C.	**Technical Approach**

7.	**Encounter Data** *(Section 16.0 Encounter Data Submissions)*

a.	Provide a detailed description of the Vendor's processes for ensuring complete, accurate, and timely encounter data submissions to the Department, including procedures for working with providers and Subcontractors to correct errors.

Humana continuously explores ways to improve the accuracy, timeliness, and completeness of encounter data. **Humana has developed customized encounter processing software, Humana Encounter Resolution, and Operation (HERO), which is replacing Edifecs in phases**. HERO expands the volume of encounters our system can handle. It also consolidates all the environments into one, which reduces costs and the risk of changes not getting deployed into one of the environments. In addition to volume expansion, HERO moves more change processes to the business side, which reduces our dependencies on Information Technology (IT). This is significant, as it reduces the amount of time for a change to get implemented from six months to less than three months.

HERO adds dashboards for real-time tracking, monitoring, and routing of our encounter inventory. This affords Humana the ability to provide up-to-date reporting as well as an immediate start on error resolution for rejected encounters. **HERO includes the ability to perform bulk updates, in which numerous changes can be executed on multiple encounters in one action, therefore greatly reducing the amount of time spent correcting erroneous encounters and ensuring Humana meets timeliness standards**. The sources of data from which HERO draws are much more extensive than those that were available through Edifecs. With more data points, Humana is able to derive how certain encounter rejections originate in a quicker, more efficient manner, leading to an earlier resolution of errors. Finally, Humana owns this software; as such, it can be customized to meet our needs for encounter creation and tracking. Using duplicate and provider logic supplied by the Commonwealth, we are able to implement rules that follow the aforementioned logic in order to submit a more accurate and complete encounter file.

NON-PHARMACY ENCOUNTERS

Accurate encounter data submissions

Accurate encounters begin with properly received and processed claims. Our network providers are contractually required to submit complete claims based on industry-standard clean claim guidelines. We require our subcontractors to include similar Contract provisions with their providers. These guidelines are enforced through our clearinghouse partners. We educate our providers about requirements for submitting accurate claims and encounters at the time of onboarding, on our website, through web-based training, in our Provider Manual, in provider communications/newsletters, via in-person meetings with our Contract management associates and Provider Relations representatives, and through our Provider Services Call Center.

Our high accuracy rate for encounters is, in part, a result of the front-end claims editing performed by our clearinghouses, direct submissions, and our Electronic Hub (eHub), which serves as the gateway to the submission of data into our Claims Adjudication System (CAS). These processes enable us to isolate and address quality issues prior to the receipt of claims and encounters in CAS. With the exception of pharmacy claims, all claims (including paper claims and encounters from sub-capitated providers and subcontractors) must pass the edits in eHub. These edits include both the State-mandated edits (e.g., key fields including Medicaid registration ID, dollar amount paid, etc.), and edits specific to Humana, e.g., National Provider Identifier (NPI). Dental

encounters are submitted to Humana by our subcontractor (Avēsis) and must clear the edits in DentalXChange (our dental clearinghouse partner) and subsequently in eHub.

Claims and encounters that do not pass Health Insurance Portability and Accountability Act (HIPAA) edits have acknowledgments returned to the provider and subcontractors via our provider portal, Availity, indicating errors that need correction. They can then review and correct failed files electronically via Availity for resubmission.

Edifecs begins the process of creating encounters. Edifecs's customized rules allow Humana to combine the 837 files we receive from providers and subcontractors with the outbound 835 files we send to providers and subcontractors in accordance with the standard X12 implementation guide.

After creating an encounter, the Edifecs software validates that the encounter is HIPAA X12-compliant. Any encounters with errors are corrected prior to submission to the Commonwealth. Encounters are then batched based on Commonwealth specifications; file-naming conventions are added, and the encounters are uploaded to our file transfer site. All acknowledgments received from the Commonwealth are loaded into the Edifecs system for tracking. Encounters identified on acknowledgments as having errors are added as a work item and then placed into a designated queue for error resolution.

Humana's Encounter Submission team analyzes the errors in Edifecs and identifies who is responsible for researching and resolving the Commonwealth's denial reasons. This team has a cumulative of 78 years of expertise in performing encounters-related functions. This team also reviews claim-associated acceptance and rejection rates to ensure accuracy and increase acceptance rates. We use our assessment of errors and denial rates to target providers for education, identify associates for additional training, and recommend system edits and process improvements.

We have designed our systems to ensure that encounters and claims are processed with appropriate Current Procedural Terminology (CPT) and Diagnosis (DX) codes. On Florida's Managed Medical Assistance (MMA) Data Submission report card, Humana was given top marks on the submission of Diagnosis, Procedure, and Revenue codes as well as Date Span Adjustments and Duplicates, proving Humana's ability to send accurate and timely encounter data.

Timely submissions of encounter data

Humana closely tracks the timeliness of our encounter submissions. In Florida, we have consistently exceeded the State's requirement that 95% of encounters be submitted within seven days of adjudication. We have achieved this milestone due to several system enhancements and operational processes we have implemented, as well as through an array of reporting tools that offer real-time results. In rare instances, when we are unable to meet the standard, Humana maintains transparency by proactively communicating any issues and the path to resolution for identified deficiencies.

One of the ways in which Humana ensures the timeliness of its encounter submissions is through our encounter reporting system. The system generates reports that help us monitor the aging of our encounter queue and generates an alert when we are at risk of missing an upcoming State timeliness standard. Humana uses a daily reporting tool that identifies encounters in jeopardy of falling out of compliance for submissions. The report allows for adequate distribution of work based on timeliness and where those encounters closest to failing State requirements are prioritized for same-day resolution.

We validate the accuracy of our reporting by comparing our own data with the results in the State's timeliness and accuracy reports. If we find a discrepancy, we request supporting information from the State to help us assess the reason. To date, we have not found a variance that has required us to request supporting documentation from the State.

Complete encounter submissions

There is a direct feed from CAS to Edifecs, which provides alerts indicating any record that failed during this process. Necessary stakeholders are notified, and immediate action is taken to address any failed process. After

an encounter is generated in Edifecs, we monitor to track the status and to ensure encounter submissions to the State occur. Our reporting, based on the encounter and service line counts, indicates the volume of encounters received into the Edifecs system that have not yet been submitted to the State. The Encounters Submission team will monitor volume and ensure complete, timely submission.

To ensure that we include complete data in our encounter submissions, we have implemented HIPAA level edits for data integrity and validity to evaluate the data being submitted in the encounter files we receive from our providers and subcontractors. Prior to submission to the State, we validate that all necessary claim and encounter fields, in particular, the key fields identified by the State, are populated with values of the appropriate range and type and have the proper layout. We maintain multiple reports that monitor the status of all encounters to ensure complete encounter submissions.

PHARMACY ENCOUNTERS

Humana uses a wholly-owned subsidiary, Humana Pharmacy Solutions, Inc. (HPS), as its pharmacy benefits management (PBM). HPS adjudicates all pharmacy claims at the point of sale, rejecting claims that do not meet point-of-sale processing requirements. HPS sends Humana a daily feed of paid claims, which are then sent to our enterprise data warehouse (EDW). The Humana Pharmacy Encounters team automatically picks up this feed and creates the National Council for Prescription Drug Programs (NCPDP) encounter data submission, ensuring we complete all required fields in the required format. This is translated into an encounter data submission that we transmit to the State's subcontractor four times a week.

One recent success of the Humana Pharmacy Encounters team was the automation of our encounter processing mechanism in Florida. To achieve this automation, we examined every guideline from the State's manual and file layout and worked with our IT team to develop, test, and deploy a submission file based on the State's requirements. We have automated the process in which the encounter data elements are captured from the submitted claims information and the end-to-end process to generate and submit the file to the State's vendor, ensuring that all data submitted are accurate, timely, and complete.

In fact, **our Pharmacy Encounters team has held leadership positions at NCPDP and informs discussions and decisions at a national level**. We also continuously monitor NCPDP updates and readily engage with the organization in implementing their guidance.

Our pharmacy encounter submission process includes daily tracking and monitoring of our submissions to the State's vendor, response reports from the State, and resubmissions. We track the timely submission of pharmacy encounter data through our monthly Timeliness Audit report. This report tracks our compliance with the State's timeliness requirements. We also trend our compliance month by month in our Timeliness Metric report. We have consistently surpassed the contractually established encounter completeness, accuracy, and timeliness metrics.

We track the accuracy of our encounter submissions through our Encounter Submission and Error Tracking report, which identifies the volume of errors in our encounter submissions and trends in our improvement opportunities. We monitor that we are submitting an encounter for every pharmacy claim through a completeness report.

To ensure we resubmit all encounters rejected by the portal used by the State's vendor, we have implemented an automatic trigger process that resubmits an encounter when it is rejected due to a system timeout by the State's vendor. Additionally, when we do not receive all encounters back from the State's vendor following processing, our system searches for those encounters and automatically resubmits them.

SUBCONTRACTOR ENCOUNTER SUBMISSION STANDARDS AND PENALTIES

As part of the contracting process, we establish key measures and performance thresholds that reflect our Contract with the State to ensure our subcontractors are performing to the same for which expectations we are accountable, thereby driving timely, accurate, and complete submission of claims and encounters. **Humana meets with key subcontractors monthly to discuss performance across all functions, including claims and encounters**. Listed below are specific standards from our Service Level Agreements (SLA) with each of our subcontractors:

- Encounter Data File Timeliness: Failure to deliver an encounter file meeting agreed-upon specifications within the times specified will result in charge of $1,000 per late submission per calendar day.
- Encounter Data Accuracy: An error rate greater than five percent in encounter data received from a subcontractor based on a Humana encounter response file will cost $1,000 per file that exceeds the standard of more than five percent errors.
- Encounter Data Completeness: We require a completeness rate of at least 90% in encounter data received from a subcontractor based on a Humana encounter response file. The fee is $1,000 per file that does not meet the standard for completeness rate.
- Encounter Data File Transfers: Files must be transferred no later than Friday 12 a.m. midnight Eastern Standard Time. The fee is $100 per late file per calendar day.
- Encounter Data Corrections: Within 30 calendar days after notice of encounters/claims failing X12 (EDI) or Humana edits by Humana, subcontractors must correct all encounter/claim records for which errors should be remedied and resubmit to Humana. The fee is $1,000 per late resubmission per calendar day after 30 days. A resubmitted file with uncorrected errors is not considered to be timely resubmitted.

b. Provide the Vendor's Encounter Data Processing policies and procedures.

Humana's Encounter Data Processing Policies and Procedures for the Kentucky Medicaid Managed Care (MMC) program are included at the end of this section as **P&P I.C.7-1 Encounter Data Processing Policies and Procedures**.

NON-PHARMACY ENCOUNTERS

Humana can ensure that encounters are coded consistently across providers and provider types because all claims and encounter submissions for all types of providers and subcontractors must clear the same edits in the claims clearinghouses and our eHub. The HIPAA Level 7 edits through which most of our claims and encounters are processed to identify and reject data for incorrect coding at the front end.

Upon receipt of claims data from our clearinghouses, Humana's eHub verifies the entry of all key fields necessary for complete encounter submissions that ensures a proper 5010 compliant submission format. Our clearinghouses are contractually required to meet HIPAA edits and standards, including edits to validate for correct coding. **Our preferred clearinghouse and trading partner, Availity, performs the highest level of HIPAA edits (HIPAA Level 7)**, reviewing fields such as CPT, ICD-9, ICD-10, CDT, National Drug Code (NDC), status codes, adjustment reason codes, and their appropriate use for the transaction. ZirMed performs HIPAA Level 5 edits and reviews for CPT, ICD-9, ICD-10, CDT, NDC, status codes, adjustment reason codes, and their appropriate use for the transaction. Direct to business submissions via our eHub platform, which do not enter Availity, are processed through HIPAA Level 4 edits, which specify inter-segment situations described in the HIPAA Implementation Guides, such that, "If A occurs, then B must be populated." This includes the validation of situational fields given values or situations present elsewhere in the file.

Humana's encounter data system, which generates more than 500,000 encounters per day, six days a week, receives claims and enrollment data from CAS, Customer Interface (CI), and eHub systems to create compliant HIPAA 837 encounters.

We also have a quality certification check with our clearinghouses through which we receive reports from the clearinghouses on the provider data submissions that have been rejected. This informs our strategy on provider education and engagement.

Humana uses the editing logic for key fields to ensure data are accurately populated during encounter data submissions. The list below describes select editing logic we have in place:

- Recipient Medicaid ID: The Enrollee's Medicaid ID is added to the encounter at the time of generation, based on the Enrollee's Medicaid ID currently stored in our enrollment system.
- Provider Medicaid ID: Humana submits the NPI included on the claim in encounter submissions for all providers who can bill with an NPI. For those providers who do not have an NPI, Humana crosswalks their information to the Medicaid ID stored in our claims platform and adds it to the outbound encounter.
- Claim type: Claim types are confirmed during HIPAA validation at the claim's clearinghouses and in the Humana claims platform. If the claim type is incorrect, the claim will be rejected, and no encounter will be generated.
- Place of service: The place of service is confirmed during HIPAA validation at the clearinghouses. If the place of service is incorrect, the clearinghouse returns the claim to the sender. Humana performs a secondary review in our eHub platform to ensure the correct place of service is included for the service being billed and the provider. If the place of service is incorrect, no encounter will be generated.
- Revenue code: Revenue codes are confirmed during HIPAA validation at the claim's clearinghouses. If the clearinghouse finds an incorrect revenue code, it returns the claim to the sender. Humana performs a secondary review in our eHub platform to ensure the correct revenue code is included for the service being billed and the provider. If the revenue code is incorrect, the claim will be rejected, and no encounter will be generated.
- Diagnosis code: Diagnosis codes are confirmed during HIPAA validation at the clearinghouses. If the clearinghouse finds an incorrect diagnosis code, it returns the claim to the sender. Humana performs a secondary review in our eHub platform to ensure the correct diagnosis code is included for the service being billed and the provider. If the diagnosis code is incorrect, the claim will be rejected, and no encounter will be generated.
- Amount paid: Humana uses standard X12 matching and balancing logic for applying the correct paid amount to the service lines for encounters or fee-for-service (FFS) claims. Encounters and claims received from a sub-capitated provider, FFS providers, and subcontractors are subject to upfront HIPAA validation edits to confirm the correct population of the paid amount field.
- Procedure code: Procedure codes are confirmed during HIPAA validation at the clearinghouses. If the clearinghouse finds an incorrect procedure code, it returns the claim to the sender. Humana performs a secondary review in our eHub platform to ensure we include the correct procedure code for the service being billed and the rendering provider. If the procedure code is incorrect, the claim will be rejected, and no encounter will be generated.

CAS also applies additional edits. We periodically update our policies and claims payment systems to align with correct-coding initiatives, as well as the following national benchmarks and industry standards:

- Centers for Medicare and Medicaid Services (CMS) guidelines
- American Medical Association (AMA) Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Diseases, Ninth Edition (ICD-9) and 10th Edition (ICD-10)

These updates support Humana's continuing efforts to process claims accurately. Thus, we apply the same logic, edits, and rules concerning coding to all claims and encounters before we prepare our encounter submission file for the State. Systematic creation of encounters ensures that data fields are coded consistently based on source data from the originally submitted claim. Any time encounter processing is changed, there is extensive testing to validate the changes.

Attachment I.C.7-1 Non-Pharmacy Encounter Submission Process shows the proposed data and process flows for non-pharmacy encounter processing in Kentucky.

PHARMACY ENCOUNTERS

For pharmacy encounters, HPS applies extensive edits at the point of sale to ensure that all claims meet appropriate standards for the claim processing. In the event we are missing a required field, the encounter is held until the data have been populated. Our Pharmacy Encounters team developed an automated process to ensure all encounter data fields are populated per the guidance from the State's companion guide. We have designed our systems to pull the appropriate data elements from our claims and to include quality control mechanisms to support the accuracy of encounter data submissions. The Pharmacy Encounters team also reviews encounters on bi-weekly basis to assess performance on encounter submission to the State's vendor and to discuss fluctuations and top errors. During these meetings, we develop action plans to resolve issues.

Pharmacy claims require the submission of all key encounter data elements, ensuring we identify all key fields for pharmacy encounters. We match these key fields to the field submitted on the claim, including Transaction Code, Service Provider ID, Date of Service, Cardholder ID, Prescription/Service Reference Number, Product/Service ID, Number of Refills Authorized, Prescriber ID, Segment Identification, Compound Ingredient Quantity, Date of Birth, Patient Gender Code, Medicaid ID Number, Quantity Dispensed, Other Payer Date, Internal Control Number, Other Payer Amount Paid (First Occurrence), Other Payer-Patient Responsibility Amount, Ingredient Cost Submitted, Dispensing Fee Submitted, Usual And Customary Charge, Compound Ingredient Drug Cost, and Gross Amount Due.

Once Humana receives these claims, Humana creates the encounter submission file based upon the American Health Care Association NCPDP guidelines to ensure accuracy. Our automated and systematic creation of encounters ensures we code encounter fields consistently based on source data from the claim. Any time the encounter processing is modified, we perform extensive testing to validate the changes. **Attachment I.C.7-2 Pharmacy Encounter Submission Process** shows the proposed data and process flows for pharmacy encounter processing in Kentucky.

P&P I.C.7-1 Encounter Data Processing Policies and Procedures

Department: KY Medicaid Administration	**Policy and Procedure No: HUM-KY1-PROC-Encounter Submissions- 001**	
Policy and Procedure Title: Desktop Process Kentucky Medicaid Encounter Data Submissions		
Process Cycle: Weekly	**Responsible Departments: Medicaid Encounter Submissions (MRA)**	
Approved By: Schaka Davis	**Issue Date: July 30, 2019**	**Revised:**

CONTRACT REFERENCE:

Attachment F

16.0 Encounter Data: Encounter Data Submissions

16.1 Encounter Data Submission
In accordance with the terms of this Contract and all applicable state and federal laws, the Contractor shall submit complete, accurate, and timely Encounter Data to the Department within thirty (30) Days of the Claim adjudication. This includes all paid and denied Claims, corrected Claims, adjusted Claims, voided Claims, and zero dollars ($0) paid Claims processed by the Contractor or by its Subcontractors.

The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports, and Encounter Files set in formats and timelines prescribed by the Department as defined in the Contract. The system shall be capable of following or tracing an Encounter within its system using a unique

Encounter identification number for each Encounter. At a minimum, the Contractor shall be required to electronically provide Encounter Files to the Department, on a weekly schedule. Encounter Files must follow the format, data elements and method of transmission specified by the Department. All changes to edits and processing requirements due to Federal or State law changes shall be provided to the Contractor in writing no less than sixty (60) business days prior to implementation, whenever possible. Other edits and processing requirements shall be provided to the Contractor in writing no less than thirty (30) business days prior to implementation. The Contractor shall submit electronic test data files as required by the Department in the format referenced in this Contract and as specified by the Department. The electronic test files are subject to Department review and approval before the production of data. The Department will process the Encounter data through defined edit and audit requirements and reject Encounter data that does not meet its requirements. Threshold edits, those which will enable the Encounter File to be accepted, and informational editing, those which enable the Encounter to be processed, shall apply. The Department reserves the right to change the number of, and the types of edits used for threshold processing based on its review of the Contractor's monthly transmissions. The Contractor shall be given thirty (30) working days' prior notice of the addition/deletion of any of the edits used for threshold editing.

The Contractor's weekly electronic Encounter data submission is to include all adjudicated (paid and denied) Claims, corrected Claims, and adjusted Claims processed by the Contractor. Contractor shall submit all Claims within thirty (30) Days of adjudication. Encounter File transmissions that exceed a five percent (5%) threshold error rate (total Claims/documents in error equal to or exceed five percent (5%) of Claims/documents records submitted) will be subject to penalties as provided in the Contract. Encounter File transmissions with a threshold error rate not exceeding five percent (5%) will be accepted and processed by the Department. Only those Erred Encounters will be returned to the Contractor for correction and resubmission. Denied Claims submitted for Encounter processing will not be held to normal edit requirements and rejections of denied Claims will not count towards the minimum five percent (5%) rejection.

Encounter data must be submitted in the format defined by the Department as follows:

Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010 transaction 837 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version 2.2. Example transactions include the following:

1. 837I – Instructional Transactions
2. 837P – Professional Transactions
3. 837D – Dental Transactions
4. 278 – Prior Authorization Transactions
5. 835 – Remittance Advice
6. 834 – Enrollment/Disenrollment
7. 820 – Capitation
8. 276/277 Claims Status Transactions
9. 270/271 Eligibility Transactions
10. 999 – Functional Acknowledgement
11. NCPDP 2.2

Encounter corrections (Encounter returned to the Contractor for correction, i.e., incorrect procedure code, blank value for diagnosis codes) will be transmitted to the Contractor electronically for correction and resubmission. The Contractor shall have the capacity to track all Erred Encounter Records and provide a report detailing transmission reconciliation of each failed transaction or file within thirty (30) Days of the transaction or file error. Penalties will be assessed against the Contractor for each Encounter record, which is not resubmitted within thirty (30) days of the date the record is returned.

The Contractor shall submit corresponding data in all data fields on each Encounter File submitted to the Department. Claims shall be submitted with a current and valid date in the format identified by the applicable Encounter File submission guidelines.

Encounters submitted without dates, including those that have previously been allowed to be submitted blank, shall be populated with a valid date or the Encounter shall threshold. A complete list of field requirements at both the detail and the header levels shall be supplied by the Department.

PURPOSE:

To ensure submissions of Encounter Data to the fiscal agent to meet the contract requirements.

POLICY AND PROCEDURE:

Policy:
The Medicaid Risk Adjustment Encounter Submission team adheres to the Encounter Data Submissions and Resubmissions, Requirements as well as Data processing for complete and Accurate Encounters for timely submissions. It is policy to comply with the encounters data submissions, reporting and implementation of processes based on a contractual obligation.

Procedure:
Humana oversees the end-to-end encounter process through reporting that provides a view from all systems, reflecting the beginning processes of claims adjudication all the way to the final encounter submission. Our processes and supporting reports monitor all encounters to ensure the completeness of our submissions based on our adjudication processes and State agency requirements. IT alerts are designed to notify key associates immediately when certain IT processes fail, anomalies in inventory, or potential trends that may require attention.

- MRA team will receive daily, weekly, and monthly reports that provide a view into encounter submissions.
- If an alert is received on report, MRA will review the alert and determine the root cause
- After root cause is identified, a decision is made if a system fix is needed, or if the error occurred as a one-time instance.
- If one-time instance it is determined if there are quality measures that can , to ensure instance does not happen again
- If system fix is needed an IT request is submitted to the HQRI Committee team for quality check, and approval
- The official ticket is accepted and implementation of new requirement begins
- If it is determined that this an issue with the State or its agency
    - The inquiry will be sent to the agency

The above are all supported and driven through our robust reporting that gives clear end-to-end tracking, trending, and monitoring of non-pharmacy encounter initial submission as well as resubmissions. The source of our reporting is derived through a combination of our Enterprise Data Warehouse (EDW) and the Edifecs data repository. All encounter data resides within our IT systems. A particular component of our reporting focuses significantly on ensuring the completeness, accuracy, and timeliness of our encounter submissions.

- Humana ensures that sufficient IT and staffing resources are available to perform encounter functions as determined by generally accepted best industry practices. Humana retains submitted encounter data for a period not less than ten (10) years in accordance with 42 CFR § 438.3(u).

Reports have been created to provide submissions results by month measuring the timeliness and accuracy for submissions. These reports are designed to ensure encounters submissions:

Humana shall submit encounter data, no later than seven (30) days following the date on which the claim adjudicated.

Encounter data must be submitted in the format defined by the Department, and after the claim has been adjudicated, it is immediately converted into a HIPAA transaction format in the standard ANSI X12N 837 transactions and submitted to the state. To ensure the accuracy and completeness of this Encounter Data, the Medicaid Encounter Submissions team sends a member of the team to participate in X12 Conferences and WEDI Conferences.

The encounter will:

- Pass internal, and HIPAA edits and is accepted by the state within 30 days
- Pend due to internal edits
- Encounter Improvement team will manually correct and resubmit encounter to the state within 30 days

If denied at the state level:

- Encounter Improvement team will manually correct and resubmit encounter to the state within 30 days

Encounter Data Submission

During instances in which rejection occurs, our Encounter Submission analyst reviews errors and assigns them to Data Improvement teams to correct or update encounter. We also monitor our rejection and acceptance rates to determine if results exceed minimum tolerance standards, identify unusual trends, give feedback and training to associates, and identify process improvements that can yield increased efficiency.

Reports have been created to provide submissions results by month measuring the timeliness and accuracy. These reports are designed to ensure encounters resubmissions:

- Erred Encounters will be corrected and resubmitted within 30 days
- An automated process submits adjusted and reversal payments to comply with the 30 days resubmission standards

The encounter process is automated to include no more than 5k files per batch based on file submission criteria for all 837s

- All outbound files are created with their unique submitter identification number Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010 transaction 837 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version 2.2. Example transactions include the following:
    - 837I – Instructional Transactions
        - 837P – Professional Transactions including Vision
        - 837D – Dental Transactions

Each transaction will be separated by the following within the file name:

- Original (new claims)
    - **R** – Resubmissions (claims that have been previously submitted but rejected)
    - **A** – Adjustments (adjustments to previously accepted encounters)
    - **V** – Void (voids for previously accepted encounters)
    - **D** – Denied (encounters denied by the MCO)
- Outbound files are then submitted to the Department IT
- If any files are rejected at the state level in its entirety, the TA1 rejection will be worked using the Attestation Procedure (see attached).
- The Managed Care Plan shall submit encounters with a 5% or lower threshold error rate. Files with a threshold error rate of 5% or lower will be accepted and processed by the state.

Encounter Corrections must be resubmitted to the state within 30 days. Includes all adjustments, corrects, voids, or any other file types the corrections may have batched on. The Medicaid Encounter Data Submissions team will use the Encounter Corrections (see attached) procedure to complete the corrections and resubmit.

c.	Describe common challenges the Vendor has experienced in encounter data development and submission, and mitigation strategies and best practices the Vendor has implemented to ensure accurate and complete encounter data.

NON-PHARMACY ENCOUNTERS

Humana ensures the consistency of volume, categorization, dollar amount, and dates for encounters across data sources by requiring that all medical claims and encounters from providers and subcontractors clear the HIPAA, State, and Humana edits in eHub. Only after a claim or encounter has passed the required edits, does it move to the next stage, Edifecs, to be converted into an encounter that Humana submits to the State. We have developed these mature systems over several years and have evolved to address challenges, as described below.

Eligibility Challenges

Eligibility issues (whether at the provider or Enrollee level) have been an ongoing challenge that Humana has made great strides to alleviate. **By developing up-front edits that capture potential eligibility problems before they make it into our encounters system, we have been able to limit the number of erroneous encounters delivered to the Department**. Using the Department's provider logic, we can match the amount the provider has billed on the claim against what the Department has listed on their Master Provider List (MPL) and deny or pend that particular claim for review. Similarly, we have logic in place that reviews the Enrollee's identifying information included on the claim we have loaded with the most recent 834 file from the Department and matches that information against our CI. We have also developed a weekly meeting with our Provider Relations Team to relay any provider eligibility issues that we have encountered. This team is then able to reach out to those particular providers and attempt to resolve those problems before the claims are initiated.

Timeliness Challenges

Timeliness standards are another common challenge that Humana continues to improve upon. One of the ways in which Humana ensures the timeliness of its encounter submissions is through our encounter reporting system. The system generates reports that help us monitor the aging of our encounter queue and generates an alert when we are at risk of missing an upcoming Department timeliness standard. Humana has developed an Encounters Aging report that is distributed daily for review. This report enables Humana to appropriately prioritize the encounter submission workload starting with those encounters in jeopardy of not meeting the Department's timeliness requirements.

Accuracy Challenges

Through targeted initiatives, Humana has met and continually exceeds accuracy requirements. For example, we developed manually written code logic, which we refer to as business and compliance edits, to capture potential errors on our encounters before they are submitted to the State. These errors are corrected by our Error Correction team and placed into a new outbound file to be sent to the State for correct adjudication. Our Error Correction, Encounter Submission, and Risk Management teams meet daily to conduct a complete and total review and analysis of inaccuracies occurring within the Contract. This collaborative process facilitates the development of more efficient processes and the rapid resolution of shared problems.

Our Error Correction team meets weekly to review the top errors received from the State. In these meetings, we analyze how the correction team adjudicates errors and determines appropriate steps for correction.

Duplicate Encounter Submissions
We will implement the code containing the duplicate encounter detection logic provided by the Department such that encounters matching this logic will be flagged before getting batched into an outbound file. We will then be able to manually review those encounters flagged as duplicates and ensure accuracy prior to submitting an encounter. Humana understands the submission of duplicate encounter data may lead to fines. Humana takes this challenge very seriously and has made it one of our top priorities for enhancements to our Management Information System (MIS).

Encounter Reconciliation
Humana has an encounter reconciliation program to ensure Humana receives all claims and codes timely and accurately from providers. We measure this by completing a reconciliation process between the provider and Humana. The reconciliation process summarizes claims and code data processed, isolates data not received by Humana, and identifies any gaps in the data. The provider resubmits data as needed. Humana and the provider will remedy any identified issues for accurate and timely submissions in support of future processing.

Because the 837 goes through a series of edits from the provider to the clearinghouse to Humana, there is the possibility of dropped or truncated claims within various provider practice management systems. **The encounter reconciliation program provides claim- and code-level analysis to determine averages and benchmarking based on overall claim performance**. Furthermore, we request a collection of claims data for a specified period, referred to as a "shadow file," from our providers and Medical Service Organizations (MSO). We use the shadow file to measure accuracy of all provider claims submitted to and received by Humana.

The reconciliation model compares shadow file data to Humana's received data to determine potential data gaps. There is matching logic behind the reconciliation model to determine a match or a non-match. During the process, Humana looks at specific key data fields, including provider tax ID, date of service, Enrollee ID, diagnosis codes, CPT/ HCPCS codes, and claim ID.

We reconcile at a claim, service line, and diagnosis code level and share the results of the reconciliation process with the provider. If we identify any gap(s), Humana and the provider will work together to locate and resubmit any missing claim(s), and identify and address any system issue(s) among the provider, the clearinghouse, and Humana. The date of service, shadow claims, matching claims, claim outage, claim outage percentage, shadow diagnosis codes, matching diagnosis codes, outlier diagnosis codes, and percentage are included in the summary report that we share with the healthcare provider.

Process Improvements
Humana has a proactive approach to conduct provider outreach. Humana's Provider Reporting, Communication and Education department develops various provider communications to promote accurate and consistent coding. This includes condition-specific coding guidelines and industry best practice materials, which are shared with providers and office staff by request or as needed. The educational materials are sourced from organizations such as the Centers for Medicare and Medicaid (CMS), the American Heart Association, Mayo Clinic, and ICD-10-CM Official Guidelines for Coding and Reporting. Examples of condition-specific coding guidelines include depression and adult wellness visits. These materials may be delivered electronically, as well as in-person by our local Provider Relations (PR) representatives or peer-to-peer, as appropriate, by the local market Medicaid Medical Director.

Additionally, Humana has developed a coding improvement process through which we give providers plans to guide them on commonly missed data points, including diagnosis codes and coding specificity. The coding improvement plan also suggests best practices to improve coding for specific conditions. Our Provider Relations Team reviews the plan and addresses specific coding issues.

PHARMACY ENCOUNTERS

Humana ensures that encounters (i.e., volume, categorization, dollar amounts, and dates) are consistent across all pharmacies in our network by applying the same edits to all pharmacy claims. We also conduct an analysis of

total claims paid, volume, and categorization of claims and our encounters to ensure they align and do not have any discrepancies.

d.	Describe educational approaches the Vendor will implement to support providers and Subcontractors that are identified as having ongoing challenges in submission of complete, accurate, and timely information.

TRADITIONAL CLAIMS AND ENCOUNTER EDUCATION

Humana understands the importance of educating our providers about our requirements for complete, accurate, and timely encounters. Our provider onboarding training materials for all new providers include information about our claims and encounter submission requirements. We supplement the initial training with refresher trainings, provider updates and alerts, and one-on-one instruction, employing multiple methods including phone outreach, webinars, online trainings, mailings, in-person meetings, and workshops. Our goal is to engage providers and their staff on coding, claims submission, and Humana's claims payment policies and processes. To support providers, we offer comprehensive provider training and accessible claims associates, such as our Provider Claims Educators. Information regarding claims processing is readily available on our website and in the Provider Manual. For example, our Provider Services associates are also available via our provider hotline to respond to claims inquiries.

"Making It Easier for Physicians and Other Healthcare Providers" is a series of educational presentations about Humana's claims payment policies and processes available on our website.

Our Provider Services Call Center plays a central role in educating providers about Humana's claims and encounters requirements. Our highly trained Provider Call Center Representatives (PCCR) can answer specific questions about claims and encounters requirements, the reason a provider's claim or encounter submission was rejected, and the status of payment on a claim. Each PCCR receives eight full weeks of training on claims and encounters, including technical training on our electronic claims processing and payment system (e.g., CAS). They have access to Humana's claims processing and payment system so they can research the reason why the provider's claim or encounter submission was rejected. They refer providers to the Humana website for claims-specific provider education materials.

When a provider or subcontractor contacts us after a claim or encounter rejection, or we notice that a provider's encounter errors have been more frequent, we view this as an opportunity to reach out to the provider or subcontractor to provide additional training on how to meet encounter requirements. Our Provider Relations Team may contact the provider and offer an onsite visit.

As part of Humana's enterprise-wide strategy to correct and complete submission of claims and encounter data, our Medicaid Risk Adjustment team has developed a proactive education strategy. In fact, we have dedicated learning facilitators who are responsible for educating our providers on documentation and coding. Education is based on approved coding guidelines.

An additional strategy that complements our enterprise-wide strategy is based on the work of our Provider Data Validation (PDV) team. The PDV team pulls a sample of Humana providers annually and conducts a coding accuracy review of the claims data submitted on the encounter. The PDV team reviews Enrollees' medical records against the submitted encounter, scores the results of the medical record review, provides education on accurate and complete submission of claims and encounter data, and (if warranted) places these providers on a Coding Improvement Plan (CIP). We identify providers for a CIP if their PDV accuracy score(s) falls below the benchmark goal of 85%.

REAL-TIME EDUCATION AND FEEDBACK THROUGH ADVANCED CODE EDITOR

Additionally, we are developing, piloting, and testing a Humana-specific tool on Availity's payer space platform called **Advanced Code Editor**. This tool offers code edits and checks to validate complete and accurate submission of claims and encounter data submitted through Availity. **The tool immediately identifies inaccurate claims and encounters, notifying the provider in near real time with rejections along with reasons for these rejections**. One edit we recently implemented is the PCD-ICD-10-CM PDO, which identifies certain Z-codes/categories that may only be reported as the principal diagnosis (except when there are multiple, related encounters on the same day).

After thorough testing, Humana has a list of additional edits scheduled for implementation to support accurate and complete submission of claim and encounter data from our providers, supporting Humana's complete and accurate submission of encounter data to the Department. Examples include edits to identify invalid modifier codes and inappropriate diagnosis combination. This tool also offers education to our providers on their claims submission.

PROVIDER-SPECIFIC EDUCATION

Sub-Capitated Primary Care Medical Groups

During Contract negotiations with sub-capitated primary care medical groups, our Provider Contracting team reviews the Contract requirements for monthly encounter data submissions with the provider and emphasizes the importance of submitting complete, accurate, and timely encounters. The onboarding training that our Provider Relations Team conducts for all new sub-capitated providers and their staff includes a segment on the reasons for encounter rejections. We reinforce this information and provide updates on new encounter submission requirements in our refresher trainings. **We also require that at least one representative from each sub-capitated medical group takes our online training program that covers encounter submission requirements and attest that he or she has completed the training**.

The Provider Relations Team targets outreach to sub-capitated Primary Care Providers who repeatedly submit incomplete or inaccurate encounter data. They meet with the provider to help them identify the cause of the problem (which might be that the provider has started using a new vendor to prepare their encounters) and provide guidance on encounter submissions. The team documents the content of the meeting with the provider's staff and requires the provider to sign an acknowledgment that they have received the training.

We determine capitation rates based on the encounter data submitted by our sub-capitated providers. When providers fail to submit complete and accurate encounter data in a timely fashion, their routinely assessed capitation rates will not reflect actual cost of services they are providing our Enrollees. To improve our validation of complete encounter submissions from our sub-capitated providers, we increased the frequency of reviews of encounter detail data and capitation payments. Through this mechanism, we track and trend quarterly claim and service counts as well as the average claims paid amount, highlighting significant variances between capitation payments and encounters to focus our provider outreach.

Additionally, our sub-capitated providers are enrolled in bonus programs through which providers receive their bonus or award in each of these programs based on submitted encounters. These programs naturally incentivize our providers to submit complete, accurate, and timely encounter data to qualify for the bonus or reward designed in these programs. To this end, when encounter data elements are not submitted, the provider will not realize the bonus to which they have worked. Continuously, we educate and engage with our sub-capitated providers to ensure they understand that it is in their best interest to ensure completeness, accuracy, and timeliness of encounter data submission. When providers consistently fail to submit encounter data in a complete, accurate, and timely fashion, Humana conducts enrollment freezes and imposes liquidated damages.

Subcontractors

Prior to executing a Contract with a prospective subcontractor and conducting testing of the entity's ability to produce complete, accurate, and timely encounters, Humana meets one-on-one with the entity to walk through

the encounter submission requirements in the Delegated Entity Companion Guide for Delegated Encounters ("Companion Guide"). The Companion Guide offers guidance on the requirements of transactions and data submitted to Humana, which is designed to ensure all data fields are populated and accurate.

We require our subcontractors to submit their encounter data to our clearinghouses. The clearinghouses and our electronic claim and encounter editing platform, eHub, identify encounters that do not include the key field combinations, have incorrect coding, or contain other encounter errors and rejects them. A claim rejection is usually an effective incentive to encourage our providers and subcontractors to take steps to meet our encounter data requirements.

Our market-based Subcontractor Performance leader ensures local oversight of our subcontracted functions, including monitoring performance of all data submitted to Humana. Our Subcontractor Oversight team is supported by the Provider Relations network leadership. The relationship managers (RM) work with our subcontractors on a regular basis to address areas of opportunity. The Subcontractor Performance leader reviews subcontractor performance on encounter data for completeness, accuracy, and timeliness of submission. We share these reports with our subcontractors during Joint Operating Committee (JOC) meetings and report them internally to the Quality Improvement Committee (QIC). We put Corrective Action Plans (CAP) in place where performance falls under the expected SLA.

Pharmacies
HPS owns and manages our pharmacy network. We educate our pharmacists about the requirements for submitting a complete, accurate, and timely claim in our Pharmacy Manual and through published payer sheets. In addition, we require our pharmacists to complete a self-guided online training program that highlights the State's requirements for claims. These requirements include the elements needed for a complete, accurate, and timely encounter.

Non-participating Providers
Humana does not mandate training of non-participating providers on encounter requirements. We direct non-participating providers to the non-secured section of Humana.com to learn about Humana's claim processing and payment requirements. This section includes detailed guidance about requirements for claims to pass our electronic edits. Providers can also speak directly with a PCCR to discuss their questions about claim and encounter requirements.

e.	Describe initiatives the Vendor proposes raising to the Encounter Technical Workgroup to enhance the data submission requirements and improve the accuracy, quality, and completeness of encounter submissions.

Humana is an active participant in the Encounter Technical Workgroups in the states where we serve Medicaid-eligible populations through MMC programs. In our more than 20 years of working with CMS, we have developed certain initiatives that have improved the accuracy, quality, and completeness of our encounter submissions. One such initiative was the creation of the internal Encounter Escalation Workgroup. This is a bi-weekly meeting among claims subject matter experts, encounter submissions experts, and IT systems support. This workgroup identifies encounter submission problems, analyzes root causes, and develops sustainable solutions. Initiatives that have recently emerged from the efforts of this workgroup include updating:

- NDC editing logic: We are in the process of finalizing rules that will verify the billed NDCs versus what appears on the verified crosswalk. This will reduce, and ultimately eliminate, any encounter rejections from the State regarding invalid NDCs submission.
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) billing logic: FQHC/RHC claims that are submitted with an invalid place of service and/or invalid HCPCS codes per the fee schedule will get stopped and routed back to the billing provider for correction, eliminating encounter rejections related to this issue.

- Child Health Checkup logic: When a child health checkup procedure code is submitted on a claim, a certification condition indicator of "Y" must be billed. If not, the claim will get rejected back to the billing provider for correction and will eliminate any encounter rejections from the State due to this requirement.

Setting up individual face-to-face meetings between the State (or State's vendor) and Humana has been a key contributor to the reduction of encounter errors. These meetings provide us the opportunity to develop a more personalized relationship with the State and subcontractor representatives and enable more in-depth discussions than we can achieve in a group MCO setting. Through these meetings, Humana representatives have influenced updates and changes to tip sheets and other published documents. Additionally, through the workgroup, we have been able to reduce provider-specific errors.

With the implementation of HERO, Humana can conduct extensive analysis on encounter submission data, which, in turn, gives us greater insight into our already detailed reporting. These reports enable Humana to identify trends such as duplicate submissions, Enrollee eligibility, and provider errors that can then be shared with the technical workgroup participants in order to improve encounter submission strategies.

Humana understands that there are times when the Department will be unable to come up with a solution to an encounter submission-related issue. During those times, we believe our expertise will enable us to bring potential solutions to the workgroup to foster effective resolution. One such example is connecting a previously rejected encounter to a now denied or voided encounter. We have encountered similar instances within other contracts and have been able to resolve issues using our extensive X12 knowledge base.