are credentialed, and all providers are monitored against the CMS preclusion list. System edits look for correct procedure and diagnosis codes, including codes that are invalid as primary codes and codes billed to the highest level of specificity. System edits also investigate claims for potential duplicate submissions and prior authorization or referral matches. Clinical edits are supplied by Optum and look for correct place of service to procedure coding, modifier to procedure code combinations, diagnosis to procedure code combinations, and other clinical edits.
  - Electronic claims: Electronic claims must be submitted via an accredited EDI clearinghouse in a HIPPA compliant format. System and clinical edits, similar to those performed on paper claims, are applied to validate the claim.
  - Pended claims: Pended claims that are not able to auto-adjudicate and require manual intervention can be received electronically or as paper claims. All pended claims are subjected to the system and clinical edits noted above.
- Prior to claims being adjudicated for payment processing, **EOCCO** does not perform any code and/or field mapping during data processing and validation. Additionally, **EOCCO** does not use outside vendors or contractors to complete adjudication.
- Provider data are collected and maintained by both **EOCCO** and a subcontracted vendor. **EOCCO** is responsible for coordinating the collection and presentation of data regarding provider demographics and contract configuration. These data are collected to supply **EOCCO**'s core claims database. Providers are required to submit changes using a provider roster or reporting changes on an ad-hoc basis directly to **EOCCO**. Once received, the roster is submitted to the Provider Data Management Configuration team, and the roster is run through a comparison tool to identify changes that need to be made. The configuration staff then enters the updates into the core claims system. **EOCCO**'s internal database holds all historical provider information received. Pharmacy provider information is maintained by MedImpact. MedImpact obtains the State provider file from the State website on a weekly basis and loads it into its system for use in point of sale adjudication for **EOCCO**.

- When linking provider data to claims and encounters, **EOCCO** coordinates the collection and presentation of provider demographics and contract configuration. These data are collected to supply **EOCCO**'s core system and its directory of providers. Data collected from providers are kept in **EOCCO**'s internal database, which holds all historical information received. The incoming provider information is matched to information on a claim to a single provider instance in Facets. When a match is found, the provider ID record is selected. If no provider is found, the next rule is executed, and this process is repeated until all match rules have been processed. The logic of the provider scrubber is to use a minimum of two criteria and a maximum of four criteria to establish a provider. If no match is found, the Provider ID record is not set, and the claim goes to Provider Not Found. These claims are routed to processors to match the claim manually to correct the provider record. All providers entered into **EOCCO**'s system are validated against the NPPES system, applicable providers are credentialled, and all providers are monitored against the CMS preclusion list. **EOCCO**'s provider data do not require modification in order to comply with OHA's provider data submission requirements.

- **EOCCO** internally manages member enrollment and updates member information based on an enrollment file that comes directly from OHA in the form of 834 files. The 834 files are loaded and processed through Moda Facets. **EOCCO** also passes through the 834 files it receives from OHA to ADS, GOBHI, and its PBM.

- To link enrollment data to claims and encounters, **EOCCO** processes enrollment information daily upon receipt of OHA's daily and monthly eligibility files. The majority of the eligibility information is automatically loaded directly into **EOCCO**'s enrollment processing system, Facets. After the eligibility is run, some members fall out and reports are generated. For members that fall out of the automatic upload, the Medicaid Membership Accounting team manually investigates the report and performs manual intervention, if necessary. The Medicaid membership accounting specialists use activity reports generated from the 834 file and the OHA website as tools for verification. Every claim received and entered into Facets for processing must be linked to the appropriate member file in order to correctly identify the member and apply benefits. If multiple matches are found, the claims processor reviews the eligibility section to ensure the correct enrollment file is being used and verifies that the correct member has been selected before releasing the manual claim for payment.

Data Exchange Policies and Procedures

EOCCO holds weekly encounter data workgroups and meetings, which include representation from all stakeholding business areas, to ensure enforcement of **EOCCO** policies and procedures. These workgroups and meetings are also used to foster strong internal cross-collaboration and adherence to the **EOCCO** encounters workflow. **EOCCO** staff members from IS, Claims, and Provider Configuration meet on a monthly basis to review all aspects of the encounter data process. During this meeting, the group reviews and monitors pended and held encounter claim counts to ensure corrections occur to meet contractual obligations. In collaboration, this group resolves system and administrative issues related to the encounter data process with the goal of meeting all contractual obligations.

Management of Encounter Data: Collection, Storage, and Processing

EOCCO outpatient claims use different payment methods based on the claim type. Percent of billed, fee schedule, and COB payments are reflected in the encounter data submission per line item. Per diem payments are reflected on the line with the revenue code or procedure code that determines what per diem is used. Case rate (OPPS) payments are displayed on the claim line for the primary procedure. If the claim caps at billed charges it will display on the line with the highest billed charges. For subcapitation, the payment is zero dollars and the CARC is 24.

For inpatient claims, percent of billed and COB payments are reflected line-by-line in the encounter data. DRG payments are displayed at the claim level, while per diem allowed amounts are displayed on the line with the revenue code or procedure code that determines what per diem is used. Case rate payments are displayed on the claim line for the revenue code that is contracted with a case rate.

Table H-2 shows **EOCCO**'s pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table H-2—Pricing Methodology for EOCCO

Outpatient	Inpatient	Pharmacy
- Case rate: 0.41% - COB: 3.67% - Fee schedule: 40.14% - OPPS: 2.65% - Per diem: 1.02% - Percent of charge: 52.11%	- Case rate: 0.09% - COB: 1.12% - DRG: 45.04% - Per diem: 1.52% - Percent of charge: 52.23%	- Pharmacies are reimbursed on a negotiated rate that takes into consideration ingredient cost and discounts according to the participating pharmacy's contract with the PBM - Claim costs represent the direct contract amount with the contracted pharmacy and include a fixed administrative fee from the PBM for each paid claim - Encounter claims data represents the actual ingredient and dispense fee amounts paid to the pharmacy

- In response to whether there are any services submitted under bundle-payment structures, **EOCCO** noted that global maternity claims are the only service **EOCCO** considers as a bundled payment. **EOCCO** does not collect prenatal service dates unless the pregnancy is considered high risk.

- When collecting other insurance and TPL data, **EOCCO** staff members use the coordination of benefits information provided by OHA to look for other coverage. In addition, **EOCCO** uses a vendor that scrubs the payment files looking for claims paid as primary for other coverage; when found, claims are corrected in the system. ADS collects other insurance information from the member, while ODS uses the claim form to collect other insurance information. Providers are required to collect and submit all TPL data, using the appropriate fields on the 837 files.

- If claims are received with TPL payment information including allowed and paid amounts, **EOCCO** processes the claim as secondary. If **EOCCO** paid the claim as primary and at a later date learns there is other primary coverage, **EOCCO** will adjust the claim by asking the primary carrier's allowed and paid amounts to determine correct liability. If the other carrier's liability is not provided, **EOCCO** estimates the liability based on **EOCCO** allowed amounts. For claims where **EOCCO** is the secondary payer, claims are subject to all source data verification, as well as system and clinical edits. All TPL allowed and paid amounts are stored in the **EOCCO** processing record of a claim, as well as the payment record from the other carrier, and are accessible in **EOCCO**'s document management system. **EOCCO** does not handle Medicare crossover payments differently than other TPL payments.

- **EOCCO** captures and stores other carriers' allowed and paid amounts and submits them as part of the encounter to OHA, regardless of whether payment is made by **EOCCO**. Capitated claims are processed by **EOCCO** and submitted to OHA. **EOCCO** randomly selects 3 percent of all claims processed each month and sends service verification letters to ensure accuracy. **EOCCO** capitated rates are modeled based on claims experience, which ensures all capitated claims are submitted to **EOCCO**.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **EOCCO** staff members from IT, Claims, Medicaid Operations, and Provider Configuration meet regularly to review all aspects of the encounter data process. During this meeting, pended encounter claims counts are reviewed and monitored to ensure corrections occur to meet contractual obligations. This group works in collaboration to resolve system and administrative issues related to the encounter data process with the goal of meeting all contractual obligations. **EOCCO** leadership is responsible for monitoring and ensuring compliance with the encounter data requirements.

A monthly tracking sheet is completed by assigned **EOCCO** staff members and reviewed at least once a month by **EOCCO** leadership. The tracking sheet includes claim type, submitter, number of encounters submitted, the date of the submission, and dollar amount of each submission. The monthly tracking sheet is used to monitor the encounters sent to Health Systems and to reconcile and verify that **EOCCO** encounters are being sent, received, and submitted to comply with **EOCCO**'s contractual requirements.

EOCCO monitors the accuracy of encounter data submitted by monitoring the average amount of claims submitted during each extraction using internal monitoring reports and trackers. To monitor the timeliness of encounter data submitted by its vendors, **EOCCO** receives claim counts and total charges to submit on a CVF for ADS every Tuesday. If **EOCCO** does not receive encounter data or is not notified of an expected submission, it will follow up with the vendor.

To evaluate the quality of encounter data submissions, **EOCCO** monitors trends in data quality. **EOCCO** strives to have no more than 100 new pends associated with each encounter data submission. Increases and decreases are tracked, monitored, and reviewed by **EOCCO** leadership on a weekly basis.

Additionally, **EOCCO** reviews all 1 percent withhold spreadsheets from OHA to ensure pends are corrected within 63 days.

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by providers, **EOCCO** follows a process in which it identifies, monitors, reports, resolves, and adjusts or rejects encounters. If a submitter is having a data issue, it must notify **EOCCO** and provide appropriate detail. **EOCCO** is notified by the Health Systems Division when data have been extracted in a noncompliant format. When a data issue is identified, **EOCCO** staff members observe and check the quality of the encounters over a period of time. All issues are reported to the OHA encounter data liaison for **EOCCO**. The plan for data issue correction, as well as an expected date a fix will be in place, is communicated to the OHA encounter data liaison. **EOCCO** submits any adjusted encounters via an 837 file; however, adjustments are not submitted for duplicates, nonspecific diagnosis denials, or voids. Files that are rejected by OHA's EDI translator are manually adjusted by **EOCCO** and submitted through the 837 file. Claims submitted by providers that are over 120 days from the date of service are denied since untimely filing is disallowed.

EOCCO monitors the status of encounter data submitted to OHA by reviewing the 835 and loading the ICNs into Facets. The status file is reviewed to correct any pended encounters within 63 days of notification. If balance discrepancies are reported from the Claim Count Validation spreadsheet provided by the encounter data liaison, the discrepancy is researched and explained on the Encounter Claim Count Verification Acknowledgement and Action Form.

EOCCO uses the following transaction response files to support encounter data submission activities:

- 999 files: Used to identify and correct failed 837 claims rejected for compliance errors, and stored in an archive folder.
- 835 files: Used to identify the Division of Medical Assistance Program (DMAP) claim ID from MMIS that is assigned to **EOCCO**'s 837 claim ID. Some information is stored from the 835 to assist **EOCCO** in identifying which claim in MMIS it is submitting the adjustment and void encounters against.
- Pended claims file: Used to identify claims requiring correction either through the 837 adjustment or through the Web portal.

On average, 3.86 percent of **EOCCO**'s encounters submitted to OHA are rejected by OHA's EDI translator. To reconcile these encounters, **EOCCO** reviews claims that are rejected, performs necessary manual adjustments, and resubmits the encounter through the 837 process. In comparison, an average of 0.46 percent of encounters submitted by **EOCCO** are pended by OHA's MMIS. To reconcile pended files, **EOCCO** creates an internal report from the pended claim status file provided by OHA, and all pended encounters are adjusted in MMIS.

EOCCO's encounter data are not used for any other purpose. The encounter data system, processes, and files represent a data "spur" from **EOCCO**'s core systems. Additional reporting and analysis comes out of the core system.

EOCCO noted the following challenges faced in submitting encounter data to OHA:

- Internal challenges:
  - Ensuring appropriate exceptions are in place to prevent unnecessary 999 rejects. To mediate this challenge, **EOCCO** attends All Plans System Technical meetings to ensure compliance and active engagement with changes administered by OHA. Additionally, **EOCCO** provides continuous education for providers regarding proper billing to prevent improper billing practices.
- External challenges:
  - Related to the OHA EDI translator, **EOCCO** noted a change in requirements that would allow **EOCCO** to deny claims for missing elements rather than rejections that need to be manually worked.
  - The volume of 837 requirements requires **EOCCO** to put in place many exceptions on internal data and reports to prevent 999 rejects.
  - Encounter data issues caused by incorrect provider billing that result in 999 rejects due to EDI specifications.
  - When correcting pended encounters in MMIS, it is not always clear what caused the pend or how to resolve it without any guidance. In these situations, once **EOCCO** has exhausted all internal resources, it will reach out to its encounter data liaison for assistance.

EOCCO noted the following processes or additional resources and support from OHA that would be helpful in overcoming the aforementioned challenges:

- Updated resources regarding NDCs and provider-type crosswalks on the encounter data webpage would be helpful. Information to help determine which provider type can bill on which claim type would clarify many internal questions.
- An encounter data troubleshooting guide or suggestions for common pend errors within MMIS.
- An encounter data workgroup for CCOs to better collaborate and discuss solutions for upcoming changes, updates, and challenges, including a workgroup that meets more frequently than the All Plan System Technical (APST).
- Submission of encounter data via flat file would prevent reformatting claims, especially paper claims to fit 837 formats.
- OHA providing sufficient lead time to allow **EOCCO** to implement systemic updates and changes.

At the time of questionnaire submission, **EOCCO** noted it would be transitioning from biweekly encounter submissions to weekly submission to OHA beginning the first week of October. This change in extract and submission frequency will not cause changes to **EOCCO**'s encounter data workflow. **EOCCO**'s existing process will remain in place, with increased frequency.

Recommendations

Based on its review, HSAG recommends the following for **EOCCO** to strengthen its encounter data quality:

- **EOCCO** indicated that a relatively small proportion of its submitted encounters are rejected by OHA's MMIS, compared to encounters rejected by OHA's EDI translator. However, **EOCCO** did not describe specific issues contributing to its higher EDI translator rejection rate. **EOCCO** should consider an assessment of all encounter rejections based on issues involving 1) identifying the distinct rejection reason, 2) ranking rejection reasons based on frequency, 3) reviewing internal edits and compliance checks for loopholes that permit noncompliance, and 4) implementing stricter edit checks for prospective claims/encounters.

- In describing its methods for ensuring completeness and accuracy of its encounter data submission, **EOCCO** did not demonstrate that chart review was one of the validations conducted. HSAG recommends that **EOCCO** consider conducting validation of encounter data based on medical record reviews by comparing medical record documentation (i.e., diagnosis codes and procedure codes) against submitted encounter data for a sample of records. Results from these reviews can be used as part of **EOCCO**'s ongoing data monitoring.

This section summarizes the findings from Health Share of Oregon's (**HSO**'s) questionnaire responses.

Encounter Data Sources and Systems

HSO delegates various plan partners with responsibilities for submitting claims to OHA. As such, **HSO**'s plan partners provided responses to a majority of the questions, as well as in supplying supporting documentation. **HSO**'s plan partners include:

- CareOregon
- Kaiser Permanente (Kaiser)
- Legacy Health—PacificSource (Legacy Health)
- Oregon Health & Science University (OHSU) Health Services
- Providence Health Assurance (Providence)

HSO ensures that all professional, dental, and institutional claims are submitted to OHA within 60 calendar days of the claim's date of adjudication, while pharmacy claims are submitted to OHA within 60 calendar days of service. All claim file submissions are certified to OHA within 24 hours of transmission. Table I-1 displays the list of entities responsible for submitting claims to OHA.

Table I-1—Entities Responsible for Submitting Claims to OHA

Submitter	Service Type	Submitting on Behalf of Partner
VisibilEDI	Pharmacy and physical health	Providence
Kaiser	Dental, pharmacy, and physical health	Kaiser
Moda	Pharmacy and physical health	OHSU Health Services
PacificSource through PBM (CVS Caremark)	Pharmacy and physical health	Legacy Health
PH TECH	Behavioral health	CareOregon
CareOregon	Pharmacy	OptumRx
CareOregon	Physical health	CareOregon
CareOregon	Vision	Vision Service Plan (VSP)[1]
CareOregon	Dental	CareOregon Dental
CareOregon	NEMT	Ride to Care
ADS	Dental	ADS
ODS	Dental	ODS
Willamette Dental	Dental	Willamette Dental

[1] Claims submitted by VSP had to be submitted directly to CareOregon since VSP is not an OHA authorized submitter. As such, these claims are included in CareOregon's files to OHA and counted in CareOregon's totals.

Each of **HSO**'s plan partners provided responses for each source of key data they receive with a description of the files received, frequency of receipt, and the approximate data volume associated with each source of key data. **HSO** also provided the source of key data received from its plan partners, with the associated frequency and approximate data volume associated with each source of key data. Table I-2 displays the all plan all claims (APAC) data for the respective types of claims received from **HSO**'s plan partners.

Table I-2—Format and Submission Frequency of APAC Data Received

	APAC Pharmacy Claims	APAC Medical Claims	APAC 835 Claim Detail	APAC NEMT Claims	APAC Provider
Data receipt	OHSU Health Services, Providence, Kaiser, Legacy Health, PacificSource, CareOregon	OHSU Health Services, Providence, Kaiser, Legacy Health, PacificSource, CareOregon	OHSU Health Services, Providence, Kaiser, Legacy Health, PacificSource, CareOregon	OHSU Health Services, Providence, Kaiser, Legacy Health, PacificSource, CareOregon	OHSU Health Services, Providence, Kaiser, Legacy Health, PacificSource, CareOregon
Frequency	Monthly	Monthly	Monthly	Monthly	Monthly
Approximate volume	On average, 320,040 unique claims per month	On average, 523,055 unique claims per month	On average, 523,055 unique claims per month	On average, 96,784 unique claims per month	On average, 15,075 unique providers each month

CareOregon, Legacy Health, and Providence also provided a detailed description of data receipt, frequency, and the volume associated with each key source data:

- **CareOregon:**
    - Inpatient, outpatient, HCBS, laboratory, long-term care, oral health (through CareOregon dental), and physician data are received daily from the in-house QNXT claims processing system.
    - Pharmacy claims are received daily from its PBM (Catamaran) in a flat file format.
    - Transportation (i.e., ambulance) claims are received daily from CareOregon members through QNXT, and NEMT claims are received daily from Ecolane's system in the 837P format.
    - Vision claim files are received daily from VSP in the 837P format.
    - Behavioral health claims are received daily either from CareOregon's in-house claims processing system or submitted directly by PH TECH for all **HSO** members.
- **Legacy Health:**
    - Inpatient, outpatient, and long-term care point of service claims are received weekly from the respective submitter (e.g., hospitals, FQHCs, long-term care, skilled nursing facility, etc.) through its clearinghouse and EDI gateway. Files are submitted using the 837I format.
    - Laboratory, physician, and vision point of service claims are received weekly from the respective submitter (e.g., laboratory/facilities, physicians, and vision physicians) through its clearinghouse and EDI gateway. Files are submitted using the 837P format.

- Pharmacy point of service claims are received weekly submitted by retail pharmacies through its vendor, CVS Caremark. Files are submitted using the NCPDP D.0 format.

- **Providence:**
  - Inpatient claims are received in paper or EDI format on a daily basis.
  - Outpatient (including laboratory, physician, transportation [ambulance], and vision) claims are received in paper or EDI format on a daily basis.
  - Pharmacy point of service claims are received weekly from retail pharmacies through HSO's vendor, SS&C. Files are submitted using the NCPDP D.0 format.

In response to whether **HSO** or its plan partners modify or reformat claims/encounter data to accommodate OHA's encounter data submission standards, **HSO**'s plan partners provided the following responses:

- **CareOregon**: All fields are formatted to meet the 837 specifications and OHA guidelines.
- **Kaiser**: Does not modify its claims data; however, it reformats encounter data to accommodate OHA's encounter data submission standards.
- **Legacy Health:**
  - PacificSource's (as the integrated data system [IDS] contracted by **HSO**) process is to roll up revenue code 250 service line items in Facets to prevent duplicate edits from OHA.
  - When processing duplicate edits within the Encounter Module, PacificSource's analysts check for different NDCs on lines with duplicate HCPCS. If the NDCs are different, a 59 modifier is added to the line so that MMIS does not deny the duplicate HCPCS as a duplicate. This is a State limitation.
  - PacificSource updates the billing provider information billed on claims for FQHCs that have multiple locations and NPIs but have the same tax ID number. The update is due to the State limitation that FQHCs can only have one enrollment with the State and they cannot enroll separate locations.
  - PacificSource removes "duplicate" inpatient ICD-10-CM procedure codes performed on different dates of service (which are not duplicates) due to 999 rejects. This is done due to the State limitation.
  - PacificSource removes the onset of illness or injury date from professional encounters if it is the same as the date of service, as this causes rejects. Paper claims submitted by providers often times have an onset of illness or injury date present on the claim. This is not appropriate for electronic standards when submitting to the State.
  - PacificSource has a system limitation where the encounters for members who have three payers error out, and PacificSource must manipulate them prior to sending to the State. In order to submit the encounter, primary and secondary payment information is removed, and an adjustment is added to the line with a CO 45 for the full charge amount of the line. This way it will show that PacificSource allowed the claim but did not pay on it.

- – If a provider bills with a service facility NPI and address that are the same as the billing provider NPI and address, PacificSource's analysts remove the service facility information to prevent 999 rejections.
- – If a provider bills 0 units and/or $0.00, a 1 unit and/or $0.01 is added for encounter purposes. If encounters are submitted to the State with zero units, the encounter pends in MMIS. These are usually informational codes.
- **OHSU Health Services**: The pharmacy encounter file is modified to the following:
  - – Limit each B1 and B2 file to no more than 5,000 records.
  - – Divide the files based on plan code (i.e., CCOA or CCOB) according to the eligibility file information.
- **Providence**: Did not modify or reformat its claim/encounter data to accommodate OHA's encounter data submission standards.

All **HSO**'s plan partners except for Legacy Health noted that they submit all types of encounters to OHA—e.g., paid, denied, voided, and adjusted claims. Legacy Health with PacificSource (as the IDS for **HSO**) noted the following:

- It does not void claims, unless specifically requested to do so by OHA. Voided claims would then be submitted to OHA but are not included in its regular processing.
- It does not send claims if they are denied in full and have invalid codes as it is expected that the provider will correct and submit a new claim for payment.
- It does not send claims that have been denied for members not enrolled for which it has received a compliance error within its Encounter Module.
- It does not submit duplicate claims.

In handling adjusted encounters that have been previously submitted, **HSO**'s plan partners described the process for transmitting the encounters to OHA:

- **CareOregon**: If a claim is adjusted in its claims system, CareOregon submits the claim as an adjustment. If certain key fields (e.g., member, claim form type) are changed, according to OHA rules, CareOregon submits the adjustment as a delete, then submits as a new claim.

  For Health Share Behavioral Health processed by PH TECH, adjusted claims are submitted using the same process as a new claim; however, unlike a new claim, the frequency code is updated to "7" with an ICN included.
- **Kaiser**: When an encounter is pended and must be corrected but cannot be resolved via the automated process, a manual encounter adjustment form with remediated information for the encounter(s) in question is sent to the **HSO** encounter team, which then manually updates the encounter(s) in MMIS. The process submits adjusted claims when a claim originally paid is later overturned to denied. Additionally, pended encounters are automatically resubmitted weekly reflecting any changes in source systems. No other adjustments are automatically captured.

- **Legacy Health**: PacificSource (as the IDS for **HSO**) submits all adjustments to OHA. The process for submitting adjustments is as follows:
    - In its claims processing system (Facets), the original claim ends in "00." When a claim is adjusted in its system, a "new" claim is created ending in "01."
    - Every week, all adjudicated claims from its system are extracted and loaded into the Edifecs Encounter Module.
    - The adjusted claim/encounter ("01") overrides the ("00") claim/encounter in the Encounter Module and takes the internal control number (ICN) from the original ("00") claim for the REF F8 segment in the adjusted claim.
    - Encounters are batched and pulled into electronic data files and submitted to OHA.
    - The encounters are loaded into the State system, and the "01" claim finds the "00" claim in MMIS by using the ICN from the REF F8 segment.
- **OHSU Health Services**: OHSU Health Services submits any adjustments through the standard 837 file. OHSU Health Services does not submit any adjustment encounters for duplicates, nonspecific diagnosis denials, or voids.

    Pharmacy claim adjustments are submitted in the encounter file when a pharmacy reverses a previously paid claim or resubmits a previously paid claim for information update. Pharmacy reversals are submitted in the B2 file (103-A3 Transaction code). Pharmacy claim adjustments are submitted as reversals, 103-A3 (transaction code) B2 (reversal), then submitted as a new billing, 103-A3 (transaction code) B1 (billing), with an updated 880-K5 (transaction reference number) field for internal tracking.
- **Providence**: Providence submits adjusted encounters by attaching the previously submitted ICN to the adjusted encounter, where all adjusted encounters are submitted to OHA. Adjusted pharmacy claims are handled manually in MMIS.

For claims that are processed internally, Table I-3 shows the types of claims validated, a description of the validation performed, and the percentage of claims validated.

Table I-3—Claims Validated, Validation Performed, and Percentage of Claims validated

Plan Partner	Type of Claims Validated	Description of Validation Performed	Percentage of Claims Validated
CareOregon	All (manually adjudicated and auto-adjudicated claims)	- Monthly claims auditing is conducted by claims supervisors and training specialists. - Internal audits are also conducted by compliance. - Audits are performed to assess the financial, procedural, and payment accuracy of claims.	0.02%
	Behavioral health	PH TECH conducts monthly audits for Metro behavioral health claims	0.001%

Plan Partner	Type of Claims Validated	Description of Validation Performed	Percentage of Claims Validated
		processed through its CIM system. These audits are performed to assess the financial, procedural, and payment accuracy of claims. Audit results are reported on the monthly service level agreement (SLA).	
Kaiser	Internally processed claims (pended, paper, and auto-adjudicated)	• Claims data are validated prior to adjudication. As a part of intake, all claims go through a validation process to ensure all codes are valid. The system employs NCCI edits to determine if the provider billing is correct. • An end-to-end audit of claims includes source of truth documents (e.g. explanation of coverage, provider fee schedules, etc.) and key factors/elements (data accuracy, benefits, payment codes, eligibility, provider pricing, prompt payment, COB, bundling/unbundling).	0.03% random, stratified sample of finalized claims
	Pharmacy	• Kaiser: Random audit. • MedImpact: Performs separate quarterly claims auditing.	Kaiser: Sample size of 500 paid claims. MedImpact: 3% of claims or 1,500 claims, whichever is lower.
Legacy Health	Paper	• Random audit.	1%
	Electronic	• Random audit.	1%
	Large dollar claims	• For professional claims above $4,999 and for hospital/facility above $19,999 based on allowed charges.	100%
	Manually processed	• Claims where analysts have manually overridden copays, coinsurance, TOS, or overridden the service rule with B18 (allows the claim to be pay in full).	100%

Plan Partner	Type of Claims Validated	Description of Validation Performed	Percentage of Claims Validated
OHSU Health Services	Paper claims	• System and clinical edits.	100%
	Electronic claims	• System edits to look for correct procedure and diagnosis codes. Clinical audits are supplied by Optum.	100%
	Pended claims	• System and clinical edits.	100%
Providence	All claim types	• Either chosen by random choice or if concerns are reported. Fraud, waste, and abuse data analytics will also determine claims chosen. • Some claims are validated following the Medicaid data validation process, other claims are validated against source documentation such as chart notes, proof of delivery, prescriptions, or other medical records. If issues are found, refunds may be sought and education will be provided.	1%

Prior to claims being adjudicated for payment processing, asked whether code and/or field mapping are performed during data processing and validation or prior to submission to OHA, **HSO**'s plan partners provided responses as follows:

- **CareOregon**: Its claim system, QNXT, and the fully integrated Optum CES edit and validate elements of claims to ensure certain claim information submitted by the provider is accurate. However, no code and/or field mapping are performed during data processing for submission to OHA.
- **Kaiser**: Does perform code and/or field mapping during data processing; however, it performs minor mappings to required fields not reflected in the encounter process, such as linking to provider Medicaid IDs, member Medicaid IDs, and provider taxonomy.
- **Legacy Health**: Does not perform code and/or field mapping during data processing; however, prior to submission to OHA, denial and adjustment codes are mapped to the standardized Washington Publishing Company CARC codes within Facets (the claims data system used by PacificSource).
- **OHSU Health Services**: Does not perform code and/or field mapping during either one of the processes.
- **Providence**: Does not perform code and/or field mapping during either one of the processes.

Only CareOregon responded that it uses outside vendors for prepayment and postpayment reviews, although the claim is adjudicated by its internal staff based on the medical record or itemized bill decision.

In response to whether the provider data are managed directly by each CCO or a subcontractor vendor, **HSO**'s plan partners responded as follows:

- **CareOregon**: CareOregon receives provider data additions, changes, and termination notices from various sources, such as credentialing applications, new provider contracting processes, monthly provider rosters received from contracted organization, claims pending for missing providers, etc. Provider data in the core QNXT system are compared to the NPPES, the OHA weekly provider file, the CMS preclusion list, the Medicare opt-out list, and the OIG exclusion list. Provider data are managed directly by the subcontracted Health Share Behavioral Health, DCOs, Vision Service Plan (VSP), PBM, PH TECH, ADS, Kaiser Dental, ODS, Willamette Dental, and OptumRx. CareOregon receives the subcontractor provider files via the weekly APAC file process.

- **Kaiser**: Provider data are collected and maintained by a subcontracted vendor, where collecting and maintaining the provider data are based on the following process steps: 1) Contracting or employment, 2) Data entry in source system, and 3) Quarterly outreach to providers for data quality assurance of contracted providers and source system updates as appropriate.

- **Legacy Health**: Provider data are collected and maintained by both the CCO and a subcontracted vendor. PacificSource gathers and maintains the large majority of its own provider data relevant to Medicaid encounters. One exception exists in which PacificSource also relies on a subcontracted partner for handling provider data. The pharmacy provider data are gathered and managed by the PBM partner (CVS Caremark). The provider data (pharmacy provider data) are not ingested into PacificSource's systems. Issues arising from pharmacy encounters specific to provider data are forwarded directly to CVS Caremark for resolution on a pass-through basis. PacificSource has contractual language in place with CVS Caremark to ensure that pharmacy provider exclusions are communicated to PacificSource in a timely fashion. CVS Caremark is a subcontractor of PacificSource; therefore, the plan performs a subcontractor performance audit annually to verify subcontractor compliance with contract rules.

- **OHSU Health Services**: OHSU Health Services is responsible for coordinating the collection and presentation of data regarding provider demographics and contract configuration. Data are collected to supply OHSU Health Services' core claims database. Providers are required to submit changes by using a provider roster and or emailing/calling OHSU Health Services to report changes on an ad-hoc basis. Upon receipt, the roster or information provided by the provider is submitted to the Provider Data Management Configuration team. The roster is run through a comparison tool to identify changes that need to be made. The configuration staff enters updates into the core claims system, which may include adding or removing providers from the network or updating any other demographic information that has changed. Data collected from providers are kept in OHSU Health Services' internal database and hold all historical information received.

- **Providence**: Provider data are collected and maintained by the CCO. It receives provider data additions and changes through various sources. Providence included the Provider Workflow & CCW Providers document along with its response. For pharmacy claims, active and inactive provider data are pulled from the OHA site. A list of active providers is maintained in the PBM claims processing system and referenced for claim processing.

HSO's plan partners describe their processes for linking provider data to claims and encounters as follows:

- **CareOregon**: Claims with missing or mismatched provider data are pended within CareOregon's core QNXT system for prepayment. Provider data specialists review the submitted claim data, and either update the core system to reflect a valid change or deny the claim for incorrect billing or enrollment. Encounters are populated with the provider NPIs as they appear in the claim EDI data as processed in the core QNXT system. Encounters that pend with incorrect provider data require troubleshooting between the Provider Data team and the OHA provider enrollment team. Generally, if there is found to be a discrepancy between provider data on file and OHA's provider file, encounters are sent back for recouping by CareOregon's claims examiners or enrollment with OHA is updated in order to address the discrepancy.

  For Health Share Behavioral Health processed by PH TECH, the provider data and claims are paired through systematic and manual processes by matching data points such as provider name, vendor name, NPI, and tax ID numbers. Provider system analysts work with the CCO to resolve discrepancies in data. Claims are pended for review prior to processing when resolving data discrepancies.

- **Kaiser**: Tapestry links claims to the correct vendor, provider, and place of service records using matching logic such as tax ID, NPI, etc. Together, these records drive various processes during auto-adjudication, including contract selection and network selection. Electronically loaded claims use American National Standards Institute (ANSI) data such as the provider's NPI, the vendor's NPI, or the vendor's tax ID to research and correct any matching errors identified. If a matching record cannot be found, the system applies a pend code for no vendor, place of service, or provider, and the claim is sent to the appropriate team to resolve. When claims pend, the ANSI data are used to search for and build the records needed to resolve the claim.

- **Legacy Health**: For the encounter component of provider matching, Legacy Health uses the Encounter Module platform, which is a product developed and managed by Edifecs. Part of this program has the ability to load the weekly OHA provider file, which contains actively enrolled as well as inactive providers. This file is loaded to the platform and is stored within the backend. The file is generated and loaded weekly to keep the platform provider information up to date. As claims enter the platform, the system runs a validation check, looking for information such as a known provider, valid taxonomy, valid NPI, valid taxonomy to NPI relationship, etc. If there are any failures, a task exception is created and added to a workflow queue to be worked on by an analyst. If there are no exceptions, then the encounter is set to ready and will batch with Legacy Health's next encounter submission to the State.

- **OHSU Health Services**: A list of criteria is used to match incoming provider information on a claim to a single provider instance in Facets. When a match is found between the claim's provider information and a single provider instance in a provider work table, with a provider type that matches the claim, that provider ID is selected. If no provider is found, the next rule is executed, and repeated until all match rules have been processed. If matches are still not found, the provider ID is not set, and the claim goes to the Provider Not Found category.

- **Providence**: Provider information is entered at the time the claim is entered into processing system. If provider information does not match provider's information in the core processing system and is part of a participating provider group, the claim is returned to the provider to contact their provider relations representative for maintenance. If a provider is not participating, Providence will have the provider entered into its core processing system in order to be able to process the claim. For pharmacy claims, the active provider is maintained in the PBM system and referenced for claims processing. Any discrepancies are verified in MMIS to confirm enrollment.

HSO indicated in its response that the enrollment data are maintained by a subcontracted vendor. The vendor is responsible for performing the following quality checks on the enrollment data on behalf of **HSO**:

- 834 Pre-enrollment report: It is common for OHA to enroll a member and then retro their effective date. Sometimes the correct effective date is not sent in an 834-enrollment file and only found in the 820-payment file for being paid during that period of time. A monthly process is run to identify any OHA payments where the payment period directly precedes the enrollment master effective date and that portion of enrollment does not exist in the CCO enrollment master table. The CCO enrollment master table is updated, and 834s are created for each impacted RAE. A lag is applied to look back two quarters plus current quarterly minus current month for payments.

- Duplicate member report: From time to time, OHA will accidentally assign the same member more than one active Medicaid ID or the same Medicaid ID to two different people in error. These can cause a lot of issues such as incorrect claim payments and member confusion. To help identify these errors, **HSO** creates and sends a duplicate member report to OHA to review and correct when needed. The report looks for any active members who either 1) have the same Social Security Number (SSN), or 2) have no SSN but the same first name, last name, and DOB. **HSO** will provide a file to each RAE on any of their active members that appear on the report to OHA. It is possible for one member to have more than one ID and be assigned to two different RAEs. This would most likely appear due to a PHP change where the two member IDs have two different mental health RAEs. If this is the case, **HSO** will send both IDs to both RAEs to make them aware of the issue. RAEs may use the file as they need to update their system or track that they have already notified OHA of the issue.

  For Health Share Behavioral Health processed by PH TECH, the Enrollment Department at PH TECH oversees the import and reconciliation of enrollment records. PH TECH monitors the daily files, scanning for any errors, and validating discrepancies against MMIS, the raw 834 data, and the 820 file, if needed. Communication directly to OHA is also required at times to resolve issues. Additionally, a monthly reconciliation is done using the OHA monthly audit file and comparing it to what is in the plan's membership system (CIM). Discrepancies are researched and corrected in CIM, if necessary.

HSO's plan partners provided their processes for linking enrollment data to the claims and encounters as follows:

- **CareOregon**: Each submitter receives the daily 834 enrollment updates. They then match incoming claims to enrollment using the Medicaid ID and reject claims that do not match to an active

enrollment. If a member is retro disenrolled prior to encounter data submission, CareOregon does not submit its claims as encounters to OHA.

For Health Share Behavioral Health processed by PH TECH, PH TECH's membership system is used for enrollment, claims payment, and encounter data exporting. Should there be any discrepancies between encounter data and enrollment within the system, the enrollment team is consulted to make any needed corrections or research, and the encounter is resubmitted.

- **Kaiser**: For institutional and professional claims, daily enrollment data from Kaiser's membership system are uploaded to KP Health Connect (KPHC). The membership upload is an automated process that does not require manual intervention. When the claims adjudication process occurs, member enrollment data are validated against the claims. In the event there is a discrepancy in the membership enrollment data and claims data, an escalation process between the claims and enrollment teams is initiated through the customer relationship management (CRM) communications process to resolve any differences within two-to-four business days.

- **Legacy Health**: The process for linking enrollment data to claims and encounters begins with the 834 files sent by **HSO** to PacificSource. The 834 files are loaded to the enrollment management system (EMS). Once in EMS, the member information, along with coverage dates, flows to Legacy Health's claims processing system, Facets. As members' information flows to Facets from EMS, their unique identifier is attached. The member's unique identifier is the link to claims and encounters.

- **OHSU Health Services**: Every claim received and entered into Facets for processing must be linked to the appropriate member file in order to correctly identify the member and apply benefits. Facets will select a member for electronically entered claims based on the member's ID number, date of birth, and name. If multiple matches are found, the claim will require that a processor review the eligibility selection to ensure the correct enrollment file is being used. Claims processors will be responsible for verifying that the correct member has been selected prior to releasing any manual claim for payment. If a member's eligibility is not loaded into the Facets system at the time of receipt, the processors are required to look up the member in the Department of Human Services (DHS) portal using the information on the claim image and DHS portal instructions. If the DHS portal shows that the member is an OHSU Health Services/**HSO** member, processors will hold the claim until eligibility is loaded into Facets. If this takes more and a week, processors are to notify their supervisor, who will reach out to Membership Accounting for assistance.

  For pharmacy claims to adjudicate, the pharmacy must submit the member's ID number, date of birth, gender code, and name in the respective 302-C2, 304-C4, 305-C5, and 311-CB fields. The claims processing system validates what the pharmacy submits for each of these data points and matches what was transmitted in the eligibility file. If all data points do not match, the claim rejects during the adjudication process.

- **Providence**: Enrollment data provided by OHA are entered into the source system daily, and member information is entered at the time claims are entered/processed. For pharmacy claims, OHA provides eligibility data, which is then loaded into Facets (the medical claims processing system). Providence then extracts and sends the eligibility file to the PBM (SS&C), which then processes the members' prescription.

Data Exchange Policies and Procedures

HSO's plan partners describe their encounter data submission processes as follows:

- **CareOregon**: Encounter data files are submitted at least once per month by each of the CCO submitters, including CareOregon. The 837 and NCPDP files are sent directly to OHA, and a copy is sent to CareOregon from the other submitters. Each encounter file must be reported to OHA on a Certification and Validation Report Form (CVF/H2) within 24 hours of the submission. The other submitters notify CareOregon when their submissions have been made. The notifications include the file name(s), claim counts, total billed amounts, and submission date. CareOregon keeps detailed accounting of each file to balance out each week's total submissions against the CCV report from OHA. Any out-of-balance amounts are reported back to OHA on a VAF/H3 form within 10 business days from receipt of the report.

  CareOregon is responsible for the data validation, testing, and fielding of encounter issues and questions from the other submitters. Weekly and monthly reports from OHA, including the Pend Error reports, Deceased Client reports, Claim Data Issue reports, Members Not Enrolled reports, Monthly Summary reports, and the 1 percent Final Withhold reports are processed, parsed out, and sent securely to each of the submitters to review and correct their own data. CareOregon monitors all of the reports to ensure that they are processed within the related time frames and follows up with the submitters and OHA as needed.

- **Kaiser**: Prior to the first quarter of 2021, KPNW used a software suite developed in-house to extract data from the claims data warehouse and membership systems and submit raw files to the National EDI (NEDI) team, which transformed them into 837 files. NCPDP files are not submitted via NEDI. This process is being discontinued.

  Effective early 2021, medical and pharmacy encounter data submission processes will be automated through implementation of the National Medicaid Encounter Reporting (NMER) platform. The platform was designed to meet the Standard Companion Guide Transaction Information V1.5. Encounter data submission to OHA and will be managed by the NMER team. The NMER team is responsible for the encounter data submission, which covers nearly 1 million Medicaid members across multiple regions.

- **Legacy Health**: Legacy Health supplied a Medicaid Encounter Data Policy document in support of its response.

  a. Each Monday, PacificSource (as the IDS for **HSO**) loads adjudicated claims from the claims processing system, Facets, into its Encounter Module (EM). The majority of encounters move straight to Channel Ready Status. An average of 1% fall out for various reasons and need to be reviewed by an analyst. Per Legacy Health contract with the State, encounters need to be submitted to OHA within 45 days of adjudication. The dates that the encounters fall out are monitored daily to ensure that encounter tasks are processed timely. When the analyst has corrected any necessary compliance errors or verified that providers are actively enrolled, the encounters are released and move to the Channel Ready Status.

  b. On Wednesday, all encounters in a Channel Ready Status are batched into 837Is and 837Ps. A separate 837I and 837P are created for each mailbox.

    c.   Once all of the 837I and 837P files are ready for submission, they are transmitted to the appropriate State mailboxes along with any NCPDP files and 837D files that were submitted that week from subcontractors.

    d.   Generally, on Wednesday evening Legacy Health receives 999 acknowledgement files and 999 rejected encounters. The 999 acknowledgment files contain an acknowledgement for each encounter submitted to the State that was not rejected, and a 999 acknowledgement is posted to each encounter in the file. When Legacy Health receive a 999 reject, a task in the EM is created for each. These tasks are processed by an analyst, and the encounter moves back into a Channel Ready Status where it is batched and submitted to the State the following week.

    e.   On Thursday, CCV forms are to be submitted to OHA attesting to the number of encounters and total dollars submitted.

    f.   On Saturday, Legacy Health receives 835 files that are loaded into the EM. Each encounter within the 835 moves to an accepted disposition, which indicates that the encounter has been successfully accepted by OHA. The EDI team runs a report each week to verify that all submitted encounters received an 835 response. If any encounters did not receive the 835 response, Legacy Health teams investigate for correction.

    g.   In addition, on Saturday, the Weekly Status File is loaded into EM. Encounters on this file are in the State system, but in a pended status and need a correction by the CCO in order for the encounter to be accepted by OHA. Tasks are created for each pended encounter in the weekly status file and are processed by analysts. This correction must be made within 63 days from the date the encounter was received by MMIS. This date is known as the Penalty Date, which is monitored daily.

- **OHSU Health Services** submits encounter data to OHA and Health Share of Oregon on a biweekly basis. The encounter data submitted represent at least 50 percent of all encounters received and adjudicated by OHSU Health Services that month. OHSU Health Services submits all initial and unduplicated encounter data to OHA within 45 days of the claims adjudication date. OHSU Health Services submits corrections to all pended medical, mental health, and pharmacy encounters reported by Health Share of Oregon and OHA within 63 days of the date Health Share of Oregon or OHA notifies OHSU Health Services of the pended encounter. For additional details, please see the encounter data policy.

- **Providence**: The encounter data process includes the extraction, submission, correction, and validation of claims data for eligible members. An inter-departmental encounter data team performs the encounter data procedures, and an oversight group, comprised of director-level representatives, oversees the process. Complete, accurate, and timely submission of encounter data, are required for biennial actuarial per capita cost calculation and annual health and geographic risk assessment. In its response, Providence listed the steps involved in processing the encounter data.

Management of Encounter Data: Collection, Storage, and Processing

Table I-4 shows **HSO**'s partner plans' pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table I-4—Pricing Methodology for HSO's Partner Plans

Partner Plans	Outpatient	Inpatient	Pharmacy
CareOregon	• APC: 72.3% • Fee schedule: 22.8% • Percent of charge: 4.9%	• DRG: 98.2% • Percent of charge: 1.8% • Per diem: – 0.0%	• For specialty and brand drugs—negotiated rate • For generic drugs—same MAC list used for all pharmacies or U&C, whichever is lower
Kaiser	• Noncontracted acute care hospital claims are priced using Optum CMS APC-OPPS pricing. Noncontracted are configured at 76% of Medicare pricing per region guidelines. APC pricing is priced line by line. • Contracted rates can vary at percentage levels, but Optum APC-OPPS pricing still applies. • Noncontracted Type A/B CAHs, price outpatient claims at a percent of billed charges. Claim is priced line by line. • Contracted—Only a couple of Type A and B are contracted and priced at the contracted of billed charges, or through Optum.	• Noncontracted acute care hospitals price using Optum CMS IPPS pricing, inpatient claims price using Medicare Severity-Diagnosis Related Group (MS-DRG) grouping weights and not All Patients Redefined Diagnosis Related Group (APR-DRG). Oregon Medicaid inpatient non-con claims also price at 76% percent of Medicare. This is why MS-DRG grouping is used. Inpatient claims bundle to the DRG for whole claim pricing. • Contracted acute care inpatient claims also price using Optum CMS IPPS pricing, MS-DRG weights. Kaiser also	• Single, national prescription drug fee schedule (received from Kaiser Permanente's Pharmacy Schedule Oversight Team).

Partner Plans	Outpatient	Inpatient	Pharmacy
		has some negotiated contracted Medicare rates. • Noncontracted inpatient Type A/B hospitals are the same as outpatient where they price at a percent of billed charges. • Contracted inpatient A/B Hospitals—also only a few are contracted. These facilities price using Optum Medicare CMS pricing, or a percent of billed charges.	
Legacy Health	Paid based on: 80% of CMS, FFS, percent of OHA, percent of invoice, percent of billed, per member per month (PMPM), capitation, Patient Centered Primary Care Home Program (PCPCH) tier (billed by PCP), PCPCH + program, or BHI.	• DRG • Percent of OHA rates	• Negotiated Rate: 99.0% • U&C: 1.0%
OHSU Health Services	• Percent of billed • Per diem • Fee schedule • Case rate OPPS • Subcapitation • COB	• DRG • Percent of billed • Per diem • COB • Case rate	• Contractual discounted rate
Providence	• Percent of OPPS allowable or contracted rate	• Percent of Medicare DRG or contracted allowable	• Negotiated rates

- In response to whether there are any services submitted to **HSO** under bundle-payment structures, **HSO**'s partner plans indicated the following:
  - **CareOregon**: CareOregon follows the standard FFS process for billing for outpatient maternity services but does not have a broader bundle in place that incorporates hospital or other ancillary services primarily including imaging, delivery, and immediate postpartum care. CareOregon does not have bundle-payment structures in place for any other services.
  - **Kaiser**: Kaiser does not submit any bundled-payments to the CCO for Medicaid.

– **Legacy Health**: For inpatient claims that may be paid based on DRG, which is based on weight for each DRG and a rate for the facility, only one DRG is assigned per admission. For labor and delivery professional claims, if a provider bills for a bundled code such as 59400 (for vaginal delivery) or 59510 (for cesarean delivery), providers are not required to submit claims for services included within the procedure code, and Legacy Health collects encounter-only claims when submitted. For outpatient claims: APCs, where total payment for the outpatient visit is calculated based on the sum of the payments for all APCs.

– **OHSU Health Services**: Global maternity claims are the only service OHSU Health considers as a bundled-payment. It does not collect prenatal service dates unless the pregnancy is considered high risk.

– **Providence**: For transplants, Providence noted that there is a bundled payment and claims with zero payment to encounter all of the services related to the transplant. The vast majority of maternity claims are paid under a global billing. If a provider bills for visits that should be paid under a global charge, the service is denied with a Global Service explanation code. For those delivery services that are paid under a bundle-payment, all claims received are encountered, both delivery and prenatal/postpartum. Providence's clinical editing package denies specific services as bundled or adjunct.

- With regard to collecting other insurance data, **HSO**'s plan partners noted the following:

– **CareOregon**: If any employee, subcontractor, provider, intern, or volunteer becomes aware of other health insurance coverage or other nongroup health insurance coverage (e.g., liability, no-fault, workers' compensation) they must collect all the initial data about the coverage and forward it to CareOregon for investigation. CareOregon provided a Claims Third Party Liability (TPL) - Personal Injury Protection (PIP) Policy document in support of the process.

– For Health Share Behavioral Health processed by PH TECH, the TPL information provided in the State enrollment file is ingested into CIM for Medicare members. Other TPL would be sent to the enrollment team by CareOregon if it is to be loaded into CIM.

– **Kaiser**: As an integrated care delivery system, 97 percent of all care is delivered by Kaiser Permanete North West (KPNW) providers. When KPNW staff interact with members, by phone or in person, KPNW asks for other insurance coverages (OIC), which are then captured in KPHC. In addition, all new members are asked for OIC during the new member welcome call from KPNW. KPNW captures OIC information from submitted claims and various data sources (e.g., passport, workers' compensation indicators). Kaiser's TPL vendors also capture and report OIC information to KPNW.

– **Legacy Health**: Other insurance data are collected through various sources: member applications, member phone calls, provider calls, member claims, internal reports, and a subcontracted vendor (Optum).

– **OHSU Health Services**: Uses the coordination of benefit information provided by OHA to look for other coverage. In addition, OHSU Health Services uses a vendor that "scrubs" its payment files looking for claims paid as primary for other coverage. When other primary coverage is found, claims are corrected in the system.

– **Providence**: Other insurance data are collected through provider submitted claims, calls from members or providers, membership report, and a subcontracted vendor (Discovery Health).

- **HSO**'s plan partners describe how they verify the accuracy of Medicare crossover and other third-party claims information as follows:
  - **CareOregon**: VisibilEDI, which is **HSO**'s vendor, handles its Medicare crossover claims. VisibilEDI receives all of the crossover claims from the CMS Benefit Coordination & Recovery Center (BCRC) and determines which **HSO** contracted plan is responsible for the claim and will distribute the applicable claims to plans in an 837, accordingly.
  - **Kaiser**: Kaiser Foundation Health Plan (KFHP) uses the Epic Clarity database and reporting system, which stores Medicare crossover and other third-party claims information. This system is used to verify the accuracy of Medicare crossover and other third-party claims information. There are no differences in the processes between Medicare crossover claims and other third-party claims.

    When a claim has other insurance carriers, the encounter reporting process creates an additional 2320 subscriber loop (for each additional payer other than KFHP) and populates the claim-level paid amount in the amount (AMT) segment field within the 837 file.

    The encounter reporting process creates and populates the following fields:
    - 2330A—Other subscriber information loop with subscriber information (first name, last name and other payer identifier)
    - 2330B—Other payer name loop with the other payer information (name and payer identifier)

    For each service, the encounter reporting process creates a 2430—Line Adjustment segment for each payer and provides the line level paid amount and adjustments for all the payers involved.
  - **Legacy Health**: PacificSource (as the IDS for **HSO**) uses Transaction Manager to verify the accuracy of electronic claim source data and the hard copy of a submitted claim to verify the accuracy of submitted paper claims. PacificSource stores primary payment information in its system directly in the Medicaid Secondary Claim.
  - **OHSU Health Services**: For medical claims where OHSU Health Services is the secondary payer, they are subject to all of the source data verification as any other claims, where all system and clinical editing is applied. All TPL allowed amounts and paid amounts are stored in the processing record of the claim as well as in the payment record received from the other carrier, which is accessible in its document management system. OHSU Health Services noted that it does not handle Medicare crossover payments any differently than it does other TPL payments. For pharmacy claims, members with other coverage such as Medicare are identified via the enrollment file. Payment by other insurers is indicated in the encounter file via the COB/other payment segments, field 338-5c. Primary and secondary payment from other insurers is indicated via a 01 or 02, respectively.
  - **Providence**: Providence noted that there is no difference in processing the Medicare crossover claims and other third-party claims. The COB information is shown on electronic images or attached to paper claims and stored in Providence's source system. Providence verifies these data and the accuracy of the Medicare crossover claims with its TRR report and checking the CMS MARx website.
- For services that **HSO** is not responsible for due to payment from a primary carrier, **HSO**'s plan partners describe how the zero-payment claim is reflected in the encounter data as follows:

- **CareOregon**: CareOregon processes the claim as a standard COB secondary claim. When it is determined there is no remaining or outstanding balance to pay on the secondary (i.e., CareOregon), the claim is processed to pay at zero dollars and is submitted through the typical encounter data submission process, which is the same for its third-party administrator (TPA) (PH TECH) as well. For Health Share Behavioral Health processed by PH TECH, in the 837, a $0.00 would reflect in the next pay in conjunction with a CARC 23 or 22.
- **Kaiser**: When KPNW is not responsible to pay for services due to the full allowable payment from the primary payer, Kaiser's National Claims Administration (NCA) does not process zero-pay claims for subcapitated providers for Medicaid. However, wherein KPNW's claim-level paid amounts and all the line-level paid amounts are represented as zero-dollar, the other payer paid amounts are represented as adjustments in the CAS segments.
- **Legacy Health**: Encounters are sent to the State with primary payment information OA 23 and an allowable adjustment CO 45 for any remaining balance over Medicaid allowable that Legacy Health does not pay. Legacy Health also noted that PacificSource processes and submits claims to OHA for capitated providers.
- **OHSU Health Services**: For medical claims, OHSU Health Services captures and stores the other carriers' allowed and paid amounts and submits them as part of the encounter to OHA whether or not a payment is made by OHSU Health Services. For pharmacy, payment by other insurers is indicated in the encounter file via the COB/other payment segments, field 338-5c. Primary and secondary payment from other insurers is indicated via a 01 or 02, respectively. For claims paid in full by the primary insurer, the plan paid does not reflect an amount.

  OHSU Health Services also noted that capitated claims are processed by OHSU Health Services and submitted to OHA. It randomly selects 3 percent of all claims processed each month and sends out service verification letters to ensure accuracy. According to OHSU Health Services, its capitated rates are modeled based on claims experience, which ensures that all capitated claims are submitted to OHSU Health Services.
- **Providence**: The zero-payment claim is reflected in the CO 22 and CO 23 CARC codes showing zero paid by **HSO**.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **HSO** and it plan partners described the following activities:

- Completeness
  - **HSO** uses two methods to determine completeness of encounter submission:
    o Unencountered claim report: Identify RAE claims that have not been encountered and report them to OHA. This process compares a RAE APAC formatted claim file to the 835 from OHA to identify claims that have been encountered. The process reports out any paid claims that have not been encountered during the reporting period.

- o Completeness is estimated by evaluating each monthly submission (claims, members, payments) against the most recent validated submissions to ensure no material or unexpected shifts have occurred.
  - **CareOregon**: As the EDI vendor for Health Share, CareOregon compares the APAC-formatted claim file against received 837 files from its subcontractors. The APAC-formatted claim file is considered a full reporting of claims payment history. This report is distributed monthly to all subcontractor encounter data submitters. Additionally, the CCO encounter data coordinators track all submissions made by submitters as reported and monitor for trends.
- Accuracy
  - Each RAE submits its 837D/I/P files directly to OHA and delivers a copy to **HSO**. These files are imported and used for encounter validation and reporting, such as unencountered claims. **HSO**'s encounter team receives the RAE 837 summary report each week and reconciles to OHA's CCV, and emails the RAE on files submitted.
  - **CareOregon**: OHA issues weekly Claim Data Issue Reports that identify duplicate encounter data records, provider enrollment issues, and mismatched claim data. The CCO reviews these reports and shares them with CareOregon subcontractors with a request for resolution. CareOregon actively parses and monitors the weekly pend status file from OHA. These pended encounters that belong to CareOregon's subcontractors are monitored for timely resolution.
- Timeliness
  - **HSO** uses OHA's pended encounter report to monitor encounter data are being submitted timely for adjudication. **HSO** supplied several documentations to support these activities.
  - **CareOregon**: OHA issues a 45-days from Date of Adjudication report on a monthly basis. CareOregon monitors this report for the count and threshold of CCO claims submitted outside the 45 days from date of adjudication. If an issue with a subcontractor is identified, CareOregon makes contact with the respective subcontractor. Additionally, the monthly APAC-formatted claim file comparison against the received 837 files makes CareOregon aware of whether or not claims are being encountered timely or at all. Subcontractors receive and respond to these reports on a monthly basis.

To monitor the completeness, accuracy, and timeliness of the encounter data submitted by its providers, **HSO**'s plan partners conduct the following activities:

- Completeness and Accuracy
  - **CareOregon**: If claims are submitted with missing, incomplete, or invalid fields, QNXT runs a rule that denies the claim line and generates a message that is communicated on the provider's remittance advice. Claims paid are submitted as encountered and monitored for acceptance. Claims submitted to PH TECH's CIM system also follows the same process.
  - **Kaiser**: Claims data are validated prior to adjudication. As a part of the intake process, all claims go through a validation process to ensure all codes are valid. If information is missing, the claim will not process. The system employs NCCI edits, which review claims to determine if the provider billing is accurate.

- **Legacy Health**: Legacy Health uses a combination of internal and State-provided reporting to monitor accuracy, timeliness, and completeness. Monitoring rejections and pends relates to accuracy of the data. Legacy Health provided supporting documentation with examples of monitoring reports.
  - **OHSU Health Services**: OHSU Health Services assigns staff members who are responsible for identifying data issues as they arise. Additionally, encounter totals are monitored weekly and monthly, where any low numbers of encounters are identified as a possible data issue. For data issues that have been identified, OHSU Health Services staff members monitor and communicate the issues to OHA's encounter data liaison, and the issues are corrected. OHSU Health Services uses the pend tracker report to monitor completeness.
  - **Providence**: Providence performs EDV for provider educational purposes and billing validation for OHP member charts to support the accuracy of encounter data. Medical record review for encounter data validation is performed on an annual and as-needed basis and is independent of medical record review conducted for evaluation of performance measures or other purposes.
- Timeliness
  - **CareOregon**: CareOregon has policies in place regarding timely filing. Providers also receive timely filing expectations through the provider handbook and provider contracts. Claims processed as paid or denied for timely filing are reflected as such in the encounter data submitted. CareOregon's TPA (PH TECH) follows the same timely filing guidelines.
  - **Kaiser**: The claims processing system calculates the timeliness of claims based upon the claim date of service and the date it was received. Claims denied for timely filing are monitored via the Claims Timely Monitoring Report. This report is run on a monthly basis.
  - **Legacy Health**: Legacy Health uses a combination of internal and State-provided reporting to monitor accuracy, timeliness, and completeness. Monitoring rejections and pends relates to accuracy of the data. Legacy Health provided supporting documentation with examples of monitoring reports.
  - **OHSU Health Services**: Claims submitted by providers that are received over 120 days from the date of services are denied since untimely filing is disallowed.
  - **Providence**: On a monthly basis, OHP monitors timeliness based on the following metrics: 1) encounter submission to OHA within 45 days of adjudication, and 2) correction of encounters within 63 days. The monthly metrics are reported to the compliance oversight committee and corrective actions are issued if metrics are not within standards.

To monitor the status of encounter data submitted to OHA, **HSO**'s partner plans describe the process as follows:

- **CareOregon**: Based on comparing the 837 submitted encounters to the 835 receipt from OHA. Additionally, CareOregon monitors the pend status report to ensure maximum acceptance of encounter data and works to resolve all issues preventing acceptance, including provider enrollment issues, claims processing, or formatting issues.

- **Kaiser**: Pends and accepted encounters are tracked weekly using a combination of the 835 file, status file, and internal reporting. Kaiser developed an Encounter Data Submission Accuracy, Completeness, and Timeliness Policy document in support of the process.
- **Legacy Health**: Legacy Health monitors the status of encounter data submission through reporting from its EDI team weekly. There is backend reporting that matches Legacy Health's Facets claim ID to the patient account number within the 835 response file. If any claim IDs show as submitted but missing an 835 event, an investigation is conducted.
- **OHSU Health Services**: OHSU Health Services noted that claims submitted by providers that are received over 120 days from the date of services are denied since untimely filing is disallowed.
- **Providence**: A weekly submission report details both submitted claims and associated responses. The report fully identifies the previous week's submission of claims, their associated claims status, balancing errors, and count of days the denied claims are aging that require correction.

Table I-5 shows the average percentage of encounters submitted to OHA that get rejected by OHA's EDI translator and the average percentage of encounters submitted to OHA that pass OHA's EDI translator but are pended by OHA's MMIS, by each of OHA's plan partners.

Table I-5—Average Percentage of Encounters Rejected and Average Percentage of Encounters Pended

Partner Plans	Average Percentage Rejected by OHA's EDI Translator	Average Percentage Pended by OHA's MMIS
CareOregon	0.02%	0.11%
Kaiser	0.0%	<0.1%
Legacy Health	0.001%	0.02%
OHSU Health Services	0.064%	0.985%
Providence	0.27%	0.79%

In reconciling files rejected by OHA's EDI translator and files pended by OHA's MMIS, **HSO**'s plan partners described the process as follows:

- **CareOregon**: CareOregon monitors and addresses encounters rejected in the 999 using an on-demand report to identify and correct impacted encounters on a quarterly basis. It invests most of its efforts to a pre-scrub reporting process whereby encounters that fail the translator are identified and addressed prior to submission as encounters. For files pended by MMIS, CareOregon receives a pend status file loaded into CareOregon Web Apps (COWA) each week. Processes are in place to correct pended claims in its claims system and resubmit as an adjustment.
- **Kaiser**: For files rejected by OHA's EDI translator, submission processes are managed by central production support team that has a series of error monitoring features. However, the specific mechanism for monitoring the 999 is a weekly manual review to ensure a 999 file is received. If this review finds errors, the team will manually diagnose and remedy the root cause and resubmit. Such a 999 file-level rejection is a very rare event. For files pended by MMIS, encounters are reconciled using a variety of methods. Internal communication is the initial step to determine the root cause. Then, Kaiser resubmits the corrected encounter, or the CCO will manually correct the encounter in MMIS.

- **Legacy Health**: The process for reconciling files rejected by OHA's EDI translator depends on the 999 and weekly status files received from OHA. These files are loaded, and tasks are automatically created and added to work queues. Legacy Health uses a collection of reports to monitor the ages of claims to make sure resubmissions are timely. Additionally, Legacy Health runs weekly reports to watch the overall flow of claims in its system, not only to ensure that internal claims are correctly processed, but that ultimately all encounters are sent, accepted, and end up in a final completed state. As for pended files, Legacy Health has policies and procedures in place where the process of reconciling the pended files involves identification (using the weekly status report files), correction, and subsequent resubmission.

- **OHSU Health Services**: In reconciling files rejected by OHA's EDI translator, OHSU Health Services reviews claims that are rejected, performs any necessary manual adjustments, and resubmits through the 837 process. For files that are pended by OHA's MMIS, OHSU Health Services creates an internal report from the pended claim status file provided by OHA. All pended encounters are adjusted in MMIS.

- **Providence**: For files that are rejected by OHA's EDI translator, Providence researches the files for root cause. Rules are reviewed/written to correct the issue within 24 hours. Once resolved, claims are re-sent during the next schedule submission. For files pended by MMIS, Providence identifies encounters to be corrected via the 835 and status files, where the status file is compared to the submitted encounter each week to ensure only those encounters that require correction are available in the portal for review.

Data in **HSO**'s encounter data system are used in various capacities. CareOregon describes that the encounter data are used to calculate clinical quality measure performances, including CCO incentive measures, HEDIS reporting, and other clinical quality measures included in the CCO value-based payment models. These measures are used internally and externally with network partners. Additionally, encounter data are used to:

- Calculate total cost of care and medical loss ratio for CCO shared-risk contracts.
- Understand patterns of member utilization.
- Segment the population according to utilization and demographics.
- Monitor engagement of membership by members' attributed primary care, behavioral health, and dental providers.
- Identify diagnoses of members for risk stratification.
- Identify members with gaps in care or who are otherwise in need of additional care coordination support.

HSO also listed the following uses of encounter data: rate setting, calculating CCO leading indicators for CCO metrics, utilization and financial monitoring, and metrics for strategic initiatives.

HSO and its plan partners noted the following challenges in submitting encounter data to OHA:

- **CareOregon**:
  - Internal challenges: In managing the submission of files to OHA, occasionally submissions are made more than once because it is not clear that a file has already been submitted, resulting in OHA processing the submission twice. CareOregon noted that it would be beneficial if there were controls in place to prevent OHA from accepting the same file more than once.
  - External challenges: CareOregon struggles to keep pace with OHA's changing encounter data edits/critical error reasons. These changes often result in large configuration projects, and there is often a lack of transparency in terms of OHA's criteria for determining clean/nonclean encounters in many instances. Additionally, CareOregon struggles with OHA system constraints; OHA is not able to handle sizable volumes, which can result in encounters being held. As a result, this causes out-of-balance amounts for multiple weeks following the instance of held files. Health Share Behavioral Health—PH TECH: OHA does not have the mapping or edits from its EDI translator available for distribution to use as a tool. As such, some errors kicked back are not easily defined.

- **HSO**:
  - Internal challenges: While **HSO** does not submit to OHA internally, **HSO** noted that for the data that they do send, **HSO** finds it cumbersome because the State uses dated systems. For example, sending and receiving TOC PA and care plans through SharePoint. In addition, submitting this questionnaire and supplemental documentation, **HSO** noted that it is not ideal to submit through email due to size. Offering secure file transport such as secure FTP, Dropbox, etc. would be beneficial for **HSO** and all its plan partners in the future.
  - External challenges: **HSO**'s plan partners continue to provide feedback that limiting files to 5,000 claims per submission is cumbersome. The State's technology has made it difficult for **HSO**'s plan partners that have more sophisticated systems to communicate with the State for proper claim submission. Oftentimes, they are adjusting or creating separate processes due to limitations the State has.

- **Kaiser**:
  - Internal challenges: There are a variety of routine technical and administrative challenges associated with a task this complex, but none have proved unsolvable. Centralizing these regional processes into a national platform (NMER) is a key strategic goal to address these challenges holistically.
  - External challenges: There are a variety of routine technical and coordination challenges such as password resets and OHA's lack of key pair authentication.

- **Legacy Health**:
  - Internal challenges: Legacy Health's biggest challenge is the provider setup in Facets to match OHA requirements.
  - External challenges: 1) Provider enrollment requirements differing between FFS and encounter only, 2) Untimely updates of procedure codes, modifiers, and diagnosis codes to MMIS processing, and 3) NCPDP rejections specific to NDC codes, where it appears the logic is seemingly random as it relates to acceptable NDC codes.

- **OHSU Health Services**:
  - Internal challenges: Ensuring appropriate exceptions are in place to prevent unnecessary 999 rejects.
  - External challenges: For pharmacy, OHA's system is only able to process files of up to 5,000 records. This requires the plan to generate and submit multiple files for claims adjudicated within the submission window. For medical claims:
    - o Change in requirements that would allow OHSU Health Services to deny claims for missing elements rather than rejections that need to be manually worked.
    - o The volume of 837 requirements requires OHSU Health Services to put in place many exceptions on internal data and reports to prevent 999 rejects.
    - o When correcting pended encounters in MMIS, it is not always clear what caused the pend or how to resolve it without any guidance. In these situations, once OHSU Health Services has exhausted all internal resources, OHSU Health Services reaches out to its encounter data liaison for assistance.

- **Providence**:
  - Internal challenges: The shortened timeline for submission versus simply submitting daily. Delays in the 835 and status file cause problems for the shortened window, since an adjustment cannot be submitted if the 835 from the previous week has not been received due to the new ICN being unknown.
  - External challenges: The only challenge is dealing with certain edits that reject a claim in the 999 related to a diagnosis code, even if that particular claim is flagged with a payer initiative (PI) Group Code.

HSO's plan partners note the following processes or additional resources and support from OHA that would be helpful in overcoming the aforementioned challenges:

- **CareOregon**; CareOregon indicated that it would be beneficial if OHA would provide the resource data or crosswalk when OHA implements new edits or critical error reasons. This would be helpful for CareOregon to know exactly what list of codes OHA requires an NDC on encounters and be able to review a published list of valid primary diagnosis codes. Additionally, it would be helpful if there was a standard amount of time granted for new edits/critical error reasons that included a published guideline to accompany the rule change. CareOregon also requests liaison consistency across CCOs; oftentimes, CareOregon receives different answers or instructions on encounter data from its different OHA liaisons.

  From Health Share Behavioral Health (PH TECH): It would be helpful for OHA to have mapping or edits from MMIS available for distribution to use as a tool.

- **Kaiser**: Kaiser noted a key pair exchange.
- **Legacy Health**: Legacy Health suggested an overhaul of the consent audit. Legacy Health explained that faxing each consent and filling out a fax coversheet individually for each consent form requested when there well are over 100 consent forms requested is extremely time consuming,

tedious, and outdated with the technology available today. Legacy Health also noted that faxes are more likely to result in HIPAA violations.

- OHSU Health Services:
  – For pharmacy, OHSU Health Services suggested an expansion of system file limitations.
  – For medical, OHSU Health Services suggested the following changes/processes:
    o Update resources regarding NDCs and provider type crosswalks on the encounter data webpage.
    o Provide an encounter data troubleshooting guide or suggestions for common errors within MMIS.
    o An encounter data workgroup for CCOs to better collaborate and discuss solutions for upcoming changes, updates, and challenges.
    o Submission of encounter data via flat file would prevent reformatting claims, in particular paper claims to fit 837I/P format.
    o OHA providing sufficient lead time to allow OHSU Health Services to implement systemic updates and changes.
- **Providence**: Providence noted that it would be beneficial if the provider file contained all of the edits used in MMIS to determine adjudication logic. Providence also suggested that the provider file should be submitted weekly to CCOs as a text file so it can be automated into an ETL process. For pharmacy, Providence suggested that it would helpful if pharmacy encounter data claims were handled the same way as medical encounter data, in that claims pend at OHA for review and correction versus rejecting claims and requiring resubmission.

At the time of questionnaire submission, **HSO**'s plan partners noted a few upcoming changes to their encounter submission process:

- **CareOregon**: CareOregon will be working to reconfigure its systems to meet three new edits proposed to be implemented by OHA on November 1, 2020. The changes could impact pend volumes if CareOregon is unable to make changes in time and/or accurately align with OHA's currently unpublished source data.
- **Kaiser**: Kaiser's current encounters submission process is slated to transition to a different organizational team in late Q1 of 2021. The team assuming this function is currently gathering all of the requirements for this transition. As such, it is not clear which, if any, changes may occur as a result of this change.
- **Legacy Health**: Does not have any upcoming changes planned.
- **OHSU Health Services**: For medical, beginning the first week of October, OHSU Health Services will transition from biweekly encounter submissions to weekly submissions. The change in extract and submission frequency will not cause changes to OHSU Health Services' encounter data workflow. The existing process will still be in place with increased frequency. There are no upcoming changes to its pharmacy encounter submission process.
- **Providence**: At the time of questionnaire submission, there are no upcoming changes.

Recommendations

Based on its review, HSAG recommends the following for **HSO** to strengthen its encounter data quality:

- Legacy Health listed modifications that were applied to both its claims and encounter data in its questionnaire response. One of the modifications relates to rolling up the revenue code 250 service line items in Facets to prevent duplicate edits from the State. While details of the roll-up process were not described in Legacy Health's questionnaire response, HSAG recommends that Legacy Health work with OHA to clarify and confirm that the process translates to accurate representation of the encounter when transmitted to OHA.

- Legacy Health also noted that when a provider bills zero units and/or zero dollars, a value of one unit and/or $0.01 is added for encounter purposes. HSAG recommends that Legacy Health work with OHA to clarify and confirm that this modification is in line with OHA's submission requirements and does not have any impact when an encounter is used for analytic purposes within OHA's system.

- While some of **HSO**'s plan partners demonstrated that chart review is one of the validations conducted to ensure completeness and accuracy of their encounter data submissions, others did not. Therefore, **HSO** may consider requiring each plan partner to conduct a validation of encounter data based on medical record reviews by comparing medical record documentation (i.e., diagnosis codes and procedure codes) against submitted encounter data for a sample of records. Results from these reviews can be used as part of **HSO**'s ongoing data monitoring.

Appendix J: Findings for InterCommunity Health Network

This section summarizes the findings from InterCommunity Health Network's (**IHN**'s) questionnaire responses.

Encounter Data Sources and Systems

IHN receives professional and institutional claims either on paper from the provider or via an EDI trading partner in standard X12 format. The trading partners are Payor Connections, Change Health, TriZetto, CHC1, and Office Ally. Claims that are received via paper are either scanned into **IHN**'s fully internal scanning process or manually entered directly into the Facets system.

Dental encounters are received from **IHN**'s DCO partners: ADS, Capitol Dental Care, Willamette Dental, and Moda. **IHN** receives pharmacy encounters via a contracted PBM in NCPDP D.0 format. The PBM vendor is Optum, which is contracted to produce the NCPDP D.0 formatted files on a weekly basis for submission to OHA.

Table J-1 shows **IHN**'s format and submission frequency of the professional, institutional, transportation, pharmacy, and dental encounters.

Table J-1—Format and Submission Frequency for Professional[1], Institutional[2], Transportation, Pharmacy, and Dental Encounters

	Professional[1]	Institutional[2]	Transportation	Pharmacy	Dental
Data receipt	Electronic claims: EDI trading partners Paper claims: Scanned in **IHN** internal scanning process	Electronic claims: EDI trading partners Paper claims: Scanned in **IHN** internal scanning process	NEMT partner: Redline	Optum	DCO partners: Advantage, Capitol, Willamette, and Moda
Format	837P	837I	EDI	NCPDP	837D
Frequency	Daily	Daily	Monthly	Weekly	Biweekly
Approximate volume	Varies	Varies	3,338	13,300	2,811

[1] Includes physician, laboratory, vision, behavioral health, durable medical equipment (DME), radiology, and ambulance
[2] Includes inpatient, outpatient, and long-term care

- **IHN** noted that it does not modify or reformat its claims/encounter data to accommodate OHA's encounter submission standards.
- NCPDP submissions are extracted and submitted by **IHN**'s PBM, Optum, while the dental 837s are extracted and submitted by **IHN**'s DCOs (Advantage, Capitol, Moda ODS, and Willamette).

However, medical data are extracted from **IHN**'s source system, Facets, and then formatted and submitted in an 837 format by **IHN**'s submission vendor, VisibilEDI.

- **IHN** noted that it does not submit all types of claims/encounters to OHA; only valid, nonduplicated claims are submitted to OHA. A valid claim does not include claims coming from providers under investigation for fraud and abuse, nor does it include claims under review for medical appropriateness. **IHN** clarified that a valid claim is a clean claim as defined by 42 CFR 447.45.

- Additionally, **IHN** responded that it does not submit certain types of payments made on behalf of the Medicaid population and/or certain types of services rendered to the Medicaid population as encounters. **IHN** explained that it does not require nonparticipating providers outside the State of Oregon to have an Oregon provider Medicaid ID when billing for ambulance, emergency, or urgent care services. Although not required, **IHN** encourages and offers to assist such out-of-state providers in obtaining an Oregon Medicaid ID. If a claim meets the criteria of policy CLM-80 and is paid out without a Medicaid ID, it is not submitted through the encounter data process.

- In handling adjusted encounters, **IHN** noted that the adjusted encounters are submitted via **IHN**'s standard claims submission process on an 837. All valid adjusted encounters are submitted, which ensures OHA has the most recent and accurate encounter record.

- For claims that are processed internally, Table J-2 shows the types of claims validated, a description of the validation performed, and the percentage of claims validated.

Table J-2—Claims Validated, Validation Performed, and Percentage of Claims Validated

Type of Claims Validated	Description of Validation Performed	Percentage of Claims Validated
Paper	Paper claims are sorted by form type and scanned for EDI conversion each business day. Scanned claims are passed through OCR software, and then the character conversion is manually verified by claims staff members. Claims that cannot be automatically converted are manually hand-keyed into Facets claims processing module or are returned to the provider for correction and resubmission. Once claims have been successfully entered into Facets, they are verified and processed in the same manner as other electronically received files.	100% of paper claims (approximately 3% of all claims received)
Paper and Electronic	During processing, all claims (including both pended and auto-adjudicated) go through an automated validation process subject to numerous systems checks to determine that the individual was eligible on the date of service, the services provided were covered under the member's plan, and prior authorization was obtained, if required.	100% of all claims

Type of Claims Validated	Description of Validation Performed	Percentage of Claims Validated
	Samaritan Health Plan (SHP) uses the Optum CES to validate industry standard coding and billing rules, including NCCI edits. As claims are adjudicated, CES returns a message to Facets, which pends or denies claims that hit these rules. CES edits available to SHP include both industry standard edits and those applicable to Medicaid plans, which gives **IHN** a robust set of rules with which to edit its incoming claims.	

- Prior to claims being adjudicated for payment processing, **IHN** does not map any codes or fields during the data processing and validation process. Similarly, codes and/or fields are not mapped during data processing for submission to OHA.

- **IHN** indicated that provider data are collected and maintained by **IHN** as well as its subcontracted vendor. For example, the DCOs' and **IHN**'s NEMT vendor are contractually obligated to collect and maintain its provider data. Similarly, the PBM collects and maintains provider data for doctors and pharmacies.

- The DCOs' responsibilities for collecting and maintaining provider data include contracting, credentialing, CCO dental benefit administration policy, and process oversight, while the NEMT's responsibilities include the NEMT quality assurance program. The PBM is responsible for loading and maintaining provider data from OHA. **IHN** provided a high-level description of the process of collecting and maintaining provider data by the DCOs, NEMT, and PBM.

- In linking provider data to medical claims, **IHN** uses the provider's practitioner NPI, group NPI, and tax ID. When there is a discrepancy between the data submitted and the provider data within the system, a notice is sent to the internal provider data management team. The provider data management team then reviews the information and makes changes based on what was submitted or contacts the provider to gather information and Facets accordingly. The DCOs are responsible for accurate encounter information as it relates to the provider. Encounter data are monitored weekly, and if any discrepancies are found, the DCO and CCO communicate and take action toward a solution. This workflow rarely occurs due to the DCOs' thorough internal encounter validation audit. DCOs catch errors submitted to CCO, electronically inform **IHN** regarding the error, retract the batch of encounters, correct the encounters, and deliver again once correction has been made.

- **IHN**'s provider data do not require modification in order to comply with OHA's provider data submission requirements.

- **IHN** internally manages member enrollment and updates member information based on enrollment files that comes directly from OHA in the form of 834 files. **IHN** also passes through the 834 files it receives from OHA to the DCO and PBM.

- According to **IHN**, the enrollment information is directly linked to the information on the claim in Facets at the time of processing. When discrepancies are identified through the Weekly Claims Not Enrolled Report provided by OHA, encounter data specialists work with enrollment to correct the

source system as needed. Any member discrepancies identified in the encounter data validation audit are also communicated to the enrollment department for additional investigation and correction, as needed.

Data Exchange Policies and Procedures

IHN has internally developed encounter data management documents aimed at collecting, translating, storing, and transmitting encounter data for pharmacy, mental, dental, and physical health services in compliance with its contract requirements, which at a minimum include the following:

- All data transmissions are compliant with HIPAA 5010 standards for EDI transactions.
- Valid encounter data are submitted at least once per calendar month.
- The encounter data submitted represent 50 percent of all encounter claim types received and adjudicated by **IHN**, including paid amounts regardless of whether the provider is paid on an FFS or capitated basis, or whether the provider is in network (participating) or out of network (nonparticipating).
- All initial and unduplicated encounter data are submitted to OHA within 45 days of the date of adjudication by **IHN** and its subcontractors. Corrective action may be initiated if more than 10 percent of the encounter data submitted are over 45 days after the date of adjudication, or if the submission of duplicate claims exceeds 10 percent per month.
- 90 percent of encounter data are processed as accepted in each file submitted.
- All corrections to pended or re-pended encounters are submitted within 63 days of the date Health Systems sends **IHN** notice that the encounters were pended.

Management of Encounter Data: Collection, Storage, and Processing

Table J-3 shows **IHN**'s pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table J-3—Pricing Methodology for IHN

Outpatient[1]	Inpatient[2]	Pharmacy
- OPPS - Medicaid fee schedules - Custom fee schedules - Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedules - Contract rates - Capitation	- Contracted hospitals are paid based on the Medicare IPPS - Noncontracted hospitals are paid based on the appropriate Oregon Medicaid DRG reimbursement or CAH payment methodology	- Paid based on a negotiated rate using the standards in the most recent version of NCPDP guidelines

[1] All outpatient claims are paid on the OPPS schedule as a percentage of Medicare.
[2] All inpatient claims are paid on the IPPS schedule as a percentage of Medicare. A small portion of claims related to trauma on the OHSU contract are paid as percent of billed.

- In response to whether there are any services submitted to **IHN** under bundle-payment structures, **IHN** noted that it did not have bundle-payment structures in place at the time of questionnaire submission.

- With regard to collecting other insurance, TPL, and COB information, **IHN** noted that data are collected through a variety of methodologies. Claims requiring COB or TPL manual processing are routed via Facets to the appropriate COB or TPL claims analyst for verification and processing. All COB leads are thoroughly investigated, including reviewing chart notes from the provider and calls to the member based on chart notes or diagnoses billed on the claim. An annual other-coverage questionnaire is sent out to check on any possible changes in coverage for **IHN**'s members. All responses are tracked and maintained in **IHN**'s claims processing system, Facets. **IHN** noted that providers are required to submit both COB and TPL data with claims.

- When processing claims where there is another carrier considered primary for **IHN**'s members, **IHN** coordinates benefits in-house at the time of claim adjudication. **IHN** noted that its system has the ability to adjudicate using the other plan's allowable amounts, track member cost share on both plans, accommodate multiple COB plan types, and track other coverage eligibility changes. SHP performs all subrogation services in-house with the assistance of SHS legal counsel and does not pay when benefits are payable under the terms of any other coverage. For TPL claims, **IHN** noted that its staff generates an investigation based on information received on a claim or through correspondence using a deny and pursue methodology. The TPL investigator will then analyze all gathered information and request additional background data if needed to make a decision regarding application of the exclusions. A decision will then be communicated to all affected parties and **IHN** will work with the members while the case is being investigated.

- To verify the accuracy of Medicare crossover claims, **IHN** noted that it receives Medicare crossover claims from several sources, including Samaritan Advantage Health Plan (internal crossover claims), COBA (Medicare Coordination of Benefits Agreement claims), and other Medicare Advantage plans. All claims data submitted, including other party payment, allowed amount, and member cost shares, are entered into **IHN**'s claims processing system, Facets. Facets then uses system edits to verify and calculate **IHN**'s allowed and payable amounts. If the other party information does not balance or the claim cannot adjudicate, claims are automatically pended for manual verification and calculation by a claims analyst. **IHN** indicated that claim payment information and source data are stored within the Facets system, where the encounter data are processed in a standard manner and reflect the information in the Facets system.

- For pharmacy claims, **IHN** noted that its PBM (Optum) system automatically rejects Part D covered drugs for dual **IHN** (Medicare and Medicaid) members since **IHN** does not pay on those claims. The claim payment information and source data are stored within Optum's system. The pharmacy encounter data are processed in NCPDP standard format that reflects the information in Optum's system. Part B claims billed to **IHN** will reject if primary coverage is not billed first. All Part B claim information is stored in **IHN**'s source Facets system since Part B accumulates.

- **IHN** noted that if **IHN** is not responsible for a service due to payment from a primary carrier, the encounters are submitted to OHA with CARC 23 to indicate **IHN**'s reduced liability due to COB payments. **IHN** explained that zero-pay capitated claims are processed within Facets with the same edits and requirements as paid claims. The encounter data are submitted to OHA with CARC 24 to

indicate capitation. There is no additional completeness or accuracy validation done by **IHN**'s encounter data team outside of the standard claim validation processes.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or sub-contractor, **IHN** conducts the following activities:

- Completeness:
  - Dental encounter data submission completeness is ensured by routinely monitoring weekly submission counts and State acceptance rates, identifying any gaps and anomalies. **IHN** noted that the process is done using the CVF submission to track and reconcile weekly submission counts against any EDI translator rejections in the 999 response files. **IHN** indicated that there is additional completeness monitoring performed through oversight and monitoring of DCOs' policies.
  - **IHN** noted that its encounter data specialists monitor the validity of the pharmacy encounter data submitted by its PBM (Optum) by requiring the PBM submit attestations that the data are complete and accurate. **IHN** tracked and monitored the attestations through weekly reporting. **IHN** communicates to the PBM if any discrepancies or concerns related to the data are identified, and **IHN** requires a timely explanation and/or resolution.

- Accuracy:
  - **IHN** noted that dental encounter data submission accuracy is ensured by routinely monitoring weekly submission counts and State acceptance rates, as well as any EDI translator rejections or MMIS pends. **IHN** returns the EDI rejections or MMIS pended encounters to the corresponding DCO to research and resubmit, as needed. **IHN** indicated that if more than 5 percent of dental 837 are rejected in the EDI translator, a formal response is required from the DCO. **IHN** also performs an encounter data validation audit on a quarterly basis for dental data against chart records. **IHN** indicated that there is additional accuracy monitoring performed through oversight and monitoring of DCOs' policies.
  - For pharmacy encounter data, **IHN** noted that accuracy is ensured by routinely monitoring the weekly submission counts and State acceptance rates and identifying any gaps or anomalies. **IHN** reports to the PBM if there are any unusual or abnormal findings. **IHN** indicated that this process is done using the NCPDP CVF submission tracker and reconciling weekly submission counts against the NCPDP response files.

- Timeliness:
  - **IHN** noted that dental encounter data submission timeliness is ensured by routinely monitoring the weekly submission counts to ensure that the 837 files are submitted on at least a biweekly basis. **IHN** indicated that there is additional monitoring of timeliness performed by reviewing counts of encounters submitted more than 45 days from the adjudication date. Per **IHN**, it ensures that no more than 5 percent of claims (dental, medical, and pharmacy) are received by

OHA more than 45 days from adjudication. **IHN** also noted that additional timeliness monitoring is performed through the oversight and monitoring of DCOs' policies.

- Samaritan Health Plan Operations (SHPO) ensures that pharmacy encounter data submissions are timely by ensuring that the PBM submits at least 50 percent of all pharmacy claims received and adjudicated by **IHN** during that calendar month. In its response, **IHN** also noted that SHPO ensures all pharmacy encounter data are submitted within 45 days of the dispense date by routinely monitoring the weekly submission counts and State acceptance rates. **IHN** indicated that this process is done using the NCPDP CVF submission tracer and reconciling the weekly submission counts against pharmacy encounter rejections in the NCPDP response files.

To monitor the completeness, accuracy, and timeliness of the encounter data submitted by its providers, **IHN** conducts the following activities:

- Completeness:
  - **IHN** noted that both the EDI clearing houses and its Facets HIPAA Gateway system require EDI compliance (completeness) before electronic claims can load to **IHN**'s system. Paper claims that are entered through its internal scanning system flow through the HIPAA Gateway system for EDI compliance. **IHN** also noted that it uses the Optum CES for coding validation, where incomplete claims are returned to providers for correction and resubmission. **IHN** indicated that its encounter data team maintains dashboards that focus on encounter data completeness.

- Accuracy:
  - **IHN** indicated that claims are monitored for accuracy through a weekly claims audit, a random monthly audit, and focused audits. The monthly quality assurance review is performed monthly by the claims quality assurance (QA) team. In this process, the QA team pulls a random 2 percent of claims processed monthly, followed by verifying all member benefits, provider contract rules, and internal departmental processes. Additionally, the encounter data team maintains dashboards that focus on encounter pend reasons, as well as acceptance rates and EDI translator rejections. These dashboards assist in monitoring and addressing inaccuracies in the encounter data.

- Timeliness:
  - **IHN** noted that during processing of its claims, its payment system, Facets, tracks **IHN**'s contracted days and applies automated workflow rules to assign the oldest claims for processing, where claims supervisory and lead staff members monitor processing queues daily. **IHN** also noted that the encounter data team maintains dashboards that focus on timeliness; specifically, claims submitted more than 45 days from the date of adjudication. Daily reports are used that calculate the number of days a claim has been pended at the State to ensure claims do not cross over the 63-day threshold.

To evaluate the quality of its encounter data submissions, **IHN** uses claim count dashboards to track counts of pends, status, as well as percent of completeness and accuracy by comparing what was sent versus what was accepted, EDI translator rejections, and submission timeliness (claims submitted more than 45 days from date of adjudication).

IHN noted that on average, the amount of EDI translator rejections for all submission types is 1.6755 percent, where the rejection was primarily due to a mapping issue that was causing missing discharge hours. At the time of the questionnaire submission, **IHN** noted that the issue has been resolved. In reconciling files rejected by OHA's EDI translator, **IHN** evaluates the 999 rejection response file upon receipt. **IHN**'s submission vendor, VisibilEDI, provides the details of the rejection (segment/loop), corrections are made as needed, and files are resubmitted by **IHN**'s encounter data team. However, some translator edits (e.g., duplicate PCS code), require claims processing.

According to **IHN**, an average of 0.285 percent of medical/dental encounters get pended by OHA's Medicaid MMIS. **IHN** provided a detailed description of the process for reconciling encounters pended by MMIS to include the procedures for the identification, correction, and subsequent resubmission of pended encounters to OHA. Dental encounters pended in MMIS are returned to the corresponding DCO to research on for resolution.

IHN uses the data in its encounter data system for quality, capitation analysis, rate-setting, and other managerial reporting. **IHN** uses the dental and NEMT encounters for oversight and monitoring purposes. NEMT encounters are also used for budget analysis.

In submitting encounter data to OHA, **IHN** noted that internally, it is challenging to obtain the provider information necessary to register out-of-state providers with Medicaid. As such, **IHN** indicated that it would be helpful if there were additional resources for obtaining necessary information to register out-of-state providers with a Medicaid ID. **IHN** also indicated that it did not face any external or EDI-related challenges in submitting its encounter data.

At the time of the questionnaire submission, **IHN** responded that it does not have any upcoming changes to its encounter submission process that may impact its response to the questions posed within the questionnaire.

Recommendations

Based on its review, HSAG recommends the following for **IHN** to strengthen its encounter data quality:

- In describing its methods for ensuring completeness and accuracy of its encounter data submission, **IHN** did not demonstrate that chart review was one of the validations conducted. HSAG recommends that **IHN** consider conducting validation of encounter data based on medical record reviews by comparing medical record documentation (i.e., diagnosis codes and procedure codes) against submitted encounter data for a sample of records. Results from these reviews can be used as part of its ongoing data monitoring.

This section summarizes the findings from Jackson Care Connect's (**JCC**'s) questionnaire responses.

Encounter Data Sources and Systems

Professional, institutional, and dental 837 files and NCPDP files are submitted by the RAEs directly to OHA via secure FTP, with a copy of each to **JCC**. OHA responds directly to each RAE with a 999 and NCPDP response per file. OHA sends a weekly CCV to **JCC**. If the CCV is not balanced, **JCC** submits a VAF to OHA. OHA submits weekly 835 remittance and status files to **JCC**. OHA submits a quarterly ASU file to **JCC**. **JCC** parses the files using a special CLM01 partner indicator and original 837 submission matching logic. RAEs then submit a balance report to **JCC** by Tuesday of each week for submission the week prior. This report includes 999 rejections and expected claims not included in the 835. Pharmacy encounters are submitted to **JCC** by its PBM, OptumRx, daily. These pharmacy encounters are bundled and submitted by **JCC** to OHA weekly. VSP must submit encounter data at least once per calendar month. The data must represent at least 50 percent of all the encounters received and adjudicated by contractor during that month. An email is generated when VSP claims are received into the **JCC** data warehouse and includes the process date and count of VSP claims received.

Table K-1 shows **JCC**'s format and submission frequency of the pharmacy, dental, and other encounters received.

Table K-1—Format and Submission Frequency for Professional[1], Institutional[2], Transportation, Pharmacy, Dental, and Vision Encounters

	Professional[1]	Institutional[2]	Pharmacy	Transportation	Dental	Vision
Data Receipt	Claims from in-house QNXT claim processing system	Claims from in-house QNXT claim processing system	Catamaran	Ecolane	Willamette Dental, Advantage, ODS, Capitol	VSP
Format	837P	837I	Flat Files	837P	837D	837P
Frequency	Daily	Daily	Daily	Daily	Monthly	Monthly
Approximate Volume	Varies	Varies	973	79.5	Advantage: 901 Capitol:2,388 ODS: 247 Willamette: 177	299

[1] Includes physician, HCBS, laboratory, and behavioral health
[2] Includes inpatient, outpatient, and long-term care

- When submitting claims/encounter data to OHA, **JCC** noted that all fields are formatted to meet 837 specifications and OHA guidelines. **JCC** does not make any material changes to the data that are in its claims system. When new edits are implemented, **JCC** adds those edits to the front end of its claims system to ensure that incoming claims meet OHS requirements.

- **JCC**'s subcontracted PBM and DCOs are direct submitters of encounter data to OHA. These organizations include ADS, Capitol Dental, ODS, Willamette Dental, and OptumRx. These organizations submit encounter data no less frequently than monthly, and with each submission they make to OHA, they also provide the CCO with a notification of their submission and an 837 file copy of that submission. Additionally, VSP submits encounters via 837 to **JCC** and it includes the files with its in-house claim submissions to OHA. These 837 copies are incorporated into **JCC**'s data warehouse.

- **JCC** indicated that it submits all types of claims/encounters (e.g., paid, denied, voided, and adjusted) to OHA. However, encounters are not submitted for incentive payments. **JCC** noted that the adjusted encounters that have previously been submitted are transmitted to OHA as an adjustment if the claim is adjusted in its claims system. According to OHA rules, if certain key fields (e.g., member, claim form type) are changed, then **JCC** submits the adjustment as a delete and then as a new claim.

- For claims processed internally, **JCC** validates all claim types via monthly claims auditing conducted by claims supervisors and training specialists. Internal audits are also conducted by compliance. All audits include all claim types (e.g., manually adjudicated and auto-adjudicated claims). These audits are performed to assess the financial, procedural, and payment accuracy of claims. **JCC** indicated that approximately 0.02 percent of claims are validated.

- Prior to claims being adjudicated for payment processing, **JCC** performs code and/or field mapping during data processing and validation. **JCC** uses a rules-based claim system, QNXT, that provides hundreds of editing functions to ensure automation and accuracy. QNXT edits and the fully integrated Optum CES validate elements of a claim to ensure claim information submitted by the provider is accurate. The system uses reference tables loaded with diagnosis codes and necessary procedural codes (e.g., CPT, HCPCS, modifiers, ICD-10-PCS, HIPPS, DRG, HHRG, etc.) with data files purchased from Optum or data provided by CMS or national coding sources. Additionally, Micro-Dyn Medical Systems' DRG grouper, DRG pricer, APC grouper, and ASC pricer are fully integrated with **JCC**'s claims system. The system edits to ensure all elements are present and valid in order to accurately price the claims. Coding and editing tables are updated with the most current information as soon as possible. Updates are handled as a high priority to prevent payment delays. CES Knowledgebase updates are released and installed quarterly. Other coding systems are dependent upon their frequency; for example, CPT, HCPCS, ICD-10, DRG, and APC updates are released and imported annually. In the case of unexpected off-cycle releases, such as those experienced with the COVID-19 public health emergency in 2020, updates may be made manually for the sake of timeliness. Provider data are stored in the QNXT core system, and edits the claims to ensure the provider data submitted by the provider match a provider record in the claims system in order to process for payment. Additionally, **JCC** compares each attending, referring, ordering, billing, and rendering provider NPI on active claims to the weekly OHA provider file to ensure

active enrollment exists prior to claim adjudication. **JCC** does not perform codes and/or field mapping during data processing for submission to OHA.

- **JCC** uses outside vendors for prepayment and postpayment reviews, although the claim is adjudicated by **JCC**'s internal staff based on the medical record or itemized bill decision.
  - **JCC** conducts a comprehensive prepayment review which allows for reimbursement to health care providers for a "clean claim." A clean claim is one that is free of defects and improprieties and contains all information necessary for adjudication on its merits before tendering payment. The health care provider must provide the required documentation at the time the claim is submitted, otherwise the claim will be denied for missing documentation for the service/item. For claims submitted with the appropriate documentation, **JCC** will conduct its review using national guidelines and analyze the claims to tender payment for properly billed charges. Once the review is complete and a determination is made that a coding and/or payment adjustment is applicable, the health care provider will receive the appropriate claim adjudication, a coding correction to the service line item billed, a disallowance of the applicable amount of the service line item billed, and a remittance advice (RA) with an explanation and/or reason code(s) for the finding(s).
  - **JCC** conducts postpayment utilization reviews of health care providers' records related to services rendered to **JCC** members. This process helps ensure that providers follow nationally accepted coding practices and are paid at the correct allowance. **JCC** may perform on-site or off-site desk reviews based on the preference of the health care provider. For off-site reviews, the health care provider must provide the required documentation within 30 days of receipt of the request. In the event the requested documentation is not received timely, the applicable claim(s) may be considered overpaid and recovered initially. Upon completion of the postpayment review, if underpayment is identified, the health care provider may be asked to resubmit a corrected claim to receive additional reimbursement. **JCC** identifies and recovers overpayments as mandated by federal and state laws and regulations. If overpayment is identified, **JCC** may be required to conduct a review that exceeds one year.
- Provider data are managed directly by **JCC**'s subcontracted DCOs, VSP, and PBMs: ADS, Capitol Dental, ODS, Willamette Dental, VSP, and OptumRx. **JCC** receives the subcontractor provider files via the weekly APAC file process. Provider data addition, change, and termination notices are received from:
  - Credentialing applications received from contracted organizations.
  - Provider information form (PIF).
  - Monthly provider rosters received from contracted organizations to which **JCC** delegated credentialing.
  - An external-facing email address used to collect change notifications from contracted organizations (providerupdates@careoregon.org).
  - Claims pending for missing provider or contract information

Each data set collected is has a predefined turnaround time. At initial entry, and then monthly, provider data in the core QNXT system are compared to NPPES for deactivated NPIs, the OHA weekly provider file, the CMS preclusion list, the Medicare opt-out list, and the OIG exclusion list.

- When collecting provider data, **JCC** checks QNXT to verify if the provider, group, or facility is present. If the provider is present, the claim/contract/notice is checked for contracting and credentialing information. If contracting and credentialing information is present, the provider is set up in the system as a participating provider. If the provider is not present, it is set up as "nonpar." If the provider is not present in QNXT, the provider is screened against various systems (e.g., NPPES, OIG, OHA provider file, license or registration board). If the provider is located, it is added to the QNXT system with no restrictions. If the provider is not located, it is added to the QNXT system with restrictions. The provider team runs weekly troubleshooting processes to identify license or eligibility issues by running Medicare opt-out, OIG, and preclusion list screenings against existing provider. Additionally, every new provider is audited, and current claims are compared to the OHA provider file to prevent incorrect claims payment or denial due to enrollment changes.

- When linking provider data to claims and encounters, claims with missing or mismatched provider data are pended within **JCC**'s core QNXT system prepayment. Provider data specialists review the submitted claim data and either update the core system to reflect a valid change or deny the claim for incorrect billing or enrollment. Encounters are populated with the provider NPIs as they appear in the claim EDI data as processed in the core QNXT system. Encounters that pend with incorrect provider data require troubleshooting between the Provider Data team and the OHA Provider Enrollment team. If a discrepancy is found between provider data in a file and OHA's provider file, encounters are sent back for recouping by **JCC**'s claims examiners or enrollment with OHA is updated to address the discrepancy. **JCC**'s provider data do not require modification in order to comply with OHA's provider data submission requirements.

- **JCC**'s enrollment data are maintained by the CCO. When linking enrollment data to the claims and encounters, each submitter receives the daily 834 enrollment updates. The submitter then matches incoming claims to the enrollment using the Medicaid ID. Claims are rejected if they do not match an active enrollment. If a member is retroactively disenrolled prior to encounter data submission, **JCC** does not submit the claim as an encounter to OHA.

Data Exchange Policies and Procedures

Encounter data files are submitted at least once per month by each submitter, including **JCC**. The 837 and NCPDP files are sent directly to OHA, and a copy is sent to **JCC** from the other submitters. Each encounter file is reported to OHA on a Certification and Validation Report Form (CVF/H2) within 24 hours of the submission, and the other submitters notify **JCC** when their submissions have been made. These notifications include the file name(s), claim counts, total billed amounts, and submission date. **JCC** keeps detailed accounting of each file to balance out each week's total submissions against the CCV report from OHA. Any out-of-balance amounts are reported back to OHA on a VAF/H3 form within 10 business days from receipt of the report.

JCC is responsible for the data validation, testing, and fielding of encounter issues and questions from the other submitters. Weekly and monthly reports from OHA are processed, parsed out, and sent securely to each of the submitters to review and correct their own data. **JCC** monitors all of the reports to ensure that they are processed within the related time frames and follows up with the submitters and OHA as needed.

Management of Encounter Data: Collection, Storage, and Processing

Table K-2 shows **JCC**'s pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table K-2—Pricing Methodology for JCC

Outpatient	Inpatient	Pharmacy
• APC: 59.0% • Fee schedule: 21.1% • Percent of charge :19.9%	• DRG: 84.5% • Percent of charge: 7.9% • Per diem: 7.6%	For specialty and brand drugs, pharmacy claims are paid using OptumRx's negotiated rate with each pharmacy, chain, or PSAO, or U&C, whichever is lower. For generic drugs, the same MAC list used for all pharmacies or U&C, whichever is lower.

- In response to whether there are any services submitted to **JCC** under bundle-payment structures, **JCC** noted that it follows the standard FFS process for billing for outpatient maternity services but does not have a broader bundle in place that incorporates hospital or other ancillary services including imaging, delivery, and immediate postpartum care. **JCC** does not have bundle-payment structures in place for any other services.

- With regard to collecting other insurance data, any employee, subcontractor, provider, intern, or volunteer that becomes aware of other health insurance coverage or other nongroup health insurance coverage (e.g., liability, no-fault, workers' compensation) must collect all initial data about the coverage and forward it to **JCC** for investigation.

- When processing claims with TPL, **JCC** follows a pay and pursue (also known as pay and chase) methodology for accidents due to the need for timely medical services and payments. **JCC** pays claims where TPL may not yet be resolved, and **JCC**'s subrogation vendor works to recover these payments when another person or entity may be responsible. If the subrogation vendor's investigation determines another person or entity was responsible for the accident, the subrogation vendor will work with the member, member's attorney, and providers to resolve the TPL.

- To verify accuracy of Medicare crossover and other third-party claims information, **JCC** receives the Medicare crossover claims for members covered by **JCC**, based on the eligibility reported by OHA, from the CMS Benefits Coordination & Recovery Center. **JCC** accepts and processes 837 claim files from EDI vendors and directly from CMS.

- If **JCC** is not responsible for a service due to payment from a primary carrier, **JCC** processes the claim as a standard COB secondary claim. If there is no remaining/outstanding balance to pay on the secondary (**JCC**) side, the claim is processed to pay at zero dollars and is submitted through the typical encounter data submission process. Audits are conducted by claims supervisors and training specialists on all claim types (e.g., manually adjudicated and auto-adjudicated claims) to assess the financial, procedural, and payment accuracy of the claims. Encounter data are also subject to periodic internal audits for completeness. Additionally, encounter data are subject to scrubbing done postpayment via pends in MMIS by OHA, and via the Actuarial Services Unit at OHA, which issues biannual clean/nonclean assessments of encounter data sets.

Encounter Data Quality Monitoring and Reporting

To monitor completeness of encounter data submitted by a vendor or subcontractor, **JCC** compares the APAC-formatted claim file against the 837s received from its subcontractors. The APAC-formatted claim file is considered a full reporting of claims payment history. This report is distributed to all subcontracted encounter data submitters. Additionally, **JCC** encounter data coordinators track all submissions made by submitters as reported and monitor for trends.

To monitor accuracy of encounter data submitted by a vendor or subcontractor, **JCC** reviews OHA's weekly Claim Data Issue Reports, which identify duplicate encounters, provider enrollment issues, and mismatched claim data, with its subcontractors, including a request for resolution. **JCC** actively parses and monitors the weekly pend status file from OHA and monitors the timely resolution by all subcontractors.

To monitor timeliness of encounter data submitted by a vendor or subcontractor, **JCC** monitors the 45 Days from Date of Adjudication Report, issued by OHA monthly, for the count/threshold of **JCC** claims submitted outside 45 days from the date of adjudication. If an issue with a subcontractor is identified, **JCC** reaches out to the subcontractor. The monthly APAC-formatted claim files comparison, used to monitor completeness, alerts **JCC** to whether claims are being encountered timely or not at all. **JCC**'s subcontractors receive and respond to these reports monthly.

When evaluating the quality of encounter data, **JCC** processes and monitors the following reports issued by OHA:

- Duplicate Report
- Claim Data Issue Reports
- Enrollment Clean-up Report
- Deceased Client Report

JCC addresses issues identified in a pre-scrub process that omits claims from submission as encounters until the errors are resolved. These claims are worked monthly focusing on both claim data issues and provider data clean-up, as needed. Any encounters rejected on the 999 response file from OHSA are addressed on a monthly basis.

JCC has policies and procedures in place to monitor the accuracy, completeness, and timeliness of claims and encounter data submitted by providers.

- Accuracy and completeness: For claims submitted with missing, incomplete, or invalid fields, QNXT will generate a rule that denies the claim line and generates a message that will be communicated on the provider's remittance advice. Similarly, encounter data are monitored for accuracy using various reporting methods. Claims paid are submitted as encounters and monitored for acceptance.

- Timeliness: Providers receive timely filing expectations through a provider handbook and contracts. Claims processed as paid or denied for timely filing are reflected as such in the encounter data submitted.

JCC monitors the status of encounter data using a comparison between the 837 submitted encounters compared to the 835 receipt from OHA. Additionally, the Pend Status report is monitored to ensure maximum acceptance of encounter data and JCC works to resolve all issues preventing acceptance, including provider enrollment, claims processing, and formatting issues.

JCC uses the following transaction response files to support encounter data submission activities:

- 999 files: The submitting entity receives these directly from OHA. Each entity is responsible for logging errors and resubmitting corrected claims. JCC monitors overall completeness of submissions by comparing encounter data to flat file data.
- 835 files: JCC parses the 835s and sends individual 835 files to each submitter. These are used to record ICNs of accepted claims, for use when claims need to be adjusted or reversed. JCC retains all 835 data in SQL tables.
- Pend status files: JCC parses the 835s and sends individualized files to each submitter. Each submitter uses them to identify and correct claims. CCO retains the master list of pends and monitors outstanding pends with all submitters to make sure they are corrected.
- NCPDP response files: JCC stores all responses to identify which pharmacy claims were rejected. Issues with provider enrollment are investigated at the JCC; other issues originate with the PBM. Rejected claims are resubmitted periodically to make sure they are corrected whenever possible.

To reconcile files rejected by OHA's EDI translator, **JCC** monitors and addresses encounters rejected in the 999 using an on-demand report to identify and correct impacted encounters. This report is worked quarterly, with **JCC** investing most of its efforts on a pre-scrub reporting process whereby encounters that fail the translator are identified and addressed prior to submission as encounters. **JCC** noted that an average of 0.02 percent of encounters submitted to OHA get rejected by OHA's EDI translator.

An average of 0.04 percent of **JCC**'s encounters that pass OHA's EDI translator are pended by OHA's MMIS. Pend Status files are loaded into COWA each week and the ED staff prioritizes corrections by date and withhold month. **JCC** reviews the claims and claim images in QNXT to determine if adjustments are required. If an adjustment is required, the claim is sent to the Claims department weekly to correct in the claims system and resubmit as an adjustment. Provider issues are sent to the Provider Data team to resolve, either through configuration changes or enrollments to avoid further pended claims. **JCC** monitors subcontractors' pended encounters for volume spikes or pends within 10 days of the correction date. When either occurs, **JCC** reaches out to the encounter data contacts to ask if they need assistance. If assistance is needed, **JCC** requests they complete a pend correction form, explaining what needs to be corrected and how, and the encounters are adjusted manually in MMIS.

Data in **JCC**'s encounter data system are used to calculate clinical quality measure performance, including incentive measures, HEDIS reporting and value-based payment models. In addition to performance measurement, encounter data are used to:

- Calculate the total cost of care and loss ratios.
- Understand patterns of member utilization.
- Segment the population according to utilization and demographics.
- Monitor engagement of membership.
- Identify diagnoses of members for risk stratification.
- Identify members with gaps in care.
- Support rate setting.

JCC noted the following challenges faced in submitting encounter data to OHA:

- Internal challenges:
  - **JCC** faces challenges managing the submission of files to OHA. Occasionally, submissions are made more than once because it is unclear whether the file has already been submitted. Therefore, OHA will processes the submission twice. **JCC** would like to see controls in place to prevent OHA from accepting the same file more than once.
- External challenges:
  - **JCC** struggles to keep pace with OHA's changing encounter data edits and critical error reasons. Often, these changes result in large configuration projects and **JCC** does not have transparency into OHA's criteria for determining clean and nonclean encounters.
  - **JCC** also struggles with OHA's system constraints. OHA cannot handle sizable volumes, which can result in encounters being held. This in turn causes out-of-balance amounts for multiple weeks following the instance of held files.

JCC noted the following processes or additional resources and support from OHA that would be helpful in overcoming the aforementioned challenges:

- Providing the resource data or crosswalk for new edits and critical error reasons when OHA implements changes so **JCC** can configure its system appropriately to match OHA's criteria.
- Knowing exactly which list of codes OHA requires an NDC on encounters.
- Reviewing a published list of valid primary diagnosis codes.
- Allowing a standard amount of time for new edits and critical error reasons, that includes a published guideline, to accompany a rule change.
- Liaison consistency across CCOs. **JCC** often receives different answers or instructions on encounter data from its different OHA liaisons.

At the time of questionnaire submission, **JCC** noted it would be working to reconfigure its system to meet three new edits proposed to be implemented on November 1, 2020. These edits could impact pend volumes if changes are not made in time or accurately aligned with OHA's currently unpublished source data.

Recommendations

Based on its review, HSAG recommends the following for **JCC** to strengthen its encounter data quality:

- In describing its methods for ensuring completeness and accuracy of its encounter data submission, **JCC** did not demonstrate that chart review was one of the validations conducted. HSAG recommends that **JCC** consider conducting validation of encounter data based on medical record reviews by comparing medical record documentation (i.e., diagnosis codes and procedure codes) against submitted encounter data for a sample of records. Results from these reviews can be used as part of its ongoing data monitoring.

Appendix L: Findings for PacificSource Community Solutions –Central Oregon

This section summarizes the findings from PacificSource Community Solutions–Central Oregon's (**PSCS-CO**'s) questionnaire responses.

Encounter Data Sources and Systems

Per **PSCS-CO**'s questionnaire response, each week, encounter eligible claims are extracted from its core adjudication system into a common format and batched for ingestion into its encounter management system (EMS). The EMS reviews the encounters for accuracy/integrity using rule sets that are regularly updated by **PSCS-CO**'s EMS platform vendor. Encounters that do not pass OHA standards are pended by the EMS to manual work queues for review and resolution. Once corrected, these pended encounters are batched together with encounters that passed automated review in preparation for submission to OHA. Prior to submission, the encounters are subjected to an additional round of external EDI compliance review to address any residual formatting errors that might otherwise produce an occasional error with the submissions. After submission, any encounters rejected or pended by the State are re-ingested into the EMS for corrective handling.

Encounter submission performance is reviewed by the IT and business teams on a weekly basis and is reviewed biweekly during Government Operations meetings. Submission and systems issues are carefully tracked and addressed on a prioritized basis. The IT and business teams meet weekly to review status and performance.

Table L-1 shows **PSCS-CO**'s format and submission frequency for professional, institutional, transportation, pharmacy, and dental encounters received.

Table L-1—Format and Submission Frequency for Professional[1], Institutional[2], Transportation, Pharmacy, and Dental Encounters

	Professional[1]	Institutional[2]	Transportation	Pharmacy	Dental
Data receipt	Clearinghouse and EDI Gateway	Clearinghouse and EDI Gateway	LogistiCare and RideSource	Caremark (CVS)	Capitol, Advantage, and ODS
Format	837P	837I	837P	NCPDP	837D
Frequency	Weekly	Weekly	Weekly	Weekly	Weekly
Approximate volume	Varies	Varies	5,295 claims/week	48,200 claims/week	3,384 claims/week

[1] Includes laboratory, physician, vision, and behavioral health
[2] Includes inpatient, outpatient, and long-term care

- **PSCS-CO** noted that the following modifications and/or reformatting changes are applied to both its claims and encounter data:
  - **PSCS-CO**'s process is to roll up revenue code 250 service line items in Facets to prevent duplicate edits from the State.
  - When processing duplicate edits within the Encounter Module, **PSCS-CO**'s analysts check for different NDC codes on lines with duplicate HCPCS codes. If the NDCs are different, a 59 modifier is added to the line to ensure MMIS does not deny the duplicate HCPCS code as a duplicate. According to **PSCS-CO**, this is a State limitation.
  - **PSCS-CO** updates the billing provider information billed on claims for FQHCs that have multiple locations and NPIs that have the same tax ID. Per **PSCS-CO**, the State has a limitation that FQHCs can only have one enrollment with the State and cannot have multiple enrollments as separate locations. As such, for FQHCs with multiple locations to receive their cost settlement and to ensure **PSCS-CO**'s encounters do not pend, the CCO modifies the billing provider information to the FQHC's enrolled provider.
  - **PSCS-CO** removes "duplicate" inpatient ICD-10-CM procedure codes performed on different dates of service due to 999 rejects. Per **PSCS-CO**, this is a State limitation.
  - **PSCS-CO** removes the Onset of Illness or Injury date from professional encounters if it is the same as the date of service, which causes rejection. Paper claims submitted by providers often have an Onset of Illness or Injury date present on the claim, which is not appropriate for electronic standards when submitting to the State.
  - **PSCS-CO** has a system limitation where the encounters for members who have three payers error out, which had to be modified in order to get submitted to the State. The primary and secondary payment information is removed, and an adjustment is added to the line with a CO 45 for the full charge amount of the line. This shows that **PSCS-CO** allowed the claim but did not pay on it.
  - If a provider bills with a service facility NPI and address that are the same as the billing provider NPI and address, **PSCS-CO**'s analysts remove the service facility NPI information to prevent 999 rejections.
  - If a provider bills zero units and/or zero dollars, a value of one unit and/or $0.01 is added for encounter purposes. If encounters are submitted to the State with zero units, the encounter pends in MMIS.
- **PSCS-CO**'s pharmacy benefit manager, CVS, and DCOs extract encounter data from their individual systems and create either NCPDP pharmacy files or 837D files. These files are then submitted to **PSCS-CO** via secure FTP, where they are then loaded to the Encounter Module. Finally, from the Encounter Module (i.e., the platform that aligns other entities with **PSCS-CO**'s data warehouse), the files are transmitted to the State.
- **PSCS-CO** noted that it submits paid, denied, voided, and adjusted claims/encounters; however, **PSCS-CO** does not submit the following claims/encounters:
  - **PSCS-CO** does not submit claims if they are denied in full and have invalid codes, as **PSCS-CO** expects that the provider will correct and submit a new claim for payment.

- **PSCS-CO** does not send claims that have been denied for members not enrolled for which **PSCS-CO** has received a compliance error within its Encounter Module.
- **PSCS-CO** does not submit duplicate claims.

- **PSCS-CO** submits all adjustments to OHA and works with its Failed Adjustments report to ensure that the information in its system matches MMIS. **PSCS-CO** describes the process for submitting adjustments as follows:
  - In Facets, the original claim ends in "00," and when a claim is adjusted, a "new" claim is created ending in "01."
  - Every week, all adjudicated claims are extracted and loaded into the Edifecs Encounter Module. The "01" adjusted claim/encounter overrides the "00" claim/encounter in the Encounter Module and takes the ICN from the "00" original claim for the REF F8 segment in the adjusted claim.
  - Encounters are batched and pulled into an electronic data file and submitted to the State. When encounters are loaded to the State system, the "01" claim finds the "00" claim in MMIS by using the ICN from the REF F8 segment.

- For claims that are processed internally, Table L-2 shows the types of claims validated, a description of the validation performed, and the percentage of claims validated.

Table L-2—Claims Validated, Validation Performed, and Percentage of Claims Validated

Type of Claims Validated	Description of Validation Performed	Percentage of Claims Validated
Paper claims	Random audit	1%
Electronic	Random audit	1%
Large dollar claims	For professional claims above $4,999 and for hospital/facility claims above $19,999 based on allowed charges	100%
Manually processed	Claims where analysts have manually overridden copays, coinsurance, or type of service (TOS), or have overridden the service rule with B18 (i.e., allowed the claim to pay in full)	100%

- During data processing for submission to OHA, **PSCS-CO** indicated that Facets denial and adjustments codes are mapped to the standardized Washington Publishing Company CARCs. The supplied reference tables are updated annually, and as needed.

- **PSCS-CO**'s provider data management (PDM) unit collects, stores, and maintains provider data for all service categories, except those managed by external vendors:
  - Pharmacy provider data are gathered and managed by **PSCS-CO**'s PBM partner, CVS Caremark. The pharmacy provider data are not ingested into **PSCS-CO**'s systems. Issues arising from pharmacy encounters specific to provider data are forwarded directly to CVS Caremark for resolution on a pass-through basis. **PSCS-CO** has contractual language in place with CVS Caremark to ensure that pharmacy provider exclusions are communicated to **PSCS-CO** in a timely fashion. CVS Caremark is a subcontractor of **PSCS-CO**'s; therefore, annually, the plan

performs a subcontractor performance audit to verify subcontractor compliance with contract rules.

– Dental provider data are gathered and managed by **PSCS-CO**'s DCOs. The dental provider data are not ingested into **PSCS-CO**'s systems. Similar to the process described above, issues impacting encounter submissions related to provider data quality are forwarded directly to **PSCS-CO**'s DCO partners for resolution on a pass-through basis. DCOs are subcontractors of **PSCS-CO**'s; therefore, annually, the plan performs subcontractor performance audits to verify subcontractor compliance with contract rules.

- For the encounter piece of provider matching, **PSCS-CO** uses the Edifecs Encounter Module. Part of this program has the ability to load the weekly OHA Provider File, which contains actively enrolled and inactive providers. This file is loaded to the Encounter Module platform and is stored within the backend. The file is generated and loaded weekly to keep the platform provider information up to date. As claims enter the platform, the system runs a validation check, looking for information such as a known provider, valid taxonomy, valid NPI, valid taxonomy to NPI relationship, etc. If there are any failures, a task exception is created and added to a workflow queue to be worked by an analyst. If there are no exceptions, then the encounter is set to ready and will batch with **PSCS-CO**'s next encounter submission to the State. **PSCS-CO** noted that provider information does not require modification in order to comply with OHA's provider data submission requirements.

- **PSCS-CO** internally manages member enrollment based on Medicaid 834 files, individual exchange 834 files, and commercial group 834 files. The process for linking enrollment data to claims and encounters begins with the 834 files sent by OHA to **PSCS-CO**. The 834 files are loaded to the enrollment management system. Once in the enrollment management system, the member information along with coverage dates flows to **PSCS-CO**'s claims processing system Facets. As member information flows into Facets from the enrollment management system, a unique identifier is attached. The member's unique identifier is the link between claims and encounters. To reconcile enrollment differences, **PSCS-CO** uses the Not Enrolled and Deceased Client reports from the State.

Data Exchange Policies and Procedures

PSCS-CO has internally developed policies and procedures aimed at collecting, translating, storing, and transmitting encounter data that meet OHA's submission specifications. **PSCS-CO** submits HIPAA compliant encounter data via 837 Professional, 837 Institutional, and 837 Dental claim file formats, as well as NCPDP pharmacy file format, every Wednesday to OHA.

PSCS-CO extracts all Medicaid claims from Facets into the Encounter Module for submission to OHA. **PSCS-CO** noted that there are only two scenarios in which Medicaid claims would be excluded from extract, and these are claims that are denied as exact duplicates and claims that are denied due to an invalid diagnosis code or CPT/HCPCS code. Claims with invalid diagnosis codes or invalid CPT/HCPCS codes are rejected as 999 errors and are not loaded to OHA's system.

The Encounter Module contains duplicate edit logic to create tasks for claim review if duplicate services are found within the database.

Encounter claims submitted to the State are reconciled the week following each submission. **PSCS-CO** receives the CCV reports from the encounter liaison at OHA. Any variance is researched and explained with a verification acknowledgement form (VAF) and submitted to the State within two weeks of the date the CCV is received. In its response, **PSCS-CO** provided a screen print of the daily reports.

Management of Encounter Data: Collection, Storage, and Processing

For outpatient and inpatient encounter data submissions, **PSCS-CO** uses 837 X12 specifications with appropriate group and claim adjustment segment (CAS) codes that accurately reflect payments and adjustments (withholds, capitation, and adjustments over allowable). For pharmacy encounters, **PSCS-CO** and CVS (PBM) use NCPDP D.0 with appropriate segments to capture payments, adjustments, or reversals.

Table L-3 shows **PSCS-CO**'s pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table L-3—Pricing Methodology for PSCS-CO

Outpatient	Inpatient	Pharmacy
• 80% of CMS • FFS • Percent of OHA • Percent of invoice • Percent of billed • Per member per month (PMPM) • Capitation • PCPCH tier (billed by primary care physician) • PCPCH tier plus program • BHI	• DRG • Percent of OHA rates	• Negotiated rate (99%) • U&C price (1%) Note: Pharmacy claims are paid based on the lower of the participating pharmacy's U&C price or the negotiated rate plus the dispensing fee

- In response to whether there are any services submitted to **PSCS-CO** under bundle-payment structures, **PSCS-CO** noted the following types of claims:
  - Inpatient claims: Inpatient claims may be paid based on DRG, which is based on weight for each DRG and a rate for the facility, and only one DRG is assigned per admission.
  - Labor and delivery professional claims: If a provider bills for a bundled code such as 59400 (for vaginal delivery) or 59510 (for cesarean delivery), providers are not required to submit claims for services included within the procedure code, and **PSCS-CO** collects encounter-only claims when submitted.
  - Outpatient claims: APCs, where total payment for the outpatient visit is calculated based on the sum of the payments for all APCs.
- **PSCS-CO** collects and tracks other insurance coverage from various sources: member applications, where enrollment information is received electronically from OHA; member phone calls; provider

calls; member claims that come in from providers; internal reports that match names and dates of birth of members for review by an analyst to verify if the member is the same and would be double-covered on any PacificSource plan; and from its subcontracted vendor (i.e., Optum).

- **PSCS-CO** uses a transaction manager to verify the accuracy of electronic claim source data (including Medicare crossover and other third-party claims information) and the hard copy of a submitted claim to verify the accuracy of submitted paper claims; all payment information is stored in Facets. **PSCS-CO** noted that it stores primary payment information in its system within the Medicaid secondary claim. Encounters are sent to OHA with primary payment information (e.g., Medicare paid has another adjustment (OA) value of 23) and an allowable adjustment reason code of 45 for any remaining balance over Medicaid allowable that **PSCS-CO** does not pay.
- **PSCS-CO** indicated that zero-pay claims for subcapitated providers are processed and submitted to OHA, where instead of showing that **PSCS-CO** made a payment, **PSCS-CO** shows in its submission to OHA an adjustment reason code of 24.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **PSCS-CO** conducts the following activities:

- Completeness:
  – **PSCS-CO** uses the CVF with claim counts and billed amounts received from all subcontractors when they submit their encounter data to **PSCS-CO**. **PSCS-CO** uses this information to reconcile against the files **PSCS-CO** submitted to OHA.
- Accuracy:
  – **PSCS-CO** uses the pharmacy rejected encounters report as well as the pended encounters report from OHA.
- Timeliness:
  – **PSCS-CO** maintains internal reporting that supplies the percentage of encounters submitted within 45 days after adjudication for any given week.
  – **PSCS-CO** also reviews reports received from the DCOs with monthly trends to determine if the service claims met criteria for various metrics.
  – **PSCS-CO** also monitors its PBM (CVS) by using the OHA report that supplies the number of encounters received within specific time frames.

PSCS-CO uses a combination of internal and State reporting tools to monitor the completeness, accuracy, and timeliness of the encounter data submitted by its providers:

- Completeness:
  – Providers are routinely audited to ensure the completeness of claim and encounter data submitted to **PSCS-CO** and ultimately OHA. A data validation audit includes a review of clinical

documentation within the provider record against the data submitted through a claim/encounter to ensure that all required information is present and complete. Specifically, service notes are reviewed to ensure all required claim/encounter data elements (e.g., provider name, service provided, signature, credentials, diagnosis, date of service, and duration of service) are present and complete. The claim/encounters captured within the clinical record are also reviewed to ensure that all services required to be reported to **PSCS-CO** are being reported.

- Accuracy:
    - **PSCS-CO** uses the rejections and pends to monitor the accuracy of the submitted encounters.
    - As noted previously, in ensuring completeness, providers are routinely audited, which includes a review of clinical documentation. To ensure accuracy, in reviewing the clinical documentation within the selected provider record, the information must match the billed claim and encounter data submitted to OHA. This includes the validation of provider and member information, diagnosis codes, procedure codes, duration of service, and date of service.

- Timeliness:
    - **PSCS-CO** uses a combination of internal and State-provided reporting to monitor accuracy, timeliness, and completeness.

PSCS-CO monitors the status of encounter data submitted to OHA through reporting from its EDI team on a weekly basis. **PSCS-CO** also processes the 999 rejections, and claims are either adjusted in **PSCS-CO**'s system as denied, or the error is corrected in the Encounter Module and the claim is resent to OHA. Other transaction response files from OHA are also used to support **PSCS-CO**'s encounter data submission activities:

- TA1: While it is rare for **PSCS-CO** to receive this file, it has alerts set up whenever it receives this file for **PSCS-CO**'s EDI team to remediate the root failure.
- 835: The file is loaded and matched with **PSCS-CO**'s source encounters; ICNs are then loaded into **PSCS-CO**'s system for easy lookup. If it is determined that an encounter does not have any failure, it is then placed in a final complete status.
- Weekly status file: **PSCS-CO** loads the file and it is matched against its claims, and analysts work on the Tasks/Exceptions platform so **PSCS-CO** may resubmit claim with corrections.

At the time of the questionnaire submission, **PSCS-CO** noted that on average, 0.06 percent (out of on average of 103,631 encounters submitted per month) of encounters get rejected by OHA's EDI translator. Some of the rejection examples include duplicate ICD-10-CM procedure codes, and the service facility being the same as the billing provider. The process for reconciling files rejected by OHA involves several steps; ultimately, all encounters are sent, accepted, and end up in a final completed state.

PSCS-CO noted that during calendar year 2020, the average pended encounter to submitted encounters is 0.03 percent. **PSCS-CO** submits corrections for all encounters requiring correction within 63 days, otherwise **PSCS-CO** will be subjected to corrective action. Pended encounters, including penalty dates, are identified by using the Weekly Status Report received from OHA and loaded into **PSCS-CO**'s

encounter management system; the system will create pend tasks for correction according to the data in the report. Analysts then process these tasks and send the tasks to OHA prior to the penalty date. **PSCS-CO** also corrects pended encounters through the MMIS portal. For subsequent resubmission, **PSCS-CO** uses the encounter management system to correct pended encounters, or analysts will use the MMIS portal for adjustments.

Prior to the encounter data being used in analytics and external customer and internal financial reporting, **PSCS-CO** noted that the encounter data are loaded and transformed into its centralized data warehouse. Some examples of such reporting/analytics include but are not limited to:

- HEDIS and QIM measure calculations and gap reporting.
- Care and case management reporting.
- Utilization and experience reporting.
- Provider contract-level and line-of-business level performance and financial reporting.
- Rate-setting.
- MLR reporting.
- Risk stratification algorithms for population assessment and programs.
- Condition program identification algorithms for program identification.
- Provider efficiency algorithm tools related to cost and use, and provider data sharing.
- Condition prevalence algorithms for population assessment and program identification among other use.
- Value-based payment settlement arrangements.

PSCS-CO noted the following challenges faced in submitting encounter data to OHA:

- Internal challenges:
  - Matching the **PSCS-CO** provider setup across multiple lines of business to meet OHA's requirements.
  - Maintenance of provider data quality relevant to encounter submissions (e.g., taxonomy codes), correct identification/matching of rendering provider, etc. **PSCS-CO** continues to make steady improvement on these issues and has invested heavily in 2020 in new systems and partnerships that directly support provider data quality/integrity.
  - Earlier in 2020, **PSCS-CO** also experienced some challenges with scalability associated with a very rapid growth in its Medicaid membership. These scalability challenges were successfully addressed early in the second quarter of 2020 and no longer pose difficulties.

- External challenges:
  - Provider enrollment requirements differing between FFS and encounter only.
  - MMIS functionality-Provider Matching-MMIS contains duplicate provider records, which cause **PSCS-CO**'s encounters to pend.
  - MMIS does not acknowledge the different NDCs within the medical encounters. **PSCS-CO** receives duplicate denials on HCPCS codes that are the same, but the NDC is different; therefore, the HCPCS codes are not for the same drug and should not be denied as duplicates. However, MMIS acknowledges NDCs on NCPDP encounters. This also presents challenges when the same NDC could be present in multiple compound drugs, with the same date of service, but different prescription numbers. These are denied as duplicates as well. **PSCS-CO** noted that it should get credit for these.
  - A claims search in MMIS is time consuming. **PSCS-CO** has to manually switch providers each time it needs to pull up a claim from a different plan number. **PSCS-CO** has 16 different plan numbers. It would be more efficient to have all plans linked together under a **PSCS-CO** and have one search page where the ICN and plan ID could be entered.
  - **PSCS-CO** has challenges with untimely additions of new CPT codes, modifiers, and revenue codes in MMIS.
  - **PSCS-CO** also has challenges with the Drug Rebate Program and NCPDP rejections. Some of **PSCS-CO**'s NCPDP encounters reject, as OHA is indicating that the NDC is not with the State Rebate Program; however, per **PSCS-CO**'s Pharmacy Department, "The NDCs that are in this OHA Rebate Program are seemingly random."

Recommendations

Based on its review, HSAG recommends the following for **PSCS-CO** to strengthen its encounter data quality:

- **PSCS-CO** listed modifications that were applied to both its claims and encounter data in its questionnaire response. One of the modifications relates to rolling up the revenue code 250 service line items in Facets to prevent duplicate edits from the State. While details of the roll-up process were not described in **PSCS-CO**'s questionnaire response, HSAG recommends that **PSCS-CO** work with OHA to clarify and confirm that the process translates to an accurate representation of the encounter when transmitted to OHA.

- Similarly, **PSCS-CO** also noted that when a provider bills zero units and/or zero dollars, a value of one unit and/or $0.01 is added for encounter purposes. HSAG recommends that **PSCS-CO** work with OHA to clarify and confirm that this modification is in line with OHA's submission requirements and does not have any impact when an encounter is used for analytic purposes within OHA's system.

This section summarizes the findings from PacificSource Community Solutions–Columbia Gorge's (**PSCS-CG**'s) questionnaire responses.

Encounter Data Sources and Systems

Per **PSCS-CG**'s questionnaire response, each week, encounter eligible claims are extracted from its core adjudication system into a common format and batched for ingestion into its encounter management system (EMS). The EMS reviews the encounters for accuracy/integrity using rule sets that are regularly updated by **PSCS-CG**'s EMS platform vendor. Encounters that do not pass OHA standards are pended by the EMS to manual work queues for review and resolution. Once corrected, these pended encounters are batched together with encounters that passed automated review in preparation for submission to OHA. Prior to submission, the encounters are subjected to an additional round of external EDI compliance review to address any residual formatting errors that might otherwise produce an occasional error with the submissions. After submission, any encounters rejected or pended by the State are re-ingested into the EMS for corrective handling.

Encounter submission performance is reviewed by the IT and business teams on a weekly basis and is reviewed biweekly during Government Operations meetings. Submission and systems issues are carefully tracked and addressed on a prioritized basis. The IT and business teams meet weekly to review status and performance.

Table M-1 shows **PSCS-CG**'s format and submission frequency for professional, institutional, transportation, pharmacy, and dental encounters received.

Table M-1—Format and Submission Frequency for Professional[1], Institutional[2], Transportation, Pharmacy, and Dental Encounters

	Professional[1]	Institutional[2]	Transportation	Pharmacy	Dental
Data receipt	Clearinghouse and EDI Gateway	Clearinghouse and EDI Gateway	LogistiCare and RideSource	Caremark (CVS)	Capitol, Advantage, and ODS
Format	837P	837I	837P	NCPDP	837D
Frequency	Weekly	Weekly	Weekly	Weekly	Weekly
Approximate volume	Varies	Varies	5,295 claims/week	48,200 claims/week	3,384 claims/week

[1] Includes laboratory, physician, vision, and behavioral health
[2] Includes inpatient, outpatient, and long-term care

- **PSCS-CG** noted that the following modifications and/or reformatting changes are applied to both its claims and encounter data:
  - **PSCS-CG**'s process is to roll up revenue code 250 service line items in Facets to prevent duplicate edits from the State.
  - When processing duplicate edits within the Encounter Module, **PSCS-CG**'s analysts check for different NDC codes on lines with duplicate HCPCS codes. If the NDCs are different, a 59 modifier is added to the line to ensure MMIS does not deny the duplicate HCPCS code as a duplicate. According to **PSCS-CG**, this is a State limitation.
  - **PSCS-CG** updates the billing provider information billed on claims for FQHCs that have multiple locations and NPIs that have the same tax ID. Per **PSCS-CG**, the State has a limitation that FQHCs can only have one enrollment with the State and cannot have multiple enrollments as separate locations. As such, for FQHCs with multiple locations to receive their cost settlement and to ensure **PSCS-CG**'s encounters do not pend, the CCO modifies the billing provider information to the FQHC's enrolled provider.
  - **PSCS-CG** removes "duplicate" inpatient ICD-10-CM procedure codes performed on different dates of service due to 999 rejects. Per **PSCS-CG**, this is a State limitation.
  - **PSCS-CG** removes the Onset of Illness or Injury date from professional encounters if it is the same as the date of service, which causes rejection. Paper claims submitted by providers often have an Onset of Illness or Injury date present on the claim, which is not appropriate for electronic standards when submitting to the State.
  - **PSCS-CG** has a system limitation where the encounters for members who have three payers error out, which had to be modified in order to get submitted to the State. The primary and secondary payment information is removed, and an adjustment is added to the line with a CO 45 for the full charge amount of the line. This shows that **PSCS-CG** allowed the claim but did not pay on it.
  - If a provider bills with a service facility NPI and address that are the same as the billing provider NPI and address, **PSCS-CG**'s analysts remove the service facility NPI information to prevent 999 rejections.
  - If a provider bills zero units and/or zero dollars, a value of one unit and/or $0.01 is added for encounter purposes. If encounters are submitted to the State with zero units, the encounter pends in MMIS.
- **PSCS-CG**'s pharmacy benefit manager, CVS, and DCOs extract encounter data from their individual systems and create either NCPDP pharmacy files or 837D files. These files are then submitted to **PSCS-CG** via secure FTP, where they are then loaded to the Encounter Module. Finally, from the Encounter Module (i.e., the platform that aligns other entities with **PSCS-CG**'s data warehouse), the files are transmitted to the State.
- **PSCS-CG** noted that it submits paid, denied, voided, and adjusted claims/encounters; however, **PSCS-CG** does not submit the following claims/encounters:
  - **PSCS-CG** does not submit claims if they are denied in full and have invalid codes, as **PSCS-CG** expects that the provider will correct and submit a new claim for payment.

- – **PSCS-CG** does not send claims that have been denied for members not enrolled for which **PSCS-CG** has received a compliance error within its Encounter Module.
  - – **PSCS-CG** does not submit duplicate claims.
- **PSCS-CG** submits all adjustments to OHA and works with its Failed Adjustments report to ensure that the information in its system matches MMIS. **PSCS-CG** describes the process for submitting adjustments as follows:
  - – In Facets, the original claim ends in "00," and when a claim is adjusted, a "new" claim is created ending in "01."
  - – Every week, all adjudicated claims are extracted and loaded into the Edifecs Encounter Module. The "01" adjusted claim/encounter overrides the "00" claim/encounter in the Encounter Module and takes the ICN from the "00" original claim for the REF F8 segment in the adjusted claim.
  - – Encounters are batched and pulled into an electronic data file and submitted to the State. When encounters are loaded to the State system, the "01" claim finds the "00" claim in MMIS by using the ICN from the REF F8 segment.
- For claims that are processed internally, Table M-2 shows the types of claims validated, a description of the validation performed, and the percentage of claims validated.

Table M-2—Claims Validated, Validation Performed, and Percentage of Claims Validated

Type of Claims Validated	Description of Validation Performed	Percentage of Claims Validated
Paper claims	Random audit	1%
Electronic	Random audit	1%
Large dollar claims	For professional claims above $4,999 and for hospital/facility claims above $19,999 based on allowed charges	100%
Manually processed	Claims where analysts have manually overridden copays, coinsurance, or type of service (TOS), or have overridden the service rule with B18 (i.e., allowed the claim to pay in full)	100%

- During data processing for submission to OHA, **PSCS-CG** indicated that Facets denial and adjustments codes are mapped to the standardized Washington Publishing Company CARCs. The supplied reference tables are updated annually, and as needed.
- **PSCS-CG**'s provider data management (PDM) unit collects, stores, and maintains provider data for all service categories, except those managed by external vendors:
  - – Pharmacy provider data are gathered and managed by **PSCS-CG**'s PBM partner, CVS Caremark. The pharmacy provider data are not ingested into **PSCS-CG**'s systems. Issues arising from pharmacy encounters specific to provider data are forwarded directly to CVS Caremark for resolution on a pass-through basis. **PSCS-CG** has contractual language in place with CVS Caremark to ensure that pharmacy provider exclusions are communicated to **PSCS-CG** in a timely fashion. CVS Caremark is a subcontractor of **PSCS-CG**'s; therefore, annually, the plan

performs a subcontractor performance audit to verify subcontractor compliance with contract rules.

  – Dental provider data are gathered and managed by **PSCS-CG**'s DCOs. The dental provider data are not ingested into **PSCS-CG**'s systems. Similar to the process described above, issues impacting encounter submissions related to provider data quality are forwarded directly to **PSCS-CG**'s DCO partners for resolution on a pass-through basis. DCOs are subcontractors of **PSCS-CG**'s; therefore, annually, the plan performs subcontractor performance audits to verify subcontractor compliance with contract rules.

- For the encounter piece of provider matching, **PSCS-CG** uses the Edifecs Encounter Module. Part of this program has the ability to load the weekly OHA Provider File, which contains actively enrolled and inactive providers. This file is loaded to the Encounter Module platform and is stored within the backend. The file is generated and loaded weekly to keep the platform provider information up to date. As claims enter the platform, the system runs a validation check, looking for information such as a known provider, valid taxonomy, valid NPI, valid taxonomy to NPI relationship, etc. If there are any failures, a task exception is created and added to a workflow queue to be worked by an analyst. If there are no exceptions, then the encounter is set to ready and will batch with **PSCS-CG**'s next encounter submission to the State. **PSCS-CG** noted that provider information does not require modification in order to comply with OHA's provider data submission requirements.

- **PSCS-CG** internally manages member enrollment based on Medicaid 834 files, individual exchange 834 files, and commercial group 834 files. The process for linking enrollment data to claims and encounters begins with the 834 files sent by OHA to **PSCS-CG**. The 834 files are loaded to the enrollment management system. Once in the enrollment management system, the member information along with coverage dates flows to **PSCS-CG**'s claims processing system Facets. As member information flows into Facets from the enrollment management system, a unique identifier is attached. The member's unique identifier is the link between claims and encounters. To reconcile enrollment differences, **PSCS-CG** uses the Not Enrolled and Deceased Client reports from the State.

Data Exchange Policies and Procedures

PSCS-CG has internally developed policies and procedures aimed at collecting, translating, storing, and transmitting encounter data that meet OHA's submission specifications. **PSCS-CG** submits HIPAA compliant encounter data via 837 Professional, 837 Institutional, and 837 Dental claim file formats, as well as NCPDP pharmacy file format, every Wednesday to OHA.

PSCS-CG extracts all Medicaid claims from Facets into the Encounter Module for submission to OHA. **PSCS-CG** noted that there are only two scenarios in which Medicaid claims would be excluded from extract, and these are claims that are denied as exact duplicates and claims that are denied due to an invalid diagnosis code or CPT/HCPCS code. Claims with invalid diagnosis codes or invalid CPT/HCPCS codes are rejected as 999 errors and are not loaded to OHA's system.

The Encounter Module contains duplicate edit logic to create tasks for claim review if duplicate services are found within the database.

Encounter claims submitted to the State are reconciled the week following each submission. **PSCS-CG** receives the CCV reports from the encounter liaison at OHA. Any variance is researched and explained with a verification acknowledgement form (VAF) and submitted to the State within two weeks of the date the CCV is received. In its response, **PSCS-CG** provided a screen print of the daily reports.

Management of Encounter Data: Collection, Storage, and Processing

For outpatient and inpatient encounter data submissions, **PSCS-CG** uses 837 X12 specifications with appropriate group and claim adjustment segment (CAS) codes that accurately reflect payments and adjustments (withholds, capitation, and adjustments over allowable). For pharmacy encounters, **PSCS-CG** and CVS (PBM) use NCPDP D.0 with appropriate segments to capture payments, adjustments, or reversals.

Table M-3 shows **PSCS-CG**'s pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table M-3—Pricing Methodology for PSCS-CG

Outpatient	Inpatient	Pharmacy
80% of CMS - FFS - Percent of OHA - Percent of invoice - Percent of billed - Per member per month (PMPM) - Capitation - PCPCH tier (billed by primary care physician) - PCPCH tier plus program - BHI	- DRG - Percent of OHA rates	- Negotiated rate (99%) - U&C price (1%) Note: Pharmacy claims are paid based on the lower of the participating pharmacy's U&C price or the negotiated rate plus the dispensing fee

- In response to whether there are any services submitted to **PSCS-CG** under bundle-payment structures, **PSCS-CG** noted the following types of claims:
  - Inpatient claims: Inpatient claims may be paid based on DRG, which is based on weight for each DRG and a rate for the facility, and only one DRG is assigned per admission.
  - Labor and delivery professional claims: If a provider bills for a bundled code such as 59400 (for vaginal delivery) or 59510 (for cesarean delivery), providers are not required to submit claims for services included within the procedure code, and **PSCS-CG** collects encounter-only claims when submitted.
  - Outpatient claims: APCs, where total payment for the outpatient visit is calculated based on the sum of the payments for all APCs.
- **PSCS-CG** collects and tracks other insurance coverage from various sources: member applications, where enrollment information is received electronically from OHA; member phone calls; provider

calls; member claims that come in from providers; internal reports that match names and dates of birth of members for review by an analyst to verify if the member is the same and would be double-covered on any PacificSource plan; and from its subcontracted vendor (i.e., Optum).

- **PSCS-CG** uses a transaction manager to verify the accuracy of electronic claim source data (including Medicare crossover and other third-party claims information) and the hard copy of a submitted claim to verify the accuracy of submitted paper claims; all payment information is stored in Facets. **PSCS-CG** noted that it stores primary payment information in its system within the Medicaid secondary claim. Encounters are sent to OHA with primary payment information (e.g., Medicare paid has another adjustment (OA) value of 23) and an allowable adjustment reason code of 45 for any remaining balance over Medicaid allowable that **PSCS-CG** does not pay.

- **PSCS-CG** indicated that zero-pay claims for subcapitated providers are processed and submitted to OHA, where instead of showing that **PSCS-CG** made a payment, **PSCS-CG** shows in its submission to OHA an adjustment reason code of 24.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **PSCS-CG** conducts the following activities:

- Completeness:
  - **PSCS-CG** uses the CVF with claim counts and billed amounts received from all subcontractors when they submit their encounter data to **PSCS-CG**. **PSCS-CG** uses this information to reconcile against the files **PSCS-CG** submitted to OHA.
- Accuracy:
  - **PSCS-CG** uses the pharmacy rejected encounters report as well as the pended encounters report from OHA.
- Timeliness:
  - **PSCS-CG** maintains internal reporting that supplies the percentage of encounters submitted within 45 days after adjudication for any given week.
  - **PSCS-CG** also reviews reports received from the DCOs with monthly trends to determine if the service claims met criteria for various metrics.
  - **PSCS-CG** also monitors its PBM (CVS) by using the OHA report that supplies the number of encounters received within specific time frames.

PSCS-CG uses a combination of internal and State reporting tools to monitor the completeness, accuracy, and timeliness of the encounter data submitted by its providers:

- Completeness:
  - Providers are routinely audited to ensure the completeness of claim and encounter data submitted to **PSCS-CG** and ultimately OHA. A data validation audit includes a review of clinical

documentation within the provider record against the data submitted through a claim/encounter to ensure that all required information is present and complete. Specifically, service notes are reviewed to ensure all required claim/encounter data elements (e.g., provider name, service provided, signature, credentials, diagnosis, date of service, and duration of service) are present and complete. The claim/encounters captured within the clinical record are also reviewed to ensure that all services required to be reported to **PSCS-CG** are being reported.

- Accuracy:
  – **PSCS-CG** uses the rejections and pends to monitor the accuracy of the submitted encounters.
  – As noted previously, in ensuring completeness, providers are routinely audited, which includes a review of clinical documentation. To ensure accuracy, in reviewing the clinical documentation within the selected provider record, the information must match the billed claim and encounter data submitted to OHA. This includes the validation of provider and member information, diagnosis codes, procedure codes, duration of service, and date of service.
- Timeliness:
  – **PSCS-CG** uses a combination of internal and State-provided reporting to monitor accuracy, timeliness, and completeness.

PSCS-CG monitors the status of encounter data submitted to OHA through reporting from its EDI team on a weekly basis. **PSCS-CG** also processes the 999 rejections, and claims are either adjusted in **PSCS-CG**'s system as denied, or the error is corrected in the Encounter Module and the claim is resent to OHA. Other transaction response files from OHA are also used to support **PSCS-CG**'s encounter data submission activities:

- TA1: While it is rare for **PSCS-CG** to receive this file, it has alerts set up whenever it receives this file for **PSCS-CG**'s EDI team to remediate the root failure.
- 835: The file is loaded and matched with **PSCS-CG**'s source encounters; ICNs are then loaded into **PSCS-CG**'s system for easy lookup. If it is determined that an encounter does not have any failure, it is then placed in a final complete status.
- Weekly status file: **PSCS-CG** loads the file and it is matched against its claims, and analysts work on the Tasks/Exceptions platform so **PSCS-CG** may resubmit claim with corrections.

At the time of the questionnaire submission, **PSCS-CG** noted that on average, 0.06 percent (out of on average of 103,631 encounters submitted per month) of encounters get rejected by OHA's EDI translator. Some of the rejection examples include duplicate ICD-10-CM procedure codes, and the service facility being the same as the billing provider. The process for reconciling files rejected by OHA involves several steps; ultimately, all encounters are sent, accepted, and end up in a final completed state.

PSCS-CG noted that during calendar year 2020, the average pended encounter to submitted encounters is 0.03 percent. **PSCS-CG** submits corrections for all encounters requiring correction within 63 days, otherwise **PSCS-CG** will be subjected to corrective action. Pended encounters, including penalty dates, are identified by using the Weekly Status Report received from OHA and loaded into **PSCS-CG**'s

encounter management system; the system will create pend tasks for correction according to the data in the report. Analysts then process these tasks and send the tasks to OHA prior to the penalty date. **PSCS-CG** also corrects pended encounters through the MMIS portal. For subsequent resubmission, **PSCS-CG** uses the encounter management system to correct pended encounters, or analysts will use the MMIS portal for adjustments.

Prior to the encounter data being used in analytics and external customer and internal financial reporting, **PSCS-CG** noted that the encounter data are loaded and transformed into its centralized data warehouse. Some examples of such reporting/analytics include but are not limited to:

- HEDIS and QIM measure calculations and gap reporting.
- Care and case management reporting.
- Utilization and experience reporting.
- Provider contract-level and line-of-business level performance and financial reporting.
- Rate-setting.
- MLR reporting.
- Risk stratification algorithms for population assessment and programs.
- Condition program identification algorithms for program identification.
- Provider efficiency algorithm tools related to cost and use, and provider data sharing.
- Condition prevalence algorithms for population assessment and program identification among other use.
- Value-based payment settlement arrangements.

PSCS-CG noted the following challenges faced in submitting encounter data to OHA:

- Internal challenges:
  – Matching the **PSCS-CG** provider setup across multiple lines of business to meet OHA's requirements.
  – Maintenance of provider data quality relevant to encounter submissions (e.g., taxonomy codes), correct identification/matching of rendering provider, etc. **PSCS-CG** continues to make steady improvement on these issues and has invested heavily in 2020 in new systems and partnerships that directly support provider data quality/integrity.
  – Earlier in 2020, **PSCS-CG** also experienced some challenges with scalability associated with a very rapid growth in its Medicaid membership. These scalability challenges were successfully addressed early in the second quarter of 2020 and no longer pose difficulties.

- External challenges:
  - Provider enrollment requirements differing between FFS and encounter only.
  - MMIS functionality-Provider Matching-MMIS contains duplicate provider records, which cause **PSCS-CG**'s encounters to pend.
  - MMIS does not acknowledge the different NDCs within the medical encounters. **PSCS-CG** receives duplicate denials on HCPCS codes that are the same, but the NDC is different; therefore, the HCPCS codes are not for the same drug and should not be denied as duplicates. However, MMIS acknowledges NDCs on NCPDP encounters. This also presents challenges when the same NDC could be present in multiple compound drugs, with the same date of service, but different prescription numbers. These are denied as duplicates as well. **PSCS-CG** noted that it should get credit for these.
  - A claims search in MMIS is time consuming. **PSCS-CG** has to manually switch providers each time it needs to pull up a claim from a different plan number. **PSCS-CG** has 16 different plan numbers. It would be more efficient to have all plans linked together under a **PSCS-CG** and have one search page where the ICN and plan ID could be entered.
  - **PSCS-CG** has challenges with untimely additions of new CPT codes, modifiers, and revenue codes in MMIS.
  - **PSCS-CG** also has challenges with the Drug Rebate Program and NCPDP rejections. Some of **PSCS-CG**'s NCPDP encounters reject, as OHA is indicating that the NDC is not with the State Rebate Program; however, per **PSCS-CG**'s Pharmacy Department, "The NDCs that are in this OHA Rebate Program are seemingly random."

Recommendations

Based on its review, HSAG recommends the following for **PSCS-CG** to strengthen its encounter data quality:

- **PSCS-CG** listed modifications that were applied to both its claims and encounter data in its questionnaire response. One of the modifications relates to rolling up the revenue code 250 service line items in Facets to prevent duplicate edits from the State. While details of the roll-up process were not described in **PSCS-CG**'s questionnaire response, HSAG recommends that **PSCS-CG** work with OHA to clarify and confirm that the process translates to an accurate representation of the encounter when transmitted to OHA.
- Similarly, **PSCS-CG** also noted that when a provider bills zero units and/or zero dollars, a value of one unit and/or $0.01 is added for encounter purposes. HSAG recommends that **PSCS-CG** work with OHA to clarify and confirm that this modification is in line with OHA's submission requirements and does not have any impact when an encounter is used for analytic purposes within OHA's system.

This section summarizes the findings from PacificSource Community Solutions–Lane County's (**PSCS-Lane**'s) questionnaire responses.

Encounter Data Sources and Systems

Per **PSCS-Lane**'s questionnaire response, each week, encounter eligible claims are extracted from its core adjudication system into a common format and batched for ingestion into its encounter management system (EMS). The EMS reviews the encounters for accuracy/integrity using rule sets that are regularly updated by **PSCS-Lane**'s EMS platform vendor. Encounters that do not pass OHA standards are pended by the EMS to manual work queues for review and resolution. Once corrected, these pended encounters are batched together with encounters that passed automated review in preparation for submission to OHA. Prior to submission, the encounters are subjected to an additional round of external EDI compliance review to address any residual formatting errors that might otherwise produce an occasional error with the submissions. After submission, any encounters rejected or pended by the State are re-ingested into the EMS for corrective handling.

Encounter submission performance is reviewed by the IT and business teams on a weekly basis and is reviewed biweekly during Government Operations meetings. Submission and systems issues are carefully tracked and addressed on a prioritized basis. The IT and business teams meet weekly to review status and performance.

Table N-1 shows **PSCS-Lane**'s format and submission frequency for professional, institutional, transportation, pharmacy, and dental encounters received.

Table N-1—Format and Submission Frequency for Professional[1], Institutional[2], Transportation, Pharmacy, and Dental Encounters

	Professional[1]	Institutional[2]	Transportation	Pharmacy	Dental
Data receipt	Clearinghouse and EDI Gateway	Clearinghouse and EDI Gateway	LogistiCare and RideSource	Caremark (CVS)	Capitol, Advantage, and ODS
Format	837P	837I	837P	NCPDP	837D
Frequency	Weekly	Weekly	Weekly	Weekly	Weekly
Approximate volume	Varies	Varies	5,295 claims/week	48,200 claims/week	3,384 claims/week

[1] Includes laboratory, physician, vision, and behavioral health
[2] Includes inpatient, outpatient, and long-term care

- **PSCS-Lane** noted that the following modifications and/or reformatting changes are applied to both its claims and encounter data:

- PSCS-Lane's process is to roll up revenue code 250 service line items in Facets to prevent duplicate edits from the State.
- When processing duplicate edits within the Encounter Module, PSCS-Lane's analysts check for different NDC codes on lines with duplicate HCPCS codes. If the NDCs are different, a 59 modifier is added to the line to ensure MMIS does not deny the duplicate HCPCS code as a duplicate. According to PSCS-Lane, this is a State limitation.
- PSCS-Lane updates the billing provider information billed on claims for FQHCs that have multiple locations and NPIs that have the same tax ID. Per PSCS-Lane, the State has a limitation that FQHCs can only have one enrollment with the State and cannot have multiple enrollments as separate locations. As such, for FQHCs with multiple locations to receive their cost settlement and to ensure PSCS-Lane's encounters do not pend, the CCO modifies the billing provider information to the FQHC's enrolled provider.
- PSCS-Lane removes "duplicate" inpatient ICD-10-CM procedure codes performed on different dates of service due to 999 rejects. Per PSCS-Lane, this is a State limitation.
- PSCS-Lane removes the Onset of Illness or Injury date from professional encounters if it is the same as the date of service, which causes rejection. Paper claims submitted by providers often have an Onset of Illness or Injury date present on the claim, which is not appropriate for electronic standards when submitting to the State.
- PSCS-Lane has a system limitation where the encounters for members who have three payers error out, which had to be modified in order to get submitted to the State. The primary and secondary payment information is removed, and an adjustment is added to the line with a CO 45 for the full charge amount of the line. This shows that PSCS-Lane allowed the claim but did not pay on it.
- If a provider bills with a service facility NPI and address that are the same as the billing provider NPI and address, PSCS-Lane's analysts remove the service facility NPI information to prevent 999 rejections.
- If a provider bills zero units and/or zero dollars, a value of one unit and/or $0.01 is added for encounter purposes. If encounters are submitted to the State with zero units, the encounter pends in MMIS.

• PSCS-Lane's pharmacy benefit manager, CVS, and DCOs extract encounter data from their individual systems and create either NCPDP pharmacy files or 837D files. These files are then submitted to PSCS-Lane via secure FTP, where they are then loaded to the Encounter Module. Finally, from the Encounter Module (i.e., the platform that aligns other entities with PSCS-Lane's data warehouse), the files are transmitted to the State.

• PSCS-Lane noted that it submits paid, denied, voided, and adjusted claims/encounters; however, PSCS-Lane does not submit the following claims/encounters:

- PSCS-Lane does not submit claims if they are denied in full and have invalid codes, as PSCS-Lane expects that the provider will correct and submit a new claim for payment.
- PSCS-Lane does not send claims that have been denied for members not enrolled for which PSCS-Lane has received a compliance error within its Encounter Module.
- PSCS-Lane does not submit duplicate claims.

- **PSCS-Lane** submits all adjustments to OHA and works with its Failed Adjustments report to ensure that the information in its system matches MMIS. **PSCS-Lane** describes the process for submitting adjustments as follows:
  – In Facets, the original claim ends in "00," and when a claim is adjusted, a "new" claim is created ending in "01."
  – Every week, all adjudicated claims are extracted and loaded into the Edifecs Encounter Module. The "01" adjusted claim/encounter overrides the "00" claim/encounter in the Encounter Module and takes the ICN from the "00" original claim for the REF F8 segment in the adjusted claim.
  – Encounters are batched and pulled into an electronic data file and submitted to the State. When encounters are loaded to the State system, the "01" claim finds the "00" claim in MMIS by using the ICN from the REF F8 segment.

- For claims that are processed internally, Table N-2 shows the types of claims validated, a description of the validation performed, and the percentage of claims validated.

Table N-2—Claims Validated, Validation Performed, and Percentage of Claims Validated

Type of Claims Validated	Description of Validation Performed	Percentage of Claims Validated
Paper claims	Random audit	1%
Electronic	Random audit	1%
Large dollar claims	For professional claims above $4,999 and for hospital/facility claims above $19,999 based on allowed charges	100%
Manually processed	Claims where analysts have manually overridden copays, coinsurance, or type of service (TOS), or have overridden the service rule with B18 (i.e., allowed the claim to pay in full)	100%

- During data processing for submission to OHA, **PSCS-Lane** indicated that Facets denial and adjustments codes are mapped to the standardized Washington Publishing Company CARCs. The supplied reference tables are updated annually, and as needed.

- **PSCS-Lane**'s provider data management (PDM) unit collects, stores, and maintains provider data for all service categories, except those managed by external vendors:
  – Pharmacy provider data are gathered and managed by **PSCS-Lane**'s PBM partner, CVS Caremark. The pharmacy provider data are not ingested into **PSCS-Lane**'s systems. Issues arising from pharmacy encounters specific to provider data are forwarded directly to CVS Caremark for resolution on a pass-through basis. **PSCS-Lane** has contractual language in place with CVS Caremark to ensure that pharmacy provider exclusions are communicated to **PSCS-Lane** in a timely fashion. CVS Caremark is a subcontractor of **PSCS-Lane**'s; therefore, annually, the plan performs a subcontractor performance audit to verify subcontractor compliance with contract rules.

- Dental provider data are gathered and managed by **PSCS-Lane**'s DCOs. The dental provider data are not ingested into **PSCS-Lane**'s systems. Similar to the process described above, issues impacting encounter submissions related to provider data quality are forwarded directly to **PSCS-Lane**'s DCO partners for resolution on a pass-through basis. DCOs are subcontractors of **PSCS-Lane**'s; therefore, annually, the plan performs subcontractor performance audits to verify subcontractor compliance with contract rules.

- For the encounter piece of provider matching, **PSCS-Lane** uses the Edifecs Encounter Module. Part of this program has the ability to load the weekly OHA Provider File, which contains actively enrolled and inactive providers. This file is loaded to the Encounter Module platform and is stored within the backend. The file is generated and loaded weekly to keep the platform provider information up to date. As claims enter the platform, the system runs a validation check, looking for information such as a known provider, valid taxonomy, valid NPI, valid taxonomy to NPI relationship, etc. If there are any failures, a task exception is created and added to a workflow queue to be worked by an analyst. If there are no exceptions, then the encounter is set to ready and will batch with **PSCS-Lane**'s next encounter submission to the State. **PSCS-Lane** noted that provider information does not require modification in order to comply with OHA's provider data submission requirements.

- **PSCS-Lane** internally manages member enrollment based on Medicaid 834 files, individual exchange 834 files, and commercial group 834 files. The process for linking enrollment data to claims and encounters begins with the 834 files sent by OHA to **PSCS-Lane**. The 834 files are loaded to the enrollment management system. Once in the enrollment management system, the member information along with coverage dates flows to **PSCS-Lane**'s claims processing system Facets. As member information flows into Facets from the enrollment management system, a unique identifier is attached. The member's unique identifier is the link between claims and encounters. To reconcile enrollment differences, **PSCS-Lane** uses the Not Enrolled and Deceased Client reports from the State.

Data Exchange Policies and Procedures

PSCS-Lane has internally developed policies and procedures aimed at collecting, translating, storing, and transmitting encounter data that meet OHA's submission specifications. **PSCS-Lane** submits HIPAA compliant encounter data via 837 Professional, 837 Institutional, and 837 Dental claim file formats, as well as NCPDP pharmacy file format, every Wednesday to OHA.

PSCS-Lane extracts all Medicaid claims from Facets into the Encounter Module for submission to OHA. **PSCS-Lane** noted that there are only two scenarios in which Medicaid claims would be excluded from extract, and these are claims that are denied as exact duplicates and claims that are denied due to an invalid diagnosis code or CPT/HCPCS code. Claims with invalid diagnosis codes or invalid CPT/HCPCS codes are rejected as 999 errors and are not loaded to OHA's system.

The Encounter Module contains duplicate edit logic to create tasks for claim review if duplicate services are found within the database.

Encounter claims submitted to the State are reconciled the week following each submission. **PSCS-Lane** receives the CCV reports from the encounter liaison at OHA. Any variance is researched and explained with a verification acknowledgement form (VAF) and submitted to the State within two weeks of the date the CCV is received. In its response, **PSCS-Lane** provided a screen print of the daily reports.

Management of Encounter Data: Collection, Storage, and Processing

For outpatient and inpatient encounter data submissions, **PSCS-Lane** uses 837 X12 specifications with appropriate group and claim adjustment segment (CAS) codes that accurately reflect payments and adjustments (withholds, capitation, and adjustments over allowable). For pharmacy encounters, **PSCS-Lane** and CVS (PBM) use NCPDP D.0 with appropriate segments to capture payments, adjustments, or reversals.

Table N-3 shows **PSCS-Lane**'s pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table N-3—Pricing Methodology for PSCS-Lane

Outpatient	Inpatient	Pharmacy
• 80% of CMS • FFS • Percent of OHA • Percent of invoice • Percent of billed • Per member per month (PMPM) • Capitation • PCPCH tier (billed by primary care physician) • PCPCH tier plus program • BHI	• DRG • Percent of OHA rates	• Negotiated rate (99%) • U&C price (1%) Note: Pharmacy claims are paid based on the lower of the participating pharmacy's U&C price or the negotiated rate plus the dispensing fee

- In response to whether there are any services submitted to **PSCS-Lane** under bundle-payment structures, **PSCS-Lane** noted the following types of claims:
  - Inpatient claims: Inpatient claims may be paid based on DRG, which is based on weight for each DRG and a rate for the facility, and only one DRG is assigned per admission.
  - Labor and delivery professional claims: If a provider bills for a bundled code such as 59400 (for vaginal delivery) or 59510 (for cesarean delivery), providers are not required to submit claims for services included within the procedure code, and **PSCS-Lane** collects encounter-only claims when submitted.
  - Outpatient claims: APCs, where total payment for the outpatient visit is calculated based on the sum of the payments for all APCs.

- **PSCS-Lane** collects and tracks other insurance coverage from various sources: member applications, where enrollment information is received electronically from OHA; member phone calls; provider calls; member claims that come in from providers; internal reports that match names and dates of birth of members for review by an analyst to verify if the member is the same and would be double-covered on any PacificSource plan; and from its subcontracted vendor (i.e., Optum).

- **PSCS-Lane** uses a transaction manager to verify the accuracy of electronic claim source data (including Medicare crossover and other third-party claims information) and the hard copy of a submitted claim to verify the accuracy of submitted paper claims; all payment information is stored in Facets. **PSCS-Lane** noted that it stores primary payment information in its system within the Medicaid secondary claim. Encounters are sent to OHA with primary payment information (e.g., Medicare paid has another adjustment (OA) value of 23) and an allowable adjustment reason code of 45 for any remaining balance over Medicaid allowable that **PSCS-Lane** does not pay.

- **PSCS-Lane** indicated that zero-pay claims for subcapitated providers are processed and submitted to OHA, where instead of showing that **PSCS-Lane** made a payment, **PSCS-Lane** shows in its submission to OHA an adjustment reason code of 24.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **PSCS-Lane** conducts the following activities:

- Completeness:
  - **PSCS-Lane** uses the CVF with claim counts and billed amounts received from all subcontractors when they submit their encounter data to **PSCS-Lane**. **PSCS-Lane** uses this information to reconcile against the files **PSCS-Lane** submitted to OHA.
- Accuracy:
  - **PSCS-Lane** uses the pharmacy rejected encounters report as well as the pended encounters report from OHA.
- Timeliness:
  - **PSCS-Lane** maintains internal reporting that supplies the percentage of encounters submitted within 45 days after adjudication for any given week.
  - **PSCS-Lane** also reviews reports received from the DCOs with monthly trends to determine if the service claims met criteria for various metrics.
  - **PSCS-Lane** also monitors its PBM (CVS) by using the OHA report that supplies the number of encounters received within specific time frames.

PSCS-Lane uses a combination of internal and State reporting tools to monitor the completeness, accuracy, and timeliness of the encounter data submitted by its providers:

- Completeness:

– Providers are routinely audited to ensure the completeness of claim and encounter data submitted to **PSCS-Lane** and ultimately OHA. A data validation audit includes a review of clinical documentation within the provider record against the data submitted through a claim/encounter to ensure that all required information is present and complete. Specifically, service notes are reviewed to ensure all required claim/encounter data elements (e.g., provider name, service provided, signature, credentials, diagnosis, date of service, and duration of service) are present and complete. The claim/encounters captured within the clinical record are also reviewed to ensure that all services required to be reported to **PSCS-Lane** are being reported.

- Accuracy:
  – **PSCS-Lane** uses the rejections and pends to monitor the accuracy of the submitted encounters.
  – As noted previously, in ensuring completeness, providers are routinely audited, which includes a review of clinical documentation. To ensure accuracy, in reviewing the clinical documentation within the selected provider record, the information must match the billed claim and encounter data submitted to OHA. This includes the validation of provider and member information, diagnosis codes, procedure codes, duration of service, and date of service.

- Timeliness:
  – **PSCS-Lane** uses a combination of internal and State-provided reporting to monitor accuracy, timeliness, and completeness.

PSCS-Lane monitors the status of encounter data submitted to OHA through reporting from its EDI team on a weekly basis. **PSCS-Lane** also processes the 999 rejections, and claims are either adjusted in **PSCS-Lane**'s system as denied, or the error is corrected in the Encounter Module and the claim is resent to OHA. Other transaction response files from OHA are also used to support **PSCS-Lane**'s encounter data submission activities:

- TA1: While it is rare for **PSCS-Lane** to receive this file, it has alerts set up whenever it receives this file for **PSCS-Lane**'s EDI team to remediate the root failure.
- 835: The file is loaded and matched with **PSCS-Lane**'s source encounters; ICNs are then loaded into **PSCS-Lane**'s system for easy lookup. If it is determined that an encounter does not have any failure, it is then placed in a final complete status.
- Weekly status file: **PSCS-Lane** loads the file and it is matched against its claims, and analysts work on the Tasks/Exceptions platform so **PSCS-Lane** may resubmit claim with corrections.

At the time of the questionnaire submission, **PSCS-Lane** noted that on average, 0.06 percent (out of on average of 103,631 encounters submitted per month) of encounters get rejected by OHA's EDI translator. Some of the rejection examples include duplicate ICD-10-CM procedure codes, and the service facility being the same as the billing provider. The process for reconciling files rejected by OHA involves several steps; ultimately, all encounters are sent, accepted, and end up in a final completed state.

PSCS-Lane noted that during calendar year 2020, the average pended encounter to submitted encounters is 0.03 percent. **PSCS-Lane** submits corrections for all encounters requiring correction

within 63 days, otherwise **PSCS-Lane** will be subjected to corrective action. Pended encounters, including penalty dates, are identified by using the Weekly Status Report received from OHA and loaded into **PSCS-Lane**'s encounter management system; the system will create pend tasks for correction according to the data in the report. Analysts then process these tasks and send the tasks to OHA prior to the penalty date. **PSCS-Lane** also corrects pended encounters through the MMIS portal. For subsequent resubmission, **PSCS-Lane** uses the encounter management system to correct pended encounters, or analysts will use the MMIS portal for adjustments.

Prior to the encounter data being used in analytics and external customer and internal financial reporting, **PSCS-Lane** noted that the encounter data are loaded and transformed into its centralized data warehouse. Some examples of such reporting/analytics include but are not limited to:

- HEDIS and QIM measure calculations and gap reporting.
- Care and case management reporting.
- Utilization and experience reporting.
- Provider contract-level and line-of-business level performance and financial reporting.
- Rate-setting.
- MLR reporting.
- Risk stratification algorithms for population assessment and programs.
- Condition program identification algorithms for program identification.
- Provider efficiency algorithm tools related to cost and use, and provider data sharing.
- Condition prevalence algorithms for population assessment and program identification among other use.
- Value-based payment settlement arrangements.

PSCS-Lane noted the following challenges faced in submitting encounter data to OHA:

- Internal challenges:
  - Matching the **PSCS-Lane** provider setup across multiple lines of business to meet OHA's requirements.
  - Maintenance of provider data quality relevant to encounter submissions (e.g., taxonomy codes), correct identification/matching of rendering provider, etc. **PSCS-Lane** continues to make steady improvement on these issues and has invested heavily in 2020 in new systems and partnerships that directly support provider data quality/integrity.
  - Earlier in 2020, **PSCS-Lane** also experienced some challenges with scalability associated with a very rapid growth in its Medicaid membership. These scalability challenges were successfully addressed early in the second quarter of 2020 and no longer pose difficulties.

- External challenges:
  - Provider enrollment requirements differing between FFS and encounter only.
  - MMIS functionality-Provider Matching-MMIS contains duplicate provider records, which cause **PSCS-Lane**'s encounters to pend.
  - MMIS does not acknowledge the different NDCs within the medical encounters. **PSCS-Lane** receives duplicate denials on HCPCS codes that are the same, but the NDC is different; therefore, the HCPCS codes are not for the same drug and should not be denied as duplicates. However, MMIS acknowledges NDCs on NCPDP encounters. This also presents challenges when the same NDC could be present in multiple compound drugs, with the same date of service, but different prescription numbers. These are denied as duplicates as well. **PSCS-Lane** noted that it should get credit for these.
  - A claims search in MMIS is time consuming. **PSCS-Lane** has to manually switch providers each time it needs to pull up a claim from a different plan number. **PSCS-Lane** has 16 different plan numbers. It would be more efficient to have all plans linked together under a **PSCS-Lane** and have one search page where the ICN and plan ID could be entered.
  - **PSCS-Lane** has challenges with untimely additions of new CPT codes, modifiers, and revenue codes in MMIS.
  - **PSCS-Lane** also has challenges with the Drug Rebate Program and NCPDP rejections. Some of **PSCS-Lane**'s NCPDP encounters reject, as OHA is indicating that the NDC is not with the State Rebate Program; however, per **PSCS-Lane**'s Pharmacy Department, "The NDCs that are in this OHA Rebate Program are seemingly random."

Recommendations

Based on its review, HSAG recommends the following for **PSCS-Lane** to strengthen its encounter data quality:

- **PSCS-Lane** listed modifications that were applied to both its claims and encounter data in its questionnaire response. One of the modifications relates to rolling up the revenue code 250 service line items in Facets to prevent duplicate edits from the State. While details of the roll-up process were not described in **PSCS-Lane**'s questionnaire response, HSAG recommends that **PSCS-Lane** work with OHA to clarify and confirm that the process translates to an accurate representation of the encounter when transmitted to OHA.
- Similarly, **PSCS-Lane** also noted that when a provider bills zero units and/or zero dollars, a value of one unit and/or $0.01 is added for encounter purposes. HSAG recommends that **PSCS-Lane** work with OHA to clarify and confirm that this modification is in line with OHA's submission requirements and does not have any impact when an encounter is used for analytic purposes within OHA's system.

This section summarizes the findings from PacificSource Community Solutions–Marion Polk's (**PSCS-MP**'s) questionnaire responses.

Encounter Data Sources and Systems

Per **PSCS-CO**'s questionnaire response, each week, encounter eligible claims are extracted from its core adjudication system into a common format and batched for ingestion into its encounter management system (EMS). The EMS reviews the encounters for accuracy/integrity using rule sets that are regularly updated by **PSCS-CO**'s EMS platform vendor. Encounters that do not pass OHA standards are pended by the EMS to manual work queues for review and resolution. Once corrected, these pended encounters are batched together with encounters that passed automated review in preparation for submission to OHA. Prior to submission, the encounters are subjected to an additional round of external EDI compliance review to address any residual formatting errors that might otherwise produce an occasional error with the submissions. After submission, any encounters rejected or pended by the State are re-ingested into the EMS for corrective handling.

Encounter submission performance is reviewed by the IT and business teams on a weekly basis and is reviewed biweekly during Government Operations meetings. Submission and systems issues are carefully tracked and addressed on a prioritized basis. The IT and business teams meet weekly to review status and performance.

Table O-1 shows **PSCS-CO**'s format and submission frequency for professional, institutional, transportation, pharmacy, and dental encounters received.

Table O-1—Format and Submission Frequency for Professional[1], Institutional[2], Transportation, Pharmacy, and Dental Encounters

	Professional[1]	Institutional[2]	Transportation	Pharmacy	Dental
Data receipt	Clearinghouse and EDI Gateway	Clearinghouse and EDI Gateway	LogistiCare and RideSource	Caremark (CVS)	Capitol, Advantage, and ODS
Format	837P	837I	837P	NCPDP	837D
Frequency	Weekly	Weekly	Weekly	Weekly	Weekly
Approximate volume	Varies	Varies	5,295 claims/week	48,200 claims/week	3,384 claims/week

[1] Includes laboratory, physician, vision, and behavioral health
[2] Includes inpatient, outpatient, and long-term care

- **PSCS-CO** noted that the following modifications and/or reformatting changes are applied to both its claims and encounter data:

- – **PSCS-CO**'s process is to roll up revenue code 250 service line items in Facets to prevent duplicate edits from the State.
- – When processing duplicate edits within the Encounter Module, **PSCS-CO**'s analysts check for different NDC codes on lines with duplicate HCPCS codes. If the NDCs are different, a 59 modifier is added to the line to ensure MMIS does not deny the duplicate HCPCS code as a duplicate. According to **PSCS-CO**, this is a State limitation.
- – **PSCS-CO** updates the billing provider information billed on claims for FQHCs that have multiple locations and NPIs that have the same tax ID. Per **PSCS-CO**, the State has a limitation that FQHCs can only have one enrollment with the State and cannot have multiple enrollments as separate locations. As such, for FQHCs with multiple locations to receive their cost settlement and to ensure **PSCS-CO**'s encounters do not pend, the CCO modifies the billing provider information to the FQHC's enrolled provider.
- – **PSCS-CO** removes "duplicate" inpatient ICD-10-CM procedure codes performed on different dates of service due to 999 rejects. Per **PSCS-CO**, this is a State limitation.
- – **PSCS-CO** removes the Onset of Illness or Injury date from professional encounters if it is the same as the date of service, which causes rejection. Paper claims submitted by providers often have an Onset of Illness or Injury date present on the claim, which is not appropriate for electronic standards when submitting to the State.
- – **PSCS-CO** has a system limitation where the encounters for members who have three payers error out, which had to be modified in order to get submitted to the State. The primary and secondary payment information is removed, and an adjustment is added to the line with a CO 45 for the full charge amount of the line. This shows that **PSCS-CO** allowed the claim but did not pay on it.
- – If a provider bills with a service facility NPI and address that are the same as the billing provider NPI and address, **PSCS-CO**'s analysts remove the service facility NPI information to prevent 999 rejections.
- – If a provider bills zero units and/or zero dollars, a value of one unit and/or $0.01 is added for encounter purposes. If encounters are submitted to the State with zero units, the encounter pends in MMIS.

- **PSCS-CO**'s pharmacy benefit manager, CVS, and DCOs extract encounter data from their individual systems and create either NCPDP pharmacy files or 837D files. These files are then submitted to **PSCS-CO** via secure FTP, where they are then loaded to the Encounter Module. Finally, from the Encounter Module (i.e., the platform that aligns other entities with **PSCS-CO**'s data warehouse), the files are transmitted to the State.

- **PSCS-CO** noted that it submits paid, denied, voided, and adjusted claims/encounters; however, **PSCS-CO** does not submit the following claims/encounters:
  - – **PSCS-CO** does not submit claims if they are denied in full and have invalid codes, as **PSCS-CO** expects that the provider will correct and submit a new claim for payment.
  - – **PSCS-CO** does not send claims that have been denied for members not enrolled for which **PSCS-CO** has received a compliance error within its Encounter Module.
  - – **PSCS-CO** does not submit duplicate claims.

- **PSCS-CO** submits all adjustments to OHA and works with its Failed Adjustments report to ensure that the information in its system matches MMIS. **PSCS-CO** describes the process for submitting adjustments as follows:
  - In Facets, the original claim ends in "00," and when a claim is adjusted, a "new" claim is created ending in "01."
  - Every week, all adjudicated claims are extracted and loaded into the Edifecs Encounter Module. The "01" adjusted claim/encounter overrides the "00" claim/encounter in the Encounter Module and takes the ICN from the "00" original claim for the REF F8 segment in the adjusted claim.
  - Encounters are batched and pulled into an electronic data file and submitted to the State. When encounters are loaded to the State system, the "01" claim finds the "00" claim in MMIS by using the ICN from the REF F8 segment.
- For claims that are processed internally, Table O-2 shows the types of claims validated, a description of the validation performed, and the percentage of claims validated.

Table O-2—Claims Validated, Validation Performed, and Percentage of Claims Validated

Type of Claims Validated	Description of Validation Performed	Percentage of Claims Validated
Paper claims	Random audit	1%
Electronic	Random audit	1%
Large dollar claims	For professional claims above $4,999 and for hospital/facility claims above $19,999 based on allowed charges	100%
Manually processed	Claims where analysts have manually overridden copays, coinsurance, or type of service (TOS), or have overridden the service rule with B18 (i.e., allowed the claim to pay in full)	100%

- During data processing for submission to OHA, **PSCS-CO** indicated that Facets denial and adjustments codes are mapped to the standardized Washington Publishing Company CARCs. The supplied reference tables are updated annually, and as needed.
- **PSCS-CO**'s provider data management (PDM) unit collects, stores, and maintains provider data for all service categories, except those managed by external vendors:
  - Pharmacy provider data are gathered and managed by **PSCS-CO**'s PBM partner, CVS Caremark. The pharmacy provider data are not ingested into **PSCS-CO**'s systems. Issues arising from pharmacy encounters specific to provider data are forwarded directly to CVS Caremark for resolution on a pass-through basis. **PSCS-CO** has contractual language in place with CVS Caremark to ensure that pharmacy provider exclusions are communicated to **PSCS-CO** in a timely fashion. CVS Caremark is a subcontractor of **PSCS-CO**'s; therefore, annually, the plan performs a subcontractor performance audit to verify subcontractor compliance with contract rules.

– Dental provider data are gathered and managed by **PSCS-CO**'s DCOs. The dental provider data are not ingested into **PSCS-CO**'s systems. Similar to the process described above, issues impacting encounter submissions related to provider data quality are forwarded directly to **PSCS-CO**'s DCO partners for resolution on a pass-through basis. DCOs are subcontractors of **PSCS-CO**'s; therefore, annually, the plan performs subcontractor performance audits to verify subcontractor compliance with contract rules.

- For the encounter piece of provider matching, **PSCS-CO** uses the Edifecs Encounter Module. Part of this program has the ability to load the weekly OHA Provider File, which contains actively enrolled and inactive providers. This file is loaded to the Encounter Module platform and is stored within the backend. The file is generated and loaded weekly to keep the platform provider information up to date. As claims enter the platform, the system runs a validation check, looking for information such as a known provider, valid taxonomy, valid NPI, valid taxonomy to NPI relationship, etc. If there are any failures, a task exception is created and added to a workflow queue to be worked by an analyst. If there are no exceptions, then the encounter is set to ready and will batch with **PSCS-CO**'s next encounter submission to the State. **PSCS-CO** noted that provider information does not require modification in order to comply with OHA's provider data submission requirements.

- **PSCS-CO** internally manages member enrollment based on Medicaid 834 files, individual exchange 834 files, and commercial group 834 files. The process for linking enrollment data to claims and encounters begins with the 834 files sent by OHA to **PSCS-CO**. The 834 files are loaded to the enrollment management system. Once in the enrollment management system, the member information along with coverage dates flows to **PSCS-CO**'s claims processing system Facets. As member information flows into Facets from the enrollment management system, a unique identifier is attached. The member's unique identifier is the link between claims and encounters. To reconcile enrollment differences, **PSCS-CO** uses the Not Enrolled and Deceased Client reports from the State.

Data Exchange Policies and Procedures

PSCS-CO has internally developed policies and procedures aimed at collecting, translating, storing, and transmitting encounter data that meet OHA's submission specifications. **PSCS-CO** submits HIPAA compliant encounter data via 837 Professional, 837 Institutional, and 837 Dental claim file formats, as well as NCPDP pharmacy file format, every Wednesday to OHA.

PSCS-CO extracts all Medicaid claims from Facets into the Encounter Module for submission to OHA. **PSCS-CO** noted that there are only two scenarios in which Medicaid claims would be excluded from extract, and these are claims that are denied as exact duplicates and claims that are denied due to an invalid diagnosis code or CPT/HCPCS code. Claims with invalid diagnosis codes or invalid CPT/HCPCS codes are rejected as 999 errors and are not loaded to OHA's system.

The Encounter Module contains duplicate edit logic to create tasks for claim review if duplicate services are found within the database.

Encounter claims submitted to the State are reconciled the week following each submission. **PSCS-CO** receives the CCV reports from the encounter liaison at OHA. Any variance is researched and explained with a verification acknowledgement form (VAF) and submitted to the State within two weeks of the date the CCV is received. In its response, **PSCS-CO** provided a screen print of the daily reports.

Management of Encounter Data: Collection, Storage, and Processing

For outpatient and inpatient encounter data submissions, **PSCS-CO** uses 837 X12 specifications with appropriate group and claim adjustment segment (CAS) codes that accurately reflect payments and adjustments (withholds, capitation, and adjustments over allowable). For pharmacy encounters, **PSCS-CO** and CVS (PBM) use NCPDP D.0 with appropriate segments to capture payments, adjustments, or reversals.

Table L-3 Table O-3 shows **PSCS-CO**'s pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table O-3—Pricing Methodology for PSCS-CO

Outpatient	Inpatient	Pharmacy
• 80% of CMS • FFS • Percent of OHA • Percent of invoice • Percent of billed • Per member per month (PMPM) • Capitation • PCPCH tier (billed by primary care physician) • PCPCH tier plus program • BHI	• DRG • Percent of OHA rates	• Negotiated rate (99%) • U&C price (1%) Note: Pharmacy claims are paid based on the lower of the participating pharmacy's U&C price or the negotiated rate plus the dispensing fee

- In response to whether there are any services submitted to **PSCS-CO** under bundle-payment structures, **PSCS-CO** noted the following types of claims:
  – Inpatient claims: Inpatient claims may be paid based on DRG, which is based on weight for each DRG and a rate for the facility, and only one DRG is assigned per admission.
  – Labor and delivery professional claims: If a provider bills for a bundled code such as 59400 (for vaginal delivery) or 59510 (for cesarean delivery), providers are not required to submit claims for services included within the procedure code, and **PSCS-CO** collects encounter-only claims when submitted.
  – Outpatient claims: APCs, where total payment for the outpatient visit is calculated based on the sum of the payments for all APCs.

- **PSCS-CO** collects and tracks other insurance coverage from various sources: member applications, where enrollment information is received electronically from OHA; member phone calls; provider calls; member claims that come in from providers; internal reports that match names and dates of birth of members for review by an analyst to verify if the member is the same and would be double-covered on any PacificSource plan; and from its subcontracted vendor (i.e., Optum).

- **PSCS-CO** uses a transaction manager to verify the accuracy of electronic claim source data (including Medicare crossover and other third-party claims information) and the hard copy of a submitted claim to verify the accuracy of submitted paper claims; all payment information is stored in Facets. **PSCS-CO** noted that it stores primary payment information in its system within the Medicaid secondary claim. Encounters are sent to OHA with primary payment information (e.g., Medicare paid has another adjustment (OA) value of 23) and an allowable adjustment reason code of 45 for any remaining balance over Medicaid allowable that **PSCS-CO** does not pay.

- **PSCS-CO** indicated that zero-pay claims for subcapitated providers are processed and submitted to OHA, where instead of showing that **PSCS-CO** made a payment, **PSCS-CO** shows in its submission to OHA an adjustment reason code of 24.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **PSCS-CO** conducts the following activities:

- Completeness:
  - **PSCS-CO** uses the CVF with claim counts and billed amounts received from all subcontractors when they submit their encounter data to **PSCS-CO**. **PSCS-CO** uses this information to reconcile against the files **PSCS-CO** submitted to OHA.
- Accuracy:
  - **PSCS-CO** uses the pharmacy rejected encounters report as well as the pended encounters report from OHA.
- Timeliness:
  - **PSCS-CO** maintains internal reporting that supplies the percentage of encounters submitted within 45 days after adjudication for any given week.
  - **PSCS-CO** also reviews reports received from the DCOs with monthly trends to determine if the service claims met criteria for various metrics.
  - **PSCS-CO** also monitors its PBM (CVS) by using the OHA report that supplies the number of encounters received within specific time frames.

PSCS-CO uses a combination of internal and State reporting tools to monitor the completeness, accuracy, and timeliness of the encounter data submitted by its providers:

- Completeness:

- – Providers are routinely audited to ensure the completeness of claim and encounter data submitted to **PSCS-CO** and ultimately OHA. A data validation audit includes a review of clinical documentation within the provider record against the data submitted through a claim/encounter to ensure that all required information is present and complete. Specifically, service notes are reviewed to ensure all required claim/encounter data elements (e.g., provider name, service provided, signature, credentials, diagnosis, date of service, and duration of service) are present and complete. The claim/encounters captured within the clinical record are also reviewed to ensure that all services required to be reported to **PSCS-CO** are being reported.
- Accuracy:
  - – **PSCS-CO** uses the rejections and pends to monitor the accuracy of the submitted encounters.
  - – As noted previously, in ensuring completeness, providers are routinely audited, which includes a review of clinical documentation. To ensure accuracy, in reviewing the clinical documentation within the selected provider record, the information must match the billed claim and encounter data submitted to OHA. This includes the validation of provider and member information, diagnosis codes, procedure codes, duration of service, and date of service.
- Timeliness:
  - – **PSCS-CO** uses a combination of internal and State-provided reporting to monitor accuracy, timeliness, and completeness.

PSCS-CO monitors the status of encounter data submitted to OHA through reporting from its EDI team on a weekly basis. **PSCS-CO** also processes the 999 rejections, and claims are either adjusted in **PSCS-CO**'s system as denied, or the error is corrected in the Encounter Module and the claim is resent to OHA. Other transaction response files from OHA are also used to support **PSCS-CO**'s encounter data submission activities:

- TA1: While it is rare for **PSCS-CO** to receive this file, it has alerts set up whenever it receives this file for **PSCS-CO**'s EDI team to remediate the root failure.
- 835: The file is loaded and matched with **PSCS-CO**'s source encounters; ICNs are then loaded into **PSCS-CO**'s system for easy lookup. If it is determined that an encounter does not have any failure, it is then placed in a final complete status.
- Weekly status file: **PSCS-CO** loads the file and it is matched against its claims, and analysts work on the Tasks/Exceptions platform so **PSCS-CO** may resubmit claim with corrections.

At the time of the questionnaire submission, **PSCS-CO** noted that on average, 0.06 percent (out of on average of 103,631 encounters submitted per month) of encounters get rejected by OHA's EDI translator. Some of the rejection examples include duplicate ICD-10-CM procedure codes, and the service facility being the same as the billing provider. The process for reconciling files rejected by OHA involves several steps; ultimately, all encounters are sent, accepted, and end up in a final completed state.

PSCS-CO noted that during calendar year 2020, the average pended encounter to submitted encounters is 0.03 percent. **PSCS-CO** submits corrections for all encounters requiring correction within 63 days,

otherwise **PSCS-CO** will be subjected to corrective action. Pended encounters, including penalty dates, are identified by using the Weekly Status Report received from OHA and loaded into **PSCS-CO**'s encounter management system; the system will create pend tasks for correction according to the data in the report. Analysts then process these tasks and send the tasks to OHA prior to the penalty date. **PSCS-CO** also corrects pended encounters through the MMIS portal. For subsequent resubmission, **PSCS-CO** uses the encounter management system to correct pended encounters, or analysts will use the MMIS portal for adjustments.

Prior to the encounter data being used in analytics and external customer and internal financial reporting, **PSCS-CO** noted that the encounter data are loaded and transformed into its centralized data warehouse. Some examples of such reporting/analytics include but are not limited to:

- HEDIS and QIM measure calculations and gap reporting.
- Care and case management reporting.
- Utilization and experience reporting.
- Provider contract-level and line-of-business level performance and financial reporting.
- Rate-setting.
- MLR reporting.
- Risk stratification algorithms for population assessment and programs.
- Condition program identification algorithms for program identification.
- Provider efficiency algorithm tools related to cost and use, and provider data sharing.
- Condition prevalence algorithms for population assessment and program identification among other use.
- Value-based payment settlement arrangements.

PSCS-CO noted the following challenges faced in submitting encounter data to OHA:

- Internal challenges:
  – Matching the **PSCS-CO** provider setup across multiple lines of business to meet OHA's requirements.
  – Maintenance of provider data quality relevant to encounter submissions (e.g., taxonomy codes), correct identification/matching of rendering provider, etc. **PSCS-CO** continues to make steady improvement on these issues and has invested heavily in 2020 in new systems and partnerships that directly support provider data quality/integrity.
  – Earlier in 2020, **PSCS-CO** also experienced some challenges with scalability associated with a very rapid growth in its Medicaid membership. These scalability challenges were successfully addressed early in the second quarter of 2020 and no longer pose difficulties.

- External challenges:
  - Provider enrollment requirements differing between FFS and encounter only.
  - MMIS functionality-Provider Matching-MMIS contains duplicate provider records, which cause **PSCS-CO**'s encounters to pend.
  - MMIS does not acknowledge the different NDCs within the medical encounters. **PSCS-CO** receives duplicate denials on HCPCS codes that are the same, but the NDC is different; therefore, the HCPCS codes are not for the same drug and should not be denied as duplicates. However, MMIS acknowledges NDCs on NCPDP encounters. This also presents challenges when the same NDC could be present in multiple compound drugs, with the same date of service, but different prescription numbers. These are denied as duplicates as well. **PSCS-CO** noted that it should get credit for these.
  - A claims search in MMIS is time consuming. **PSCS-CO** has to manually switch providers each time it needs to pull up a claim from a different plan number. **PSCS-CO** has 16 different plan numbers. It would be more efficient to have all plans linked together under a **PSCS-CO** and have one search page where the ICN and plan ID could be entered.
  - **PSCS-CO** has challenges with untimely additions of new CPT codes, modifiers, and revenue codes in MMIS.
  - **PSCS-CO** also has challenges with the Drug Rebate Program and NCPDP rejections. Some of **PSCS-CO**'s NCPDP encounters reject, as OHA is indicating that the NDC is not with the State Rebate Program; however, per **PSCS-CO**'s Pharmacy Department, "The NDCs that are in this OHA Rebate Program are seemingly random."

Recommendations

Based on its review, HSAG recommends the following for **PSCS-CO** to strengthen its encounter data quality:

- **PSCS-CO** listed modifications that were applied to both its claims and encounter data in its questionnaire response. One of the modifications relates to rolling up the revenue code 250 service line items in Facets to prevent duplicate edits from the State. While details of the roll-up process were not described in **PSCS-CO**'s questionnaire response, HSAG recommends that **PSCS-CO** work with OHA to clarify and confirm that the process translates to an accurate representation of the encounter when transmitted to OHA.
- Similarly, **PSCS-CO** also noted that when a provider bills zero units and/or zero dollars, a value of one unit and/or $0.01 is added for encounter purposes. HSAG recommends that **PSCS-CO** work with OHA to clarify and confirm that this modification is in line with OHA's submission requirements and does not have any impact when an encounter is used for analytic purposes within OHA's system.

Appendix P: Findings for Trillium Community Health Plan, Inc.

This section summarizes the findings from Trillium Community Health Plan, Inc.'s (**TCHP**'s) questionnaire responses.

Encounter Data Sources and Systems

Per **TCHP**'s questionnaire response, end-to-end claims and encounter processing starts with the member going to the provider. The provider then submits the claim to Centene, which sends the claim to EDI/IT for compliance. If the claim is compliant, it moves to the EDI translator and is sent to AMISYS, which adjudicates the claim. Once the claim is adjudicated and scrubbed, it is sent to the encounter data manager repository. At this point in the process, the encounter data manager creates 837P and 837I encounters, which are then sent to OHA, and response files are sent to Centene.

Table P-1 shows **TCHP**'s format and submission frequency of the professional, institutional, transportation, vision, pharmacy, and dental encounters received.

Table P-1—Format and Submission Frequency for Professional[1], Institutional[2], Transportation, Vision, Pharmacy, and Dental Encounters

	Professional[1]	Institutional[2]	Transportation	Vision	Pharmacy	Dental
Data receipt	Received from providers to Centene	Received from providers to Centene	MTM	Envolve Vision	CVS—Envolve Pharmacy	Advantage, Capitol, and ODS
Format	837P and paper claims	837I and paper claims	837P	837P	NCPDP D.0	837D
Frequency	Weekly	Weekly	Monthly	Bi-Weekly	Weekly	Weekly
Approximate volume	Varies	Varies	25,000 unique claims/month	300 unique claims/biweekly	14,000 unique claims/week	1,500 unique claims/week

[1] Includes physician, (HCBS, laboratory, and behavioral health
[2] Includes inpatient, outpatient, and long-term care

- **TCHP** noted that it does not modify or reformat its claims/encounter data to accommodate OHA's encounter data submission standards.
- In response to whether any of the data submitted to OHA are extracted from another entity's claims/encounter data system/data warehouse, **TCHP** responded that it acts as a pass-through for its vendor encounters. The encounters produced by **TCHP**'s vendors are produced from their own source systems.

- **TCHP** does submit all types of encounters (e.g., paid, denied, voided, and adjusted claims) to OHA. **TCHP** also noted that it does not submit certain types of payments made on behalf of the Medicaid population and/or certain types of services rendered to the Medicaid population as encounters.

- In handling adjusted encounters that have been previously submitted, **TCHP** responded that references the CRN of the previously submitted claim in the "REF*F8" segment of the latest version of the claim as a replacement (void if approved by OHA).

- For claims that are processed internally, **TCHP** validates 100 percent of these claims and provided the following responses:

  – To check for validity of the procedure and diagnosis codes (e.g., obsolete codes, required number of digits), both medical and behavioral claims are done in the PROC_M, and DIAG_M tables in AMISYS through the translation process in EDI.

  – To verify member validity, both medical and behavioral claims are compared based on business unit, Medicaid ID, and date of birth to the member table in AMISYS in the EDI translation program.

  – For checks on valid coding (e.g., recalculating the DRG or procedure validity for the member's gender), Medical claims are compared to AMISYS in most cases. For behavioral claims, the function of recalculating DRG is performed by Web Strat for Cenpatico. Procedure validation for a member's age or gender is done through benefit configuration.

  – For checks on field size, the process happens in the EDI translation program for both medical and behavioral claims to ensure that fields are billed appropriately.

  – For checks on date ranges, the process happens in the EDI translation program for both medical and behavioral claims to ensure they are in the correct place and not out of order.

  – For checks for valid practitioners, the process happens in the provider selection process in the EDI translation program for both medical and behavioral claims.

- **TCHP** does perform code and/or field mapping during data processing for submission to OHA. **TCHP** refers to this process as the "EDI/PREADJUDICATION" process. The process involves screening claims before they get to AMISYS to apply rules and exclusions and to make sure the claim is ready for adjudication. TCHP then receive claims electronically in 837 EDI files, through the Web portal or on paper. The 837 claims data, Web portal claim data, and paper claim data are all translated to MIS files and fed through the EDI. All paper claims are scanned and sent through a centralized data management system, where an 837 file is created. The 837 file is sent to EDI and is processed. The EDI portion of the process applies HIPAA guidelines and EDI business rules, screens for accuracy, and accepts or rejects claims based on what is submitted. Accepted claims are then fed from EDI to the preadjudication tables and are assigned a status of "Staged." At this point, they are picked up and moved to AMISYS. The preadjudication job screens the data in these claims, applying business-specific rules and guidelines that cannot be applied through EDI and moves the final data to AMISYS ; first to batch tables and then to health. While there are very large amounts of claims data received, and they are all kept in the Claims Data Repository (CDR), the only fields that are fed to the preadjudication tables are those that are required to process and pay a claim.

- **TCHP** does perform code and/or field mapping during data processing for submission to OHA. **TCHP** coordinates with its corporate office on the transmittal, where OR Market sends all encounter

data through the normal Oregon encounter process and follows the OHA guide and industry standards for codes and references.

- **TCHP** does use outside vendors or contractors to complete adjudication. For prepay code editing, Centene contracts with external vendors for the use of editing software applications that apply a comprehensive set of rules addressing national correct coding inaccuracies, such as bundling, frequency limitations, duplication, invalid codes, up-coding, mutually exclusive procedures, and other coding inconsistencies. The external vendors may provide clinical validation. Quality assurance of vendor operations and decisions is maintained by Centene Payment Integrity. The pricing of claims is maintained by Centene Claim Operations.

- Provider data are collected and maintained by **TCHP**. The process begins with the provider submitting the PDM change request by either fax or email. If the PDM request passes quality control, it is then transformed into a standard format and submitted via a change request (CR) ticket through PDC. The corporate PDM then completes the CR ticket.

- In linking provider data to claims and encounters, **TCHP**'s process is for encounters to match on NPI + date of service (DOS). If there is a single match, the record is written to the outbound 837 encounter file. The following steps are then followed if multiple matches are found:
  1. NPI + Taxonomy + DOS
  2. NPI + Taxonomy + DOS + Zip9
  3. NPI + Zip9 + DOS
  4. NPI + Zip5 + DOS
  5. NPI + MedicaidID + DOS
  6. NPI + DOS + Typecode
  7. NPI + Zip9 + DOS + Typecode
  8. Scrub and send back to Claims team

- **TCHP**'s provider data do not require modification in order to comply with OHA's provider data submission requirements.

- **TCHP**'s enrollment data are maintained by **TCHP**. **TCHP**'s enrollment data follow the path below from receipt to maintenance:
  - 834 files received from the State come in electronically to four separate secure mailboxes/folders:
    o MB000760 500647090 CCOE
    o MB000765 500660424 CCOG
    o MB000757 218756 CCOB
    o MB000752 218777 CCOA
  - The Corporate Automation team removes the 834 files from the mailboxes/folders and sends them to the Corporate EDI team.
  - The Corporate EDI team prepares the 834 files and drops them into the eligibility program for processing.
  - The health plan eligibility specialist processes the 834 files into the eligibility program.

– The health plan eligibility specialist pushes information from the eligibility program to the claims program.

– The claims program feeds the information downstream to the medical management program, the customer service program, and the provider portal. Enrollment data from this program are collected for the daily vendor files that the health plan sends to the DCOs and the PBM.

- **TCHP**'s completes the process for linking enrollment data to claims and encounters in the following order:

  – The health plan eligibility specialist processes the 834 files into the eligibility program.

  – The health plan eligibility specialist pushes information from the eligibility program to the claims program.

  – The health plan eligibility specialist receives a BCP2400 error file provided by the claims program after pushing the information over.

  – The health plan eligibility specialist reviews and works any errors that may be indicated.

  – The health plan eligibility specialist releases all information downstream to the medical management program, the customer service program, and the provider portal.

  – If a discrepancy between submitted a claim and member eligibility in the claims program is encountered by an analyst, he or she will reach out to the health plan eligibility specialist to verify member coverage.

Data Exchange Policies and Procedures

TCHP has internally developed policies and procedures aimed at collecting, translating, storing, and transmitting encounter data and that ensures the policies and procedures are enforced accordingly.

TCHP's Encounter Business Operations (EBO) team is responsible for overseeing the accurate and timely delivery of encounters to the State departments. EBO will work with IT Encounters team and subcontracted vendors to ensure successful encounter delivery. It is the EBO team's policy to comply with all HIPAA and government regulations as well as the contractual agreements related to encounters. The EBO team will participate in agency-sponsored workgroups directed at continuous improvements in encounter data quality and operations.

Tasks such as documenting and implementing encounter business requirements, managing schedules, monitoring file processing and delivery, collaborating externally, and the analysis and triage of encounter holds and rejects are the responsibilities of the department. This includes working with the inbound EDI, WEB, and Claims teams to ensure billing edits are in place to support the State encounter requirements.

The EBO team works with the health plan to ensure provider billing manuals and communications address the billing requirements and inbound edits in place. The EBO team works with Finance and the health plan on encounter reconciliations and auditing of submissions. The team will also deliver

effective encounter communications to all departments, including the health plan, Finance, IT, Claim Operations, and subcontracted vendor submission management.

The Encounters team uses Encounter Data Manager (EDM), which is written primarily to give analysts a comprehensive tool to schedule or request on-demand creation of encounter files, run reports, and load inbound response files. Encounter rules and edits are set up in EDM to ensure that encounters are HIPAA compliant according to national industry standards, code sets, and American Medical Association (AMA) data guidelines, and that health plan and OHA quality and data guidelines are met.

The EBO team hosts monthly meetings with each of their Health Plan Encounter/Finance representatives. The EBO team also hosts regular meetings with all vendors responsible for producing encounter files. These meetings are geared toward a focus on timely, accurate, and complete encounter reporting. The EBO team coordinates the expertise of multiple teams through regular meetings, which include the **TCHP** claims analysts, IT Encounters staff members, and others from various teams related to encounter submissions such as Finance, Compliance, and representatives from subcontracted vendors, as appropriate, to ensure encounter processes and performance requirements are consistently met. Agenda items during the meetings can include 1) overall encounter status, including pass rates, paid claims to encounters reconciliation, as well as outstanding and upcoming business concerns; 2) any underlying claims issues; and 3) subcontractor encounter reporting status.

The standard online retention policy for claims and encounter data is a "current year plus 10 years" retention period. To systematically apply **TCHP** record retention policies, IBM Tivoli Storage Manager (TSM), an automated hierarchical storage management system, is used. TMS is also used for data recovery operations if needed.

Management of Encounter Data: Collection, Storage, and Processing

Table P-2 shows **TCHP**'s pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table P-2—Pricing Methodology for TCHP

Outpatient	Inpatient	Pharmacy
Outpatient claims payment methods are as follows with percent of claim dollars per each: • Percent of CMS: 58.0% • Percent of billed charge: 42.0%	Inpatient claims payment methods are as follows with percent of claim dollars per each: • Per diem: 63.4% • Percent of CMS: 29.7% • Percent of billed charge: 6.9%	Pharmacy claims payment methods are as follows with percent of claim dollars per each: • Retail brand and generic percent discount off average wholesale price (AWP) • Specialty brand percent discount off AWP • Mail order brand and generic Percent discount off AWP • Vaccines 100% pass-through

Note: The encounter data submission does not include payment methodology field.

- **TCHP** responded that it does not have any services submitted to **TCHP** under bundle-payment structures.

- **TCHP** is not required to use a vendor to collect TPL data; however, **TCHP** is contracted with a vendor to ensure that **TCHP** has adequate coverage. **TCHP** states that the TPL data are curated from the daily State 834 file; a biweekly vendor OIC file; and Utilization Management provider, member telecommunication, and claims data.

- In response to how claims are processed with TPL, **TCHP** noted that TPL data are picked up through preadjudication and placed into AMISYS, where COB calculations are built into configuration in processing the primary payment and allowing for Oregon to pay secondary. If the system cannot finalize, the claim will pend for manual review and processing will be completed manually following the OR State COB guidelines for payment. If a claim is denied requesting a primary insurance EOB, the provider will resubmit, allowing for the claim be reprocessed as secondary.

- With regard to data used to verify the accuracy of Medicare crossover and other third-party claims information, **TCHP** noted that from an encounter's perspective, there are no differences. **TCHP** stated that it will list other third-party payers in its file and list **TCHP** (i.e., Medicaid) as the payer of last resort.

- When **TCHP** is not responsible to pay for a service due to payment from a primary carrier, **TCHP** stated that it would submit the encounter with the primary carrier information and payment, and list Medicaid as zero paid. This is identified in the Medicare outpatient adjudication (MOA) segment of the outbound 837 file.

- **TCHP** indicated in its response that zero-pay claims for subcapitated claims are submitted to OHA. Completeness and accuracy of the claims is assessed by the EBO team working with the IT Encounters team to reconcile that all adjudicated claims expected are being reported in encounter files created. This process is completed according to the submission schedule that exists between **TCHP** and OHA. On a monthly basis, a process is completed by the EBO team, IT Encounters, and the Encounters Analytics team to reconcile adjudicated claims to their current encounter status. This reconciliation is based on paid dollars by date of service month. If discrepancies arise in these reconciliations, it is the responsibility of EBO team and IT Encounters team members to reconcile and resolve these issues to ensure all encounters are submitted to OHA in a timely and complete manner. The EBO team regularly examines the highest encounter "scrub" reasons as reported in EDM. Wherever possible, the encounter edits that occur frequently on the "back end" (in EDM) are moved to the "front end" of **TCHP**'s management information system, at the point of claim submission, including **TCHP**'s EDI subsystem and AMISYS claims software, to enforce those edits and reject or deny inaccurate claims as early as possible in the process so that the claim can be corrected and submitted accurately by the provider. EDM also allows **TCHP** to identify an encounter issue from the batch level down to the individual service line detail level, as well as the processing history of an encounter record and corresponding claim record. This allows the EBO team to rapidly identify the issue and any needed follow-up work, including subsequent resubmission to the State.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **TCHP** indicated that its subcontracted vendors that receive and adjudicate claims from providers on behalf of OHA programs are contractually obligated to submit encounter data to **TCHP** in accordance with OHA requirements. Subcontractor encounter files are created by the contracted vendor and are provided to the EBO for pass-through to the State for processing. Subcontractor encounter files are created by the contracted vendor and are provided to the EBO for pass-through to the State for processing.

TCHP holds its subcontracted vendors responsible for the integrity and quality of claims data and encounter transactions provided to OHA. **TCHP** oversees the subcontractors' encounter submissions and requires them to monitor and address issues regarding incomplete, inaccurate, or untimely data. Interaction between the vendor and EBO occurs as frequently as is required to ensure that all parties are successful in meeting production submission timelines.

Encounters IT runs all 837 files through Edifecs, which is **TCHP**'s HIPAA compliance checking system, to ensure that the encounter file has been produced in accordance with the State companion guide. If errors exist in a vendor file, the compliance report will be sent to the vendor, and a replacement encounter submission file will be required. No modifications are made by the encounters teams to correct a vendor's encounter submission file. OHA response files are parsed back to the appropriate vendor. Vendor encounter submission errors processed by **TCHP**'s subcontracted vendors are corrected by the vendor in collaboration with EBO.

Once corrected, encounters are resubmitted in the next encounter cycle. Upon receipt of the response files, EBO will perform an analysis to understand the acceptance rates received on the encounter submissions for the time period. This allows **TCHP** to support its subcontractors by identifying trends that require attention before they compromise the integrity of encounter timeliness, accuracy, and completeness. If at any time the weekly acceptance rate is at risk, **TCHP**'s encounter resources (**TCHP**, EBO, and the Claims, and IT teams) will work together to quickly identify and resolve the issue with **TCHP**'s subcontractors in order to meet or exceed OHA's acceptance rates.

To monitor the completeness, accuracy, and timeliness of the encounter data submitted by its providers, **TCHP** conducts the following activities:

- Completeness:
  - **TCHP** generates monthly lag reports that track its overall completeness by both the claim's date of service and adjudication date. The document includes the date of service quarter; paid per lags; accepted, rejected, and pending status for submitted encounters; and void, staged, not processed, and scrubbed statuses for not yet submitted encounters. Additionally, it includes internal write-offs and the total paid versus total encounters.

- Accuracy:
  - **TCHP** maintains an encounter submission tracking document to monitor accuracy. **TCHP** provided an example report and dashboard to monitor encounter accuracy.
- Timeliness:
  - **TCHP** has a dashboard dedicated to monitoring **TCHP**'s overall timeliness of encounter submissions. The dashboard includes paid claims, target quantity, claims submitted, claims not submitted with time expired and time remaining, and a timely percentage.

In response to whether **TCHP** has monitoring metrics in place to evaluate the quality of encounter data submissions, **TCHP** noted that all 837 files are run through Edifecs, to confirm that no compliance errors exist. EBO and Encounters IT will review any issues to determine the root cause and resolution. Encounter files are submitted in accordance with OHA submission time frames. The finalized encounter submission files are submitted via secure FTP to OHA. The Coviant Transaction Manager handles **TCHP**'s automated, scheduled file exchanges between **TCHP** and OHA to ensure delivery of encounter submissions. To confirm successful transmission, **TCHP** monitors EDI acknowledgments returned by OHA for each encounter file submission, including the vendor encounter file submissions.

With regard to the process to monitor the status of encounter data submitted to OHA, **TCHP** responded that its encounter tracking document monitors not only **TCHP**'s overall acceptance, but it also verifies whether there are any submissions that are waiting for outstanding responses.

TCHP noted in its response that it has a process to monitor the status of encounter data submitted to OHA using the following files:

- 999: The 999 file is loaded and matched back to outbound 837 encounter file to ensure the file was processed by OHA.
- 835: The 835 file is loaded to each individual encounter and is matched to ensure that 100 percent of the responses are received. Then, the status of the encounter (accepted, rejected, pended) is loaded at the claim level.
- MCO pend file: The MCO pend file is loaded, and a secondary report is generated to work pends on a weekly basis.

TCHP indicated that the average percentage of encounters that are submitted to OHA that get rejected by OHA's EDI translator is less than 0.5 percent. To reconcile files that get rejected, once **TCHP** receives and loads the response files with any encounter errors/rejections received, the EBO and Encounters IT will perform a root cause analysis to determine the changes needed, and will ensure that necessary changes are implemented. The EBO then parses out the errors/rejects to the appropriate teams for resolution. This would include the Claims Department for any claims-related issues, the health plan for member- or provider-related issues, or the encounters teams for 837 format-related issues. When appropriate, change requests (CRs) are completed by **TCHP** to amend the AMISYS system. The EBO team will submit requests for any errors in encounter data or data submission attributable to applicable program logic within EDM.

TCHP has an average of less than 1 percent of its encounters submitted to OHA that pass OHA's EDI translator but are pended by OHA's MMIS. **TCHP**'s process for reconsidering files pended by MMIS is performed by the eligibility specialist, who checks the aged pended claims daily to the State MMIS to verify pend status.

In response to describing how the encounter data system and data warehouse were used, **TCHP** noted its Encounter Business Operations team uses the encounter data to produce accuracy, timeliness, and completeness dashboards. Encounter data are also used as a tool to correct and resubmit encounter rejects and pends. Company-wide, the encounter data are used by the rate setting and risk adjustment teams.

TCHP noted that it does not experience any internal challenges and offered positive feedback on the responsiveness and help received by the OHA encounters team. Additionally, **TCHP** indicated that the MMIS portal is user friendly and a great tool for the CCOs.

Recommendations

Based on its review, HSAG recommends the following for **TCHP** to strengthen its encounter data quality:

- In describing its methods for ensuring completeness and accuracy of its encounter data submission, **TCHP** did not demonstrate that chart review was one of the validations conducted. HSAG recommends that **TCHP** to consider conducting validation of encounter data based on medical record reviews by comparing medical record documentation (i.e., diagnosis codes and procedure codes) against submitted encounter data for a sample of records. Results from these reviews can be used as part of **TCHP**'s ongoing data monitoring.

This section summarizes the findings from Umpqua Health Alliance, LLC's (**UHA**'s) questionnaire responses.

Encounter Data Sources and Systems

Professional and institutional claims are processed by **UHA**'s vendor, PH TECH. Dental claims are received by **UHA**'s vendor, ADS, directly from providers via the 837D format. ADS sends the files to PH TECH, which delivers a copy to **UHA**. For pharmacy claims, **UHA** receives biweekly NCPDP claims from its PBM, along with a summary receipt. Following submission from its PBM, **UHA** reviews the files for accuracy before uploading the NCPDP files to OHA via secure FTP. All professional, institutional, and dental claims are audited and validated by PH TECH, and any errors are sent for resolution. These claims are corrected, and all errors are exported before being reprocessed. Once validated, the 837 files for each claim type are run through the encounter and file integrity audits before submission to OHA and the CCO partner. A copy of vendor files received directly from providers is delivered to **UHA**, where paper claims are scanned and entered into the system.

Table Q-1—Format and Submission Frequency for Professional[1], Institutional[2], Pharmacy, and Dental Encounters

	Professional[1]	**Institutional[2]**	**Pharmacy**	**Dental**
Data receipt	PH TECH	PH TECH	MedImpact	ADS and PH TECH
Format	837P	837I	NCPDP	837D
Frequency	Weekly	Weekly	Bi-Weekly	Weekly
Approximate volume	Varies	Varies	13,284	600

[1] Includes physician, HCBS, laboratory, transportation, vision, behavioral health, and DME

[2] Includes inpatient, outpatient, and long-term care

- **UHA** noted that it does not modify or reformat its claims/encounter data to accommodate OHA's encounter submission standards.
- Dental encounters are extracted by ADS from its claims adjudication database as an 837 file and are submitted to OHA by PH TECH.
- **UHA** indicated that it submits all types of encounters to OHA. Similarly, **UHA** submits all types of payments made on behalf of the Medicaid population as encounters, unless they are included within one of the following exclude or withhold groups:
  – Claim lines in: voided status
  – Claim lines in refund request status
  – Claim lines in refund cancel status

– Claim lines in refund void status

– Copied claim

– Claim in not encounterable due to being an interim bill

– Custom payment (PCP, DCO, programs)

– Claim in not encounterable due to a custom procedure code

– Duplicate claim indicated with CARC 18

– Not for encounter data indicated with a CARC R01 or R2

– Non-encounter client

– Invalid encounter status

– Test claim

- In handling adjusted encounters that have been previously submitted, **UHA** noted that adjusted claims are submitted using the same process as a new claim; however, unlike a new claim, the frequency code is updated to "7," and an ICN is included.

- **UHA** and/or its vendors (PH TECH, ADS, and MedImpact) validate all claims against standard elements (e.g., claim number, received date, provider, member data). The current auto-adjudication rates have been between 64 and73 percent weekly, leaving 36 to 27 percent of claims to be manually reviewed.

- Prior to claims being adjudicated for payment processing, **UHA** does not map any codes or fields during the data processing and validation process. Similarly, codes and/or fields are not mapped during data processing for submission to OHA.

- With regard to the use of outside vendors or contractors for claim adjudication, **UHA** noted it is contracted with Equian to provide forensic claims auditing based on a high dollar billing threshold **UHA** has provided, currently set at $50,000. PH TECH provides prepayment information to **UHA**, and **UHA** then opens a case with Equian. Once a review is complete, **UHA** communicates the outcome to PH TECH, which then processes the case accordingly. **UHA** and PH TECH both sign off on the claim.

- **UHA** is also contracted with DRG Claims Management for DRG claims validation and recovery services and diagnosis-specific clinical validation. Through this process, the claim, along with the clinical documentation, is reviewed by **UHA**'s chief medical officer prior to being sent for review. DRG Claims Management analyzes and validates the coding configuration, along with the physician's clinical validation findings, to establish if additional coding errors are present and/or if the removal of diagnoses and resequencing of a different principal diagnosis results in a reduced DRG weight and/or price. In the event the coding changes result in a lower priced DRG assignment, DRG Claims Management communicates the revised coding and pricing information to **UHA**. **UHA** attaches the Coding and Clinical Validation report to the claim.

- Per **UHA**, provider data are collected by the CCO and maintained by its subcontracted vendor, PH TECH. PH TECH is responsible for receiving, processing, and maintaining the provider data. PH TECH is also responsible for loading the provider data into the CIM Provider Portal. Data are obtained from the CCO, OHA provider data file, and via claim submissions. **UHA** noted that its provider data do not require modification in order to comply with OHA's provider data submission

requirements. **UHA** oversees the quality of the provider data processed by PH TECH based on specific validation checks and has outlined a corrective action plan process should **UHA** identify deficiencies or areas for improvement related to PH TECH's performance.

- When linking provider data to claims and encounters, provider data and claims are paired through systematic and manual processes by matching data points such as provider name, vendor name, NPI, and tax ID numbers. Provider system analysts work with the CCO to resolve discrepancies in the data. When resolving data discrepancies, claims are pended for review prior to processing.

- **UHA**'s enrollment data are also maintained by PH TECH, which is responsible for receiving, processing, and maintaining the enrollment data. As part of the oversight process, PH TECH provides **UHA** with a copy of the enrollment files, which are stored by **UHA** for reference. PH TECH also submits a monthly enrollment reconciliation report, which is reviewed for accuracy by the customer care program director.

- When reconciling differences between data submitted on the claim/encounter and **UHA**'s enrollment data, both **UHA** and its subcontractor, PH TECH, receive the monthly and weekly Members Not Enrolled Report from OHA. This report is used to review and reconcile or update the enrollment data in **UHA**'s database to match OHA's enrollment data. The corrections of the enrollment data and the claim/encounter submissions are managed by PH TECH. Additionally, **UHA** reviews the Members Not Enrolled Report to ensure the data corrections were made and there are no outstanding claims/dollars to be recouped by the health plan.

Data Exchange Policies and Procedures

UHA has internally developed policies and procedures aimed at collecting, translating, storing, and transmitting encounter data that meet OHA's submission specifications. **UHA** has contracted with PH TECH to submit its encounter data to OHA, with the exception of NCPDP pharmacy files. PH TECH generates and submits the professional and institutional encounters. The dental encounters are generated by the dental care organization and then submitted by PH TECH. MedImpact generates the NCPDP pharmacy files, which are submitted by **UHA**. To ensure that encounter data meet OHA's submission specifications, **UHA** has outlined operational policies with the subcontractors. Enforcement of these policies is done by required reporting of compliance with the key performance indicators to **UHA**'s Compliance Department on a monthly basis. Failure of a subcontractor to meet the agreed upon performance standards has the minimum result of a corrective action plan, and the maximum result of financial penalties.

Management of Encounter Data: Collection, Storage, and Processing

- **UHA** pays outpatient claims using the following methods:
  - Percent of billed—CAHs—CCO/PHP rates for type A/B hospitals.
  - Percent of Medicare—prices with OPPS pricer.
  - Subcapitated—In response to COVID-19, **UHA** entered into a subcapitated arrangement with the sole community hospital in Roseburg effective April 1, 2020. The subcapitated outpatient encounters for this facility submitted to OHA include the prior FFS contract equivalent per the OPPS pricer. Data are submitted to OHA through 837 files and indicated within the file by the capitation monetary adjustment in the CAS03 segment in conjunction with a CARC 24 in the CAS segment.
- **UHA** pays inpatient claims using the following methods:
  - Percent of billed—CAHs—CCO/PHP rates for type A/B hospitals.
  - Percent of Medicare DRG inpatient payment amount, using OHA rate-setting base data methodology amount as follows:
    - o **UHA** uses claims adjudication software known as IPPS PC Pricer.
    - o **UHA** selects "HMO Paid Claim" and enters other applicable claim information in Pricer.
  - The "Medicare DRG inpatient payment amount, using OHA Rate-Setting Base Data Methodology". Subcapitated—In response to COVID-19, **UHA** entered into a subcapitated arrangement with the sole community hospital in Roseburg effective April 1, 2020. The subcapitated inpatient encounters for this facility submitted to OHA include the prior FFS contract equivalent per the IPPS PC Pricer.
    - o For encounter data submission, these payments are shown in the 837 data file. Within the header level, the payment is indicated by subscriber amount (SBR AMT) and CAS segments.
- **UHA**'s non-340B pharmacy claims are paid based on **UHA**'s contracted rates, ingredient costs, and administrative or dispensing fees. For 340B claims, the net cost savings realized by the 340B covered entity is shared (49 percent to **UHA** and 51 percent retained by the covered entity), where the net cost savings is the difference between the 340B price and the lower of the network price or the network pharmacy's U&C price as paid to the network pharmacy under the agreement with the network pharmacy, when the 340B price is lower. The payment is reflected in the NCPDP file in field 509-F9.
- **UHA** indicated that it receives claims that fall under bundle-payment structures. All services performed are submitted to the CCO and submitted in the encounter data. **UHA** uses Umpqua Health Business Intelligence (UBHI), an analytics tool, to analyze patterns in provider claims history. This allows the monitoring of all service areas, including capitated services, done monthly by comparing similar time periods with a minimum three-year look-back period. Claim counts, distinct members receiving service, PMPM, and units are reviewed for any anomalies/variances for further investigation. **UHA** noted that the following claims fall under the bundle-payment structures:
  - Ambulatory surgical center (ASC)
  - Maternity
  - Outpatient claims paid under OPPS

- Inpatient claims paid under IPPS
- Case rate for hospitals (at local contracted hospital)

- **UHA** requires its subcontractors to collect TPL data. **UHA** uses a robust TPR Department and other insurance is collected and then stored in the claims adjudication database. Every Monday, **UHA** pulls the Medicare report, **UHA** 834 COB Information—Medicare Included, from the TPA's secure FTP. The report is processed and any case not reflecting an effective date is considered a new investigation. **UHA** verifies coverage with Medicare (www.noridianmedicareportal.com) using the member's Medicaid number, name, and DOB. The system then populates the appropriate effective dates, and **UHA** completes the COB field following specific policies and procedures. Once coverage is confirmed, **UHA** evaluates the claims section to process the claim. **UHA**'s TPR Department maintains the COB information for all **UHA** members. This information is found under the COB tab in the database of the record, with a member-level note for commercial and motor vehicle accident (MVA)/worker's compensation (WC) insurances. Claims received for a member with a COB record are pended for manual review of member notes and the requirement of COB in source data/paper EOB/letter of denial/exhaustion letter, etc., indicating what the primary insurance paid/denied with the following guidelines:
  - Claims received as primary when there is COB indicated in the member profile are denied.
  - Claims received with secondary processing information are processed and paid line-by-line on each line; **UHA** will pay the difference between what the primary insurance paid and **UHA**'s contract amount up to the deductible and coinsurance amount due. The primary payments and coinsurance deductible amounts are reflected in each line of the claim, and a payment will only be made if there is a coinsurance/deductible amount due and will never exceed **UHA**'s contract amount.

- **UHA** noted that the accuracy of the COB information in all **UHA** secondary payer claims (including Medicare crossover) is determined by the claims analyst and pended for manual adjudication and/or review. The COB data are stored in the claim as they are used to adjudicate the claim for payment.
  - If **UHA** is not responsible to pay for a service due to payment from a primary carrier, the zero-pay claim is reflected in the 837 with a $0.00 amount in the next pay conjunction with a CARC 22 or 23. **UHA** processes and submits zero-pay encounters from its capitated providers to OHA.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **UHA** conducts the following activities:

- Accuracy:
  - Determined by prospective audits in the form of adjudication edits applied to claims to ensure processing in accordance with **UHA** guidelines. Retroactive audits of claims are processed on a per check-run basis. Claims are selected by predetermined criteria and reviewed to determine accuracy and further follow-up actions. The focus of the weekly audit includes, but is not limited to:

- o Claims paid to nonparticipating providers without a prior authorization.
- o Claims billed by locum tenens.
- o Duplicate claims.
- o Unit of measure (UOM) on NDCs.
- o DRG pricing.
- o Comparing claims payments with the rate listed in the provider's contract or Division of Medical Assistance Programs (DMAP) rates, if applicable.
- Completeness:
  - Determined by chart audits to determine the accuracy of the diagnosis and procedure codes billed on a claim. EDV audits provide a quarterly review of a random selection of claims to validate that the actual claim operation process and systems produced the expected results. Policies, procedures, and oversight methods are in place for these purposes.
- Timeliness:
  - **UHA** uses the payment date and the stated date of receipt to calculate the timeliness of claim submissions. **UHA** requires that both contracted and nonparticipating providers submit claims within 120 days from the DOS, consistent with the provisions of OAR 410-141-3565. However, under the following circumstances a provider may, if necessary, submit its billings to **UHA** within 12 months from the DOS:
    - o Billing delayed by retroactive deletions or enrollments;
    - o Pregnancy;
    - o Medicare as a primary payer;
    - o Cases involving third-party resources;
    - o Covered services provided by nonparticipating providers who are enrolled with OHA; or
    - o Other cases that delay the initial billing to **UHA**, unless the delay was due to the provider's failure to verify a member's eligibility
- **UHA** uses various reports to screen for completeness, logic, and consistency in volume of its encounter data. **UHA** further complies and analyzes its encounter data using the 2020 Encounter Data Tracking Sheet Copied report, which tracks the following data points by claim type (i.e., pharmacy, professional, institutional, dental):
  - Number of members per month
  - Number of claims received/processed by **UHA**'s TPA, PBM, and DCO per month
  - Number of encounters submitted per month
  - Number of encounters accepted/acceptance rate
  - Number of encounters rejected
- **UHA** has processes in place to ensure that the quality of its data is constant with OHA's CCO Measure Specification Sheets as it is used to determine the providers' performance on the CCO Quality Metrics program. Additionally, **UHA** uses various reports to screen the completeness, accuracy, and timeliness of claims/encounters with prospective payment/adjudication edits and

retrospective payment audits. PH TECH uses the weekly 835 validation report in conjunction with reconciling the CCV provided by OHA to the CVF numbers submitted by the CCO.

- To support encounter data submission activities, **UHA** uses the following transaction response files:
  - Pharmacy: The NCPDP Response files are saved to **UHA** network drive, and the data are placed in a tracking sheet, which tracks the following data points:
    - ○ Total number of pharmacy claims paid/processed
    - ○ Total number of pharmacy claims submitted
    - ○ Total number of pharmacy encounters accepted
    - ○ Total number of pharmacy claims rejected
    - ○ Acceptance rate
  - 999: Used to determine if a file was accepted into OHA's translator. Also used to determine which claims will need to be corrected and resubmitted. This is saved into **UHA**'s source system.
  - 835: Used to validate the submission (typically the response is in coordination with several files submitted). **UHA** uses this response file to ensure that the submission matches what was processed by OHA. **UHA** uses this to look at the volume of accepted, failed adjudicated, duplicated, pended, and 999 error claims.
  - Status file: Used to define and resolve pend errors.
  - CCV report: Used to validate CVF submission details versus what OHA processed.
  - Various reports sent by email from OHA (e.g., duplicate, failed adjustment, rejected liability, non-enrolled): Used to validate against PH TECH's developed reporting tool using **UHA**'s source data to ensure that OHA's reporting matches PH TECH's reporting.

At the time of the questionnaire submission, **UHA** noted there were zero outstanding 999 errors that had not been resolved in the specified time frame. **UHA** tracks any claims that are rejected by OHA's EDI translator closely. Among the encounters submitted for 2020, an average of 0.05 percent pass OHA's EDI translator, but are pended by OHA's MMIS. To reconcile files pended by MMIS, **UHA** uses a reporting tool to track and resubmit rejected files, which are corrected upon rejection, resubmitted, and accepted.

In response to describing how the encounter data system and data warehouse were used, **UHA** noted that its encounter data are used for rate setting; CCO quality metric monitoring; utilization management; fraud, waste, and abuse monitoring; value-based payment modeling; contract development; budgeting trends; continuity of care; cost management; and other functions.

UHA noted that it currently does not face any internal challenges in submitting encounter data to OHA. However, **UHA** indicated that OHA does not have the mapping or edits from its EDI translator available for distribution to use as a tool. Some errors sent back to **UHA** are not easily defined. In response to processes or additional resources and support from OHA that would be most helpful in overcoming challenges with successfully submitting encounter data to OHA, **UHA** noted that OHA does not have the NDC data table/mapping tool available to assist the CCO in identifying an NDC error. **UHA** does

not have any upcoming changes to its encounter submission process that would impact the answers provided at the time of questionnaire submission.

Recommendations

Based on its review, HSAG recommends the following for **UHA** to strengthen its encounter data quality:

- HSAG does not have any recommendations to offer at this time.

Appendix R: Findings for Yamhill Community Care Organization

This section summarizes the findings from Yamhill Community Care Organization's (**YCCO**'s) questionnaire responses.

Encounter Data Sources and Systems

Providers and other contracted entities typically submit professional (including physician, HCBS, laboratory, transportation, vision, behavioral health, and NEMT); institutional (including inpatient, outpatient, and long-term care); and dental claims or encounters through PH TECH, and the CIM system processes claims and encounter data on behalf of **YCCO**. The CIM system processes claims and encounter data, then transmits an electronic X12/837 file to **YCCO**. For paper claim forms, these documents are scanned, or the data are entered into the encounter data processing system to create an electronic X12/837 format that is returned to **YCCO**.

YCCO contracts with SS&C Technologies (SS&C) to perform pharmacy contracting, benefit management, and claim/encounter processing. For pharmacy claims, the member receives a prescription from the provider, and the pharmacy then submits the prescription electronically to SS&C, which provides the medication to the member. Pharmacies provide SS&C with claims and encounters data, which SS&C formats into an NCPDP file and provides to **YCCO**, along with additional encounter details, in a proprietary file layout. Once pharmacy encounters are received by **YCCO**, they are submitted in NCPDP D.0 formatted files to OHA.

Table R-1 shows **YCCO**'s format and submission frequency of the professional, institutional, pharmacy, and dental encounters received.

Table R-1—Format and Submission Frequency for Professional[1], Institutional[2], Pharmacy, and Dental Encounters

	Professional[1]	Institutional[2]	Pharmacy	Dental
Data receipt	PH TECH	PH TECH	SS&C	PH TECH
Format	X12/837 and paper claims	X12/837 and paper claims	Point-of-service claims submitted by retail pharmacies from vendor, SS&C, which then formats them into NCPDP D.0	X12/837 and paper claims
Frequency	Weekly	Weekly	Weekly	Weekly
Approximate volume	Varies	Varies	4,800	Five unique claims per week; one or less unique claims per week

[1] Includes physician, HCBS, laboratory, transportation, vision, behavioral health, and NEMT
[2] Includes inpatient, outpatient, emergency room, and long-term care

- **YCCO** noted that it does not modify or reformat its claims/encounter data to accommodate OHA's encounter data submission standards.
- In response to whether any of the data submitted to OHA are extracted from another entity's claims/encounter data system/data warehouse, **YCCO** noted that it uses PH TECH, and the CIM system processes physical, mental, dental, and NEMT claims and encounter data on behalf of **YCCO**. Providence Plan Partners uses SS&C for pharmacy data. For encounter-only submissions, the 837 file is sent to PH TECH's secure FTP site to be parsed and validated. Once the data are clean and loaded into CIM, they are sent as a summary report to **YCCO** on weekly. **YCCO** provided process maps for both its internal and encounter-only submission processes.
- **YCCO** does submit all types of encounters (e.g., paid, denied, voided, and adjusted claims) to OHA. However, **YCCO** does not submit certain types of payments made on behalf of the Medicaid population and/or certain types of services rendered to the Medicaid population as encounters. YCOO submits all claims to OHA, unless they are included in the exclude or withhold group. **YCCO** provided code to provide background on how it filters the Medicaid population, and claim types that are pulled for extract. Additionally, **YCCO** provided the exclude and withhold reasons, which include:
  - Claim lines in voided status.
  - Claim lines in refund request status.
  - Claim lines in voided status.
  - Claim lines in refund cancel status.
  - Claim lines in refund void status.
  - Copied claim.
  - Claim is not encounterable due to being an interim bill.
  - Custom payment—PCP, DCO, programs.
  - Claim is not encounterable due a custom procedure code.
  - Duplicate claim indicated with CARC 18.
  - Not for encounter data indicated with CARC R01 or R2.
  - Non-encounter client.
  - Invalid encounter status.
  - Test claim.
- In handling adjusted encounters that have been previously submitted, **YCCO** noted that the adjusted claims are submitted using the same process as a new claim. However, unlike a new claim, the frequency code is updated to "7" and an ICN is included. For adjusted pharmacy claims, those are handled manually in MMIS.
- For claims that are processed internally, the types of claims validated are inpatient, outpatient, laboratory, physician, vision, behavioral health, and oral health. The types of validation performed are authorization requirements, benefit elements (benefits as outlined by the plan), contract rates, coordination of benefits, and data elements including claim number, received date, provider, vendor, tax ID, member data, date of service, CPT, diagnosis code, revenue codes, DRG grouping modifiers,

and units. **YCCO** noted that of claims validated, on average 75 percent are auto-adjudicated, and 25 percent manually reviewed across all claim types.

- **YCCO** noted that its claims data are not altered, mapped, or changed prior to adjudication. CIM contains editing to validate diagnoses and CPT codes to ensure that correct coding principles are applied. **YCCO** also does not perform code and/or field mapping during data processing for submission to OHA, and it does not use any outside vendors or contractors to complete adjudication.

- **YCCO**'s provider data are collected and maintained by a subcontracted vendor. For pharmacy claims, active and inactive provider data are pulled from the OHA site. A list of active providers is maintained in the PBM claims processing systems and referenced for claims processing. PH TECH is responsible for collecting and maintaining provider demographic information within CIM for **YCCO**. Provider data are embedded within the **YCCO** data warehouse tables and received on a quarterly basis to support various reporting needs. **YCCO** uses these data for report generation, CCO review and analytic studies, and quality oversight. The data are cross-referenced with W9s, if available, and checked for provider exclusions.

- In linking provider data to claims and encounters, **YCCO**'s process is to ensure provider data and claims are paired through systematic and manual processes by matching data points such as provider name, vendor name, NPI, and tax ID numbers. Provider system analysts work with **YCCO** to resolve any discrepancies in data. Claims are pended for review prior to processing when resolving data discrepancies. **YCCO** reviews policies, procedures, and data flow diagrams via desk review. Additional oversight of provider data and claims/encounter happen through ongoing operational meeting discussions, mutual review of the issues log, and transparency reporting. **YCCO** provided supporting documentation for additional details. For pharmacy claims, active provider data are maintained in PBM and referenced for claims processing. Any discrepancies are verified in MMIS to confirm enrollment. **YCCO**'s provider data do not require modification in order to comply with OHA's provider data submission requirements.

- **YCCO**'s enrollment data are maintained by a subcontractor, PH TECH. The Enrollment Department at PH TECH oversees the import and reconciliation of enrollment records. PH TECH monitors the daily files, scans for any errors, and validates discrepancies against MMIS, the raw 834 data and the 820 files, if needed. Communication of issues goes straight to the OHA claims services unit (CSU) team. Additionally, a monthly reconciliation is done using the OHA monthly audit file and comparing it to what is in the plan's membership system (CIM). Discrepancies are researched and corrected in CIM if necessary. **YCCO** then records and monitors enrollment policies and procedures, as well as reports, including Service Level Agreement (SLA) reports, received on a monthly basis. As part of a larger set of transparency reports, **YCCO** uses these for the completion of contract-required deliverables and for operational oversight and system monitoring. In its response, **YCCO** provided a diagram illustrating this process.

- The PH TECH membership system is used for enrollment, claims payment, and encounter data exporting. If there are any discrepancies between encounter data and enrollment within the system, the enrollment team is consulted to make any needed corrections or research, and the encounter is resubmitted. For pharmacy claims, OHA provides the eligibility data to **YCCO**. **YCCO** then loads the eligibility data into Facets (the medical claims processing system). **YCCO** extracts eligibility data from Facets daily and sends an eligibility file to SS&C (PBM). SS&C processes **YCCO**

member prescriptions, creates the encounter data file, and sends it to **YCCO**. **YCCO** submits the encounter data file to OHA, and OHA sends a response file back to **YCCO**, which provides information detailing which claims were accepted and rejected with reason codes. **YCCO** reviews rejected claims, and when applicable, resubmits to OHA via MMIS.

Data Exchange Policies and Procedures

YCCO's encounter data process includes the extraction, submission, correction, and validation of claims data for eligible members. An interdepartmental encounter data team performs the encounter data procedures, and an oversight group, comprised of director-level representatives, oversees the process. Key objectives of the policies and procedures include compliance with encounter data regulatory requirements, including HIPAA, which are contained in OHA Health Plan Services Contract, and a complete, accurate, and timely submission of encounter data, which is required for biennial actuarial per capita cost calculation and annual health and geographic risk assessment. **YCCO**'s procedure includes an encounter data extract that is run weekly by SS&C, which is sent to **YCCO** and then to OHA. OHA sends a response file back to the CCO, which provides information detailing which claims were accepted and rejected with reason codes. The CCO reviews the rejected claims, and where applicable resubmits them to OHA via MMIS. A Financial Analytics representative reviews submissions and rejected statuses to monitor compliance with the OHA Health Plan Services Contract.

Management of Encounter Data: Collection, Storage, and Processing

Table R-2 shows **YCCO**'s pricing methodology for outpatient, inpatient, and pharmacy encounters.

Table R-2—Pricing Methodology for YCCO

Outpatient	Inpatient	Pharmacy
• Percentage of billed payments is determined by hospital designation by OHA if they are a type A/B facility. Each hospital is designated a different percentage as set by OHA or the contract between **YCCO** and the hospital. • If designated as a DRG hospital by OHA, the claims are paid based on CMS outpatient pricing rules and methodology. A percentage of the Medicare rates is set between **YCCO** and hospital. Case rates are paid based on	• Percentage of billed payments are determined by hospital designation by OHA if they are a type A & B facility. Each hospital is designated a different percentage as set by OHA or the contract between **YCCO** and the hospital. • If designated as a DRG hospital by OHA, the claims are paid based on CMS inpatient pricing rules and methodology. A percentage of the Medicare rates is set between **YCCO** and hospital.	Pharmacy claims are paid weekly based on negotiated rates per the pharmacy contract.

Outpatient	Inpatient	Pharmacy
the letter of agreement between **YCCO** and the hospital. • Capitated arrangements are also determined between **YCCO** and the hospital. Data are submitted to OHA through 837 files and indicated within the file by the capitation monetary adjustment in the CAS03 segment in conjunction with a CARC 24 in the CAS segment.	• Capitated arrangements are also determined between **YCCO** and hospital. For encounter data submission, these payments are shown in the 837 data file. Within the header level, the payment is indicated by the SBR, AMT, and CAS segments.	

- In response to whether there are any services are submitted to **YCCO** under bundle-payment structures, **YCCO** noted that its maternity global payments and surgery services that fall under a global payment structure are submitted to **YCCO** as bundled-payments. All services performed are submitted to **YCCO** and submitted as encounter data.

- **YCCO** uses PH TECH as its subcontractor to collect TPL data. PH TECH's Enrollment Department oversees the research and updating of member accounts that have TPL. The information gathered is from the State's 834 file, member and provider phone calls, attorney case notification, and claims payments with a primary payment noted. PH TECH also uses the services of HMS, which recovers payment from primary payers who were never billed and recoups them for **YCCO**. YCCO then shares the primary payer information with PH TECH. The PH TECH Enrollment Department staff contacts all primary payers to gather effective dates, termination dates, pay types, and subscriber information. This information is then loaded into CIM in order for the claims to be paid in the required order or denied if other coverage is present. These data are exported to the PBM, where prescriptions are also paid in the proper order using all available primary insurance first.

- In response to how claims are processed with TPL, **YCCO** noted that if a claim is received and the member has an open COB record within CIM indicating primary coverage is in effect, the claim will be denied unless accompanied by an EOB from the primary payer showing what is left over after its processing. If notification of other coverage is received after a claim is paid, it is investigated and loaded into a COB record in CIM. **YCCO**'s recovery vendor, HMS, then receives that information and will send a claim to the primary payer on **YCCO**'s behalf to recover the claim amount. Additionally, monthly reports are received and passed through to **YCCO**. Then, claims are updated in CIM to re-encounter. Accident claims are paid but noted and are pursued by the Phia Group, with liens being established to recover from insurance carriers and settlements. When funds are recovered, PH TECH receives the recoveries and reports and passes them through to **YCCO**. Then claims are adjusted and re-encountered.

- For source data used to verify the accuracy of Medicare crossover and other third-party claims information, **YCCO** notes that Medicare crossover claims data are downloaded directly from CMS (COBA process) into CIM and then populated into an 837 format to submit to OHA. These crossover claims are indicated in an 837, just as any other COB claim. The line payment would reflect as applicable in the AMT in conjunction with the CARC 22 or 23.

- **YCCO** reflects the zero-pay claim in the encounter data in the 837. A zero dollar amount is reflected in the next pay conduction with a CARC 22 or 23.
- For zero-pay claims for subcapitated providers processed, **YCCO** submits these in the 837. The capitation monetary adjustment is included in the 837 in the CAS03 segment in conjunction with a CARC 24 in the CAS segment. The completeness and accuracy are assessed using the same process as all other claims.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness, accuracy, and timeliness of claims and encounter data submitted by its vendor or subcontractor, **YCCO** conducts the following activities:

- Completeness:
  - **YCCO** receives copies of all 837 files that are submitted to OHA for monitoring of completeness. For additional validation, **YCCO** is provided control log reports. For pharmacy claims, a weekly retrospective comparison is performed to ensure that all paid claims are included in the pharmacy encounter data files.
- Accuracy:
  - Encounter data are monitored by **YCCO** through transparency reports and service-level agreement reporting, as well as the CCO's EDV process. For pharmacy, all claims and billed amounts in the encounter file are tallied when submitted to OHA.
- Timeliness:
  - Encounter data are monitored by **YCCO** through transparency reports and service-level agreement reporting, as well as the CCO's EDV process.

To monitor the completeness, accuracy, and timeliness of the encounter data submitted by its providers, **YCCO** conducts the following activities:

- Completeness:
  - **YCCO** ensures completeness of provider data by using consistent and reliable data sources (data warehouse tables, analytic performance tracking system, and performance measure chart review) to ensure data are accurate and timely with consistent formats to limit/eliminate changes in source data.
- Accuracy:
  - **YCCO** ensures accuracy of provider data by using consistent and reliable data sources (data warehouse tables, analytic performance tracking system, and performance measure chart review) to ensure data are accurate and timely with consistent formats to limit/eliminate changes in source data.

- Timeliness:
  - **YCCO** ensures timeliness of provider data by using consistent and reliable data sources (data warehouse tables, analytic performance tracking system, and performance measure chart review) to ensure data are accurate and timely with consistent formats to limit/eliminate changes in source data.
  - For **YCCO**'s pharmacy claims, all claims must be submitted within 45 days.

YCCO has the following monitoring metrics in place to evaluate the quality of encounter data submissions:

- Percent of encounters submitted within 30 days
- Percent of encounters submitted within 45 days
- Percent of encounters pended
- Percent of pends corrected in 62 days

Regarding the process to monitor the status of encounter data submitted to OHA, **YCCO** responded that a weekly 835 validation report, in conjunction with reconciling CCV, is provided by OHA to supplement the CVF numbers submitted by **YCCO**. Encounter data activities are tracked in the data system as follows:

- 999: Used to determine if a file was accepted into OHA's translator. Also used to determine which claims will need to be corrected and resubmitted. This is saved into PH TECH's source system.
- 835: Used to validate the submission (typically, the response is in coordination with several files submitted). This response file is used to ensure that the submission matches what was processed by OHA. It is also used to look at the volume of accepted, failed adjustment, duplicated, pended 999 errors.
- Status file: Used to define and resolve pending errors.
- CCV report: Used to validate CVF submission details versus what OHS processed.
- Various reports sent via email from OHA (these can include duplicate, failed adjustment, rejected liability, non-enrolled): Used to validate against the PH TECH-developed reporting tool using source data to ensure OHA's reporting matches PH TECH's reporting.

Any claims that are rejected by OHA's EDI translator are tracked closely and corrected upon rejection. These claims are resubmitted and accepted. There are zero outstanding 999 errors that have not been resolved in the time frame specified. **YCCO**'s rejected pharmacy encounters account for less than 1 percent of total encounters. In addition to monitoring the 999 status, a reporting tool is used to track and resubmit any rejected files and/or claims.

An average of 0.13 percent of **YCCO**'s encounters submitted to OHA pass OHA's EDI translator but are pended by OHA's MMIS.

In response to describing how the encounter data system and data warehouse are used, **YCCO** noted that encounter data are used for a variety of functions. Examples include financial/budgetary analysis; provider performance on quality measures; validation of value-based contracting agreements; provider fraud, waste, and abuse detection and investigation; and analysis of service coverage and utilization management.

YCCO noted that it does not experience any internal challenges, but identified the following external challenges faced in submitting encounter data to OHA:

- OHA does not have the mapping or edits from its EDI translator available for distribution to use as a tool.
- Some errors kicked back are not easily defined.
- If an encounter file is inadvertently submitted twice, there is no option to back the file out of the system.

Recommendations

Based on its review, HSAG recommends the following for **YCCO** to strengthen its encounter data quality:

- In describing its methods for ensuring completeness and accuracy of its encounter data submission, **YCCO** did not demonstrate that chart review was one of the validations conducted. HSAG recommends that **YCCO** consider conducting validation of encounter data based on medical record reviews by comparing medical record documentation (i.e., diagnosis codes and procedure codes) against submitted encounter data for a sample of records. Results from these reviews can be used as part of **YCCO**'s ongoing data monitoring.