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.

April 30, 2024

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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Executive Summary

The Nebraska Department of Health and Human Services (DHHS, or "State"), Division of Medicaid and Long-Term Care (MLTC) engaged Myers and Stauffer to perform CMS' External Quality Review (EQR) Protocol 5, *Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*, to evaluate the completeness and accuracy of the supplemental claims data submitted by Nebraska Total Care, Inc. (NETC or health plan) and used for rate setting for the State's Medicaid Managed Care program, Heritage Health. The health plan's calendar year (CY) 2022 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), April 2022 and November 2022, 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, April 2022 and November 2022.
- Medical records for review, which were randomly sampled from the supplemental claims data with dates of service occurring during CY 2022. 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 2022, which contained all data received through May 2023.
- A copy of the encounter data Optumas received from HealthInteractive (HIA), which included encounters received and processed through May 31, 2023, which was used to inform only Activities one and two of this report.

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.

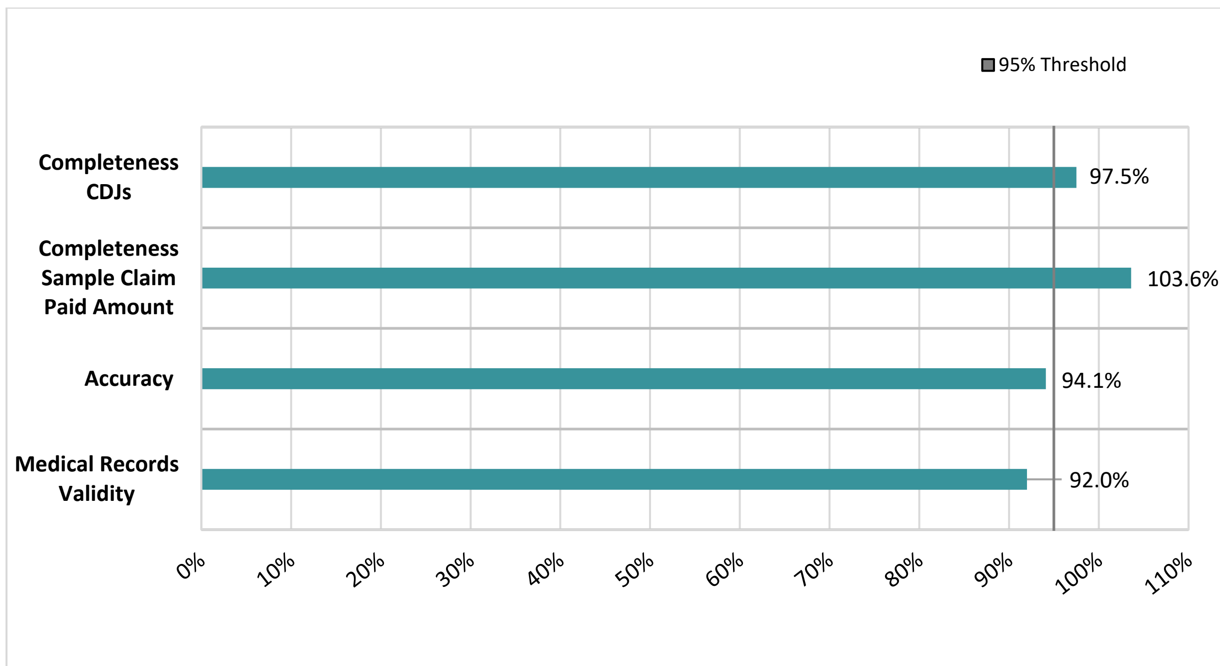
Observations and findings are based on the information provided and known at the time of the review. The health plan should work with DHHS, HIA and/or Optumas to resolve issues noted within the supplemental claims data or the encounter data.

Findings

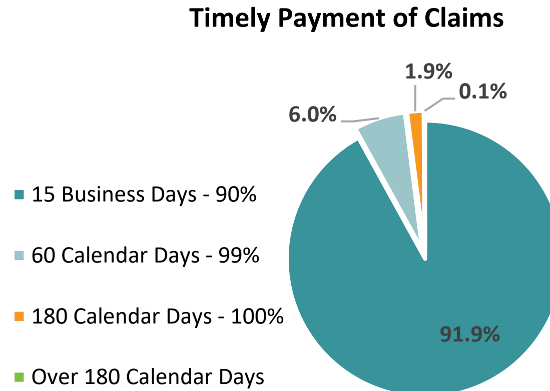
- **Completeness:** The aggregate CDJ and sample claim paid amount completion percentages were above the 95 percent threshold (97.5 and 103.6 percent, respectively). The medical, transportation, and vision supplemental claims data completion percentages met the 95 percent threshold when compared to CDJ transactions and sample claim data paid amounts. Pharmacy supplemental claims data were below the 95 percent threshold when compared to CDJ paid amounts and above the 95 percent threshold when compared to sample claims data paid amounts.

- **Accuracy:** The overall accuracy percentage was 94.1 percent for all claim types and all key data elements reviewed.

- **Medical Record Validation Rates:** 110 of the 120 medical records requested were submitted for review. The validation rate for the medical records tested was below the 95 percent threshold (92.0 percent).



- **Timeliness:** The health plan paid 91.9 percent of claims to providers within 15 business days. The health plan did not pay a minimum of 99 percent of claims to providers within 60 calendar days.



We have made recommendations within the report related to the findings and weaknesses identified within the CY 2022 supplemental claims data. These recommendations are intended to improve the integrity of the supplemental claims data. A detailed summary of our findings can be found in the Activity 5 section of the report. The report also includes appendices which provide the detailed analyses behind the counts, amounts and percentage values reflected in 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]

The Centers for Medicare & Medicaid Services (CMS) established requirements for states to improve the reliability of encounter data collected from managed care health plans. In 2016, the Medicaid managed care final rule, required states to conduct an independent audit of encounter data reported by each managed care health plan. Revisions to the Medicaid managed care regulations enhanced quality oversight criteria. Under the 2020 final rule, encounter data must include allowed and paid amounts and states must annually post on its website health plans that are exempt from external quality review[2].

CMS indicated that states could meet the independent audit requirement by conducting an encounter data validation study based on EQR Protocol 5[3]. Protocol 5 assesses the completeness and accuracy of the encounter data that has been adjudicated (i.e., paid or denied) by the health plan and submitted to the State. Although Protocol 5 is a voluntary protocol, CMS strongly encourages states to contract with qualified entities to implement Protocol 5 to meet the audit requirement of the final rule. 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. The state is in the process of working through known issues prior to utilizing the data from the system for rate setting purposes. In

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[1] https://dhhs.ne.gov/Pages/Heritage-Health-Contacts.aspx
[2] https://www.cms.gov/newsroom/fact-sheets/medicaid-childrens-health-insurance-program-chip-managed-care-final-rule-cms-2408-f
[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

order to calculate the 2022 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) 2022 and paid through May 2023.

The Nebraska Department of Health and Human Services (DHHS) Division of Medicaid and 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 2022 for the State's Medicaid Managed Care program. CMS guidelines were followed and implemented during the review.

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.

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's 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 tested for the SFY 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. Optumas plans to implement a field for interest payments starting with the request for the calendar year 2025 rate setting process.
1-C	There was no clear guidance as to what was being attested to in the encounter level attestation segment within the health plans encounter submissions during the measurement period.	DHHS has implemented a process to obtain an attestation from each health plan, annually, indicating what is being attested to on the encounter level attestation. This documentation was obtained for the first time in 2024 and will be obtained annually, going forward.

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[5]. 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**
There were no findings related to our review of the health plan's capabilities.	

[5] 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 medical 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 that 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 (April 2022 and November 2022) from the health plan**.** The health plan's CY 2022 supplemental claims data was reviewed to determine the data's completeness when compared to the CDJ files from a financial perspective. **Figure 1** shows the completion percentages for the combination of the two sample months tested for CY 2022.

Supplemental Claims Data and CDJ Completion Percentages

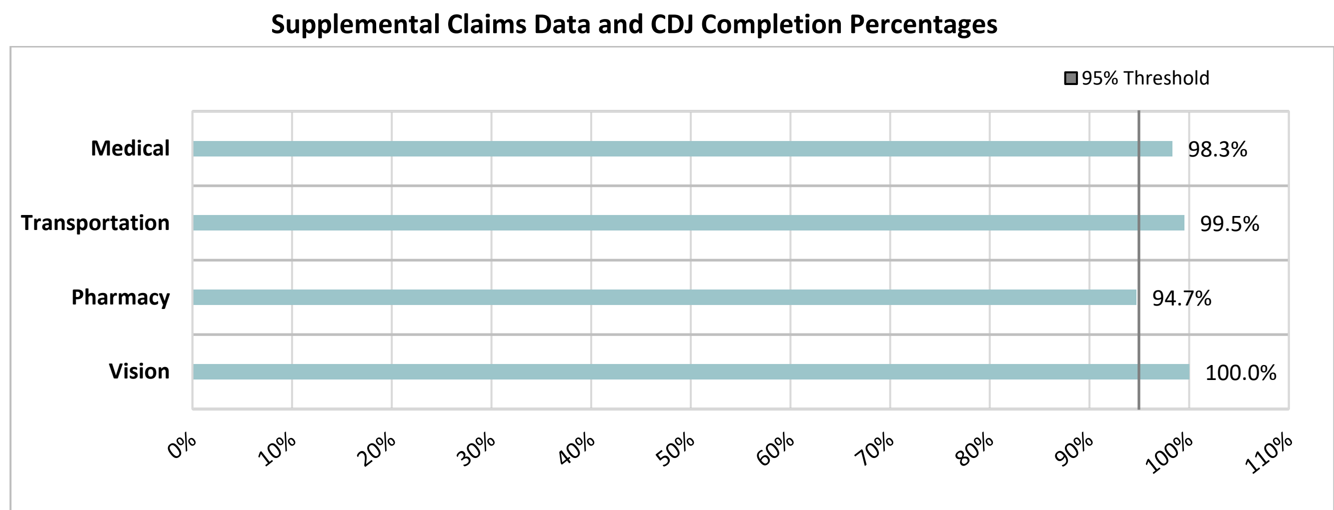

Figure 1: CDJ Completion Percentages. CDJ transactions compared to supplemental claims data transactions**.** Detailed results can be found in Appendix A.

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 criterion:

- Sample Claim Paid Amount: Sample claims data paid amounts compared to supplemental claims data paid amounts.

The comparison between sample claims data counts and those identified in the supplemental claims data was excluded from our analysis. This decision was based on the difference in data composition: the Optumas data extract contains only final claims, while the sample claims data includes all iterations. This disparity would lead to inflated sample claims data counts if compared directly.

Denied ($0.00) claims were removed from the sample claims data during the analysis since they bear no impact on paid amounts and since there is only final paid claims in the supplemental claims data.

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 paid amounts to supplemental claims data 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

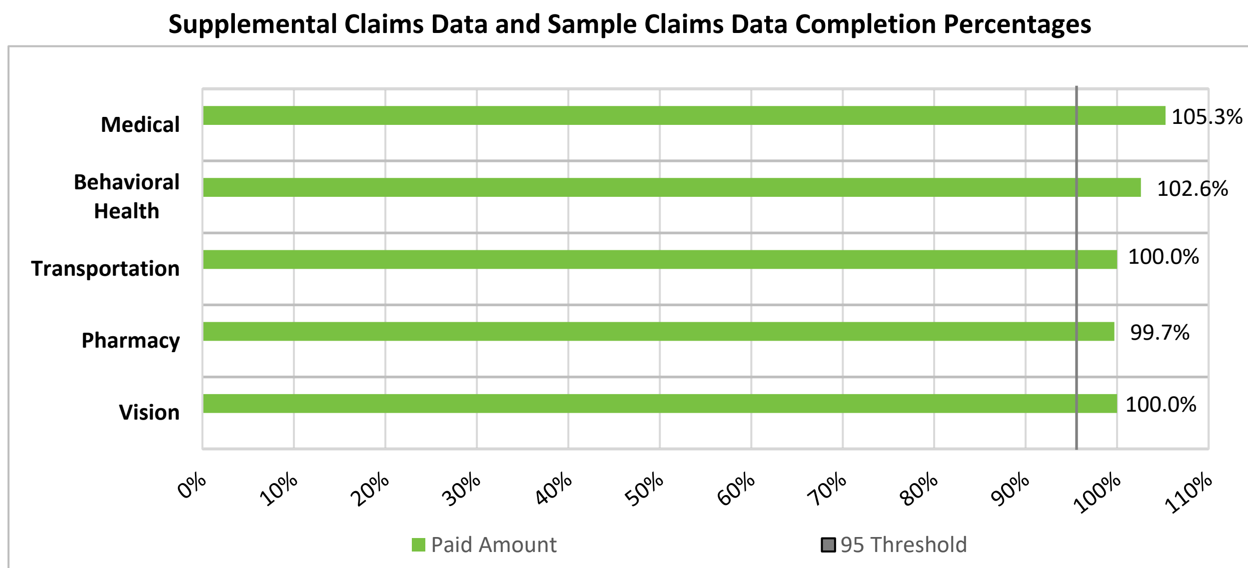

Figure 2: Completion Percentages for Paid, Adjusted, and/or Void Sample Claims. Sample claims data paid amounts compared to supplemental claims data paid amounts**.** Detailed results can be found in Appendix B.

Completion percentages for the supplemental claims data when compared to sample claims data met the 95 percent threshold for all claim types. Values reflect the two sample months of April 2022 and November 2022. Sample claims with paid (adjudication) dates outside of the sample months were excluded from the validation. Completion percentages greater than 100 percent may be due to incomplete data, potential duplicates, or claims, voids, replacements, adjustments and/or other transactions present or absent from the supplemental data.

Accuracy

For the purpose of validating supplemental claims data accuracy, certain key data elements were selected for testing. See Appendix C 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 in the sample claims data. Consistency checks on blank or null data element values were also applied. The key data elements were evaluated based on the following criteria:

- Valid Values: The supplemental claim's key data element value matched the sample claim's key data element value. If the supplemental claim's key data element was blank (or NULL) and the data element in the sample claim was also blank (or NULL), it was considered valid.
- Missing Values: The supplemental claim's 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 supplemental claim's 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. Or, the sample claim's key data element was blank (or NULL) and the data element in the supplemental claim was populated (i.e., had a value).

Accuracy issues concerning health plan paid dates were observed in the supplemental claims data for vision and pharmacy claims. Additionally, discrepancies were noted in billed charges and refill numbers for pharmacy claims. Further accuracy issues were identified with procedure codes and procedure code modifiers for NEMT claims. Accuracy percentages for the supplemental claims data are presented in **Table 1** by claim type. The key data elements evaluated and specific testing results are presented in Appendix C.

Accuracy Percentages – Key Data Elements Analysis			
Claim Type	**Valid Values**	**Missing Values**	**Erroneous Values**
Medical	99.6%	0.0%	0.4%
Behavioral Health	99.6%	0.0%	0.4%
Transportation	72.8%	0.0%	27.2%
Pharmacy	74.4%	1.7%	24.0%
Vision	91.8%	0.0%	8.2%
Total Average	***94.1%***	***0.3%***	***5.6%***

Table 1: Key Data Elements Accuracy Analysis. Key data elements in the supplemental claims data were compared to those in the sample claims data for accuracy validation. Detailed results can be found in Appendix C.

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 not meet the 95 percent threshold compared to the CDJ amounts (94.7 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.
3-B	**Completeness – Sample Claims Paid Amount**: The medical, transportation, pharmacy and vision claims included in the supplemental claims data met the 95 percent threshold for completeness when compared to the sample claims data paid amounts.	The health plan should continue to monitor completion percentages to ensure the supplemental claims data is complete and accurately reflects the services rendered and payments made to providers.
3-C	**Accuracy – Health Plan Paid Dates:** *Pharmacy and Vision* – The sample and supplemental claims data are both populated but the values do not agree. The majority of vision claim dates exhibit a discrepancy of one day. For example, the sample claim is dated 2022-04-06 and the supplemental claim is dated 2022-04-05.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate paid dates are being reported.
3-D	**Accuracy – Billed Charges:** *Pharmacy* – The billed charges were populated in the sample claims data and supplemental claims data, but their values do not agree.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate billing charges are being reported.
3-E	**Accuracy – Refill Number:** *Pharmacy* – The refill numbers were populated in the sample claims data and supplemental claims data, but their values do not agree. For another portion of claims, the refill numbers were 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.

Findings and Recommendations		
	Findings	**Recommendations**
3-F	**Accuracy – Procedure Code:** *NEMT* – The sample and supplemental claims data are both populated, but their values do not agree. The majority of procedure codes exhibit a discrepancy in the specific nature of the NEMT services they represent. For example, the sample claim is populated with A0100 (Non-emergency transportation; taxi) and the supplemental claim is populated with A0120 (Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems).	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate procedure codes are being reported.
3-G	**Accuracy – Procedure Code Modifier:** *NEMT* – The procedure code modifiers were populated in the sample claims data but were not populated in the supplemental claims data.	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 2022 dates of service were analyzed for consistency among attributes such as member utilization and paid amounts. The sample claims data were analyzed for consistency in the health plan's timely adjudication of claims submitted by providers.

Members, Utilization and Paid Amounts

The total number of utilized services (i.e., procedures) and total paid amounts in CY 2022 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 D.

The health plan's membership represented 34.4% percent of Heritage Health's members receiving services in 2022. Average per member counts were less than Heritage Health's, as a whole, average per member utilization, while per member paid amounts were greater than Heritage Health's average per member paid amounts.

Average Per Member Utilization and Paid Amounts by Service Type, CY 2022						
	Heritage Health		NETC		Percentage of Heritage Health	
Members						
Distinct member count receiving services based on supplemental claims data - CY 2022	364,587		125,481		34.4%	
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	2.8	*$289*	0.0	*$-*	-100.0%	-100.0%
Inpatient	1.6	*$751*	1.5	*$1,049*	-1.6%	39.6%
Non-Emergent Transportation	0.7	*$30*	0.7	*$37*	8.7%	24.5%
Outpatient	3.3	*$403*	5.5	*$716*	68.4%	77.8%
Pharmacy	13.5	*$1,240*	12.5	*$1,341*	-7.8%	8.2%
Primary Care	9.0	*$676*	8.6	*$714*	-4.4%	5.6%
Specialty	8.7	*$1,392*	10.7	*$991*	22.2%	-28.8%
Vision	1.4	*$44*	1.1	*$37*	-16.9%	-15.3%
Total Health Plan Services	***41.0***	***$4,824***	***40.7***	***$4,885***	***-0.7%***	***1.3%***

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. Detailed results can be found in Appendix D.

Timely Payment of Claims

This analysis measured 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[6]. **Table 3** shows the results of the analysis. Detailed results can be found in Appendix E.

Timely Payment of Claims				
Claim Type	**15 Business Days 90% Threshold**	**60 Calendar Days 99% Threshold**	**180 Calendar Days 100% Threshold**	**Average Days**
Inpatient	64.9%	95.2%	99.9%	19
Outpatient	80.2%	94.5%	99.9%	15
Professional	95.7%	98.9%	99.8%	9
Behavioral Health	97.1%	99.5%	99.9%	8
Vision	99.9%	99.9%	100.0%	5
NEMT	100.0%	100.0%	100.0%	11
Pharmacy	100.0%	100.0%	100.0%	0
Overall Average	***91.9%***	***97.9%***	***99.9%***	***8***

Table 3: Timely Payment of Claims. Measurement of the percentage of claims paid (adjudicated) by the health plan within the designated number of days. Percentages reflect claims with CY 2022 dates of service. Detailed results can be found in Appendix E.

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.

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

Findings and Recommendations

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

Findings and Recommendations		
	Findings	**Recommendations**
3-H	**Timely Payment of Claims**: The health plan's delegated vision, NEMT and pharmacy vendors met the 15 business day, 60 calendar day and 180 calendar day claims payment timeliness thresholds. The health plan did not meet the 15, 60 or 180 business day timeliness threshold for inpatient and outpatient claims. For professional claims, the plan met the 15 business day timeliness threshold but did not meet the 60 calendar day or 180 calendar day timeliness thresholds. For behavioral health claims, the health plan met the 15 and 60 calendar day thresholds but did not meet the 180 calendar day threshold.	The health plan should ensure their claims are adjudicated promptly in order to meet the timeliness requirements established within the contract between the DHHS and the health plan.

Activity 4: Review of Medical Records

Activity 4 provides supporting information for the findings detailed in the Activity 3 analysis of supplemental claims data. This is done by tracing certain key data elements from the supplemental claims data to the member's medical record obtained from the service provider. Supplemental claims data with dates of service during the measurement period were used as the population for the selection of sample records for review. A non-statistical[7], 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 9, 2023 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 December 8, 2023.

Table 4 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	23	27	39	31	120
Missing	5	2	3	0	10
Incorrect Record Submitted	0	0	0	0	0
Replaced	0	0	0	0	0
Medical Records Received and Tested	18	25	36	31	110
Percentage of Requested Records Tested	***78.3%***	***92.6%***	***92.3%***	***100.0%***	***91.7%***

Table 4: Medical Records Summary. 110 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

[7] 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

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 validation was categorized 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 all claim types within the supplemental claims data. **Table 5** reflects the validation rates from the medical record key data element review. The detailed analysis is included in Appendix F.

Medical Records Validation Rates		
Data Types	Supported Validation Rate	Unsupported Validation Rate
Inpatient	86.4%	13.6%
Outpatient	93.5%	6.5%
Professional (includes Vision and NEMT)	93.4%	6.6%
Pharmacy	94.8%	5.2%
Total	***92.0%***	***8.0%***

Table 5: Medical Record Validation Rates. 110 of the 120 medical records requested were tested. Supported and unsupported determinations were made at the level of each key data element, not at the claim level. Detailed results can be found in Appendix F.

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 10 of 120 records requested.	The health plan should work with its providers to ensure medical records are available and submitted for the members and dates of service requested.
4-B	Validation rates for all claim types were below the 95 percent accuracy threshold for the 110 records that were tested (92 percent).	The health plan should review the claims with accuracy issues and determine the root cause of missing or mismatched data then develop a plan to address the issue with adjustment to their processes.

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 tested for the SFY 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. Optumas plans to implement a field for interest payments starting with the request for the calendar year 2025 rate setting process.
1-C	There was no clear guidance as to what was being attested to in the encounter level attestation segment within the health plans encounter submissions during the measurement period.	DHHS has implemented a process to obtain an attestation from each health plan, annually, indicating what is being attested to on the encounter level attestation. This documentation was obtained for the first time in 2024 and will be obtained annually, going forward.
Activity 2 – Review Health Plan Capability		
There were no findings related to our review of the health plan's capabilities.		
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 (94.7 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.
3-B	**Completeness – Sample Claims Paid Amount**: The medical, transportation, pharmacy and vision claims included in the supplemental claims data met the 95 percent threshold for completeness when compared to the sample claims data paid amounts.	The health plan should continue to monitor completion percentages to ensure the supplemental claims data is complete and accurately reflects the services rendered and payments made to providers.

Findings and Recommendations		
	Findings	**Recommendations**
3-C	**Accuracy – Health Plan Paid Dates:** *Pharmacy and Vision* – The sample and supplemental claims data are both populated but the values do not agree. The majority of vision claim dates exhibit a discrepancy of one day. For example, the sample claim is dated 2022-04-06 and the supplemental claim is dated 2022-04-05.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate paid dates are being reported.
3-D	**Accuracy – Billed Charges:** *Pharmacy* – The billed charges were populated in the sample claims data and supplemental claims data, but their values do not agree.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate billing charges are being reported.
3-E	**Accuracy – Refill Number:** *Pharmacy* – The refill numbers were populated in the sample claims data and supplemental claims data, but their values do not agree. For another portion of claims, the refill numbers were 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-F	**Accuracy – Procedure Code:** *NEMT* – The sample and supplemental claims data are both populated, and their values do not agree. The majority of procedure codes exhibit a discrepancy in the specific nature of the NEMT services they represent. For example, the sample claim is populated with A0100 (Non-emergency transportation; taxi) and the supplemental claim is populated with A0120 (Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems).	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate procedure codes are being reported.
3-G	**Accuracy – Procedure Code Modifier:** *NEMT* – The procedure code modifiers were populated in the sample claims data but were not populated in the supplemental claims data.	The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate procedure code modifiers are being reported.

Findings and Recommendations		
	Findings	**Recommendations**
3-H	**Timely Payment of Claims**: The health plan's delegated vision, NEMT and pharmacy vendors met the 15 business day, 60 calendar day and 180 calendar day claims payment timeliness thresholds. The health plan did not meet the 15, 60 or 180 business day timeliness threshold for inpatient and outpatient claims. For professional claims, the plan met the 15 business day timeliness threshold but did not meet the 60 calendar day or 180 calendar day timeliness thresholds. For behavioral health claims, the health plan met the 15 and 60 calendar day thresholds but did not meet the 180 calendar day threshold.	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 10 of 120 records requested.	The health plan should work with its providers to ensure medical records are available and submitted for the members and dates of service requested.
4-B	Validation rates for all claim types were below the 95 percent accuracy threshold for the 110 records that were tested (92 percent).	The health plan should review the claims with accuracy issues and determine the root cause of missing or mismatched data then develop a plan to address the issue with adjustment to their processes.

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) – The system of record for encounters within 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.

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			NEMT			Pharmacy			Vision			Total		
	April 2022	**November 2022**	**Total**	**April 2022**	**November 2022**	**Total**	**April 2022**	**November 2022**	**Total**	**April 2022**	**November 2022**	**Total**	**April 2022**	**November 2022**	**Total**
CDJ Data															
CDJ Paid Amount Total	$45,228,873	$49,102,135	$94,331,008	$319,438	$429,706	$749,144	$14,388,769	$14,903,654	$29,292,422	$423,531	$395,733	$819,265	$60,360,611	$64,831,229	$125,191,840
Reconciling Adjustment	$0	$0	$0	$0	$0	$0	$126,133	$475,565	$601,698	$0	$0	$0	$126,133	$475,565	$601,698
Net CDJ Data Paid Amount Total	***$45,228,873***	***$49,102,135***	***$94,331,008***	***$319,438***	***$429,706***	***$749,144***	***$14,514,902***	***$15,379,218***	***$29,894,120***	***$423,531***	***$395,733***	***$819,265***	**$60,486,744**	**$65,306,793**	**$125,793,537**
Supplemental Claims Data															
Supplemental Paid Amount Total	$43,755,950	$49,212,625	$92,968,575	$319,338	$426,432	$745,770	$13,405,821	$14,911,306	$28,317,127	$419,153	$389,707	$808,859	$57,900,262	$64,940,070	$122,840,332
Payment Adjustments	$242,752	($443,360)	($200,608)	$0	$0	$0	$0	$0	$0	$4,262	$6,027	$10,289	$247,015	($437,333)	($190,319)
Net Supplemental Paid Amount Total	***$43,998,702***	***$48,769,265***	***$92,767,967***	***$319,338***	***$426,432***	***$745,770***	***$13,405,821***	***$14,911,306***	***$28,317,127***	***$423,415***	***$395,733***	***$819,149***	**$58,147,276**	**$64,502,737**	**$122,650,013**
Supplemental Completeness Percentage	***97.3%***	***99.3%***	***98.3%***	***100.0%***	***99.2%***	***99.5%***	***92.4%***	***97.0%***	***94.7%***	***100.0%***	***100.0%***	***100.0%***	***96.1%***	***98.8%***	***97.5%***

Note: The medical CDJ completeness analysis includes behavioral health claims.

Appendix B: Sample Claims Completeness

	Medical			Behavioral Health			NEMT		
	April 2022	November 2022	Total	April 2022	November 2022	Total	April 2022	November 2022	Total
Claims Sample Data									
Claims Sample Total	$40,092,363	$42,296,299	$82,388,661	$5,119,362	$6,799,390	$11,918,752	$318,965	$429,397	$748,362
Claims Outside Requested Paid Month	$3,766,158	$4,235,207	$8,001,365	$384,661	$143,310	$527,971	$0	$0	$0
Claims Within Requested Paid Month	$36,326,205	$38,061,092	$74,387,296	$4,734,701	$6,656,080	$11,390,781	$318,965	$429,397	$748,362
Total Denied in Claims Sample Data	($9)	$0	($9)	$0	($341)	($341)	$0	$0	$0
Net Claims Sample Total	***$36,326,214***	***$38,061,092***	***$74,387,305***	***$4,734,701***	***$6,656,422***	***$11,391,123***	***$318,965***	***$429,397***	***$748,362***
Supplemental Claims Data									
Total Matched Supplmental Claims	$36,462,272	$41,738,645	$78,200,918	$4,969,637	$6,736,343	$11,705,980	$318,842	$429,316	$748,159
Less Payment Adjustment	$370,282	($262,289)	$107,993	($8,484)	($13,954)	($22,438)	$0	$0	$0
Net Matched Supplmental Claims	***$36,832,554***	***$41,476,356***	***$78,308,911***	***$4,961,153***	***$6,722,389***	***$11,683,542***	***$318,842***	***$429,316***	***$748,159***
Completeness Percentage	***101.4%***	***109.0%***	***105.3%***	***104.8%***	***101.0%***	***102.6%***	***100.0%***	***100.0%***	***100.0%***

	Pharmacy			Vision			Total		
	April 2022	**November 2022**	**Total**	**April 2022**	**November 2022**	**Total**	**April 2022**	**November 2022**	**Total**
Claims Sample Data									
Claims Sample Total	$13,141,875	$14,569,978	$27,711,853	$454,225	$389,707	$843,932	$59,126,790	$64,484,770	$123,611,560
Claims Outside Requested Paid Month	$0	$0	$0	$0	$0	$0	$4,150,819	$4,378,517	$8,529,336
Claims Within Requested Paid Month	$13,141,875	$14,569,978	$27,711,853	$454,225	$389,707	$843,932	$54,975,971	$60,106,253	$115,082,224
Total Denied in Claims Sample Data	$0	$0	$0	$0	$0	$0	($9)	($341)	($350)
Net Claims Sample Total	***$13,141,875***	***$14,569,978***	***$27,711,853***	***$454,225***	***$389,707***	***$843,932***	***$54,975,980***	***$60,106,595***	***$115,082,575***
Supplemental Claims Data									
Total Matched Supplmental Claims	$12,228,402	$15,393,822	$27,622,224	$454,224	$389,707	$843,931	$54,433,378	$64,687,833	$119,121,212
Less Payment Adjustment	$0	$0	$0	$0	$0	$0	$361,798	($276,243)	$85,555
Net Matched Supplmental Claims	***$12,228,402***	***$15,393,822***	***$27,622,224***	***$454,224***	***$389,707***	***$843,931***	***$54,795,176***	***$64,411,591***	***$119,206,766***
Completeness Percentage	***93.0%***	***105.7%***	***99.7%***	***100.0%***	***100.0%***	***100.0%***	***99.7%***	***107.2%***	***103.6%***

Appendix C: Key Data Element Matching

Medical																					
	April 2022							November 2022							Total						
Key Data Element	Number of Supplemental Claims Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Supplemental Claims Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Supplemental 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)	175,246	175,246	100.0%	0	0.0%	0	0.0%	200,817	200,817	100.0%	0	0.0%	0	0.0%	376,063	376,063	100.0%	0	0.0%	0	0.0%
Billed Charges	356,720	356,715	100.0%	0	0.0%	5	0.0%	424,363	424,362	100.0%	0	0.0%	1	0.0%	781,083	781,077	100.0%	0	0.0%	6	0.0%
Billing Provider NPI/Number	356,720	356,720	100.0%	0	0.0%	0	0.0%	424,363	424,363	100.0%	0	0.0%	0	0.0%	781,083	781,083	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	356,720	353,257	99.0%	0	0.0%	3,463	1.0%	424,363	419,730	98.9%	0	0.0%	4,633	1.1%	781,083	772,987	99.0%	0	0.0%	8,096	1.0%
Date of Service	356,720	356,720	100.0%	0	0.0%	0	0.0%	424,363	424,363	100.0%	0	0.0%	0	0.0%	781,083	781,083	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	356,720	354,173	99.3%	0	0.0%	2,547	0.7%	424,363	422,883	99.7%	0	0.0%	1,480	0.3%	781,083	777,056	99.5%	0	0.0%	4,027	0.5%
Health Plan Paid Date	356,720	348,492	97.7%	0	0.0%	8,228	2.3%	424,363	418,439	98.6%	0	0.0%	5,924	1.4%	781,083	766,931	98.2%	0	0.0%	14,152	1.8%
Member ID (Medicaid)	356,720	356,719	100.0%	0	0.0%	1	0.0%	424,363	424,348	100.0%	0	0.0%	15	0.0%	781,083	781,067	100.0%	0	0.0%	16	0.0%
Place of Service	181,474	181,474	100.0%	0	0.0%	0	0.0%	223,546	223,546	100.0%	0	0.0%	0	0.0%	405,020	405,020	100.0%	0	0.0%	0	0.0%
Procedure Code	337,398	337,301	100.0%	0	0.0%	97	0.0%	404,276	404,062	99.9%	0	0.0%	214	0.1%	741,674	741,363	100.0%	0	0.0%	311	0.0%
Procedure Modifiers	337,398	337,398	100.0%	0	0.0%	0	0.0%	404,276	404,276	100.0%	0	0.0%	0	0.0%	741,674	741,674	100.0%	0	0.0%	0	0.0%
Revenue Code	175,246	175,219	100.0%	27	0.0%	0	0.0%	200,817	200,740	100.0%	77	0.0%	0	0.0%	376,063	375,959	100.0%	104	0.0%	0	0.0%
Service Provider NPI/Number	356,720	350,690	98.3%	0	0.0%	6,030	1.7%	424,363	417,658	98.4%	0	0.0%	6,705	1.6%	781,083	768,348	98.4%	0	0.0%	12,735	1.6%
Surgical Procedure Codes	19,322	19,322	100.0%	0	0.0%	0	0.0%	20,087	20,087	100.0%	0	0.0%	0	0.0%	39,409	39,409	100.0%	0	0.0%	0	0.0%
Total	***4,079,844***	***4,059,446***	***99.5%***	***27***	***0.0%***	***20,371***	***0.5%***	***4,848,723***	***4,829,674***	***99.6%***	***77***	***0.0%***	***18,972***	***0.4%***	***8,928,567***	***8,889,120***	***99.6%***	***104***	***0.0%***	***39,343***	***0.4%***

Vision																		
Key Data Element	April 2022						November 2022						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	13,810	100.0%	0	0.0%	0	0.0%	11,873	100.0%	0	0.0%	0	0.0%	25,683	100.0%	0	0.0%	0	0.0%
Billing Provider NPI	13,810	100.0%	0	0.0%	0	0.0%	11,873	100.0%	0	0.0%	0	0.0%	25,683	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	13,809	100.0%	1	0.0%	0	0.0%	11,873	100.0%	0	0.0%	0	0.0%	25,682	100.0%	1	0.0%	0	0.0%
Date of Service	13,810	100.0%	0	0.0%	0	0.0%	11,873	100.0%	0	0.0%	0	0.0%	25,683	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	13,358	96.7%	0	0.0%	452	3.3%	11,716	98.7%	0	0.0%	157	1.3%	25,074	97.6%	0	0.0%	609	2.4%
Health Plan Paid Date	1,118	8.1%	0	0.0%	12,692	91.9%	2,150	18.1%	0	0.0%	9,723	81.9%	3,268	12.7%	0	0.0%	22,415	87.3%
Member ID	13,809	100.0%	0	0.0%	1	0.0%	11,872	100.0%	0	0.0%	1	0.0%	25,681	100.0%	0	0.0%	2	0.0%
Place of Service	13,808	100.0%			2	0.0%	11,867	99.9%			6	0.1%	25,675	100.0%	0	0.0%	8	0.0%
Procedure Code	13,810	100.0%	0	0	0	0.0%	11,873	100.0%	0	0	0	0.0%	25,683	100.0%	0	0.0%	0	0.0%
Procedure Code Modifiers	13,789	99.8%	0	0	21	0.2%	11,862	99.9%	0	0	11	0.1%	25,651	99.9%	0	0.0%	32	0.1%
Service/Rendering Provider NPI	13,810	100.0%	0	0	0	0.0%	11,873	100.0%	0	0	0	0.0%	25,683	100.0%	0	0.0%	0	0.0%
Total	***138,741***	***91.3%***	***1***	***0.0%***	***13,168***	***8.7%***	***120,705***	***92.4%***	***0***	***0.0%***	***9,898***	***7.6%***	***259,446***	***91.8%***	***1***	***0.0%***	***23,066***	***8.2%***
Total Records in the Supplemental Claims Data	13,810						11,873						25,683					
Number of Key Data Element Evaluated	11						11						11					
Maximum Count	151,910	100.0%					130,603	100.0%					282,513	100.0%				

NEMT																		
Key Data Element	April 2022						November 2022						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	7,730	100.0%	0	0.0%	0	0.0%	7,698	100.0%	0	0.0%	0	0.0%	15,428	100.0%	0	0.0%	0	0.0%
Date of Service	7,730	100.0%	0	0.0%	0	0.0%	7,698	100.0%	0	0.0%	0	0.0%	15,428	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	7,730	100.0%	0	0.0%	0	0.0%	7,698	100.0%	0	0.0%	0	0.0%	15,428	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	7,730	100.0%	0	0.0%	0	0.0%	7,698	100.0%	0	0.0%	0	0.0%	15,428	100.0%	0	0.0%	0	0.0%
Member ID (Medicaid)	7,730	100.0%	0	0.0%	0	0.0%	7,698	100.0%	0	0.0%	0	0.0%	15,428	100.0%	0	0.0%	0	0.0%
Procedure Code	720	9.3%	0	0.0%	7,010	90.7%	715	9.3%	0	0.0%	6,983	90.7%	1,435	9.3%	0	0.0%	13,993	90.7%
Procedure Modifiers	0	0.0%			7,730	100.0%	0	0.0%			7,698	100.0%	0	0.0%			15,428	100.0%
Total	***39,370***	***72.8%***	***0***	***0.0%***	***14,740***	***27.2%***	***39,205***	***72.8%***	***0***	***0.0%***	***14,681***	***27.2%***	***78,575***	***72.8%***	***0***	***0.0%***	***29,421***	***27.2%***
Total Records in the Supplemental Claims Data	7,730						7,698						15,428					
Number of Key Data Element Evaluated	7						7						7					
Maximum Count	54,110	100.0%					53,886	100.0%					107,996	100.0%				

Pharmacy																		
Key Data Element	April 2022						November 2022						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	1,501	1.2%	669	0.5%	121,519	98.2%	2,229	1.6%	1,640	1.2%	132,637	97.2%	3,730	1.4%	2,309	0.9%	254,156	97.7%
Fill Date	123,689	100.0%	0	0.0%	0	0.0%	136,506	100.0%	0	0.0%	0	0.0%	260,195	100.0%	0	0.0%	0	0.0%
Days Supply	123,689	100.0%	0	0.0%	0	0.0%	136,506	100.0%	0	0.0%	0	0.0%	260,195	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	123,689	100.0%	0	0.0%	0	0.0%	136,506	100.0%	0	0.0%	0	0.0%	260,195	100.0%	0	0.0%	0	0.0%
Health Plan Paid Date	1,841	1.5%	0	0.0%	121,848	98.5%	5,631	4.1%	0	0.0%	130,875	95.9%	7,472	2.9%	0	0.0%	252,723	97.1%
Member ID	123,683	100.0%	0	0.0%	6	0.0%	136,497	100.0%	0	0.0%	9	0.0%	260,180	100.0%	0	0.0%	15	0.0%
NDC	123,689	100.0%	0	0.0%	0	0.0%	136,506	100.0%	0	0.0%	0	0.0%	260,195	100.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	123,677	100.0%	0	0.0%	12	0.0%	136,491	100.0%	0	0.0%	15	0.0%	260,168	100.0%	0	0.0%	27	0.0%
Quantity Dispensed	123,689	100.0%	0	0.0%	0	0.0%	136,506	100.0%	0	0.0%	0	0.0%	260,195	100.0%	0	0.0%	0	0.0%
Refill Number	46,871	37.9%	20,181	16.3%	56,637	45.8%	55,255	40.5%	21,542	15.8%	59,709	43.7%	102,126	39.2%	41,723	16.0%	116,346	44.7%
Total	***916,018***	***74.1%***	***20,850***	***1.7%***	***300,022***	***24.3%***	***1,018,633***	***74.6%***	***23,182***	***1.7%***	***323,245***	***23.7%***	***1,934,651***	***74.4%***	***44,032***	***1.7%***	***623,267***	***24.0%***
Total Records in the Supplemental Claims Data	123,689						136,506						260,195					
Number of Key Data Element Evaluated	10						10						10					
Maximum Count	1,236,890	100.0%					1,365,060	100.0%					2,601,950	100.0%				

Behavioral Health																		
Key Data Element	April 2022						November 2022						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	38,304	100.0%	0	0.0%	0	0.0%	43,200	100.0%	0	0.0%	0	0.0%	81,504	100.0%	0	0.0%	0	0.0%
Billing Provider NPI	38,304	100.0%	0	0.0%	0	0.0%	43,200	100.0%	0	0.0%	0	0.0%	81,504	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	37,983	99.2%	0	0.0%	321	0.8%	42,677	98.8%	0	0.0%	523	1.2%	80,660	99.0%	0	0.0%	844	1.0%
Date of Service	38,304	100.0%	0	0.0%	0	0.0%	43,200	100.0%	0	0.0%	0	0.0%	81,504	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	38,257	99.9%	0	0.0%	47	0.1%	43,164	99.9%	0	0.0%	36	0.1%	81,421	99.9%	0	0.0%	83	0.1%
Health Plan Paid Date	38,049	99.3%	0	0.0%	255	0.7%	42,998	99.5%	0	0.0%	202	0.5%	81,047	99.4%	0	0.0%	457	0.6%
Member ID	38,297	100.0%	0	0.0%	7	0.0%	43,190	100.0%	0	0.0%	10	0.0%	81,487	100.0%	0	0.0%	17	0.0%
Place of Service	38,304	100.0%	0	0.0%	0	0.0%	43,200	100.0%	0	0.0%	0	0.0%	81,504	100.0%	0	0.0%	0	0.0%
Procedure Code	38,304	100.0%	0	0.0%	0	0.0%	43,198	100.0%	0	0.0%	2	0.0%	81,502	100.0%	0	0.0%	2	0.0%
Procedure Code Modifiers	38,304	100.0%			0	0.0%	43,200	100.0%			0	0.0%	81,504	100.0%	0	0.0%	0	0.0%
Service/Rendering Provider NPI	37,614	98.2%	0	0.0%	690	1.8%	42,006	97.2%	0	0.0%	1,194	2.8%	79,620	97.7%	0	0.0%	1,884	2.3%
Total	***420,024***	***99.7%***	***0***	***0.0%***	***1,320***	***0.3%***	***473,233***	***99.6%***	***0***	***0.0%***	***1,967***	***0.4%***	***893,257***	***99.6%***	***0***	***0.0%***	***3,287***	***0.4%***
Total Records in the Supplemental Claims Data	38,304						43,200						81,504					
Number of Key Data Element Evaluated	11						11						11					
Maximum Count	421,344	100.0%					475,200	100.0%					896,544	100.0%				

Total																					
Key Data Element	April 2022							November 2022							Total						
	Number of Supplemental Claims Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Supplemental Claims Evaluated	Valid Values (Matching)		Missing Values (Invalid)		Erroneous Values (Non-matching/ Invalid)		Number of Supplemental 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)	175,246	175,246	100.0%	0	0.0%	0	0.0%	200,817	200,817	100.0%	0	0.0%	0	0.0%	376,063	376,063	100.0%	0	0.0%	0	0.0%
Billed Charges	540,253	418,060	77.4%	669	0.1%	121,524	22.5%	623,640	489,362	78.5%	1,640	0.3%	132,638	21.3%	1,163,893	907,422	78.0%	2,309	0.2%	254,162	21.8%
Billing Provider NPI/Number	408,834	408,834	100.0%	0	0.0%	0	0.0%	479,436	479,436	100.0%	0	0.0%	0	0.0%	888,270	888,270	100.0%	0	0.0%	0	0.0%
Diagnosis Codes	408,834	405,049	99.1%	1	0.0%	3,784	0.9%	479,436	474,280	98.9%	0	0.0%	5,156	1.1%	888,270	879,329	99.0%	1	0.0%	8,940	1.0%
Date of Service	416,564	416,564	100.0%	0	0.0%	0	0.0%	487,134	487,134	100.0%	0	0.0%	0	0.0%	903,698	903,698	100.0%	0	0.0%	0	0.0%
Health Plan Paid Amount	540,253	537,207	99.4%	0	0.0%	3,046	0.6%	623,640	621,967	99.7%	0	0.0%	1,673	0.3%	1,163,893	1,159,174	99.6%	0	0.0%	4,719	0.4%
Health Plan Paid Date	540,253	397,230	73.5%	0	0.0%	143,023	26.5%	623,640	476,916	76.5%	0	0.0%	146,724	23.5%	1,163,893	874,146	75.1%	0	0.0%	289,747	24.9%
Member ID (Medicaid)	540,253	540,238	100.0%	0	0.0%	15	0.0%	623,640	623,605	100.0%	0	0.0%	35	0.0%	1,163,893	1,163,843	100.0%	0	0.0%	50	0.0%
Place of Service	233,588	233,586	100.0%	0	0.0%	2	0.0%	278,619	278,613	100.0%	0	0.0%	6	0.0%	512,207	512,199	100.0%	0	0.0%	8	0.0%
Procedure Code	397,242	390,135	98.2%	0	0.0%	7,107	1.8%	467,047	459,848	98.5%	0	0.0%	7,199	1.5%	864,289	849,983	98.3%	0	0.0%	14,306	1.7%
Procedure Modifiers	397,242	389,491	98.0%	0	0.0%	7,751	2.0%	467,047	459,338	98.3%	0	0.0%	7,709	1.7%	864,289	848,829	98.2%	0	0.0%	15,460	1.8%
Revenue Code	175,246	175,219	100.0%	27	0.0%	0	0.0%	200,817	200,740	100.0%	77	0.0%	0	0.0%	376,063	375,959	100.0%	104	0.0%	0	0.0%
Service Provider NPI/Number	408,834	402,114	98.4%	0	0.0%	6,720	1.6%	479,436	471,537	98.4%	0	0.0%	7,899	1.6%	888,270	873,651	98.4%	0	0.0%	14,619	1.6%
Surgical Procedure Codes	19,322	19,322	100.0%	0	0.0%	0	0.0%	20,087	20,087	100.0%	0	0.0%	0	0.0%	39,409	39,409	100.0%	0	0.0%	0	0.0%
Date Filled	123,689	123,689	100.0%	0	0.0%	0	0.0%	136,506	136,506	100.0%	0	0.0%	0	0.0%	260,195	260,195	100.0%	0	0.0%	0	0.0%
Days Supply	123,689	123,689	100.0%	0	0.0%	0	0.0%	136,506	136,506	100.0%	0	0.0%	0	0.0%	260,195	260,195	100.0%	0	0.0%	0	0.0%
National Drug Code (NDC)	123,689	123,689	100.0%	0	0.0%	0	0.0%	136,506	136,506	100.0%	0	0.0%	0	0.0%	260,195	260,195	100.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	123,689	123,677	100.0%	0	0.0%	12	0.0%	136,506	136,491	100.0%	0	0.0%	15	0.0%	260,195	260,168	100.0%	0	0.0%	27	0.0%
Quantity Dispensed	123,689	123,689	100.0%	0	0.0%	0	0.0%	136,506	136,506	100.0%	0	0.0%	0	0.0%	260,195	260,195	100.0%	0	0.0%	0	0.0%
Refill Number	123,689	46,871	37.9%	20,181	16.3%	56,637	45.8%	136,506	55,255	40.5%	21,542	15.8%	59,709	43.7%	260,195	102,126	39.2%	41,723	16.0%	116,346	44.7%
Total	***5,944,098***	***5,573,599***	***93.8%***	***20,878***	***0.4%***	***349,621***	***5.9%***	***6,873,472***	***6,481,450***	***94.3%***	***23,259***	***0.3%***	***368,763***	***5.4%***	***12,817,570***	***12,055,049***	***94.1%***	***44,137***	***0.3%***	***718,384***	***5.6%***

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

Description	Heritage Health				NETC				Percentage of Heritage Health	
Distinct member count receiving services based on supplemental claims data - CY 2022	364,587				125,481				34.4%	
									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	1,018,073	2.8	$105,259,656	$289	0	0.0	$0	$0	-100.0%	-100.0%
Inpatient	572,898	1.6	$273,886,941	$751	194,117	1.5	$131,588,853	$1,049	-1.6%	39.6%
NEMT	244,374	0.7	$10,888,575	$30	91,443	0.7	$4,664,360	$37	8.7%	24.5%
Outpatient	1,187,083	3.3	$146,758,568	$403	688,118	5.5	$89,811,738	$716	68.4%	77.8%
Pharmacy	4,934,194	13.5	$451,957,244	$1,240	1,566,194	12.5	$168,265,566	$1,341	-7.8%	8.2%
Primary Care	3,297,328	9.0	$246,518,925	$676	1,085,020	8.6	$89,608,055	$714	-4.4%	5.6%
Specialty	3,182,063	8.7	$507,444,162	$1,392	1,337,999	10.7	$124,336,190	$991	22.2%	-28.8%
Vision	497,103	1.4	$16,052,421	$44	142,155	1.1	$4,678,784	$37	-16.9%	-15.3%
Total Services [2]	***14,933,116***	***41.0***	***$1,758,766,492***	***$4,824***	***5,105,046***	***40.7***	***$612,953,546***	***$4,885***	***-0.7%***	***1.3%***

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

[2] Differences are due to rounding.

Appendix E: Timely Payment of Claims

CY 2022													
Claim Type	15 Business Days 90%		60 Calendar Days 99%			180 Calendar Days 100%			Over 180 Calendar Days			Total Count	Average Calendar Days
	Count	Percentage Absolute	Count	Percentage Absolute	Percentage Cumulative	Count	Percentage Absolute	Percentage Cumulative	Count	Percentage Absolute	Percentage Cumulative		
Inpatient	38,214	64.9%	17,836	30.3%	95.2%	2,755	4.7%	99.9%	52	0.1%	100.0%	58,857	19
Outpatient	435,986	80.2%	77,920	14.3%	94.5%	29,195	5.4%	99.9%	725	0.1%	100.0%	543,826	15
Professional	496,484	95.7%	16,451	3.2%	98.9%	4,704	0.9%	99.8%	1,177	0.2%	100.0%	518,816	9
Behavioral Health	91,694	97.1%	2,310	2.4%	99.5%	349	0.4%	99.9%	79	0.1%	100.0%	94,432	8
Vision	29,655	99.9%	0	0.0%	99.9%	24	0.1%	100.0%	0	0.0%	100.0%	29,679	5
Transportation	15,445	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	15,445	11
Pharmacy	642,649	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	0	0.0%	100.0%	642,649	0
Total	***1,750,127***	***91.9%***	***114,517***	***6.0%***	***97.9%***	***37,027***	***1.9%***	***99.9%***	***2,033***	***0.1%***	***100.0%***	***1,903,704***	***8***

Appendix F: Medical Records Validity Rate

Inpatient					
	Total Elements Sampled	Supported Elements		Unsupported Elements	
Key Data Element	Count	Count	Percent	Count	Percent
Member Name	17	17	100.0%	0	0.0%
Member DOB	18	17	94.4%	1	5.6%
Admit Date	18	14	77.8%	4	22.2%
First DOS	18	14	77.8%	4	22.2%
Last DOS	18	13	72.2%	5	27.8%
Type of Bill Code	18	18	100.0%	0	0.0%
Revenue Code	103	92	89.3%	11	10.7%
Diagnosis Codes	63	49	77.8%	14	22.2%
Servicing Provider	18	16	88.9%	2	11.1%
Surgical Procedure Codes	36	31	86.1%	5	13.9%
Billing Provider	18	17	94.4%	1	5.6%
Total	***345***	***298***	***86.4%***	***47***	***13.6%***

Note: 18 of the 23 medical records requested were tested.

Outpatient					
Key Data Element	Total Elements Sampled	Supported Elements		Unsupported Elements	
	Count	Count	Percent	Count	Percent
Member Name	24	24	100.0%	0	0.0%
Member DOB	25	25	100.0%	0	0.0%
DOS	25	25	100.0%	0	0.0%
Type of Bill Code	25	23	92.0%	2	8.0%
Revenue Code	67	64	95.5%	3	4.5%
Procedure Code	110	100	90.9%	10	9.1%
Procedure Modifiers	25	19	76.0%	6	24.0%
Diagnosis Codes	62	58	93.5%	4	6.5%
Servicing Provider	25	24	96.0%	1	4.0%
Billing Provider	25	24	96.0%	1	4.0%
Total	***413***	***386***	***93.5%***	***27***	***6.5%***

Note: 25 of the 27 medical records requested were tested.

	Professional					Vision					Transportation					Professional Total (includes Vision and NEMT)				
	Total Elements Sampled	Supported Elements		Unsupported Elements		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	Count	Count	Percent	Count	Percent
Member Name	33	33	100.0%	0	0.0%	1	1	100.0%	0	0.0%	1	0	0.0%	1	100.0%	35	34	97.1%	1	2.9%
Member DOB	34	28	82.4%	6	17.6%	1	1	100.0%	0	0.0%	1	0	0.0%	1	100.0%	36	29	80.6%	7	19.4%
DOS	34	32	94.1%	2	5.9%	1	1	100.0%	0	0.0%	1	0	0.0%	1	100.0%	36	33	91.7%	3	8.3%
Place of Service	34	32	94.1%	2	5.9%	1	1	100.0%	0	0.0%	N/A					35	33	94.3%	2	5.7%
Procedure Code	97	96	99.0%	1	1.0%	1	1	100.0%	0	0.0%	1	1	100.0%	0	0.0%	99	98	99.0%	1	1.0%
Procedure Modifiers	26	26	100.0%	0	0.0%	1	1	100.0%	0	0.0%	N/A					27	27	100.0%	0	0.0%
Diagnosis Codes	86	78	90.7%	8	9.3%	1	1	100.0%	0	0.0%	N/A					87	79	90.8%	8	9.2%
Servicing Provider	34	33	97.1%	1	2.9%	1	1	100.0%	0	0.0%	N/A					35	34	97.1%	1	2.9%
Billing Provider	34	29	85.3%	5	14.7%	1	1	100.0%	0	0.0%	N/A					35	30	85.7%	5	14.3%
Total	***412***	***387***	***93.9%***	***25***	***6.1%***	***9***	***9***	***100.0%***	***0***	***0.0%***	***4***	***1***	***25.0%***	***3***	***75.0%***	***425***	***397***	***93.4%***	***28***	***6.6%***

Note: 36 of the 39 medical records requested were tested.

Pharmacy					
Key Data Element	Total Elements Sampled	Supported Elements		Unsupported Elements	
	Count	Count	Percent	Count	Percent
Member Name	31	31	100.0%	0	0.0%
Member DOB	31	31	100.0%	0	0.0%
Date of Service	31	28	90.3%	3	9.7%
Billing Provider	31	30	96.8%	1	3.2%
Nation Drug Code (NDC)	31	27	87.1%	4	12.9%
Quantity Dispensed	31	29	93.5%	2	6.5%
Days Supply	31	28	90.3%	3	9.7%
Prescribing Provider	31	31	100.0%	0	0.0%
Total	***248***	***235***	***94.8%***	***13***	***5.2%***

Note: 31 of the 31 medical records requested were tested.

Total					
Key Data Element	Total Elements Sampled	Supported Elements		Unsupported Elements	
	Count	Count	Percent	Count	Percent
Member Name	107	106	99.1%	1	0.9%
Member DOB	110	102	92.7%	8	7.3%
Admit Date	18	14	77.8%	4	22.2%
First DOS	110	100	90.9%	10	9.1%
Last DOS	18	13	72.2%	5	27.8%
Type of Bill Code	43	41	95.3%	2	4.7%
Place of Service	35	33	94.3%	2	5.7%
Revenue Code	170	156	91.8%	14	8.2%
Procedure Code	209	198	94.7%	11	5.3%
Procedure Modifiers	52	46	88.5%	6	11.5%
Diagnosis Codes	212	186	87.7%	26	12.3%
Servicing Provider	78	74	94.9%	4	5.1%
Surgical Procedure Codes	36	31	86.1%	5	13.9%
Billing Provider	109	101	92.7%	8	7.3%
Nation Drug Code (NDC)	31	27	87.1%	4	12.9%
Quantity Dispensed	31	29	93.5%	2	6.5%
Days Supply	31	28	90.3%	3	9.7%
Prescribing Provider	31	31	100.0%	0	0.0%
Total	***1,431***	***1,316***	***92.0%***	***115***	***8.0%***

Appendix H Plan Response Letter

HERITAGE HEALTH | nebraska total care
2525 N. 117th Ave, Suite 100
Omaha, Nebraska 68164

May 24, 2024

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 2022, 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

1-A: Interest on claims included in the total amounts paid in health plan's submitted encounters.

1-A Recommendation: 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-A Response: *NETC will await further guidance from DHHS pertaining to updates of encounter fields.*

1-B: Interest on claims is not reported in a separate field in the health plan's supplemental claims data tested for the SFY submitted to Optumas.

1-B Recommendation: 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. Optumas plans to implement a field for interest payments starting with the request for the calendar year 2025 rate setting process.

1-B Response: *NETC will await further guidance from DHHS pertaining to updates of encounter fields.*

1-C: There was no clear guidance as to what was being attested to in the encounter level attestation segment within the health plans encounter submissions during the measurement period.

1-C Recommendation: DHHS has implemented a process to obtain an attestation from each health plan, annually, indicating what is being attested to on the encounter level attestation. This documentation was obtained for the first time in 2024 and will be obtained annually, going forward.

1-C Response: *NETC will continue to comply with any and all attestation requirements of DHHS and provide required attestations according to DHHS reporting cadence.*

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 (94.7 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: *CDJ files were pulled by Nebraska Total Care including claim transactions with paid dates in April 2022 and November 2022 plus subsequent adjustments etc., that may have occurred outside the sample months of April 2022 and November 2022. Optumas supplemental claims data will not directly be tied to CDJ files due to ongoing adjustments that occurred between the timeframes of when the CDJ was pulled.*

3-B Finding: The medical, transportation, pharmacy, and vision claims included in the supplemental claims data met the 95 percent threshold for completeness when compared to the sample claims data paid amounts.

3-B Recommendation: The health plan should continue to monitor completion percentages to ensure the supplemental claims data is complete and accurately reflects the services rendered and payments made to providers.

3-B Response: *NETC will continue to monitor completion percentages to ensure supplemental claims data is complete and accurately reflects the services rendered and payments made to providers.*

3-C Finding: The sample and supplemental claims data are both populated for pharmacy and vision, but the values do not agree. The majority of vision claim dates exhibit a discrepancy of one day. For example, the sample claim is dated 2022-04-06 and the supplemental claim is dated 2022-04-05.

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

3-C Response: *The vision claims paid date discrepancy of one day is due to the date the claim was finalized and the date the provider receives an explanation of payment (EOP). The supplemental claim reflected the date the claim was finalized, and the sample claim reflected the date the EOP and payment was received. The supplemental pharmacy claims data was submitted by Optumas to Myers & Stauffer, and contained all data received from Nebraska Total Care for calendar year 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 the timeframes of when the claims data was pulled.*

3-D Finding: Pharmacy – The billed charges were populated in the sample claims data and supplemental claims data, but their values do not agree.

3-D Recommendation: The health plan should review its process for submitting supplemental claims data to Optumas to ensure accurate billing charges 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: Pharmacy – The refill numbers were populated in the sample claims data and supplemental claims data, but their values do not agree. For another portion of claims, the refill numbers were not populated in the supplemental claims data.

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

3-E 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-F Finding: NEMT – The sample and supplemental claims data are both populated, but their values do not agree. The majority of procedure codes exhibit a discrepancy in the specific nature of the NEMT services they represent. For example, the sample claim is populated with A0100 (Non-emergency transportation; taxi) and the supplemental claim is populated with A0120 (Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems).

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

3-F Response: *NETC has communicated the process enhancements needed and will continue to work with our subcontractors to ensure consistency between datasets.*

3-G Finding: NEMT – The procedure code modifiers were populated in the sample claims data but were not populated in the supplemental claims data.

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

3-G Response: *NETC has communicated the process enhancements needed and will continue to work with our subcontractors to ensure consistency between datasets.*

3-H Finding: The health plan's delegated vision, NEMT, and pharmacy vendors met the 15 business day, 60 calendar day, and 180 calendar day claims payment timeliness thresholds. The health plan did not meet the 15, 60, or 180 business day timeliness threshold for inpatient and outpatient claims. For professional claims, the plan met the 15 business day timeliness threshold but di not meet the 60 calendar day or 180 calendar day timeliness thresholds. For behavioral health claims, the health plan met the 15 and 60 calendar day thresholds but did not meet the 180 calendar day threshold.

3-H Recommendation: 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.

3-H Response: *NETC disagrees with this finding and recommendation as the health plan has consistently and continues to meet QPP metrics for claims payment timeliness. Monthly claims reports are shared with MLTC reflecting constant claims payment timeliness thresholds being met. Audit review considerations should be consistent with claim processing practices of claim adjustments occurring after original adjudication.*

Activity 4: Review of Medical Records

4-A Finding: The health plan was not able to provide a medical record to support 10 of 120 records requested.

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.

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 all claim types were below the 95 percent accuracy threshold for the 110 records that were tested (92 percent).

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 disagrees with this finding and recommendation as the health plan has consistently and continues to meet QPP metrics for claims payment and accuracy. NETC historically submitted monthly claims accuracy reports to MLTC during the 2022 review period, to support claims accuracy tracking, solution status, and review, reflecting accuracy thresholds met.*