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.

In keeping with our stewardship and commitment to submit quality data to the Commonwealth and to support providers in Kentucky, UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) will submit complete, accurate and timely encounter data weekly and within 30 days of claim adjudication to DMS. As we have in the 30-plus Medicaid states UnitedHealthcare currently serves (including D-SNP), we will have a dedicated encounter-data management team (encounter team) for the Kentucky MCO program. Our encounter team leaders have reviewed the requirements pertaining to encounter data in the draft Medicaid Managed Care Contract, including the reporting requirements in Appendix B, and we will comply with all encounter data requirements described in the Contract. We have an organized encounter data collection, processing and reporting system in place that includes all elements noted in the contract, including provisions applying to contracted providers and subcontractors.

Submitting Complete, Accurate and Timely Encounter Data

UnitedHealthcare has substantial experience submitting encounter data, and has processes, policies and procedures in place to confirm that we submit complete, timely and accurate data to DMS. This experience includes encounters for subcontractors under the direct oversight of our dedicated national encounter program management team. Our national encounter process supports states with multiple programs or contracts.

A Proven Record of Success
With the very first encounter data transactions in three recent implementations, UnitedHealthcare exceeded performance requirements:

- **Missouri** Medicaid: 99% timeliness and 98% acceptance rate
- **Virginia LTSS**: 99% 837 and NCPDP acceptance rates
- **Virginia** Medicaid: 99% 837 and NCPDP acceptance rates

National Encounter Management Information System (NEMIS) is our internally developed encounter data submission and reporting system. NEMIS facilitates reliable reporting built on sound, accurate data. It initiates submission, tracks responses, and provides error correction and resubmission of encounter data. NEMIS also generates integrity reports that search for questionable data received from our subcontracted vendors, allowing us to review discrepancies and take appropriate corrective action. Using NEMIS, we analyze medical claim, encounter, enrollee and provider data and identify deficiencies in the quality and completeness of all data.

We perform scheduled reviews of claims for accuracy of transaction processing. These audits, in coordination with our Community Strategic Platform (CSP) system edits for claims, confirm the reliability of all data and provide high levels of confidence in data files and the hundreds of reports we generate. CSP is our comprehensive, cohesive technology suite that houses our claims data and serves as the main data source for encounter data extracts. Based upon adjudicated claims data from CSP, we collect encounter data in HIPAA transaction formats and code sets through NEMIS. Our delegated service vendors (subcontractors) submit their claims directly to NEMIS (via Vendor DB) and we use a pre-processor to validate that those claims are complete and accurate. Similarly, for providers to confirm claims are accurate and complete before proceeding through NEMIS, claims quality pre-checks built into CSP validate that those claims are complete and accurate.

The illustration herein shows the process of gathering encounter data from numerous sources and providing a single repository of data for submission to DMS.

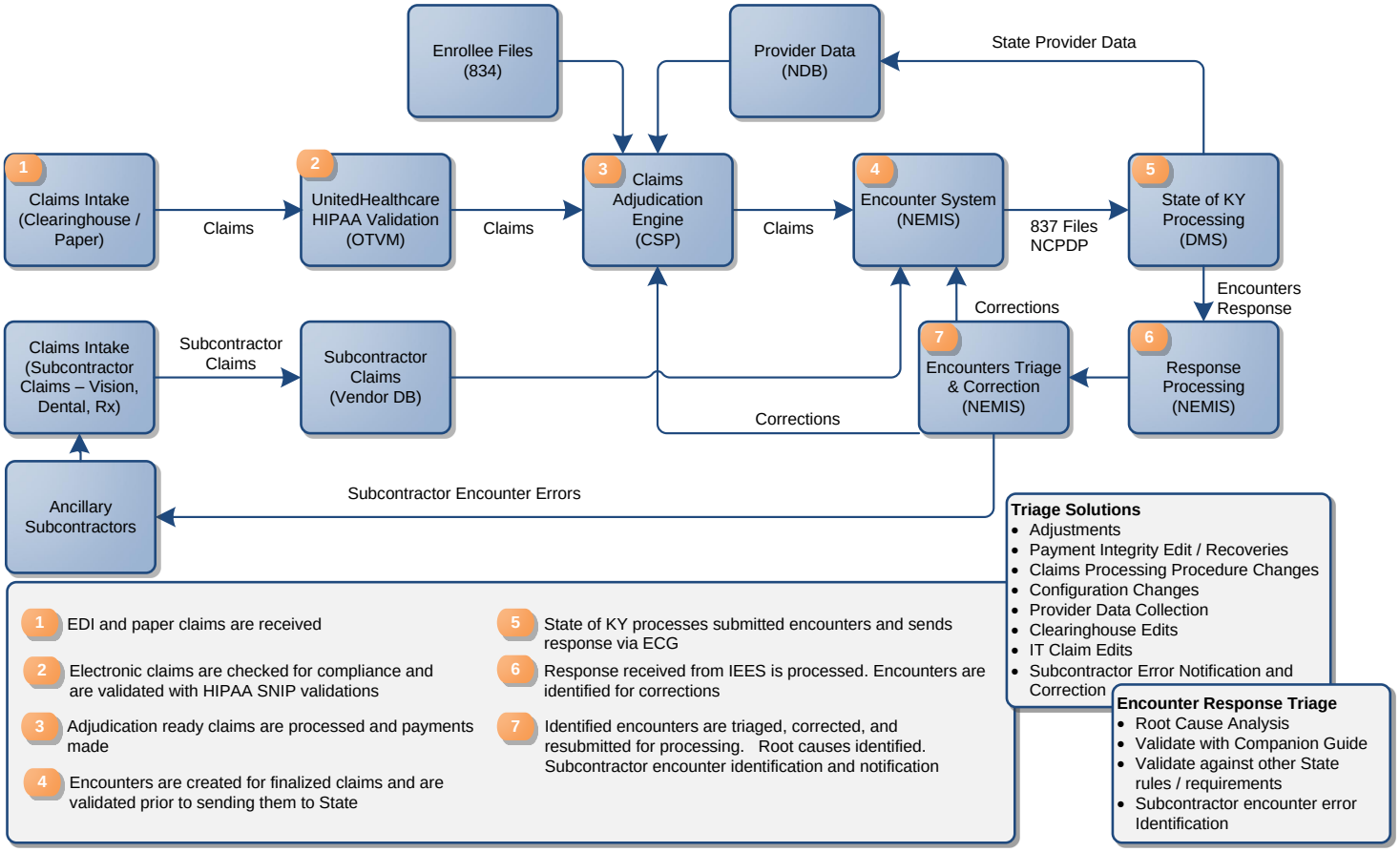

Figure 1. Encounter Data Flow. This flowchart illustrates the process of gathering encounter data from internal and external sources into a single repository for processing, quality check and reporting purposes.

Methods used for Encounter Data Processing

NEMIS processes encounters across the breadth of UnitedHealth Group's Medicaid businesses and initiates submission, tracks responses, and provides error correction and resubmission of Medicaid encounters. If DMS or its Fiscal Agent or subcontractors find errors that require encounters to be adjusted or voided, we will correct the error within 30 days of the date the record was returned.

We have extensive local and national experience submitting and receiving all encounters in standard HIPAA transaction formats as required by DMS, including, but not limited to, 837P (professional claims), 837I (institutional claims), 837D (dental claims) and NCPDP (National Council for Prescription Drug Program) file formats for electronic transactions. We have reviewed the current Kentucky companion guides from DMS, and we are very familiar with HIPAA transaction and code set regulations. We acknowledge the importance of using the HIPAA Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010 transaction 837 Companion Guides and NCPDP version 2.2 Payer Sheet and HIPAA TR3 Implementation Guides to achieve a successful encounter program.

As part of our implementation work plan and readiness review processes, we will configure any necessary changes to NEMIS, adding any Kentucky-specific edits into our claim system to confirm that prior to submitting encounter reports to the Commonwealth, all data passes known edits that DMS's Fiscal Agent will be applying to incoming files. We also conduct comprehensive end-to-end testing before the operational start date. Successful end-to-end testing with DMS's Fiscal Agent will be dependent upon understanding and deploying the specific requirements noted within the respective X12 5010 companion guides, NCPDP 2.2 payer sheet and TR3 implementation guides.

Encounter Data File Submission Processes

We will use NEMIS to submit encounters under this contract. All claims, including paid, denied, zero-dollar, corrected, adjusted, voided and paper claims that we or our subcontractors process, are included in our encounter file submissions. Compliant HIPAA-formatted encounter files will be submitted electronically each week, at a document level and line level per the requirements within theTR3 Implementation Guide, the X12 5010 companion guides, the NCPDP 2.2 payer sheet and any other applicable guides. NEMIS creates a unique control number that is used for submissions and tying responses back to the submission. The encounter management team works with internal information technology (IT) partners to schedule file submissions to meet Commonwealth-specific timeliness requirements.

Encounter Data and Section 340B Identification

Our reporting processes and procedures identify drugs administered under Section 340B of the Public Health Service Act. There is also a process for providers and pharmacies to report whether the drug was part of the 340B program. Those codes, whether modifiers or other indicators, are passed to the Commonwealth as part of our encounters submission.

Encounter Data Continuous Quality Improvement Initiatives

Submission of accurate encounter data begins with accurate claims. As noted previously and depicted in the flowchart, all new claims are subject to a series of reviews to confirm we have all of the data needed to process the claim through CSP and produce accurate encounters through NEMIS. UnitedHealthcare continuously reviews encounter requirements and processes for opportunities to improve encounter quality. We review pended and denied encounter reports for the top issues experienced and perform internal root cause analyses. For the short term, we develop mitigation plans to correct identified issues before the next submission. For the long-

term, we identify and develop edits to improve future results. We monitor encounter rejections to identify all providers in need of additional claim billing education. We welcome collaborative work sessions with DMS staff on encounters as our experience shows these sessions are very effective in improving quality.

Procedures for Working with Providers and Subcontractors to Correct Errors

When encounters are rejected, the encounter team partners with our operational teams or the subcontractor to resolve and resubmit timely the rejected encounters as replacements, adjustments or voids. If DMS has encounter provider file requirements and providers need to be added to its provider file, we work with our provider team and resubmit the encounter when providers are added. NEMIS generates encounter post submission completeness reports that provide our encounter team with detailed insight into the process with key checkpoints that verify all transactions are balanced and reported.

We work with our providers to avoid rejecting claims if possible. In 2018, we initiated over 40,000 outbound calls nationwide to providers to gather missing or incorrect information instead of rejecting claims, and are on track to make over 100,000 of those calls this year. However, if a claim still needs to be resubmitted or updated, our payment integrity team works with the provider on resubmission and offers any refresher training needed to avoid recurrence of the issue or error. When we identify provider education opportunities, we engage the provider relations team to work with or re-educate providers on how to prevent encounter data errors and omissions.

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

UnitedHealthcare policy and procedures regarding encounter data processing and submission are provided as Attachment C.7.b Encounter Data Processing Policy 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.

Experienced Encounter Team
Our encounter data management team of 85 professionals with over 300 years of collective state encounter experience, continuously monitors state encounter requirements and seeks opportunities to improve encounter data quality.

The most common challenges we have experienced in developing and submitting encounter data are when provider data on claims received does not match the state file record, and when timing of receipt of the state enrollment file does not align with the timing of our encounter file submission, which causes the state to deny encounter data based upon eligibility discrepancies.

To overcome these challenges, our encounter team applies error prevention techniques, uses its experience with other states to work in a consultative manner with the state to remedy the issue, and actively participates in state-assembled work groups by asking the right questions of the state or their fiscal agent to get the answers needed to create the best preventive solutions. The best practices we have implemented to verify accurate, complete encounter data submission with every submission are well-defined tracking and monitoring practices, including well-executed error prevention and correction processes for claims validation. Error prevention begins during the implementation phase by applying DMS rules and requirements on inbound provider claims, along with applying system code that withstands full end-to-end testing.

Mitigation Strategies to Ensure Accurate and Complete Encounter Data

We have the experienced staff in Kentucky and throughout our organization to proactively manage and remedy encounter data issues. Examples of effective mitigation strategies we have implemented include, but are not limited to:

- ***Managing Denied Claim Submissions:*** If denied claims must be submitted as encounters yet excluded from encounter editing, we recommend a field in the 837 to allow the MCO to clearly identify whether the claim or claim line was paid or denied.
- ***Managing Duplicate Records:*** Submitting denied claims as encounters increases the risk of duplicate encounter rejects. Excluding plan denied claims from DMS's duplicate editing is a solution, which is built into our NEMIS automated adjustment logic.
- ***Understanding Sub-capitated Claims:*** If DMS requires a paid amount to be submitted on sub-capitated encounters, we will confirm how capitation should be indicated on the encounter and any additional considerations to support financial reports.
- ***Deploying Value-based Arrangements:*** The encounters are submitted as fee-for-service with the same paid amount used in the value-based performance evaluation. The submission method may vary depending upon individual state contracts and rules.

Best Practice: Track, Trend and Monitor Encounter Submissions and Revisions

Our encounter team uses reports, audits and review of findings to track, trend and monitor encounters, including:

- ***Tracking Transactions:*** Continuously monitoring response transactions to determine the encounter data files were read and accepted by the state and tracking the total submitted, received accepted and pended percentages for every encounter file
- ***Trending Submissions and Revisions:*** Reviewing monthly transaction reports and encounter cycles to assess submission compliance and using this data to assist providers or subcontractors not meeting requirements. Sorting encounter data by financial category of service to reconcile with NEMIS records.
- ***Monitoring Billing Codes and Claims:*** Monitoring uniform billing requirements to confirm continued compliance with contractual and regulatory changes. Monitoring provider submission statistics and conducting chart reviews to verify proper coding.

Best Practice: Prepare, Monitor and Analyze Claims and Encounter Reports

The encounter team uses a variety of reports to verify providers and subcontractors submit timely, accurate, complete and required encounter data elements for transmission to our state clients. These reports include, but are not limited to, aging, trending, error, transmission reconciliation and integrity reports — all aimed at continuous quality improvement of our encounter data collection and submission activities.

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.

NEMIS generates encounter post submission completeness reports that provide our encounter team with detailed process insight into key checkpoints, causes and culprits. In addition, the encounter team collaborates with the claims team to clarify encounter rules that affect encounter acceptance and to identify issues warranting outreach to providers or subcontractors. When provider or subcontractor error is found to be the root cause of the issue, the encounter team collaborates with the appropriate functional areas to implement corrective measures and:

- Reviews the issue with a provider advocate who will re-educate the provider or subcontractor

- Pends claims during processing to educate providers or subcontractors in real time
- Creates and shares language regarding process or program changes for dissemination with broad and targeted provider education campaigns

As an ongoing preventive measure, teams within each functional business unit continually monitor provider and subcontractor claims, encounter reporting, and submission activities. These teams apply an early warning system approach to identify problem areas and the provider or subcontractor associated with the concern, so the appropriate staff can intervene to educate and assist the provider or subcontractor in correcting the problem. When trends emerge, dedicated staff quickly engages the provider or subcontractor associated with the trend to identify root causes, resolve the problem and track progress through resolution.

As noted previously, complete encounter data submissions start with clean claims. The curriculum we use as part of our provider and subcontractor onboarding training includes state-specific details and contractual requirements for timely, clean claims and encounter data submissions. These requirements are also made available to providers and subcontractors in our *Care Provider Manual.* Our network management team trains providers, subcontractors and their staff on these requirements in group or one-on-one training sessions held throughout the state.

Helping Providers and Subcontractors to Submit Quality Encounter Data

As claims come in, the encounter team collaborates with the claims team daily to clarify encounter rules that affect encounter acceptance and to identify issues warranting outreach to providers or subcontractors. Depending upon the size and scope of the issue and the provider or subcontractor identified with the issue, we proactively:

- Review the issue with a provider advocate who will re-educate the provider or subcontractor
- Pend claims during processing to educate providers or subcontractors in real time
- Create and share language regarding process or program changes for dissemination with broad and targeted provider education campaigns

Dedicated teams from each functional business unit continually monitor provider and subcontractor claims and encounter reporting and submission activities. These teams apply an early warning system approach to identify problem areas and the provider or subcontractor associated with the concern, so the appropriate staff can intervene to educate and assist the provider or subcontractor in correcting the problem. When trends emerge, dedicated staff quickly engages the provider or subcontractor associated with the trend to identify root causes, resolve the problem and track progress through resolution. Remediation may involve providing education to providers, implementing a corrective action plan (CAP), or seeking intervention from the appropriate quality committee as needed.

Quality Committee and Subcontractor Oversight

We have strong longstanding relationships with our subcontractors and provide comprehensive training on our processes. Our subcontractors fully understand the importance of reporting any issues immediately. In addition to ongoing oversight, we complete a thorough annual review of our subcontracted vendors. The annual review consists of the following:

- Encounter data completeness, accuracy and timeliness for the prior year

- Results data completeness, accuracy and timeliness for the prior year (if applicable)
- Responsiveness and compliance to any requested action or CAPs
- Annual audit report

We draw upon our Delegated Vendor Oversight Committee (DVOC) to confirm the entity remains accountable to the Commonwealth for subcontracted services. Our DVOC has proven to be the most effective way to ensure subcontractor compliance with encounter data completeness, accuracy and timeliness requirements and policies and procedures. Our DVOC meets quarterly and includes legal and compliance expertise, and provider and subcontracted vendor contracting. The DVOC reviews performance metrics and focuses on making certain our subcontractors comply with agreement terms, regulations and instructions, and NCQA and HEDIS requirements.

Corrective Actions or Assessments

In most instances where we have discovered deviation from standards, early educational outreach directly with the provider or subcontractor resolves the issue. When a provider or subcontractor does not resolve the issue within the defined time frame, or if the issue surpasses certain quality standards or monetary thresholds, we will implement a CAP. For subcontractors, the DVOC may issue CAPs and report status to the Quality Improvement Committee.

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.

Discussion topics we would propose to raise with **Kentucky's Encounter Technical Workgroup** include claims and encounter issues that we find to be chronic or common. For example, in other states we have brought forth lists of the top encounter rejections affecting encounter submission quality and processes. The workgroup reviews the lists to discover commonalities and to develop agreed upon solutions to the issues jointly. In other states, we have found all-MCO workgroups that meet regularly to be a win-win for the states and MCOs as a best practice. Such forums bring effective resolution to key issues and yield improvements to encounter quality, timeliness, accuracy and completeness.

We would like to establish work streams and have a single point of contact for DMS staff to expedite resolution of identified issues. We would want to discuss regulatory or systems changes that will influence the state or MCOs. For example, the next major release of electronic health care administrative transaction standards through X12 version 7030 has been a topic with many of our state partners. In our weekly meetings with TennCare (Tennessee's Medicaid agency), we have discussed the release timing and key changes. In Kentucky, we would raise this as a topic to understand the preparations being made in the Commonwealth.

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