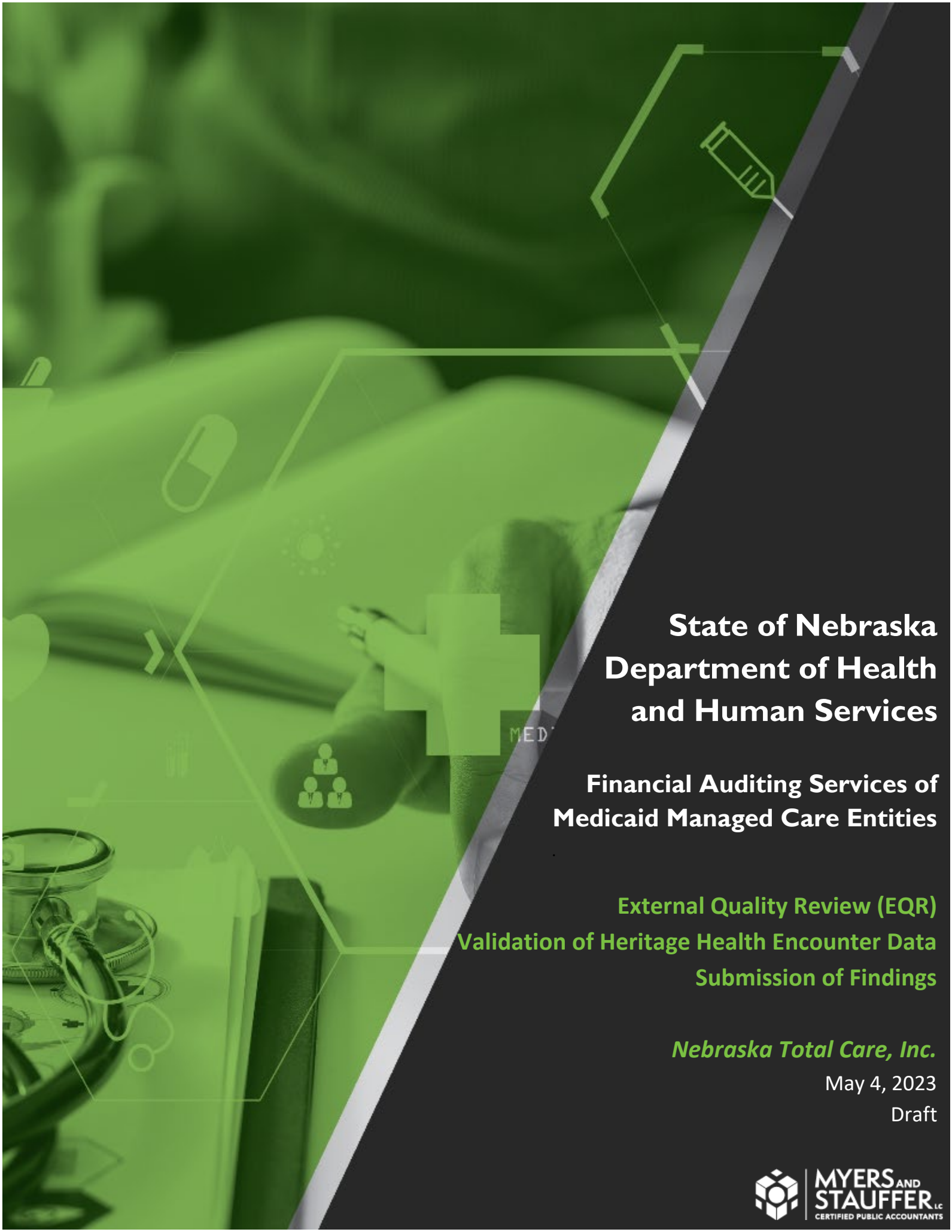


State of Nebraska Department of Health and Human Services

Financial Auditing Services of Medicaid Managed Care Entities

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

Nebraska Total Care, Inc.

May 4, 2023

Draft

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

Executive Summary

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

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

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

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

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

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

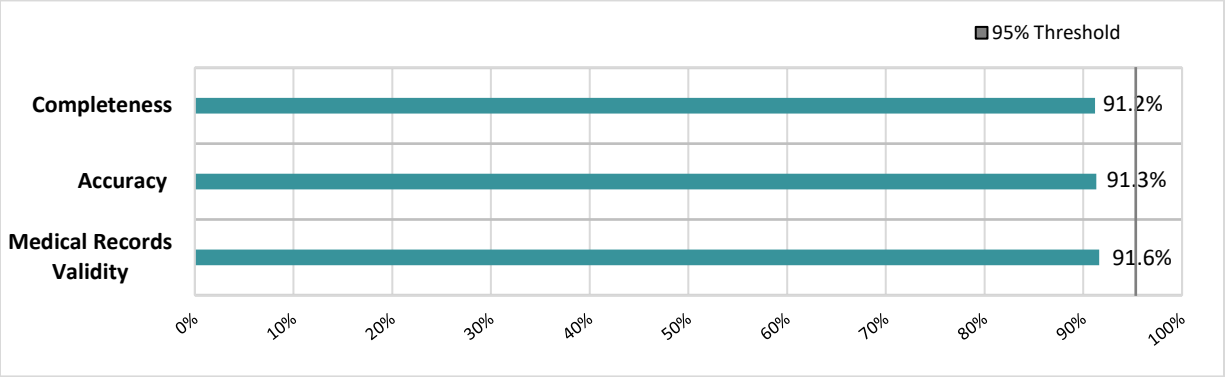
Observations and findings are based on the information provided and known at the time of the review. The health plan should work with DHHS, HIA and/or Optumas to resolve issues noted within the supplemental claims data or the encounter data.

Findings

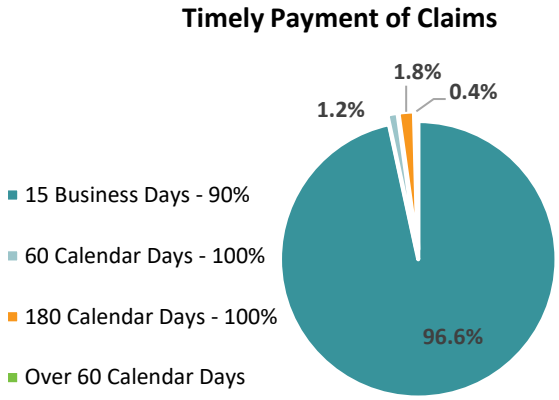
- **Completeness:** The medical, transportation, and vision supplemental claims data completion percentages met the 95 percent threshold when compared to CDJ paid amounts, claims sample paid amounts and claims sample counts. Pharmacy claims data was below the 95 percent

threshold when compared to CDJ paid amounts, claims paid amounts and claims sample counts. The aggregate completion percentage was below the 95 percent threshold (91.5 percent).

- **Accuracy:** The overall accuracy percentage was 91.3 percent for all claim types and all key data elements reviewed.
- **Medical Record Validation Rates:** 119 of the medical records requested were submitted for review. Eight (8) of the medical records submitted were for the incorrect dates of service resulting in 111 records (91.6 percent) being tested. The validation rate for the medical records tested was below the 95 percent threshold (91.2 percent).



- **Timeliness:**



A detail summary of our findings can be found in the Activity 5 section of the report.

Introduction

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

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

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

The State of Nebraska's new data warehouse, HealthInteractive (HIA), went live in November 2020 in order to house the Medicaid Encounter data from the Heritage Health Plans and MCNA, the state's dental vendor. The state is in the process of working through known issues prior to utilizing the data from the system for rate setting purposes. In order to calculate the 2021 capitation rates, supplemental claims data was provided by the health plans to Optumas for this purpose. The supplemental claims data included final claims with dates of service occurring during calendar year (CY) 2021 and paid through May 2022.

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

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

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

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

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

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

Activity 1: Review State Requirements

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

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

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

Findings and Recommendations		
	Findings	**Recommendations**
1-A	Interest on claims is included in the total amount paid in health plan's submitted encounters.	DHHS should consider adding a separate encounter field for interest paid on claims. This will allow the separate consideration of interest in rate setting.
1-B	Interest on claims is not reported in a separate field in the health plan's supplemental claims data submitted to Optumas.	Optumas should consider adding a separate field for interest paid on claims in the supplemental claims data request. This will help to ensure the plan identifies any interest paid on claims and allow Optumas to consider it in Rate Setting. This is currently done through a separate question in Optumas supplemental claims data request.
1-C	There is no clear guidance as to what is being attested to in the encounter level attestation segment within the health plans encounter submissions.	DHHS should consider publishing what the health plan is attesting to within the encounter segment either through enhanced language in the contract or additional detail in the encounter submission guidance.

Activity 2: Review Health Plan Capability

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

Observations and findings related to the review and interviews are summarized below along with recommendations for DHHS and the health plan.

Findings and Recommendations		
	Findings	**Recommendations**
2-A	The health plan's DRP consists of 4 levels of testing (walkthroughs, simulations, parallel testing, and interruption testing.) According to the health plan's policies, the health plan's ability to recover from a disaster successfully should be tested annually with one or more of these tests being completed. Per the company personal interviewed in January 2023, a table top activity occurred in December 2021 but no further testing has occurred since that time. Additionally, the plan could not provide a record of the last time higher level testing was conducted beyond a walkthrough.	The health plan should ensure their policy of performing an annual test is followed consistently and that the testing level is adequate to provide assurances that its recovery strategy is effective.

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

Activity 3: Analyze Electronic Encounter Data

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

The health plan contracted with third party vendors to administer its vision, non-emergency transportation (NEMT), and pharmacy benefits. CDJs and sample claims data were also submitted by the third party vendors. These files were separately compared to the supplemental claims data to determine the completeness and accuracy of the data submitted to Optumas, via the health plan's delegated vendors.

Completeness

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

Cash Disbursement Journals

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

Supplemental Claims Data and CDJ Completion Percentages

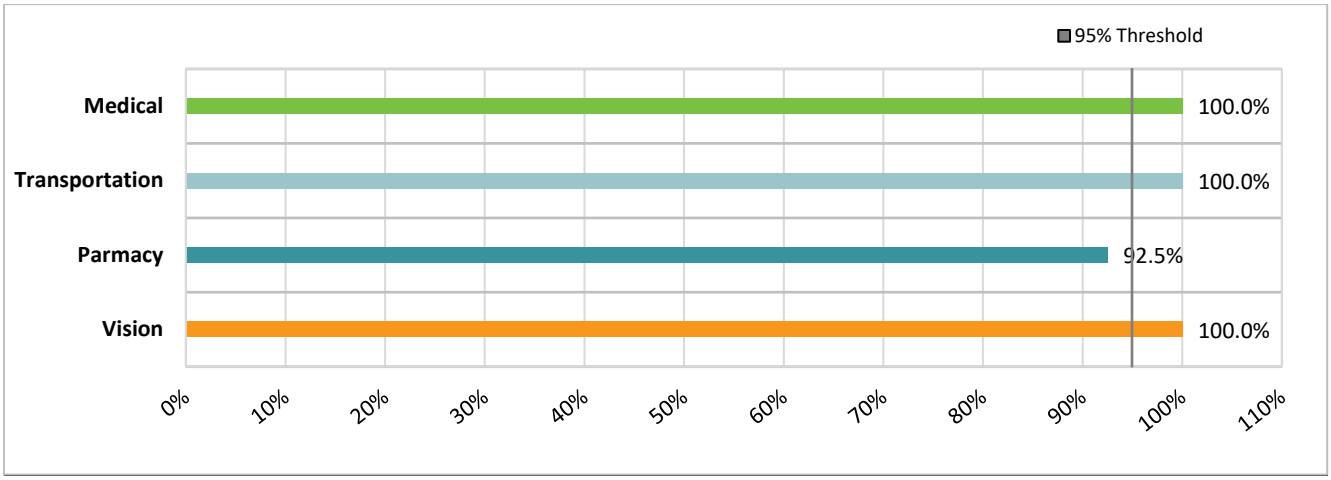


Figure 1 –Detailed results can be found in Appendix A.

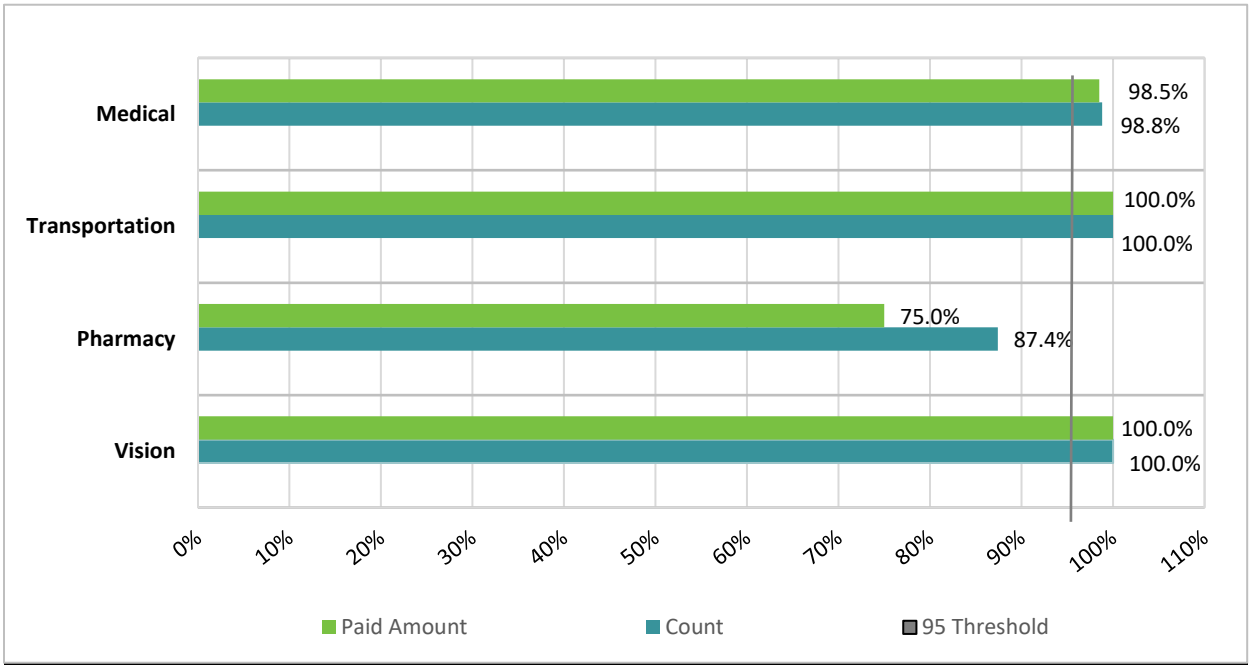
Sample Claims

The comparison of the sample claims data to the supplemental claims data sought to ensure that all sample claims were included in the supplemental claims data. The supplemental claims data was evaluated against the sample claims data based on the following criteria:

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

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

Supplemental Claims Data and Sample Claims Data Completion Percentages



Completion percentages below 100 percent indicate there are records missing from the supplemental claims data. Completion percentage for the supplemental claims data when compared to sampled claims were below the 95 percent accuracy on both count and paid amount for pharmacy.

Accuracy

For the purpose of validating supplemental claims data accuracy, certain key data elements were selected for testing. See Appendix C-1 for key data elements tested by claim type. The key data elements of the supplemental claims data were traced and compared to the corresponding key data elements on the sample claim. Consistency checks on blank or null data element values were also applied. The key data elements were evaluated based on the following criteria:

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

Supplemental claims data accuracy issues with Paid Dates were noted for all claims types except transportation. Additionally, accuracy issues were identified with Billed Charges, Billing Provider, MMIS Member ID, Prescribing NPI, Quantity Dispensed, and Servicing Provider for some claims types. Accuracy percentages by supplemental claims data type are presented in **Table 1**. The key data elements evaluated and specific testing results are presented in Appendix D.

Accuracy Percentages – Key Data Elements Analysis

Claim Type	Valid Values	Missing Values	Erroneous Values
Inpatient	98.6%	0.1%	1.4%
Outpatient	98.5%	0.0%	1.5%
Professional	98.3%	0.0%	1.7%
Transportation	58.7%	0.0%	41.3%
Pharmacy	78.1%	1.3%	20.6%
Vision	91.6%	0.0%	8.4%
Total Average	***91.3%***	***0.4%***	***8.3%***

Findings and Recommendations

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

Findings and Recommendations

	Findings	Recommendations
3-A	**Completeness – CDJs**: The pharmacy claims included in the supplemental claims data did	The health plan should review the process in place for preparing the supplemental claims data to be

Findings and Recommendations		
	Findings	**Recommendations**
	not meet the 95 percent threshold compared to the CDJ amounts (92.5 percent).	submitted to Optumas to ensure all claims are included.
3-B	**Completeness – Sample Claims Count**: The pharmacy claims included in the supplemental claims data did not meet the 95 percent threshold for completeness when compared to the claims counts (87.4 percent).	
3-C	**Completeness – Sample Claims Paid Amount**: The transportation, pharmacy and vision claims included in the supplemental claims data did not meet the 95 percent threshold for completeness when compared to the claims paid amounts (75.0 percent).	
3-D	**Accuracy - Health Plan Paid Dates:** *Inpatient, Outpatient, Professional, Pharmacy and Vision* – The dates were populated in both the claims and supplemental claims data populations but do not agree for all claims which were identified as having accuracy issues.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate paid dates are being reported.
3-E	**Accuracy - Paid Amounts:** *Professional, Pharmacy and Vision* – The paid amounts were populated in both the claims and supplemental claims data populations but do not agree for all claims which were identified as having accuracy issues.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate paid amounts are being reported.
3-F	**Accuracy - Billing Provider NPIs-** *Vision*– The Billing provider NPIs were populated in the claims sample claims data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure Billing Provider NPIs are being reported.
3-G	**Accuracy – Billed Charges-** *Pharmacy*– The billed charges were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate Billed charges are being reported.

Findings and Recommendations		
	Findings	**Recommendations**
3-H	**Accuracy – Refill Number-** *Pharmacy*– The refill numbers were populated in the claims sample data and supplemental claims data but did not match for some claims that were identified as having accuracy issues. For another portion of claims, the Refill Number was not populated in the supplemental claims data.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate refill numbers are being reported.
3-I	**Accuracy – First Date of Service -** *Transportation*– The first dates of service were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate first date of service are being reported.
3-J	**Accuracy – Procedure Code -** *Transportation*– The procedure codes were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate procedure codes are being reported.
3-K	**Accuracy – Procedure Code Modifier-** *Transportation*– The procedure code modifiers were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate procedure code modifiers are being reported.

Statistics and Distributions

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

Members, Utilization and Paid Amounts

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

The health plan's membership represented 37.2% percent of Heritage Health's members receiving services in 2021. Average per member counts where less than Heritage Health's, as a whole, average per

member utilization, while per member paid amounts where greater than Heritage Health's average per member paid amounts.

Average Per Member Utilization and Paid Amounts by Service Type, CY 2021						
	Heritage Health		Health Blue		Percentage of Heritage Health	
Members						
Distinct Member Count receiving services based on supplemental claims data - CY 2021	369,789		137,393		37.2%	
Service Type	Average Per Member Utilization	Average Per Member Paid Amount	Average Per Member Utilization	Average Per Member Paid Amount	Percentage Variance	
					Count	Paid Amount
Ancillary	2.0	*$169*	0.0	*$-*	-100.0%	-100.0%
Inpatient	1.7	*$994*	1.7	*$1,053*	-0.3%	6.0%
Non-Emergent Transportation	0.5	*$16*	0.5	*$19*	3.2%	20.5%
Outpatient	7.5	*$1,059*	6.9	*$892*	-7.9%	-15.7%
Pharmacy	11.4	*$979*	10.1	*$1,015*	-11.8%	3.6%
Primary Care	6.8	*$451*	6.6	*$461*	-3.7%	2.2%
Specialty	3.7	*$285*	7.4	*$553*	97.5%	94.3%
Vision	1.0	*$32*	0.9	*$30*	-9.6%	-5.3%
Total Health Plan Services	***34.8***	***$3,984***	**34.1**	***$4,024***	**-1.9%**	**1.0%**

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

Timeliness

Timely Payment of Claims

This analysis measures the compliance of the health plan in paying or denying claims submitted by providers for payment. The contract between DHHS and the health plan requires that the health plan pay

or deny at least 90 percent of all claims within 15 business days of receipt, 99 percent within 60 calendar days of the date of receipt and all claims within six months of receipt[7]. **Table 3** shows the results of the analysis. Detailed results can be found in Appendix F.

Timely Payment of Claims				
Claim Type	**15 Business Days 90%**	**60 Calendar Days 99%**	**180 Calendar Days 100%**	**Average Days**
Inpatient	84.8%	92.9%	98.3%	19
Outpatient	95.3%	97.8%	99.6%	10
Professional	94.7%	96.2%	99.4%	12
Vision	100.0%	100.0%	100.0%	6
NEMT	99.6%	100.0%	100.0%	11
Pharmacy	99.6%	99.9%	100.0%	2
Overall Average	96.6%	97.8%	99.6%	8

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

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

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

Findings and Recommendations

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

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

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

Activity 4: Review of Medical Records

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

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

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

Medical Records Testing Summary					
Description	**Inpatient**	**Outpatient**	**Professional** (includes Vision and NEMT)	**Pharmacy**	**Total**
Requested	9	38	42	31	120
Missing	0	0	1	0	1
Incorrect Record Submitted	2	1	5	0	8
Replaced	0	0	0	0	0
Medical Records Received and Tested	7	37	36	31	111
Percentage of Requested Records Tested	***77.8%***	***97.4%***	***85.7%***	***100.0%***	***91.6%***

Table 5: Medical Records Summary. 119 of the 120 medical records requested were submitted.

Validation

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

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

validation was segregated in the following manner:

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

Validity issues were noted with outpatient and professional claims within the supplemental claims data. The elements with the lowest supported percentages from the medical records were: Billing Provider, Revenue Codes, and Procedure Codes. **Table 6**, below, reflects the validation rates from the medical record key data element review. The detail analysis is included in Appendix G.

Medical Records Validation Rates		
Data Types	**Supported Validation Rate**	**Unsupported Validation Rate**
Inpatient	95.1%	4.9%
Outpatient	87.6%	12.4%
Professional (includes Vision and/or NEMT)	92.2%	7.8%
Pharmacy	99.5%	0.5%
Total	***91.2%***	***8.8%***

Table 6: Medical Record Validation Rates. 111 of the 120 medical records requested were tested. Supported and unsupported determinations were for each key data element tested and not a claim level determination.

Findings and Recommendations

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

Findings and Recommendations		
	Findings	**Recommendations**
4-A	The health plan was not able to provide a medical record to support 1 of 120 records requested. Additionally, the health plan provided medical records for the wrong timeframe for 8 of the 100 records that were submitted.	The health plan should work with its providers to ensure medical records are available and submitted for the members and dates of service requested, and are submitted within the requested time frame(s).
4-B	Validation rates for outpatient and professional claims were below the 95 percent accuracy threshold for the 89 records that were tested (87.6 percent and 92.2 percent respectively)	The health plan should review the claims with accuracy issues and determine the root cause of missing or mismatched data then develop a plan to address the issue with adjustment to their processes.

Activity 5: Submission of Findings

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

Findings and Recommendations		
	Findings	**Recommendations**
Activity 1 – Review State Requirements		
1-A	Interest on claims is included in the total amount paid in health plan's submitted encounters.	DHHS should consider adding a separate encounter field for interest paid on claims. This will allow the separate consideration of interest in rate setting.
1-B	Interest on claims is not reported in a separate field in the health plan's supplemental claims data submitted to Optumas.	Optumas should consider adding a separate field for interest paid on claims in the supplemental claims data request. This will help to ensure the plan identifies any interest paid on claims and allow Optumas to consider it in Rate Setting. This is currently done through a separate question in Optumas supplemental claims data request.
1-C	There is no clear guidance as to what is being attested to in the encounter level attestation segment within the health plans encounter submissions.	DHHS should consider publishing what the health plan is attesting to within the encounter segment either through enhanced language in the contract or additional detail in the encounter submission guidance.
Activity 2 – Review Health Plan Capability		
2-A	The health plan's DRP consists of 4 levels of testing (walkthroughs, simulations, parallel testing, and interruption testing.) According to the health plan's policies, the health plan's ability to recover from a disaster successfully should be tested annually with one or more of these tests being completed. Per the company personal interviewed in January 2023, a table top activity occurred in December 2021 but no further testing has occurred since that time. Additionally, the plan could not provide a record of the last time higher level testing was conducted beyond a walkthrough.	The health plan should ensure their policy of performing an annual test is followed consistently and that the testing level is adequate to provide assurances that its recovery strategy is effective.
Activity 3 – Analyze Electronic Encounter Data		
3-A	**Completeness – CDJs**: The pharmacy claims included in the supplemental claims data did not meet the 95 percent threshold compared to the CDJ amounts (92.5 percent).	The health plan should review the process in place for preparing the supplemental claims data to be submitted to Optumas to ensure all claims are included.

Findings and Recommendations		
	Findings	**Recommendations**
3-B	**Completeness – Sample Claims Count**: The pharmacy claims included in the supplemental claims data did not meet the 95 percent threshold for completeness when compared to the claims counts (87.4 percent).	
3-C	**Completeness – Sample Claims Paid Amount**: The transportation, pharmacy and vision claims included in the supplemental claims data did not meet the 95 percent threshold for completeness when compared to the claims paid amounts (75.0 percent).	
3-D	**Accuracy - Health Plan Paid Dates:** *Inpatient, Outpatient, Professional, Pharmacy and Vision* – The dates were populated in both the claims and supplemental claims data populations but do not agree for all claims which were identified as having accuracy issues.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate paid dates are being reported.
3-E	**Accuracy - Paid Amounts:** *Professional, Pharmacy and Vision* – The paid amounts were populated in both the claims and supplemental claims data populations but do not agree for all claims which were identified as having accuracy issues.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate paid amounts are being reported.
3-F	**Accuracy - Billing Provider NPIs-** *Vision*– The Billing provider NPIs were populated in the claims sample claims data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure Billing Provider NPIs are being reported.
3-G	**Accuracy – Billed Charges-** *Pharmacy*– The billed charges were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate Billed charges are being reported.
3-H	**Accuracy – Refill Number-** *Pharmacy*– The refill numbers were populated in the claims sample data and supplemental claims data but did not match for some claims that were identified as having accuracy issues. For another portion of claims, the Refill Number was not populated in the supplemental claims data.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate refill numbers are being reported.
3-I	**Accuracy – First Date of Service -** *Transportation*– The first dates of service were populated in the claims sample data and supplemental claims data but did not match for	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate first date of service are being reported.

Findings and Recommendations		
	Findings	**Recommendations**
	all claims that were identified as having accuracy issues.	
3-J	**Accuracy – Procedure Code -** *Transportation*– The procedure codes were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate procedure codes are being reported.
3-K	**Accuracy – Procedure Code Modifier-** *Transportation*– The procedure code modifiers were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate procedure code modifiers are being reported.
3-L	**Timely Payment of Claims**: The plan did not meet the timeliness standards for inpatient, outpatient or professional claims.	The health plan should ensure their claims are adjudicated promptly in order to meet the timeliness requirements established within the contract between the DHHS and the health plan.
	Activity 4 – Review of Medical Records	
4-A	The health plan was not able to provide a medical record to support 1 of 120 records requested. Additionally, the health plan provided medical records for the wrong timeframe for 8 of the 100 records that were submitted.	The health plan should work with its providers to ensure medical records are available and submitted for the members and dates of service requested, and are submitted within the requested time frame(s).
4-B	Validation rates for outpatient and professional claims were below the 95 percent accuracy threshold for the 89 records that were tested (87.6 percent and 92.2 percent respectively)	The health plan should review the claims with accuracy issues and determine the root cause of missing or mismatched data then develop a plan to address the issue with adjustment to their processes.

Glossary

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

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

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

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

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

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

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

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

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

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

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

CFR – Code of Federal Regulations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(DCN).

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

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

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

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

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

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

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

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

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

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

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

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

Appendices

Appendix A: Cash Disbursement Journal (CDJ) Completeness

	Medical			Transportation			Pharmacy			Vision		
	March 2021	September 2021	Total	March 2021	September 2021	Total	March 2021	September 2021	Total	March 2021	September 2021	Total
CDJ Data												
CDJ Paid Amount Total	$37,446,935	$32,074,217	$69,521,152	$193,239	$308,918	$502,157	$11,923,241	$13,851,386	$25,774,627	$401,640	$332,483	$734,122
Reconciling Adjustment	$2,547,388	$1,908,757	$4,456,146	-$1,142	-$607	-$1,748	$206,187	$1,978,292	$2,184,480	$0	$62	$62
Net CDJ Data Paid Amount Total	***$39,994,324***	***$33,982,975***	***$73,977,298***	***$192,098***	***$308,311***	***$500,409***	***$12,129,429***	***$15,829,678***	***$27,959,107***	***$401,640***	***$332,544***	***$734,184***
Supplemental Claims Data												
Supplemental Paid Amount Total	$50,002,635	$37,263,578	$87,266,213	$109,827	$168,845	$278,672	$11,305,550	$11,631,642	$22,937,192	$401,640	$332,544	$734,184
Payment Adjustments	-$10,009,132	($3,280,604)	-$13,289,736	$82,270	$139,467	$221,737	$447,669	$2,483,455	$2,931,124	$0	$0	$0
Net Supplemental Paid Amount Total	***$39,993,503***	***$33,982,975***	***$73,976,477***	***$192,098***	***$308,311***	***$500,409***	***$11,753,219***	***$14,115,097***	***$25,868,316***	***$401,640***	***$332,544***	***$734,184***
Supplemental Completeness Percentage	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***96.9%***	***89.2%***	***92.5%***	***100.0%***	***100.0%***	***100.0%***

Appendix B: Claims Sample Completeness

Description	Medical						Transportation					
	March 2021		September 2021		Total		March 2021		September 2021		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Sample Data												
Total Submitted Claims Sample Data	231,607	$46,875,556	173,707	$34,548,599	405,314	$81,424,155	6,031	$192,527	7,146	$310,087	13,177	$502,615
Claim Lines Not Identified in the Supplemental Claims Data												
Entire Claim	(3,196)	($658,849)	(1,832)	($539,138)	(5,028)	($1,197,987)	0	$0	0	$0	0	$0
Matched Sample Claims	***228,411***	***$46,216,708***	***171,875***	***$34,009,461***	***400,286***	***$80,226,169***	***6,031***	***$192,527***	***7,146***	***$310,087***	***13,177***	***$502,615***
Supplemental Claims Data												
Total Matched Supplemental Claims	228,411	$50,832,200	171,875	$34,328,744	400,286	$85,160,944	6,031	$192,527	7,146	$310,087	13,177	$502,615
Less Payment Adjustment	0	($4,615,493)	0	($319,283)	0	($4,934,776)	0	$0	0	$0	0	$0
Net Matched Supplemental Claims	***228,411***	***$46,216,708***	***171,875***	***$34,009,461***	***400,286***	***$80,226,169***	***6,031***	***$192,527***	***7,146***	***$310,087***	***13,177***	***$502,615***

Description	Pharmacy						Vision					
	March 2021		September 2021		Total		March 2021		September 2021		Total	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Sample Data												
Total Submitted Claims Sample Data	146,252	$17,594,833	126,963	$19,683,464	273,215	$37,278,296	4,145	$408,054	3,321	$326,038	7,466	$734,092
Claim Lines Not Identified in the Supplemental Claims Data												
Entire Claim	***(19,383)***	***($4,510,225)***	***(15,141)***	***($4,796,755)***	***(34,524)***	***($9,306,981)***	***0***	***$0***	***(1)***	***$0***	***(1)***	***$0***
Matched Sample Claims	***126,869***	***$13,084,607***	***111,822***	***$14,886,708***	***238,691***	***$27,971,316***	***4,145***	***$408,054***	***3,320***	***$326,038***	***7,465***	***$734,092***
Supplemental Claims Data												
Total Matched Supplemental Claims	126,869	$13,128,514	111,822	$12,157,092	238,691	$25,285,606	4,145	$216,702	3,320	$177,822	7,465	$394,524
Less Payment Adjustment	0	($43,907)	0	$2,729,617	0	$2,685,710	0	$191,352	0	$148,216	0	$339,568
Net Matched Supplemental Claims	***126,869***	***$13,084,607***	***111,822***	***$14,886,708***	***238,691***	***$27,971,316***	***4,145***	***$408,054***	***3,320***	***$326,038***	***7,465***	***$734,092***

Appendix C: Key Data Element Tested

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

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

Appendix D: Key Data Element Matching

Medical																							
Key Data Element	March 2021							September 2021							Total								
	Number of Claims Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Claims Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Claims Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		
		Count	Percent	Count	Percent	Count	Percent		Count	Percent	Count	Percent	Count	Percent		Count	Percent	Count	Percent	Count	Percent		
Bill Type (digits 1 and 2)	51,022	50,941	99.8%	72	0.1%	9	0.0%	39,895	39,870	99.9%	9	0.0%	16	0.0%	90,917	90,811	99.9%	81	0.1%	25	0.0%		
Billed Charges	228,411	227,727	99.7%	0	0.0%	684	0.3%	171,875	171,569	99.8%	0	0.0%	306	0.2%	400,286	399,296	99.8%	0	0.0%	990	0.2%		
Billing Provider NPI/Number	228,411	228,396	100.0%	0	0.0%	15	0.0%	171,875	171,875	100.0%	0	0.0%	0	0.0%	400,286	400,271	100.0%	0	0.0%	15	0.0%		
Diagnosis Codes	228,411	228,363	100.0%	0	0.0%	48	0.0%	171,875	171,805	100.0%	0	0.0%	70	0.0%	400,286	400,168	100.0%	0	0.0%	118	0.0%		
Date of Service - First	228,411	228,410	100.0%	0	0.0%	1	0.0%	171,875	171,875	100.0%	0	0.0%	0	0.0%	400,286	400,285	100.0%	0	0.0%	1	0.0%		
Date of Service - Last	228,411	228,261	99.9%	0	0.0%	150	0.1%	171,875	171,826	100.0%	0	0.0%	49	0.0%	400,286	400,087	100.0%	0	0.0%	199	0.0%		
Health Plan Paid Amount	228,411	216,257	94.7%	0	0.0%	12,154	5.3%	171,875	162,684	94.7%	0	0.0%	9,191	5.3%	400,286	378,941	94.7%	0	0.0%	21,345	5.3%		
Health Plan Paid Date	228,411	173,859	76.1%	0	0.0%	54,552	23.9%	171,875	169,212	98.5%	0	0.0%	2,663	1.5%	400,286	343,071	85.7%	0	0.0%	57,215	14.3%		
MMIS Member Number (Medicaid ID)	228,411	228,403	100.0%	0	0.0%	8	0.0%	171,875	171,875	100.0%	0	0.0%	0	0.0%	400,286	400,278	100.0%	0	0.0%	8	0.0%		
Place of Service	177,389	177,236	99.9%	0	0.0%	153	0.1%	131,980	131,927	100.0%	0	0.0%	53	0.0%	309,369	309,163	99.9%	0	0.0%	206	0.1%		
Procedure Code	225,098	224,872	99.9%	0	0.0%	226	0.1%	169,366	169,365	100.0%	0	0.0%	1	0.0%	394,464	394,237	99.9%	0	0.0%	227	0.1%		
Procedure Code Modifiers	225,098	224,843	99.9%	0	0.0%	255	0.1%	169,366	169,172	99.9%	0	0.0%	194	0.1%	394,464	394,015	99.9%	0	0.0%	449	0.1%		
Revenue Code	51,022	50,902	99.8%	90	0.2%	30	0.1%	39,895	39,839	99.9%	51	0.1%	5	0.0%	90,917	90,741	99.8%	141	0.2%	35	0.0%		
Service/Rendering Provider NPI / Number	228,411	228,371	100.0%	0	0.0%	40	0.0%	171,875	171,775	99.9%	0	0.0%	100	0.1%	400,286	400,146	100.0%	0	0.0%	140	0.0%		
Surgical Procedure Codes	3,313	3,310	99.9%	0	0.0%	3	0.1%	2,509	2,509	100.0%	0	0.0%	0	0.0%	5,822	5,819	99.9%	0	0.0%	3	0.1%		
Total	***2,788,641***	***2,720,151***	***97.5%***	***162***	***0.0%***	***68,328***	***2.5%***	***2,099,886***	***2,087,178***	***99.4%***	***60***	***0.0%***	***12,648***	***0.6%***	***4,888,527***	***4,807,329***	***98.3%***	***222***	***0.0%***	***80,976***	***1.7%***		

Note: Contains Inpatient, Outpatient, and Professional

Non-Emergent Transportation																		
Key Data Element	March 2021						September 2021						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Billed Charges	6,031	100.0%	0	0.0%	0	0.0%	7,146	100.0%	0	0.0%	0	0.0%	13,177	100.0%	0	0.0%	0	0.0%
Date of Service - First	61	1.0%	0	0.0%	5,970	99.0%	143	2.0%	0	0.0%	7,003	98.0%	204	1.5%	0	0.0%	12,973	98.5%
Health Plan Paid Amount	6,031	100.0%	0	0.0%	0	0.0%	7,146	100.0%	0	0.0%	0	0.0%	13,177	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	6,031	100.0%	0	0.0%	0	0.0%	7,146	100.0%	0	0.0%	0	0.0%	13,177	100.0%	0	0.0%	0	0.0%
MMIS Member Number (Medicaid ID)	6,016	99.8%	0	0.0%	15	0.2%	7,126	99.7%	0	0.0%	20	0.3%	13,142	99.7%	0	0.0%	35	0.3%
Procedure Code	456	7.6%	0	0.0%	5,575	92.4%	814	11.4%	0	0.0%	6,332	88.6%	1,270	9.6%	0	0.0%	11,907	90.4%
Procedure Code Modifiers	32	0.5%	N/A		5,999	99.5%	0	0.0%	N/A		7,146	100.0%	32	0.2%	N/A		13,145	99.8%
Total	***24,658***	***58.4%***	***0***	***0.0%***	***17,559***	***41.6%***	***29,521***	***59.0%***	***0***	***0.0%***	***20,501***	***41.0%***	***54,179***	***58.7%***	***0***	***0.0%***	***38,060***	***41.3%***
Total Records in the Supplemental Claims Data	6,031						7,146						13,177					
Number of Key Data Element Evaluated	7						7						7					
Maximum Count	42,217	100.0%					50,022	100.0%					92,239	100.0%				

Pharmacy																		
Key Data Element	March 2021						September 2021						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Billed Charges	121,334	95.6%	0	0.0%	5,535	4.4%	2,587	2.3%	0	0.0%	109,235	97.7%	123,921	51.9%	0	0.0%	114,770	48.1%
Days Supply	124,651	98.3%	0	0.0%	2,218	1.7%	111,507	99.7%	0	0.0%	315	0.3%	236,158	98.9%	0	0.0%	2,533	1.1%
Fill Date	126,869	100.0%	0	0.0%	0	0.0%	111,822	100.0%	0	0.0%	0	0.0%	238,691	100.0%	0	0.0%	0	0.0%
MCO Paid Amount	124,523	98.2%	0	0.0%	2,346	1.8%	79,850	71.4%	0	0.0%	31,972	28.6%	204,373	85.6%	0	0.0%	34,318	14.4%
MCO Paid Date	10,496	8.3%	0	0.0%	116,373	91.7%	3,988	3.6%	0	0.0%	107,834	96.4%	14,484	6.1%	0	0.0%	224,207	93.9%
MMIS Member Number (Medicaid ID)	126,868	100.0%	0	0.0%	1	0.0%	111,822	100.0%	0	0.0%	0	0.0%	238,690	100.0%	0	0.0%	1	0.0%
National Drug Code (NDC)	126,869	100.0%	0	0.0%	0	0.0%	111,790	100.0%	0	0.0%	32	0.0%	238,659	100.0%	0	0.0%	32	0.0%
Prescribing Provider NPI	126,769	99.9%	0	0.0%	100	0.1%	111,758	99.9%	0	0.0%	64	0.1%	238,527	99.9%	0	0.0%	164	0.1%
Quantity Dispensed	125,097	98.6%	0	0.0%	1,772	1.4%	111,522	99.7%	0	0.0%	300	0.3%	236,619	99.1%	0	0.0%	2,072	0.9%
Refill Number	45,934	36.2%	15,526	12.2%	65,409	51.6%	47,976	42.9%	15,359	13.7%	48,487	43.4%	93,910	39.3%	30,885	12.9%	113,896	47.7%
Total	***1,059,410***	***83.5%***	***15,526***	***1.2%***	***193,754***	***15.3%***	***804,622***	***72.0%***	***15,359***	***1.4%***	***298,239***	***26.7%***	***1,864,032***	***78.1%***	***30,885***	***1.3%***	***491,993***	***20.6%***
Total Records in the Supplemental Claims Data	126,869						111,822						238,691					
Number of Key Data Element Evaluated	10						10						10					
Maximum Count	1,268,690	100.0%					1,118,220	100.0%					2,386,910	100.0%				

Vision																		
Key Data Element	March 2021						September 2021						Total					
	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Billed Charges	4,145	100.0%	0	0.0%	0	0.0%	3,320	100.0%	0	0.0%	0	0.0%	7,465	100.0%	0	0.0%	0	0.0%
Billing Provider NPI/Number	3,468	83.7%	0	0.0%	677	16.3%	2,911	87.7%	0	0.0%	409	12.3%	6,379	85.5%	0	0.0%	1,086	14.5%
Diagnosis Codes	4,145	100.0%	0	0.0%	0	0.0%	3,319	100.0%	0	0.0%	1	0.0%	7,464	100.0%	0	0.0%	1	0.0%
Date of Service - First	4,145	100.0%	0	0.0%	0	0.0%	3,320	100.0%	0	0.0%	0	0.0%	7,465	100.0%	0	0.0%	0	0.0%
Date of Service - Last	4,145	100.0%	0	0.0%	0	0.0%	3,320	100.0%	0	0.0%	0	0.0%	7,465	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	4,145	100.0%	0	0.0%	0	0.0%	3,319	100.0%	0	0.0%	1	0.0%	7,464	100.0%	0	0.0%	1	0.0%
Health Plan Paid Date	652	15.7%	0	0.0%	3,493	84.3%	385	11.6%	0	0.0%	2,935	88.4%	1,037	13.9%	0	0.0%	6,428	86.1%
MMIS Member Number (Medicaid ID)	4,145	100.0%	0	0.0%	0	0.0%	3,320	100.0%	0	0.0%	0	0.0%	7,465	100.0%	0	0.0%	0	0.0%
Place of Service	4,145	100.0%	0	0.0%	0	0.0%	3,320	100.0%	0	0.0%	0	0.0%	7,465	100.0%	0	0.0%	0	0.0%
Procedure Code	4,145	100.0%	0	0.0%	0	0.0%	3,320	100.0%	0	0.0%	0	0.0%	7,465	100.0%	0	0.0%	0	0.0%
Procedure Code Modifiers	4,145	100.0%	N/A		0	0.0%	3,320	100.0%	N/A		0	0.0%	7,465	100.0%	N/A		0	0.0%
Service/Rendering Provider NPI / Number	4,145	100.0%	0	0.0%	0	0.0%	3,320	100.0%	0	0.0%	0	0.0%	7,465	100.0%	0	0.0%	0	0.0%
Total	***45,570***	***91.6%***	***0***	***0.0%***	***4,170***	***8.4%***	***36,494***	***91.6%***	***0***	***0.0%***	***3,346***	***8.4%***	***82,064***	***91.6%***	0	0.0%	***7,516***	***8.4%***
Total Records in the Supplemental Claims Data	4,145						3,320						7,465					
Number of Key Data Element Evaluated	12						12						12					
Maximum Count	49,740	100.0%					39,840	100.0%					89,580	100.0%				

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

Description	Heritage Health				NETC				Heritage Health	
	Members									
Distinct Member Count receiving services based on supplemental claims data - CY 2021	369,789				137,393				37.2%	
									Percentage Variance	
Service Type	***Count***	***PMPY[1] Count***	***Paid Amount***	***PMPY[1] Amount***	***Count***	***PMPY[1] Count***	***Paid Amount***	***PMPY[1] Amount***	***Count***	***Amount***
Ancillary	750,773	2.0	$62,525,550	$ 169	0	0.0	$0	$ -	-100.0%	-100.0%
Inpatient	618,960	1.7	$367,549,774	$ 994	229,181	1.7	$144,736,213	$ 1,053	-0.3%	6.0%
Non-Emergent Transportation	181,764	0.5	$5,954,958	$ 16	69,727	0.5	$2,666,787	$ 19	3.2%	20.5%
Outpatient	2,784,094	7.5	$391,509,493	$ 1,059	952,487	6.9	$122,596,792	$ 892	-7.9%	-15.7%
Pharmacy	4,230,948	11.4	$362,119,011	$ 979	1,386,485	10.1	$139,452,810	$ 1,015	-11.8%	3.6%
Primary Care	2,529,758	6.8	$166,694,966	$ 451	904,976	6.6	$63,277,574	$ 461	-3.7%	2.2%
Specialty	1,385,024	3.7	$105,326,121	$ 285	1,016,516	7.4	$76,025,578	$ 553	97.5%	94.3%
Vision	378,797	1.0	$11,697,296	$ 32	127,241	0.9	$4,117,502	$ 30	-9.6%	-5.3%
Total Services[2]	***12,860,118***	***34.8***	***$1,473,377,168***	***$3,984***	***4,686,613***	***34.1***	***$552,873,254***	***$4,024***	***-1.9%***	***1.0%***

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

[2] Differences are due to rounding.

Appendix F: Timely Payment of Claims

Encounter Type	30 Days - 90%		90 Days - 99%			180 Days - 100%			Over 180 Days - 100%			Total Count	Average Days
		Percentage		Percentage			Percentage			Percentage			
	Count	Absolute	Count	Absolute	Cumulative	Count	Absolute	Cumulative	Count	Absolute	Cumulative		
Inpatient	4,865	84.8%	467	8.1%	92.9%	309	5.4%	98.3%	97	1.7%	100.0%	5,738	19
Outpatient	80,781	95.3%	2,183	2.6%	97.8%	1,524	1.8%	99.6%	317	0.4%	100.0%	84,805	10
Professional	292,345	94.7%	4,828	1.6%	96.2%	9,774	3.2%	99.4%	1,906	0.6%	100.0%	308,853	12
Vision	7,465	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	7,465	6
NEMT	13,124	99.6%	53	0.4%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	13,177	11
Pharmacy	237,751	99.6%	601	0.3%	99.9%	284	0.1%	100.0%	55	0.0%	100.0%	238,691	2
Total	***636,331***	***96.6%***	***8,132***	***1.2%***	***97.8%***	***11,891***	***1.8%***	***99.6%***	***2,375***	***0.4%***	***100.0%***	***658,729***	***8***

Appendix G: Medical Records Validity Rate

Inpatient					
	Total Elements Sampled	Supported Elements		Unsupported Elements	
Key Data Element	Count	Count	Percent	Count	Percent
Member DOB	7	7	100.0%	0	0.0%
Admit Date	7	7	100.0%	0	0.0%
First DOS	7	7	100.0%	0	0.0%
Last DOS	7	6	85.7%	1	14.3%
Type of Bill Code	7	7	100.0%	0	0.0%
Revenue Code	216	205	94.9%	11	5.1%
DRG	5	2	40.0%	3	60.0%
Diagnosis Codes	28	28	100.0%	0	0.0%
Servicing Provider	7	7	100.0%	0	0.0%
Surgical Procedure Codes	10	10	100.0%	0	0.0%
Billing Provider	7	7	100.0%	0	0.0%
Total	**308**	**293**	**95.1%**	**15**	**4.9%**

Note: 111 of the 120 medical records requested were tested.

Outpatient					
	Total Elements Sampled	Supported Elements		Unsupported Elements	
Key Data Element	Count	Count	Percent	Count	Percent
Member DOB	37	34	91.9%	3	8.1%
First DOS	37	37	100.0%	0	0.0%
Last DOS	37	36	97.3%	1	2.7%
Type of Bill Code	28	26	92.9%	2	7.1%
Revenue Code	307	257	83.7%	50	16.3%
Procedure Code	311	263	84.6%	48	15.4%
Procedure Modifiers	26	25	96.2%	1	3.8%
Diagnosis Codes	110	99	90.0%	11	10.0%
Servicing Provider	37	35	94.6%	2	5.4%
Billing Provider	37	35	94.6%	2	5.4%
Total	***967***	***847***	***87.6%***	***120***	***12.4%***

Note: 111 of the 120 medical records requested were tested.

	Vision					Other Professional					Professional Total				
	Total Elements Sampled	Supported Elements		Unsupported Elements		Total Elements Sampled	Supported Elements		Unsupported Elements		Total Elements Sampled	Supported Elements		Unsupported Elements	
Key Data Element	Count	Count	Percent	Count	Percent	Count	Count	Percent	Count	Percent	Count	Count	Percent	Count	Percent
Member DOB	1	1	100.0%	0	0.0%	35	33	94.3%	2	5.7%	36	34	94.4%	2	5.6%
First DOS	1	0	0.0%	1	100.0%	35	33	94.3%	2	5.7%	36	33	91.7%	3	8.3%
Last DOS	1	0	0.0%	1	100.0%	35	33	94.3%	2	5.7%	36	33	91.7%	3	8.3%
Place of Service	1	1	100.0%	0	0.0%	35	34	97.1%	1	2.9%	36	35	97.2%	1	2.8%
Procedure Code	3	3	100.0%	0	0.0%	126	114	90.5%	12	9.5%	129	117	90.7%	12	9.3%
Procedure Modifiers	0	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%
Diagnosis Codes	1	1	100.0%	0	0.0%	75	72	96.0%	3	4.0%	76	73	96.1%	3	3.9%
Servicing Provider	1	1	100.0%	0	0.0%	35	32	91.4%	3	8.6%	36	33	91.7%	3	8.3%
Billing Provider	1	1	100.0%	0	0.0%	35	29	82.9%	6	17.1%	36	30	83.3%	6	16.7%
Total	***10***	***8***	***80.0%***	***2***	***20.0%***	***411***	***380***	***92.5%***	***31***	***7.5%***	***421***	***388***	***92.2%***	***33***	***7.8%***

Note: 111 of the 120 medical records requested were tested.

Pharmacy					
	Total Elements Sampled	Supported Elements		Unsupported Elements	
Key Data Element	Count	Count	Percent	Count	Percent
Member DOB	31	31	100.0%	0	0.0%
Date of Service	31	31	100.0%	0	0.0%
Billing Provider	31	31	100.0%	0	0.0%
Nation Drug Code (NDC)	31	31	100.0%	0	0.0%
Quantity Dispensed	31	31	100.0%	0	0.0%
Days Supply	31	31	100.0%	0	0.0%
Prescribing Provider	31	30	96.8%	1	3.2%
Total	***217***	***216***	***99.5%***	***1***	***0.5%***

Note: 111 of the 120 medical records requested were tested.

Appendix H Plan Response Letter

2525 N. 117th Ave, Suite 100
Omaha, Nebraska 68164

June 8, 2023

Myers & Stauffer, LC
CC: Nebraska Department of Health and Human Services

Dear Myers & Stauffer, LC,

Nebraska Total Care, Inc. (NETC) participated in a CMS External Quality Review (EQR) Protocol 5, *Validation of Encounter Data*, to evaluate the completeness and accuracy of supplemental claims data, used for rate setting in the State's Medicaid Managed Care program, Heritage Health. Calendar year 2021, was the review period for supplemental claims data submitted to Optumas, the State's actuary.

Protocol 5 is a voluntary protocol that CMS strongly encourages states contract with qualified entities to evaluate Medicaid encounter data and meet audit requirements of the final rule. NETC understands the importance that Protocol 5 enables for states to meet data validation and monitoring requirements, in addition to identifying potential gaps in service, evaluating program effectiveness, and noting strengths, as well as opportunities for enhancing program oversight.

The accompanying responses were prepared for consideration to the results and observations noted by Myers & Stauffer, LC, as based on information NETC provided, interviews with subject matter experts, and known data limitations, at the time of review. NETC will continue to partner with Medicaid Long Term Care (MLTC) and implement required and or recommended objectives that result from this CMS EQR Protocol 5, *Validation of Encounter Data,* based on the State's Medicaid Managed Care program guidance, going forward.

Sincerely,

Jennifer Cintani,
Vice President, Compliance

Activity 2: Review Health Plan Capability

2-A: The health plan's DRP consists of four (4) levels of testing (walkthroughs, simulations, parallel testing, and interruption testing.) According to the health plan's policies, the health plan's ability to recover from a disaster successfully should be tested annually with one or more of these tests being completed. Per the company personnel interviewed in January 2023, a tabletop activity occurred in December 2021, but no further testing has occurred since that time. Additionally, the plan could not provide a record of the last time higher level testing was conducted beyond a walkthrough.

2A Recommendation: The health plan should ensure their policy of performing an annual test is followed consistently and that the testing level is adequate to provide assurance that its recovery strategy is effective.

2-A Response: *NETC understands the importance of regular business continuity testing. NETC and its service partners with Centene performed intensive revisions and updates to the Business Continuity Plan in 2022. These activities involved validating, refreshing, and adjusting NETC's business impact analysis, and loaded into Centene's Risk Management software. As a result of this immersive and collaborative refresh work, NETC did not perform an exercise in 2022. NETC currently has planned an exercise in September of 2023. This will allow NETC to evaluate the changes and adjustments made during 2022.*

Activity 3: Analyze Electronic Encounter Data

3-A Finding: The pharmacy claims included in the supplemental claims data did not meet 95 percent threshold compared to the CDJ amounts (92.5 percent).

3-A Recommendation: The health plan should review the process in place for preparing the supplemental claims data to be submitted to Optumas to ensure all claims are included.

3-A Response: *Supplemental claims data was submitted by Optumas to Myers & Stauffer, and contained all data received from Nebraska Total Care for calendar year 2021, through May 2022. Per claims data request requirements, CDJ files were pulled by Nebraska Total Care including claim transactions with paid dates in March 2021 and September 2021 plus subsequent adjustments etc., that may have occurred outside the sample months of March 2021 and September 2021. Optumas supplemental claims data will not directly tied to CDJ due to adjustments that occurred between May 2022 through November when the CDJ was pulled.*

3-B Finding: The pharmacy claims included in the supplemental claims data did not meet the 95 percent threshold for completeness when compared to the claims counts (87.4 percent).

3-B Recommendation: The health plan should review the process in place for preparing the supplemental claims data to be submitted to Optumas to ensure all claims are included.

3-B Response: *Supplemental claims data was submitted by Optumas to Myers & Stauffer, and contained all data received from Nebraska Total Care for calendar year 2021, through May 2022. Per claims data request requirements, Pharmacy Claims Data included all claims activity based on*

adjudication date. Optumas supplemental claims data will not directly tie to plan pharmacy claims due to claims activity adjustments that occurred between May 2022 through November, when the claims data was pulled.

3-C Finding: The transportation, pharmacy, and vision, claims included in the supplemental claims data did not meet the 95 percent threshold for completeness when compared to the claims paid amounts (75.0 percent).

3-C Recommendation: The health plan should review the process in place for preparing the supplemental claims data to be submitted to Optumas to ensure all claims are included.

3-C Response: *NETC will work with our subcontractors to ensure consistency between datasets. The supplemental pharmacy claims data was submitted by Optumas to Myers & Stauffer, and contained all data received from Nebraska Total Care for calendar year 2021, through May 2022. Per claims data request requirements, Pharmacy Claims Data included all claims activity based on adjudication date. Optumas supplemental claims data will not directly tie to plan pharmacy claims due to claims activity adjustments that occurred between May 2022 through November when the claims data was pulled.*

3-D Finding: Related to Inpatient, Outpatient, Professional, Pharmacy, and Vision; the dates were populated in both the claims and supplemental claims data populations but do not agree for all claims which were identified as having accuracy issues.

3-D Recommendation: The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate paid dates are being reported.

3-D Response: *NETC will work with our subcontractors to ensure consistency between datasets. Per claims data request requirements, pharmacy claims data was submitted based on adjudication date within the sampled months. Any subsequent adjustments (reversal, resubmission) on a claim that occurred outside the sampled months would impact health plan paid date. Field specs: Date the claim was adjudicated (paid or denied) by the MCP or its subcontractor.*

3-E Finding: Related to Professional, Pharmacy, and Vision; the paid amounts were populated in both the claims and supplemental claims data populations but do not agree for all claims which were identified as having accuracy issues.

3-E Recommendation: The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate paid amounts are being reported.

3-E Response: *NETC will work with our subcontractors to ensure consistency between datasets. As requested by Myers & Stauffer, pharmacy claims data was submitted based on adjudication date. Any subsequent adjustments (reversal, resubmission) on a claim that occurred outside the sampled months would impact health plan paid amount. Field specs: Total amount paid by the MCP or subcontractor on the claim (excluding interest, capitation/sub-capitation).*

3-F Finding: Related to Vision; the billing provider NPIs were populated in the claims sample claims data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.

3-F Recommendation: The health plan should review its process for submitting supplemental claims data to Optumas to ensure billing provider NPIs are being reported.

3-F Response: *NETC will work with our subcontractors to ensure consistency between datasets.*

3-G Finding: Related to Pharmacy; the billed charges were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.

3-G Recommendation: The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate billed charges are being reported.

3-G Response: *As requested by Myers & Stauffer, claims data was submitted based on adjudication date. Any subsequent adjustments (reversal, resubmission) on a claim that occurred outside the sampled months may impact billed charges (changes in drug cost/pricing, coordination of benefits/eligibility, etc.)*

3-H Finding: Related to Pharmacy; the refill numbers were populated in the claims sample data and supplemental claims data but did not match for some claims that were identified as having accuracy issues. For another portion of claims, the refill number was not populated in the supplemental claims data.

3-H Recommendation: The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate refill numbers are being reported.

3-H Response: *As requested by Myers & Stauffer, claims data was submitted based on adjudication date. Any subsequent adjustments (reversal, resubmission) on a claim that occurred outside the sampled months may impact refill number. Per the pharmacy claims data file specifications, "blank" was a data input option. The number indicating whether a prescription is an original or a refill*
Field Specs:
Blank = Unknown
0 = New Script
1 = First Refill
2 = 2nd Refill
3 = 3rd Refill
4 = 4th Refill
5 = 5th Refill
6 = 6th Refill
7 = 7th Refill
8 = 8th Refill
9 = 9th Refill
A = 10th Refill
B = 11th Refill

3-I Finding: Related to Transportation; the first dates of service were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.

3-I Recommendation: The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate first date of service are being reported.

3-I Response: *NETC will work with our subcontractors to ensure consistency between datasets.*

3-J Finding: Related to Transportation; the procedure codes were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.

3-J Recommendation: The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate procedure codes are being reported.

3-J Response: *NETC will work with our subcontractors to ensure consistency between datasets.*

3-K Finding: Related to Transportation; the procedure code modifiers were populated in the claims sample data and supplemental claims data but did not match for all claims that were identified as having accuracy issues.

3-K Recommendation: The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate procedure code modifiers are being reported.

3-K Response: *NETC will work with our subcontractors to ensure consistency between datasets.*

3-L Finding: The plan did not meet the timeliness standards for inpatient, outpatient, or professional claims.

3-L Recommendation: The health plan should ensure their claims are adjudicated promptly in order to meet the timeliness requirements established within the contract between DHHS and the health plan.

3-L Response: *NETC is meeting contractual claims payment timeliness standards in aggregate of 90% or more claims paid within 15 business days.*

Activity 4: Review of Medical Records

4-A Finding: The health plan was not able to provide a medical record to support 1 of 120 records requested. Additionally, the health plan provided medical records for the wrong timeframe for 8 of the 100 records that were submitted.

4-A Recommendation: The health plan should work with its providers to ensure medical records are available and submitted for the members and dates of service requested, and are submitted within the requested time frame(s).

4-A Response: *Nebraska Total Care has partnerships in place across the state with the provider community. Our Utilization Management, Quality, and Provider Services/Relations teams, work to support timely receipt of medical records for services requiring authorization and as needed for ad hoc review when services don't require prior authorization.*

4-B Finding: Validation rates for outpatient and professional claims were below the 95 percent accuracy threshold for the 89 records that were tested (87.6 percent and 92.2 percent respectively).

4-B Recommendation: The health plan should review the claims with accuracy issues and determine the root cause of missing or mismatched data then develop a plan to address the issue with adjustment to their processes.

4-B Response: *NETC consistently submits claims accuracy reports monthly to MLTC in line with identified template to support claims accuracy tracking, solution status and review.*