C.7   Encounter Data

> **REQUIREMENT: RFP Section 60.7.C.7**
> 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.
>   b. Provide the Vendor's Encounter Data Processing policies and procedures.
>   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.
>   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.
>   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.

> **Our seasoned Encounters team and proven data workflow will ensure we submit complete, accurate, and timely encounter data to support Department efforts.**

a. ENSURING COMPLETE, ACCURATE, AND TIMELY ENCOUNTER DATA SUBMISSIONS

Our encounter data efforts provide additional evidence of the commitment to quality care, sound fiscal management, and provider service excellence that Molina proposes to put to work for Kentucky. Our parent company, Molina Healthcare, Inc., has a long history of receiving HIPAA-compliant 837 encounter files and transmitting them to state agencies, vendors, providers, and other regulatory agencies. This experience reflects the successful combination of a sophisticated end-to-end encounter process, a highly disciplined approach, proactive provider service efforts emphasizing partnership and training, and an experienced and dedicated Encounters team led by our parent company's vice president of operations.

Configurable systems, mature processes, advanced tools, and appropriate reports are already in place at our affiliated health plans and will be customized to achieve all Kentucky encounter requirements. Molina will generate encounter data for all paid and denied services and extract and submit encounter data as frequently as required to comply with encounter submission requirements and processing needs*. **In fact, as of December 2019, our parent company achieved an overall completeness and accuracy rate of 97.15% across all our affiliated health plans, with a timeliness rate of 98.3%.***

Encounter Success

As of December 2019, our parent and affiliated health plans:

- Processed an average of 5 million inbound claims and encounters each month
- Submitted an average of 4.2 million encounters to states each month
- Achieved an overall **completeness** and **accuracy** rate of 97.15% across all state health plans
- Accomplished an **overall timeliness rate of 98.3%** across all state health plans

As a process-driven organization committed to improvement, we mentor providers and partner with state agencies and other MCOs. We understand that even though encounter data may be submitted by MCOs as required, data may not always be used to its fullest potential for the benefit of Kentucky, Enrollees, and providers. That is why we welcome the opportunity to work with the Department and other MCOs to collaborate on encounters process improvements—as well as data mining and analysis—to help deliver the best possible care at the best value.
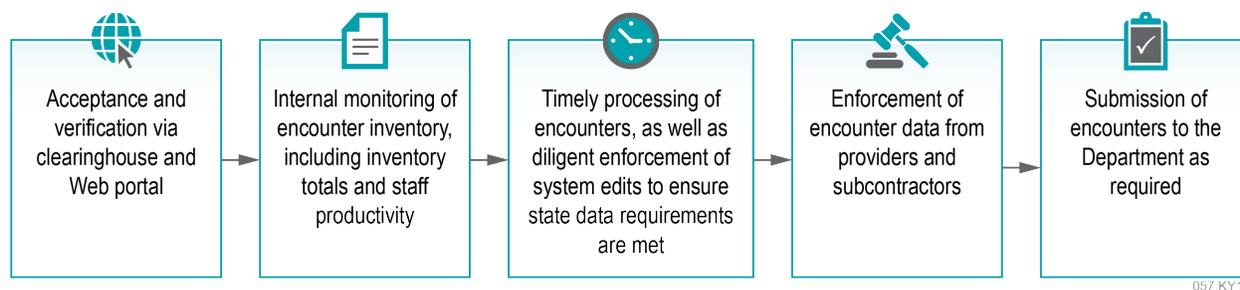
In the following pages, we outline our response to Proposal Section C.7, Encounter Data, and describe how we will submit encounter data in accordance with the requirements set forth in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 16, Encounter Data, and all Commonwealth

and federal laws and requirements, including those for timeliness, accuracy, and completeness. We also will provide relevant policies and procedures, describe common challenges and mitigation strategies as well as education approaches, and propose potential initiatives that may be raised to the Encounter Technical Workgroup. Exhibit C.7-1 provides an overview of our encounters process.

| Acceptance and verification via clearinghouse and Web portal | Internal monitoring of encounter inventory, including inventory totals and staff productivity | Timely processing of encounters, as well as diligent enforcement of system edits to ensure state data requirements are met | Enforcement of encounter data from providers and subcontractors | Submission of encounters to the Department as required |

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Exhibit C.7-1. Key Features and Functions of our Encounters Process

RECEIPT OF ENCOUNTERS

Both encounter and claims data are received through electronic submissions via an electronic data interchange (EDI) clearinghouse (for example, 837 P/I file) and Web portal transactions. Our parent company's Claims and Encounters Management System (CEMS) manages the flow, generation, and submission of encounter data. Our parent company's internal workflow for Kentucky Medicaid will include monitoring and reporting on encounters throughout their lifecycle—from claims payment through encounter submission to the Department.

All encounters will be thoroughly validated before they are sent to the Commonwealth. This automated process will ensures completeness of encounter submissions and that key fields, such as the National Provider Identifier and/or provider Medicaid ID as per requirement, claim type, place of service, revenue code, diagnosis codes, amount paid, and procedure code) are populated accurately for every encounter submission.

Before encounters are submitted for processing, they will be run through a series of internal outbound edits to ensure data is complete and meets applicable, contract-specific requirements. An EDI clearinghouse for claim and encounter submissions will identify opportunities to promote electronic encounters submission and improve the quality of submitted encounters.

PROMOTING PROVIDER AND SUBCONTRACTOR COMPLIANCE

Erroneous or non-submission of encounter data by a provider or subcontractor can result in an incomplete health history and, potentially, a critical gap in care and services for Enrollees. It may also limit correct reporting and evaluation. Our parent company performs quality and completeness checks throughout the claims/encounter submission process, as described above. Monthly reports identify, track, and benchmark metrics, such as encounter submission rates, which enables our parent to identify underperforming or non-compliant entities. Our corporate parent consistently validates encounter data to ensure appropriate volumes of encounters are received and submitted.

Molina will work proactively to ensure provider and subcontractor compliance with encounter data submission requirements. Encounter data submission will be covered in Molina's Provider Manual, which will serve as the foundation for our Provider Services training efforts. The Provider Manual will be available to providers upon contracting with Molina, including 24/7 online access to the manual via our provider website. The Provider Manual will explain what providers need to do to successfully submit encounters, including the time frames for timeliness and other parameters.

Finally, providers and subcontractors may qualify for pay-for-performance rewards for submitting timely and accurate data; they also will be subject to potential financial penalties for failure to submit timely and

accurate data. If the provider or subcontractor does not improve, or the cause cannot be remediated, we may consider terminating their agreement. Similar pay-for-performance incentives are common in provider contract language at our affiliated health plans and will likely be included as part of our Kentucky pay-for-performance model.

Working with Providers and Subcontractors to Correct Errors

If we identify missing, inaccurate, or invalid data elements, required fields, or code sets during the validation process upon receipt of encounter data, we may reject the claim/encounter and return it for correction and resubmission. We will use internally developed tools to help track and trend vendor-submitted data. If data is missing, we will work with our local, high-touch Provider Services team to coordinate remediation/resolution efforts, including communication with the provider or subcontractor. Provider Services also will deliver ongoing communication and training to further promote complete, accurate, and timely encounter submissions.

Provider Services will be ready to engage our providers and ensure encounter data is complete and meets our quality standards, valid code sets, HIPAA compliance, and so forth. Should an inconsistency be noted or identified in encounter submission rates, or a missing data element identified, we will engage the provider directly for resolution. In our affiliated health plans' experience, non-submissions are often the result of technical issues that can be remediated in a timely manner. If appropriate, our Provider Services team may request that providers and subcontractors participate in additional training.

Program Monitoring and Corrective Action

Our parent company holds Joint Operating Committee meetings regularly with sub-capitated providers and large volume fee-for-service (FFS) providers where claims and/or encounter status and issues are a standing agenda item. The meetings help focus providers on achieving maximum compliance rates. Our parent also has established an Encounters Compliance team led by its corporate compliance officer. In addition, our parent's Delegation Oversight team performs ongoing review and assessments as well as annual audits of subcontractor performance regarding each delegated function within 12 months of the previous assessment date. By conducting consistent report monitoring for such things as compliance with report content, reporting frequency, assessment activity, or member complaint information requirements, our parent can determine if a subcontractor is not carrying out delegated activities in accordance with the terms of their Delegated Service Agreement. If our parent validates such a determination, it may implement a corrective action plan, with consequences up to and including revocation of the subcontractor's right to perform any delegated function or activity.

> **High Touch, Higher Acceptance**
>
> Our affiliated health plan in Illinois saw a high number of encounter rejections for a transportation subcontractor in March 2018. After thoroughly troubleshooting the error, our parent company discovered the subcontractor was triggering the rejections by submitting encounters using a provider name that did not match their Medicaid provider ID.
>
> Our Illinois affiliate's Provider Services team met with the subcontractor, which made system changes resulting in improved acceptance rates. By April 2018, the transportation provider's acceptance rate had exceeded the state-required threshold, bringing our Illinois affiliate back into compliance with the state's requirements for transportation. Today, they remain above the state threshold and are one of the top health plans in the state for that measure.

SUBMISSION IN COMPLIANCE WITH ENCOUNTER DATA FORMATS

Molina will submit *physical health and behavioral health* encounter data in time frames and formats that meet all Department requirements. National industry standards and Commonwealth companion guides will be used to support HIPAA-compliant 5010 Medical (837P), Institutional (837I), and Dental (837D) formats, as well as National Council for Prescription Drug Programs formats. Our parent company has also adopted HIPAA-compliant code sets for specific diagnoses and procedures to ensure outbound encounter data is ICD-10 compliant. Our parent trades with and provides technical assistance to our subcontractors and providers to ensure compliance with required formats.

Our parent company implements quality and completeness checks throughout the claims/encounter submission process to ensure that encounter submissions are complete and meet required standards. Our parent works closely with providers to ensure receipt of complete encounter data that meets quality standards and other criteria, such as valid code sets and HIPAA compliance.

Upon receipt, our parent will validate encounter files to ensure they are HIPAA compliant. Invalid HIPAA files will be sent back to the provider for correction. Once the encounter file passes HIPAA validation, the encounter data is reviewed to ensure the file content meets HIPAA and Molina standards. All encounters failing any of the inbound edits will be returned to the provider for correction. Before encounters are submitted to the Commonwealth for processing, they will be run through another series of internal outbound edits to ensure data is complete and meets state encounter data edit requirements. Any encounters failing the internal edits will be pended for manual review until any errors are resolved. Only then will Molina submit the encounters to the Commonwealth for processing.

Molina will maintain an internal workflow system to monitor and report on each encounter throughout its entire life cycle—from claims payment through submission to the Commonwealth. This workflow will be able to pinpoint where the error resides if indicated based upon validation edits established within our encounter or claims payment processes. Additionally, we will use daily, weekly, and monthly reports to verify, trend, and track the key performance indicators of each encounter.

Our state-of-the-art technologies ensure a comprehensive business process supports quality encounter submissions. The process caters to various sources of encounters and is agile enough to address provider-specific nuances. Exhibit C.7-2, Encounters Process Flowchart, depicts our end-to-end encounter submissions, correction, voiding, and resubmission process.
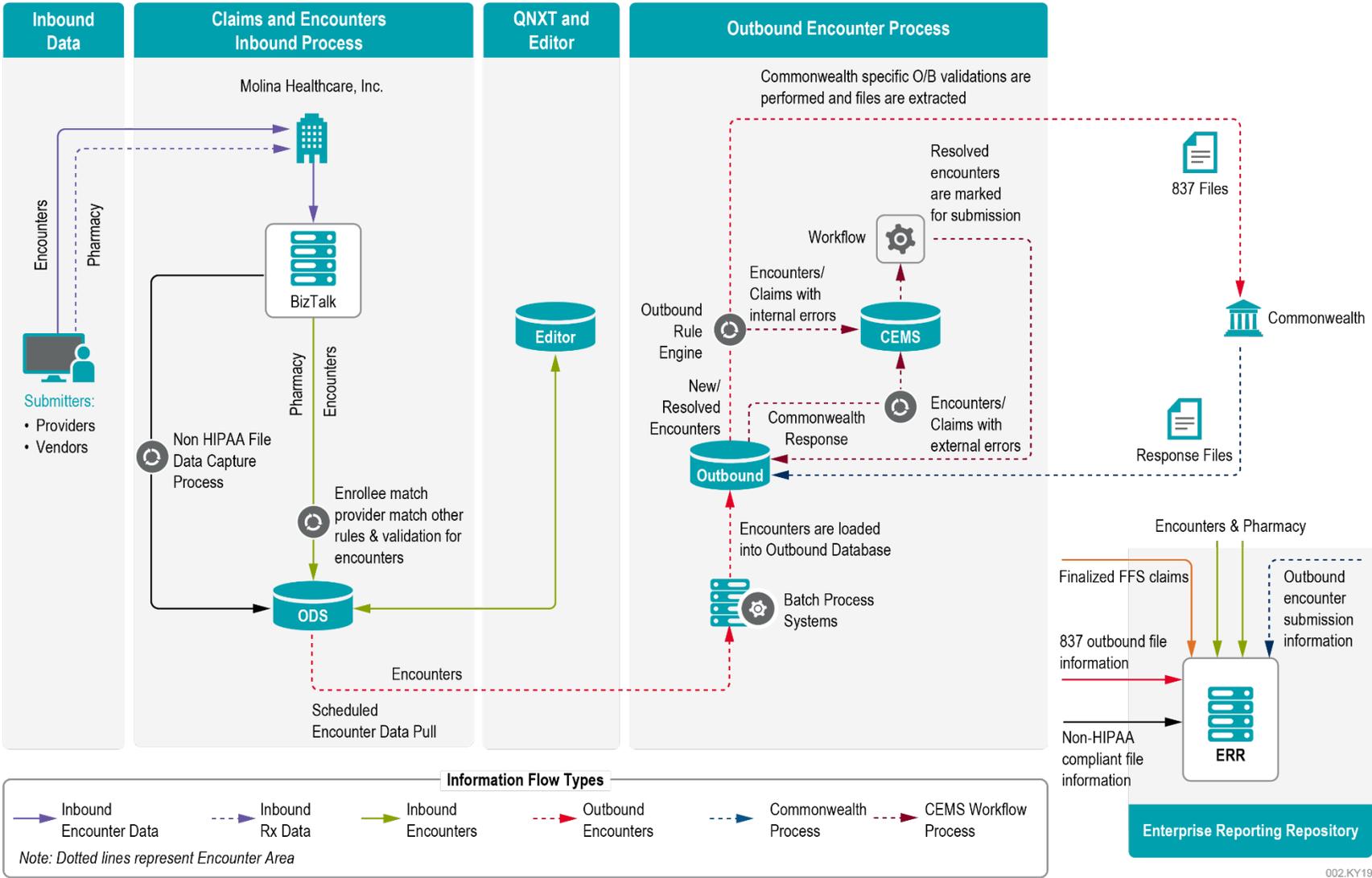
Exhibit C.7-2. Encounters Process Flowchart

ENCOUNTER REPORTS

Consistent with our focus on providing complete, accurate, and timely encounter data, our parent has developed a number of custom encounter dashboards and reports, as shown in Exhibit C.7-3, for review by senior management. To operate in a transparent manner, these dashboards and reports, which detail the end-to-end status of encounter submissions, are also shared with partner agencies and providers.
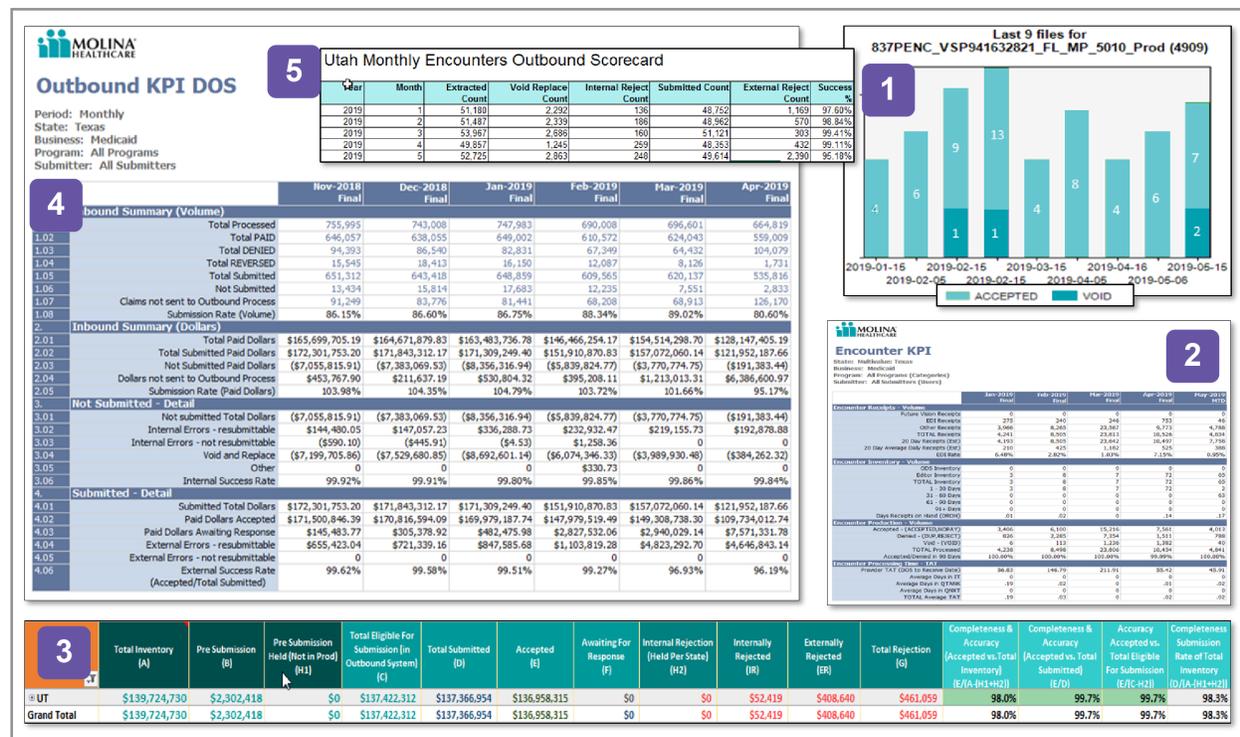

Exhibit C.7-3. Snapshots of Encounters Reports and Dashboards

These dashboards and reports will make the right information available to the appropriate personnel who will conduct oversight to ensure Molina and its vendors not only meet Kentucky requirements but exceed them. Any discrepancies identified will be quickly escalated to Molina and our Provider Services department for provider/vendor outreach to rectify the issues as soon as possible. Dashboards and reports will be monitored by the Encounter Management team daily and monthly. These sample reports can be generated as needed (daily, weekly, monthly, quarterly, annually, and so forth) and include:

1. Encounter Trending Dashboard. This dashboard identifies the number of encounters accepted, rejected, or identified as duplicates by submission file and can be used to help the provider or submitter quickly understand the outcome of their encounter file submissions to Molina. It provides the file name, dates of submission, and encounter status. In addition, the provider or submitter can proactively review encounter rejections, remediate any issues, and resubmit.

2. Inbound Encounter Key Performance Indicator (KPI). This report summarizes encounter receipts (daily or monthly), encounter inventory, encounter production, and encounter processing turnaround time.

3. Encounter Dashboard. This dashboard provides a complete end-to-end overview of total claims/encounters processed, submitted, accepted, and rejected.

4. Outbound KPI. This report summarizes inbound encounters, non-submitted (internal rejects) encounters, and outbound submission details.

5. Monthly Encounter Outbound Scorecard. This scorecard provides a snapshot, by submitter, of Commonwealth encounter submissions to understand outcomes. It shows totals for encounters extracted, void replaced, internal/external rejections, submitted, and accepted.

b. ENCOUNTER DATA PROCESSING POLICIES AND PROCEDURES

Molina will apply the same proven encounter data processing policies and procedures used for our affiliated health plans nationally to our Kentucky operations. Following contract award, we will tailor these policies and procedures to Kentucky-specific requirements and develop customized job aids to best support encounter submissions to the Commonwealth. We provide attachments, described below, which represent the corporate encounter data processing policies and procedures we will adapt and employ:

- **Attachments to Section C.7, MHI Claim and Encounter Submission Methods.** This document informs our team about the different types of claim and encounter submission methods available at Molina, along with specific provider submission requirements.

- **Attachments to Section C.7, MHI Encounter Error Workflow Process.** As part of the encounter process, internal and external rejection errors are created for encounter outbound submissions. This document identifies the process and responsibility for resolution of encounter errors in the outbound encounter error workflow process.

- **Attachments to Section C.7, MHI Claims and Encounters End-to-End Data Flow.** This job aid outlines Molina's claims and encounters data flow, and documents the process for receiving, loading, and processing FFS claims and encounters.

c. COMMON CHALLENGES, MITIGATION STRATEGIES, AND BEST PRACTICES TO ENSURE ACCURATE AND COMPLETE ENCOUNTER DATA

Common challenges with encounter data development and submission that our organization has experienced—and addressed—over the years are included in Table C.7-1.

Table C.7-1. Common Encounter Challenges and Solutions

Challenge	Description of Challenge	Mitigation Strategies / Best Practices Applied
National Drug Code (NDC) Errors	During the claims adjudication process, our parent discovered that claims were being processed without the appropriate NDC / Healthcare Common Procedure Coding System (HCPCS).	We partnered with our claims team and state agencies to learn more about NDC and HCPCS dependencies and resolved the issue by creating and maintaining an NDC-to-HCPCS crosswalk to match the appropriate codes with one another, so we can successfully adjudicate—and obtain acceptance of—submitted encounters.
Invalid Provider Registration	In some states, providers must register or affiliate with the state to provide services—and for encounter acceptance. In one situation, our parent saw a high number of encounter rejections due to requirements that did not clearly state how to handle provider registration.	We reached out to the state for clarification and, after a couple of interactions, reconfigured the logic for validating provider registration, enabling us to successfully resubmit rejected encounters. Molina will establish logic to follow the requirements outlined in the Draft Contract, Section 28.11, Provider Electronic Transmission of Data, and will work closely with the Department during initial setup to better understand the logic for validating provider data against the Medicaid master provider file.
Unclear Present on Admission (POA) Indicators	Our parent experienced a high volume of encounter rejections due to differences in state POA indicator requirements.	We partnered with state agencies to clarify encounter requirements. This enabled us to configure the claims adjudication system and encounter validation edits correctly, so we can successfully validate and resubmit encounters to the state or CMS.

Challenge	Description of Challenge	Mitigation Strategies / Best Practices Applied
Registration Edits	During the recent implementation of a state health plan, there were some additional clarifications required from the state regarding the logic used to edit encounters for provider registration. This situation increased the volume of claim denials for providers due to invalid registration.	We collaborated with the state to ensure front-end edits were accurate for providers to be registered. Our affiliated health plan then engaged providers, educating them about the registration process to prevent claim denials due to registration and encounter rejections. In cases where claims were denied incorrectly, claims were reprocessed, submitted, and accepted. In cases where providers were incorrectly registered or not registered, our affiliated health plan continued provider outreach and education.

To address these challenges and others like them, our parent company has developed various mitigation strategies and best practices. Among them, a series of internal inbound and outbound edits validate encounters for accuracy and completeness. Any encounters that are rejected via inbound or outbound rules are shared with the provider or vendor. Our parent also holds regular Joint Operating Committee meetings with sub-capitated providers and large-volume FFS providers where encounter status and issues are a standing agenda item. Our joint operations work dovetails with our internal processes while focusing providers on achieving maximum compliance rates.

In addition, before go-live in Kentucky, the overall system will undergo thorough user acceptance testing (e.g., claims, provider configuration, eligibility, and encounters). End users will perform a comprehensive series of scenarios, conditions, and test cases to demonstrate that business requirements are met before the system is placed in production. Any issues identified during this testing phase will be remediated to ensure the system is configured to support processing according to Commonwealth requirements.

d. EDUCATIONAL APPROACHES TO SUPPORT PROVIDERS AND SUBCONTRACTORS THAT HAVE ONGOING SUBMISSION CHALLENGES

We will work closely with our Provider Services team and leverage our health plan headquarters in Louisville and five regional offices across the Commonwealth to deliver training to providers and subcontractors, so they comply with encounter data submission requirements and submit complete, accurate, and timely information. Our educational approach in Kentucky will include training, technical assistance, and other activities to support providers and subcontractors and their compliance with HIPAA 837 format. We have found that specific and targeted educational approaches are perhaps the most important factor in ensuring an efficient and accurate encounters process—and in avoiding ongoing challenges altogether.

EDUCATIONAL APPROACH FOR INDIVIDUAL PROVIDERS

Our approach for individual providers will begin with identifying their challenges and needs. This approach will include ongoing monitoring and analysis of their encounter submissions. We will evaluate the accuracy of their submissions through internal monitoring tools, which will provide us with a scorecard of accuracy. This scorecard will allow us to quickly identify submission challenges by individual providers, triggering targeted outreach to provider groups, so we can work directly with them to resolve the specific submission or data accuracy challenges they are facing. Individual providers most

Mississippi Webinars and More

Representatives from our affiliated health plan in Mississippi met with the Medical Association's senior leadership to propose educational Webinars to communicate our process to providers and proactively troubleshoot potential issues. They also discussed a train-the-trainer program where our Mississippi affiliate would instruct Medical Association provider relations staff on Mississippi health plan processes, so they could help educate Medical Association physician offices and minimize administrative challenges. Both ideas were well-received, and our Mississippi affiliate's transparency was welcomed.

frequently encounter difficulty when trying to accurately bill the services they have provided. For example, correct coding of a service on the claim as required by state agencies can at times be a challenge for providers. Our proactive approach of monitoring, educating, and creating submission guidelines and provider bulletins will resolve these issues expeditiously.

Molina will schedule calls and/or visits with providers to review encounters that are not being submitted correctly. Weekly or monthly follow-up calls will be scheduled as needed. Subsequent monitoring of encounter submissions and additional follow-up, as needed, will typically resolve any identified issues. Our experience indicates the following items are frequent challenges for providers and, therefore, are key training topics:

- Billing with correct provider type, specialty, and taxonomy codes
- Correct coding—appropriate value, condition, and occurrence codes on institutional claims
- Use of correct NDC
- Accurate use of POA codes

We also will address ongoing submission challenges by identifying opportunities where electronic submission might improve the quality of the encounters a provider submits. Our parent company's partnership with EDI claims clearinghouses supports this effort. In addition, our affiliated health plans operating in other states regularly contact providers to educate them about electronic submission methods and Web portal resources. Because of these combined efforts with providers, we have been able to dramatically increase rates of EDI adoption across health plans enterprise wide. In 2016, the EDI rate was 91.35%. In 2019, the EDI rate across the enterprise was 97.46%. We encourage providers to use electronic health records, e-prescribing, and electronic claims/encounter submissions to increase data capture and decrease possible medical errors.

EDUCATIONAL APPROACH FOR SUBCONTRACTORS

Our educational approach for subcontractors, on the other hand, will involve more continuous monitoring and engagement through regularly scheduled meetings. Subcontractors tend to encounter challenges providing data to our affiliated health plans in an accurate data format that they, in turn, can submit to encounter agencies. That is why Molina will monitor closely all inbound 837 submissions from our subcontractors, evaluate our internal acceptance rates with the subcontractors, and track overall data completeness. We will hold weekly meetings with our subcontractors to review their specific scorecards for data accuracy and successful encounter submissions. Each subcontractor will follow a standard approach for submission, and Molina will provide a comprehensive tool to ensure success.

In addition, Molina will schedule calls and/or visits with our subcontractors to review encounters that are not being submitted correctly. Emergent issues will be added to our ongoing agenda as new topics. Our affiliated health plans' experience indicates the following items are frequent challenges for subcontractors and, therefore, will be key training topics for Molina:

- 837 file balancing—ensuring all loops and segments are accurate
- Representing coordination of benefits accurately within the 837
- Resubmitting encounters initially rejected by Molina
- Resubmitting encounters rejected by the Commonwealth and federal agencies

Our distinct educational approaches to improve submission accuracy and resolve emergent issues for providers and subcontractors have contributed to superior encounter acceptance rates for all our affiliated health plans. In addition, we will build into our contracts with providers and subcontractors requirements for encounter data and submission accuracy.

Contractually, Molina providers and subcontractors who are not sub-capitated will be required to submit claims relating to all services provided to Enrollees via the claims submission process. Regardless of the capitation model, providers and subcontractors must submit encounter data. Providers and subcontractors

may qualify for pay-for-performance rewards when they submit timely and accurate data. Likewise, providers and subcontractors who do not submit timely and accurate data may be subject to financial penalties. As applicable, we will highlight incentives and penalties alike in our provider and subcontractor education efforts.

e. PROPOSED INITIATIVES FOR THE ENCOUNTER TECHNICAL WORKGROUP

To enhance data submission requirements and improve the accuracy, quality, and completeness of encounter submissions, Molina will bring forward any best practices identified as a direct result of reviewing and resolving rejected encounters. Table C.7-2 shares six initiatives that we propose for Kentucky, drawn from our affiliated health plans' experiences serving similar covered populations enterprise wide.

Table C.7-2. Proposed Initiatives for Kentucky

Initiative Topic	Initiative Description
Analysis	Conduct a thorough analysis of encounter submissions completed during the first three months of the contract period.
Job Aids	Develop specific job aids to address training opportunities and system enhancements.
Technical Workgroup	Partner with Commonwealth agencies to identify and resolve common encounter issues. Molina affiliated health plans have historically partnered with state agencies, through state calls much like Kentucky's Encounter Technical Workgroup, to bring issues to their attention and, together, resolve them.
NDC Discrepancies	Collaborate with the Department to review the state's NDC logic, which, when not up to date, can lead to NDC rejections. **Success story:** Our affiliated health plan in Michigan identified discrepancies in that state's NDC logic that caused NDC rejections. The state NDC crosswalk was not up to date with all HCPCS. After bringing the issue forward, the state agreed encounters had been rejected incorrectly. This led the state to update their NDC crosswalk and ask our parent company to resubmit encounters, which were then promptly accepted. Working closely with the state, our parent was able to resolve and resubmit rejected encounters.
Provider Registration	Address any errors in provider registration in partnership with the Commonwealth. **Success story:** Our affiliated health plan in Utah partnered with the state to address errors in provider registration. The state's Master Provide File had inconsistencies, with some providers showing as registered and others as not registered. Our parent partnered with the state and made several test submissions to have the state validate provider data and provide feedback. Through this exercise, the state was able to fix discrepancies on their end, which enabled the resubmission and acceptance of a large volume of encounters.
Texas Provider Registration	Work with the Commonwealth and other stakeholders to review provider registration practices, policies, and systems for improvement opportunities. **Success story:** Our affiliated health plan in Texas successfully partnered with the state and resolved provider registration discrepancies relating to long-term services and supports (LTSS). Texas requires LTSS providers to register with the state using their Atypical Provider Identifier (API) instead of their NPI. The state updated their requirements through a series of bulletins that created confusion surrounding the requirement for billing using the API and/or NPI on claims. Our parent, working with providers and the state, was able to identify discrepancies in the policy related to provider billing practices and partnered with the state to clarify those billing practices. After several meetings, the state was able to update their policy and encounter systems, which allowed APIs to be submitted as the provider's primary identification. The state allowed providers that did not have APIs to bill using their NPI as a secondary identifier. This process allowed the resubmission and acceptance of a large volume of encounters.

The initiatives and examples we have shared demonstrate how our parent company, working with providers and state agencies, has been able to enhance data submission processes and requirements to improve the accuracy, quality, and completeness of encounter submissions. Partnering with providers, our parent brings their ideas and suggestions to the attention of state encounter agencies to provide a holistic solution to emergent issues. By facilitating collaboration between providers and state agencies, our parent company has been able to improve encounters data collection and submission.

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