Michigan Department of Health and Human Services

State Fiscal Year 2023 External Quality Review Encounter Data Validation Aggregate Report

for Integrated Care Organizations

February 2024

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, the Michigan Department of Health and Human Services (MDHHS) requires its contracted Medicaid managed care entities (MCEs) and waiver agencies to submit high-quality encounter data. During state fiscal year (SFY) 2023, MDHHS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct an encounter data validation (EDV) study.

Methods

In alignment with Centers for Medicare & Medicaid Services (CMS) external quality review (EQR) *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP [Children's Health Insurance Program] Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5),[1-1] HSAG conducted the following two core evaluation activities for the EDV study:

- Information systems (IS) review—assessment of MDHHS' and the MCEs'/waiver agencies' information systems and processes. The goal of this activity is to examine the extent to which MDHHS' and the MCEs'/waiver agencies' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's [Managed Care Plan's] Capability in CMS EQR Protocol 5.
- Administrative profile—analysis of MDHHS' electronic encounter data completeness, timeliness, and accuracy. The goal of this activity is to evaluate the extent to which the encounter data in MDHHS' data warehouse are complete, accurate, and submitted by the MCEs and waiver agencies in a timely manner for encounters with dates of service from October 1, 2021, through September 30, 2022. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in CMS EQR Protocol 5.

HSAG conducted the EDV study for 47 MCEs/waiver agencies. This report, however, presents results and findings for the integrated care organizations (ICOs) [1-2] under the MI Health Link Program.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 24, 2023.

[1-2] Refer to Appendix A for a list of ICOs included in this report.

Information Systems Review Findings

The IS review gathered input from all six ICOs about their encounter data processes. Questionnaire responses showed the ICOs and their subcontractors could handle, process, and send data to MDHHS that align with established quality specifications. Their unique methods, supported by encounter data systems and warehouses, helped address MDHHS' quality concerns. Software and subcontractors assisted tasks such as claims adjudication, verifying provider and member information, and managing third party liability (TPL) information. Data quality checks varied across ICOs; most ICOs did not consistently verify encounter data completeness, but all ICOs checked at least one subcontractor's data. MDHHS used the volume report and the encounter comparison report (ECR) process to monitor completeness. Field-level completeness and accuracy checks were common, as was reconciling payment fields in claims with financial reports. Timeliness checks were mentioned by some ICOs, with MDHHS using the timeliness report to ensure monthly contractual requirements were met. Notably, none chose medical record review (MRR) as a check, likely due to the labor- and resource-intensive nature of MRR.

The ICOs were accountable for their own and their subcontractors' encounter data as per the contract. Most encounter data were submitted directly by the ICOs, while some exceptions existed. Moreover, the ICOs typically stored the data collected by their subcontractors and reviewed the data either before and/or after submission to MDHHS. These practices highlighted the ICOs' ability to oversee subcontractor-collected data, assuring accuracy, completeness, and timely submission. While the ICOs largely fulfilled the requirement of submitting accurate, complete, and timely data, there existed areas for enhancement (see the Recommendations section). According to the questionnaire responses, the main aspect in need of improvement pertained to the diverse methods of encounter data monitoring used by the ICOs, which varied in scope and depth.

Recommendations

To improve the quality of encounter data submissions from the ICOs, HSAG offers the following recommendations to assist MDHHS and the ICOs in addressing opportunities for improvement:

- **Meridian Health Plan** noted that it did not store any of its subcontractor data, while **Molina Health Care of Michigan** did not store its pharmacy subcontractor's data. HSAG recommends both ICOs consider storing data from their subcontractors for several reasons. Storing subcontractor encounter data within the ICOs' claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.
- **HAP Empowered** and **Molina Health Care of Michigan** noted that it performed modifications on encounters from some or all of their subcontractors before sending them to MDHHS. These ICOs should collaborate with MDHHS to verify that the modifications done by the ICOs do not necessitate returning the data to the subcontractors.

- Although the ICOs conducted timeliness checks on at least one subcontractor's encounters, the ICOs should consider building or enhancing their monitoring reports for encounters collected by each of their subcontractors to comprehensively assess encounter data timeliness:
  - **Aetna Better Health of Michigan** (i.e., pharmacy and fiscal intermediary)
  - **AmeriHealth Caritas** (i.e., long-term services and supports [LTSS])
  - **HAP Empowered** (i.e., all encounters)
  - **Meridian Health Plan** (i.e., behavioral health and pharmacy encounters)
  - **Molina Health Care of Michigan** (i.e., pharmacy encounters)
  - **Upper Peninsula Health Plan** (i.e., all encounters)
- **Aetna Better Health of Michigan** and **Upper Peninsula Health Plan** each indicated that they perform only one quality check for claims/encounters stored in their data warehouses. Considering this, these ICOs should explore the possibility of constructing or improving monitoring reports to assess the claim volume submission, accuracy, completeness, and/or timeliness of these claims/encounters.
- Three ICOs reported that their dental subcontractor's encounters had been rejected and remained unaccepted by MDHHS when the questionnaire responses were submitted. Rejection rates varied from 6.5 percent to 26.8 percent. MDHHS may consider conducting an assessment to identify any common root causes for these rejections.
- HSAG recommends MDHHS continue its collaboration with the ICOs to address challenges highlighted in the ICOs' responses noted in Table 3-9, such as aligning its encounter processing logic with MDHHS' due to lack of essential data elements and processing rules, eligibility data discrepancies between the State and CMS, and insufficient documentation for resolving 999 response file errors.

Administrative Profile Findings

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Overall, the data were largely complete, timely, and accurate for each ICO. For the number of encounters per 1,000 MM, **Aetna Better Health of Michigan**, **AmeriHealth Caritas**, **Molina Healthcare of Michigan**, and **Upper Peninsula Health Plan** remained relatively consistent in all categories of service throughout the measurement year. Across all categories of service, professional encounters had the highest volume per 1,000 MM, with an all ICO rate averaging around 2,500 encounters per 1,000 MM. Pharmacy encounters had the second largest volume with an all ICO rate averaging around 450 encounters per 1,000 MM. Institutional and dental encounters both had an average all ICO rate below 100 encounters per 1,000 MM, at about 90 and 45 encounters per 1,000 MM, respectively. Additionally, the amount paid per member per month (PMPM) also represented complete

data from the ICOs. Interestingly, despite having an institutional encounter volume per 1,000 MM near the all ICO rate, **Upper Peninsula Health Plan** was well above the all ICO payment amount PMPM. Conversely, **Meridian Health Plan** had the highest institutional encounter volume per 1,000 MM of the ICOs, yet was below the all ICO rate for the amount paid PMPM. These findings indicate that **Upper Peninsula Health Plan** had a higher amount paid PMPM for institutional encounters compared to other ICOs, whereas **Meridian Health Plan** had a lower amount paid PMPM for institutional encounters compared to the other ICOs. Finally, all ICOs had low percentages of duplicative records, with all four categories of service having an all ICO rate of 0.5 percent or less.

The timeliness evaluation of the MDHHS data also suggested that ICOs mostly submitted data in a timely manner to MDHHS after payment date. Both **Aetna Better Health of Michigan** and **AmeriHealth Caritas** had greater than 95 percent of encounters submitted to MDHHS with 90 days from payment in all four categories of service, whereas **HAP Empowered** and **Upper Peninsula Health Plan** submitted greater than 95 percent of encounters in three of the four categories of service within 90 days from payment date. **Meridian Health Plan** took slightly longer to submit its data to MDHHS, reaching 95 percent of professional and institutional encounters submitted within 270 days, and not reaching greater than 95 percent of pharmacy encounters submitted to MDHHS until after 360 days from payment date. Overall, **Molina Healthcare of Michigan** took the longest to submit encounters to MDHHS in three of the four categories of service, not submitting 95 percent of encounters until 360 days for institutional encounters, and after 360 days for professional and dental encounters. Despite this, **Molina Healthcare of Michigan** submitted 99.2 percent of pharmacy encounters within 30 days.

Additionally, the ICOs displayed complete and accurate encounter data, with all expected data elements populated at least 98 percent of the time across all categories of service. While there is no set requirement to be present, the billing provider National Provider Identifier (NPI) data element for professional encounters was low with an all ICO rate of 58.6 percent. All ICOs except **AmeriHealth Caritas** had less than 94 percent of the billing provider NPI populated. All data elements that were populated were 90 percent valid or higher, with most data elements valid greater than 99 percent of the time. Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes with Procedure-to-Procedure (PTP) edits in institutional encounters had the lowest validity rate at 93.1 percent across all ICOs. Finally, the referential integrity results between the encounter data, pharmacy data, enrollment data, and provider data were all high, indicating that these files can be linked together via the member identification (ID) or provider NPI fields. However, when linking the pharmacy data to the provider data, 96.3 percent of providers identified in the pharmacy data were identified in the provider data. This is lower than the >99.9 percent rate when linking the medical/dental data to the provider data and indicates that the provider data may not contain all the providers who provide pharmaceutical services.

Overall, MDHHS' encounter data were largely complete, timely, and accurate. Although there are some areas that MDHHS can collaborate with the ICOs on improving (see Recommendations section), the high levels of completeness, timeliness, and accuracy suggest that the encounter data can be used in subsequent analyses with a high degree of reliability.

Recommendations

To improve the quality of encounter data submissions from the ICOs, HSAG offers the following recommendations to assist MDHHS and the ICOs in addressing opportunities for improvement:

- **HAP Empowered** had a high percentage of pharmacy encounters where the submit date was prior to the payment date. Accurate dates for these fields are essential for assessing the timeliness and accuracy of the data. Additionally, subsequent analyses may rely on these fields to subset the data. MDHHS should collaborate with **HAP Empowered** to help improve the accuracy of these fields.
- Timely data are crucial to subsequent analyses, and if data are not submitted in a timely manner, then subsequent analyses may not include complete information and results may not reflect accurate encounter volume. Therefore, **Molina Healthcare of Michigan** should evaluate the delay between submitting professional, institutional, and dental encounters to MDHHS after payment; **Meridian Health Plan** should evaluate the delay between submitting professional, institutional, and pharmacy encounters to MDHHS after payment; and **Upper Peninsula Health Plan** should evaluate the delay between submitting dental encounters to MDHHS after payment.
- All ICOs demonstrated lower than expected rates when examining the referential integrity of the provider NPIs in the pharmacy data compared to the provider NPIs in the provider data. Since subsequent analyses may require the ability to link these datasets together, MDHHS should collaborate with ICOs to determine if the MDHHS provider data accurately reflect each ICO's current contracted provider network.
- All ICOs demonstrated lower than 95 percent validity rates on CPT/HCPCS codes with PTP edits in institutional data. MDHHS should collaborate with the ICOs to ensure CPT/HCPCS codes pass PTP edit checks to help prevent improper payments.
- Dental services should be covered by Medicaid, and **Meridian Health Plan** submitted these services marked as Medicare. MDHHS should collaborate with the ICOs to ensure Medicaid and Medicare cover appropriate services and that these services are submitted to MDHHS appropriately.

2. Overview and Methodology

Overview

Pursuant to Title 42 of the Code of Federal Regulations (42 CFR) §438.242, MDHHS must ensure that each of its contracted MCEs and waiver agencies maintains a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. MDHHS must also review and validate encounter data collected, maintained, and submitted by the MCEs and waiver agencies to ensure that the encounter data are a complete and accurate representation of the services provided to its Medicaid members. Accurate and complete encounter data are critical to the success of a managed care program. Therefore, MDHHS requires its contracted Medicaid MCEs and waiver agencies to submit high-quality encounter data. MDHHS relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During SFY 2023, MDHHS contracted with HSAG to conduct an EDV study. In alignment with CMS EQR Protocol 5, HSAG conducted the following two core evaluation activities for the EDV study:

- IS review—assessment of MDHHS' and the MCEs'/waiver agencies' information systems and processes. The goal of this activity is to examine the extent to which MDHHS' and the MCEs'/waiver agencies' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in CMS EQR Protocol 5.
- Administrative profile—analysis of MDHHS' electronic encounter data completeness, timeliness, and accuracy. The goal of this activity is to evaluate the extent to which the encounter data in MDHHS' data warehouse are complete, accurate, and submitted by the MCEs in a timely manner for encounters with dates of service from October 1, 2021, through September 30, 2022. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in CMS EQR Protocol 5.

HSAG conducted the EDV study for 47 MCEs/waiver agencies. Table 2-1 displays the programs, MCEs/waiver agencies, and number of MCEs/waiver agencies included in the EDV study. This report, however, will present results and findings for the ICOs[2-1] under the MI Health Link Program.

[2-1] Refer to Appendix A for a list of ICOs included in this report.

Table 2-1—Michigan Medicaid Managed Care Programs

Program	MCE/Waiver Agency Type	Number of MCEs/Waiver Agencies
Comprehensive Health Care Program	Medicaid health plans (MHPs)	9
Healthy Kids Dental Program	Dental health plans (DHPs)	2
MI Health Link Program	ICOs	6
Behavioral Health Managed Care Program	Prepaid inpatient health plans (PIHPs)	10
MI Choice Waiver Program	Waiver agencies	20

Methodology

Information Systems Review

The IS review seeks to define how each participant in the encounter data process collects and processes encounter data such that the data flow from the ICOs to MDHHS is understood. The IS review is key to understanding whether the IS infrastructures are likely to produce complete and accurate encounter data. To ensure the collection of critical information, HSAG employed a three-stage review process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

Stage 1—Document Review

HSAG initiated the IS review with a thorough desk review of existing documents related to encounter data initiatives/validation activities currently put forth by MDHHS. Documents requested for review included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, work group meeting minutes, and MDHHS' current encounter data submission requirements, among others. The information obtained from this review was important for developing the targeted questionnaire to address important topics of interest to MDHHS.

Stage 2—Development and Fielding of Customized Encounter Data Assessment

To conduct a customized encounter data assessment, HSAG first evaluated each ICO's most recent Information Systems Capabilities Assessment (ISCA) to assess whether the information was complete and up to date. HSAG developed a questionnaire customized in collaboration with MDHHS to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. Where applicable, this assessment also included a review of supplemental documentation regarding other data systems, including enrollment and provider data. Lastly, this review included specific topics of interest to MDHHS. For example, the reviews included questions regarding how the ICOs ensure their vendors are submitting complete and accurate encounter data in a timely manner.

The questionnaire for MDHHS had similar domains; however, it focused on MDHHS' data exchange with the ICOs.

Since the encounter data submission requirements and processes for each program may be different, HSAG sent an ICO-specific questionnaire to each ICO to collect information for each program. Additionally, since there were six ICOs included in the study, HSAG distributed the questionnaire via an online tool to streamline collection of the responses.

Stage 3—Key Informant Interviews

After reviewing the completed assessments, HSAG followed up with key MDHHS and ICO information technology (IT) personnel to clarify any questions from the questionnaire responses.

Overall, the IS reviews allowed HSAG to document current processes and develop a thematic process map identifying critical factors that impact the submission of quality encounter data. From this analysis, HSAG was able to provide actionable recommendations to the ICOs regarding the existing encounter data systems on areas for improvement or enhancement.

Administrative Profile

The administrative profile, or analysis, of the State's encounter data is essential to gauging the general completeness, timeliness, and accuracy of encounter data, as well as whether encounter data are sufficiently robust for other uses, such as performance measure calculation. The degree of the ICOs' data file completeness across ICOs provides insight into the quality of MDHHS' overall encounter data system and represents the basis for establishing confidence in subsequent analytical and rate setting activities.

HSAG assessed the final paid encounters with service dates from October 1, 2021, through September 30, 2022, and extracted from MDHHS' data warehouse on or before March 31, 2023. In addition, the EDV study used member demographic/eligibility/enrollment data and provider data to evaluate the validity of key data elements in the encounter data. HSAG submitted a data submission requirements document to notify MDHHS of the required data needed for the study. The data submission requirements document was based on the study objectives and data elements evaluated in this study. It included a brief description of the study, criteria for data extraction, required data elements, and information regarding the submission of the requested files. In addition, to assist MDHHS in preparing the requested data files, HSAG performed the following two actions:

- HSAG initially requested a set of test files from MDHHS before MDHHS extracted the complete set of data. The test data were smaller in size (e.g., encounters for one month) and allowed HSAG to detect any data extraction issues before the full data extract was submitted. In addition, the test data helped HSAG prepare for the analyses in advance while waiting to receive the complete data.
- After submitting the draft data submission requirements document to MDHHS, HSAG scheduled a meeting with MDHHS to review the document to ensure that all questions related to data preparation

and extraction were addressed. Afterward, HSAG submitted the final version of the data submission requirements document to MDHHS for review/approval.

Once HSAG received the data files from MDHHS, HSAG conducted a preliminary file review to ensure that the submitted data were adequate to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—extracted based on the data requirements document.
- Percentage present—required data fields were present in the file and had values in those fields.
- Percentage of valid values—the values were as expected (e.g., valid International Classification Diseases, Tenth Revision [ICD-10] codes in the diagnosis field).

Based on the preliminary file review results, HSAG followed up with MDHHS to resubmit data, as needed.

Once the final data had been received and processed, HSAG conducted a series of analyses for metrics listed in the sections below. In general, HSAG calculated rates for each metric by encounter type (i.e., 837 Professional [837P], 837 Institutional [837I], 837 Dental [837D], and National Council for Prescription Drug Programs [NCPDP]) and ICO. However, when the results indicated a data quality issue(s), HSAG conducted an additional investigation to determine whether the issue was for a specific category of service (e.g., nursing facilities, hospice), provider type (e.g., vision vendor, non-emergency medical transportation [NEMT] vendor), or subpopulation. HSAG documented all noteworthy findings in this aggregate report.

Encounter Data Completeness

HSAG evaluated encounter data completeness through the following metrics:

- Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occur or the last date of service [DOS]): If the number of members remains stable and there are no major changes to members' medical/dental needs, the monthly visit/service counts should have minimal variation. A low count for any month indicates incomplete data. Of note, instead of the claim number, HSAG evaluated the encounter volume based on a unique visit key. For example, for an office visit, the visit key is based on the member ID, rendering provider NPI, and date of service.
- Monthly encounter volume (i.e., visits) per 1,000 member months (MM) by service month: Compared to the metric above, this metric normalized the visit/service counts by the member counts. Of note, HSAG calculated the member counts by month for each ICO based on the member enrollment data extracted by MDHHS.
- PMPM by service month: This metric will help MDHHS determine whether the encounter data were complete from a payment perspective. Of note, HSAG used the header paid amount or detail paid amount to calculate this metric.
- Percentage of duplicate encounters: HSAG determined the detailed methodology (e.g., data elements and criteria) for defining duplicates after reviewing the encounter data extracted for the study and

documented the method in the final report. This metric will allow MDHHS to assess the number of potential duplicate encounters in MDHHS' database.

Encounter Data Timeliness

HSAG evaluated encounter data timeliness through the following metrics:

- Percentage of encounters received by MDHHS within 360 days from the ICO payment date, in 30-day increments. This metric will allow MDHHS to evaluate the extent to which the ICOs are in compliance with MDHHS' encounter data timeliness requirements.
- Claims lag triangle to illustrate the percentage of encounters received by MDHHS within two calendar months, three months, etc., from the service month. This metric will allow MDHHS to evaluate how soon it may use the encounter data in the data warehouse for activities such as performance measure calculation and utilization statistics.

Field-Level Completeness and Accuracy

HSAG evaluated whether the data elements in the final paid encounters were complete and accurate through the two study indicators described in Table 2-2 for the key data elements listed in Table 2-3. In addition, Table 2-2 shows the criteria HSAG used to evaluate the validity of each data element. These criteria are based on standard reference code sets or referential integrity checks against member or provider data.

Table 2-2—Study Indicators for Percent Present and Percent Valid

Study Indicator	Denominator	Numerator
Percent Present: Percentage of records with values present for a specific key data element.	Total number of final paid encounter records based on the level of evaluation noted in Table 2-3 (i.e., at either the header or detail line level) with dates of service in the study period.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 2-3.
Percent Valid: Percentage of records with values valid for a specific key data element.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 2-3.	Number of records with values valid for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 2-3. The criteria for validity are listed in Table 2-3.

Table 2-3—Key Data Elements for Percent Present and Percent Valid

Key Data Element	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Member ID[H]	√	√	√	√	• In member file • Enrolled in a specific ICO on the date of service • Member date of birth is on or before date of service
Header Service From Date[H]	√	√	√		• Header Service From Date ≤ Header Service To Date • Header Service From Date ≤ Paid Date
Header Service To Date[H]	√	√	√		• Header Service To Date ≥ Header Service From Date • Header Service To Date ≤ Paid Date
Detail Service From Date[D]	√	√	√		• Detail Service From Date ≤ Detail Service To Date • Detail Service From Date ≤ Paid Date
Detail Service To Date[D]	√	√	√		• Detail Service To Date ≥ Detail Service From Date • Detail Service To Date ≤ Paid Date
Date of Service				√	• Detail Service To Date ≤ Paid Date
Billing Provider NPI[H]	√	√	√	√	• In provider data when service occurred • Meets Luhn formula requirements
Rendering Provider NPI[H]	√		√		• In provider data when service occurred • Meets Luhn formula requirements
Attending Provider NPI[H]		√			• In provider data when service occurred • Meets Luhn formula requirements

Key Data Element	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Referring Provider NPI[H]	√	√	√		• In provider data when service occurred • Meets Luhn formula requirements
Prescribing Provider NPI				√	• In provider data when service occurred • Meets Luhn formula requirements
Rendering Provider Taxonomy Code[H]	√				• In standard taxonomy code set • Matches the value in provider data
Attending Provider Taxonomy Code[H]		√			• In standard taxonomy code set • Matches the value in provider data
Primary Diagnosis Codes[H]	√	√	√		• In national ICD-10-Clinical Modification (CM) diagnosis code sets for the correct code year (e.g., in 2022, code set for services that occurred between October 1, 2021, and September 30, 2022)
Secondary Diagnosis Codes[H]	√	√			• In national ICD-10-CM diagnosis code sets for the correct code year
CPT/HCPCS Codes[D]	√	√			• In national CPT/HCPCS code sets for the correct code year (e.g., in 2022, code set for services that occurred in 2022) AND satisfies CMS' Procedure-to-Procedure edits
Current Dental Terminology (CDT) Codes[D]			√		• In national CDT code sets for the correct code year (e.g., in 2022, code set for services that occurred in 2022)

Key Data Element	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Tooth Number			√		Primary • A–J: Maxillary • K–T: Mandibular Permanent • 1–16: Maxillary • 17–32: Mandibular
Tooth Surface 1–5			√		• M—Mesial • O—Occlusal • D—Distal • I—Incisal • L—Lingual • B—Buccal • F—Facial (or Labial)
Oral Cavity Code			√		• 00—Entire oral cavity • 01—Maxillary arch • 02—Mandibular arch • 03—Upper right sextant • 04—Upper anterior sextant • 05—Upper left sextant • 06—Lower left sextant • 07—Lower anterior sextant • 08—Lower right sextant • 09—Other area of oral cavity • 10—Upper right quadrant • 20—Upper left quadrant • 30—Lower left quadrant • 40—Lower right quadrant
Primary Surgical Procedure Codes[H]		√			• In national ICD-10-CM surgical procedure code sets for the correct code year
Secondary Surgical Procedure Codes[H]		√			• In national ICD-10-CM surgical procedure code sets for the correct code year

Key Data Element	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Revenue Codes[D]		√			• In national standard revenue code sets for the correct code year
Diagnosis-Related Group (DRG) Codes[H]		√			• In national standard All Patients Refined (APR)-DRG code sets for the correct code year
Type of Bill Codes[H]		√			• In national standard type of code set
National Drug Codes (NDCs)[D]	√	√		√	• In national NDC code sets
Submit Date[D]	√	√	√	√	• ICO Submission Date (i.e., the date when ICO submits encounters to MDHHS) ≥ ICO Paid Date
ICO Paid Date[D]	√	√	√	√	• ICO Paid Date ≥ Detail Service To Date
Header Paid Amount[H]	√	√	√		• Header Paid Amount equal to sum of the Detail Paid Amount
Detail Paid Amount[D]	√	√	√		• Zero or positive
Paid Amount				√	• Zero or positive
Header TPL Paid Amount[H]	√	√	√		• Header TPL Paid Amount equal to sum of the Detail TPL Paid Amount
Detail TPL Paid Amount[D]	√	√	√		• Zero or positive
TPL Paid Amount				√	• Zero or positive

[H] Conduct evaluation at the header level
[D] Conduct evaluation at the detail level

Encounter Data Referential Integrity

HSAG evaluated if data sources could be joined with each other based on whether a unique identifier (e.g., unique member ID, unique provider NPI) was present in both data sources (i.e., unique member IDs that are in both the encounter and member enrollment files). If an encounter contained more than one NPI (e.g., attending provider NPI and billing provider NPI on an institutional encounter), HSAG included both unique NPIs in the analysis. Table 2-4 lists the study indicators that HSAG calculated.

Table 2-4—Key Indicators of Referential Integrity

Data Source	Indicator
Medical/Dental Encounters vs Member Enrollment	• Direction 1: Percentage of Members With a Medical/Dental Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Medical/Dental Encounter
Pharmacy Encounters vs Member Enrollment	• Direction 1: Percentage of Members With a Pharmacy Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Pharmacy Encounter
Medical/Dental Encounters vs Pharmacy Encounters	• Direction 1: Percentage of Members With a Medical/Dental Encounter Who Also Have a Pharmacy Encounter • Direction 2: Percentage of Members With a Pharmacy Encounter Who Also Have a Medical/Dental Encounter
Medical/Dental Encounters vs Provider File	• Direction 1: Percentage of Providers in the Medical/Dental Encounter File Who Were Also in the Provider File • Direction 2: Percentage of Providers in the Provider File Who Were Also in the Medical/Dental Encounter File
Pharmacy Encounters vs Provider File	• Direction 1: Percentage of Providers in the Pharmacy Encounter File Who Were Also in the Provider File • Direction 2: Percentage of Providers in the Provider File Who Were Also in the Pharmacy Encounter File

Encounter Data Logic

Based on the likely use of the encounter data in future analytic activities (e.g., performance measure development/calculation), HSAG developed logic-based checks to ensure the encounter data could appropriately support additional activities.

- Continuous member enrollment to identify the length of time members were continuously enrolled during the measurement year. This assessment provides insight into how well encounter data may be used to support future analyses, such as Healthcare Effectiveness Data and Information Set (HEDIS®)[2-2] performance measure calculations. For instance, many measures require members be enrolled for the full measurement year, allowing only one gap of up to 45 days.

[2-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

3. Information Systems Review Findings

Representatives from all six ICOs completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on the ICO's original questionnaire responses, and the ICOs responded to these ICO-specific questions. To support their questionnaire responses, the ICOs submitted a wide range of documents with varying formats and levels of detail. MDHHS also completed its state-specific questionnaire. For more details regarding the questionnaires provided to MDHHS and the ICOs, please refer to Appendix B and Appendix C, respectively.

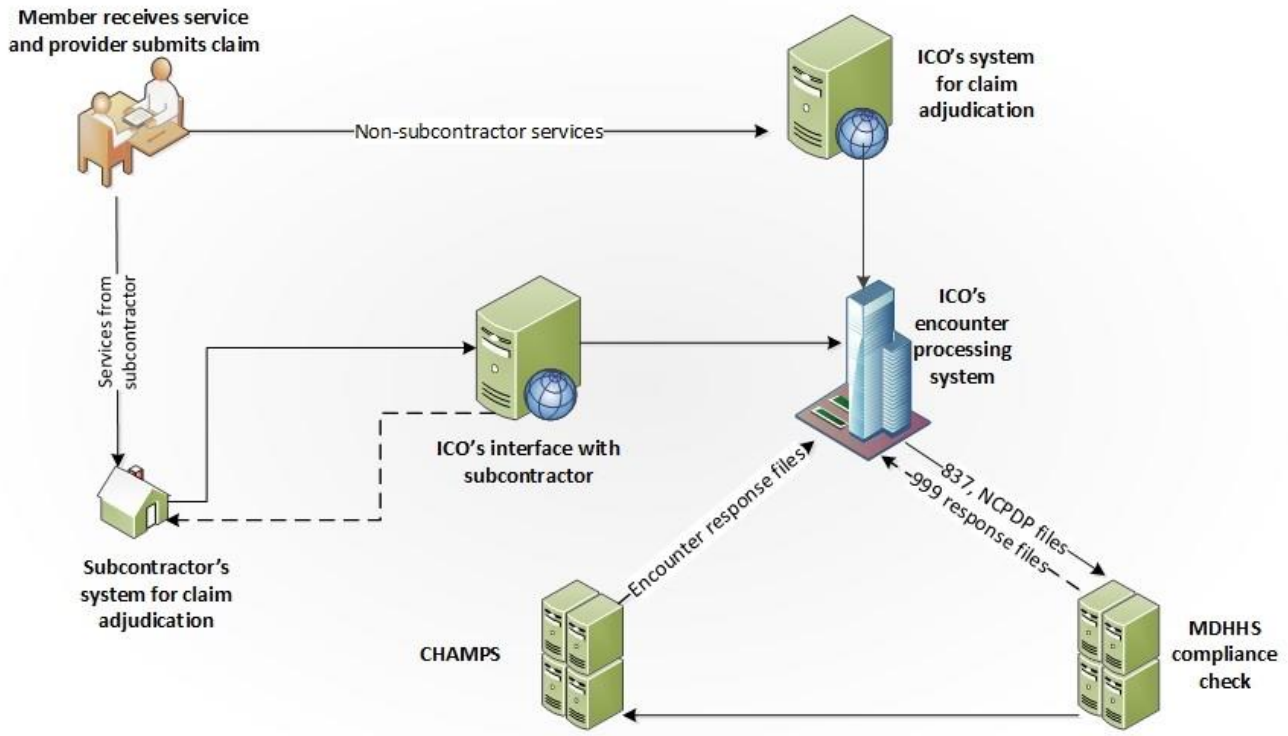
Encounter Data Sources and Systems

This report section provides an overview of the data sources utilized in the claims data to encounter data cycle. It also outlines the systems employed for data processing, any systematic formatting performed before submission (if handled by a third party), and the methods employed to verify data accuracy in terms of provider and member information.

Claims/Encounter Data Flow

Figure 3-1 shows a high-level general process that outlines the path of an ICO's encounter data from the point when a member receives a service (or services) until MDHHS processes the encounter. Solid lines represent the main transaction paths between each process agent, while dotted lines indicate data transfer feedback loops.

Figure 3-1—Claims/Encounter Data Path From Origin Through Submission to MDHHS



The process of handling claims and encounter data involves several steps, as shown in Figure 3-1. It starts with a member receiving a healthcare service from a provider. Providers then send claims electronically or via paper to a clearinghouse that organizes and formats the claims. The claims are then processed and sent to the ICO's encounter data system. If a third party is involved, it sends the data to the ICO's system.

The ICO and/or its subcontractors are responsible for ensuring that the encounter data are accurate, complete, and properly formatted for timely submission to MDHHS using specific file types (i.e., 837P, 837I, 837D, or NCPDP). The data may be submitted directly to MDHHS or through a subcontractor or vendor.

When the ICOs send 837I, 837P, and 837D files to MDHHS, they are downloaded and run through an Electronic Data Interchange (EDI) translator for compliance checks. MDHHS generates X12 999 response files to send back to the ICOs. Encounters that pass the compliance checks are stored in the Community Health Automated Medicaid Processing System (CHAMPS) and undergo additional MDHHS edits. For encounters that fail these edits, Encounter Transmission Results Report (ETRR) response files are sent back to the ICOs to make corrections.

Pharmacy files from the ICOs are moved to MDHHS' extract transform and load (ETL) server by the file transfer system (FTS) team. These files go through the data warehouse for processing. Encounters

that pass compliance checks are stored in the data warehouse and transferred to CHAMPS. If any records fail the edits, the ICOs receive response and error files for encounters to be corrected.

Once the ICOs receive the response files, they review them, making any necessary corrections and resubmitting the data if needed. If a subcontractor or vendor was involved, it corrects and resubmits the data to the ICO. This process varies based on the ICO's agreements with different parties such as healthcare providers, networks, and vendors. Each ICO has a unique process, and the following section explores their encounter data processes, focusing on factors that could lead to incomplete or inaccurate data sent to MDHHS.

Information Systems Infrastructure

MDHHS receives 837P, 837I, 837D, and NCPDP files either directly or indirectly from the ICOs, which might have been generated by the ICOs or their subcontractors in different formats. The ICOs follow various submission frequencies, including daily, weekly, monthly, or other intervals. Once claims are received, the ICOs use a range of software tools to manage, process, validate, and structure the encounter data files, as illustrated in Table 3-1.

Table 3-1—Primary Software for Encounter Processing

ICO[1]	Primary Software for Claims Adjudication and Encounter Preparation	Workgroup for Electronic Data Interchange Strategic National Implementation Process (WEDI SNIP) Level for 837P and 837I Encounters
AET	QNXT, Edifecs, and Ramp Manager	Levels 1 through 5
AMI	International Business Machines' (IBM's) Sterling File Gateway, IBM's Standards Processing Engine, TriZetto Encounter Data Manager (EDM)	Levels 1 and 2
HAP	Facets, Change Healthcare; uses Sterling Integrator and Optum EDI Transaction Integrity for dental	Levels 1, 2, 3, 4, 6, and 7 Dental: Levels 1, 2, 3, 6, and 7
MER	Edifecs (X-Engine)	Levels 1 through 5
MOL	Microsoft Solutions (MS SQL and BizTalk)	BizTalk handles levels 1 and 2, while other SNIP levels (3 through 7) are enforced by Molina code.
UPP	Python, PCE/ELMER	Levels 1 through 7

[1] For detailed descriptions of each of the ICO acronyms, please refer to Appendix A.

Duplicate, Denied, and Adjusted Claims

All ICOs shared their processes to detect and identify duplicate claims, including the key fields used, identification timing, and how they are handled. Common fields such as member ID, service date, provider, and codes are examined. Other encounter-specific fields, such as revenue code or NDC, are

also considered as needed. Table 3-2 shows points in the process and descriptions of common fields examined for duplication across the ICOs.

Table 3-2—Point in the Process and Some Common Fields Used by ICOs to Examine Claims for Duplication

ICO	Point in the Process and Field Description
AET	During auto-adjudication process where duplicate editing is applied based on: • Member's name, date of service rendering provider, procedure code, modifier, and place of service. • Pharmacy claims: Pharmacy ID, prescription number, fill date, and refill number.
AMI	Uses three-tiered approach: • Sterling File Gateway: ICO's file transfer tool, checks for duplicates based on sender ID, receiver ID, control number, and file name to prevent duplicate uploads. • Facets: ICO's core processing system, where the ICO defines the rules to apply during claims adjudication to determine if a duplicate claim has already been entered into Facets. • EDM system: Configured according to its business rules in which ICO created encounter data scrubs and edits to identify duplicate encounters.
HAP	• Institutional claims: Member ID, service date, procedure code, revenue code, charged amount, units, and servicing provider. • Professional claims: Member ID, service date, place of service, procedure code, modifier, charged amount, units, and servicing provider. • Pharmacy claims: Member ID, NDC, date of service, pharmacy NPI, prescription number, refill number, and others.
MER	MER identifies duplicate claims by considering the same factors for both in-house and vendor claims: the date of service, procedure code/modifier combination, member ID, and Group NPI/Servicing NPI. MER also employs an internal process for encounters. If a claim is reprocessed with a different linked claim number, and the original claim is either accepted by the State or pending a response, it is put on hold. Before resubmission, the EDM checks to ensure that encounters have received a response. This step helps prevent duplicate original encounters from being resubmitted. If necessary, the system automatically processes them as a void/replacement once the encounter response is loaded into EDM during the ICO's weekly batch update.
MOL	A claim considered a duplicate is determined based on specific data elements: member information, claim form type, rendering provider ID, date of service, revenue code, procedure code, modifiers, historical claim status, and historical line status. Duplicate detection process takes place as a claim enters QNXT, where providers will be notified if a duplicate is detected.

ICO	Point in the Process and Field Description
UPP	The ICO's claims system identifies duplicate claims before they go into the encounter file based on having the same provider, date, and procedure information. If a claim accidentally slips through, ICO partners with Change Healthcare to catch it. Change Healthcare has checks to find duplicate or conflicting services. These get denied, keeping them out of the encounter file. If in any instances a duplicate claim is included on the encounter file, the ICO's data vendor checks again to assess various details such as member ID, provider information, and dates. If any information matches another encounter, it will be marked as a duplicate and reviewed before sending to MDHHS. This review occurs weekly.

All ICOs reported submitting all types of claims/encounters (i.e., paid, denied, voided, or adjusted claims) to MDHHS. Each ICO described its submission practices as follows:

- **Aetna Better Health of Michigan**: Only submits complete claims and does not submit voided claims. Additionally, its vendors do not send denied claims.
- **AmeriHealth Caritas**: Sends all encounter data to MDHHS. These data include paid claims, voided claims, interest and penalties (both paid and recovered), incentive payments (both paid and recovered), "zero paid" claims, cost settlements, sub-capitated services, third-party liability denials, claim line adjustments, and other financial activities related to payments and recoveries.
- **HAP Empowered**: Does not submit encounters for specific scenarios such as pharmacy claims that were reversed out, paid, and voided in the same cycle; administrative expense claims; non-U.S. billing providers; duplicates; member ineligibility; missing data; and invalid diagnoses.
- **Meridian Health Plan**: Does not submit rejected and voided claims.
- **Molina Healthcare of Michigan**: Does not submit denied claims unless they are administrative denials; voided claims are also not submitted.
- **Upper Peninsula Health Plan**: Does not submit encounters for claims that are denied due to primary insurance, member ineligibility, inappropriate providers, or those that would not pass CHAMPS editing.

Each ICO outlined its approach to identifying and locating encounters requiring adjustments, as well as its process for submitting those adjustments to MDHHS. While the processes did not include a universal process for the ICOs to follow, there were some common elements in the ICOs' processes, particularly related to how they handled claims and adjustments. The ICOs indicated that they have systems in place to identify adjustments by comparing the current data with previously submitted data. These adjustments could be due to corrected errors, voided claims, or new paid claims. The encounters were then tagged with frequency codes to indicate their nature:

- 1 (Original): Used for adjustments when the original claim was rejected.
- 7 (Replacement): Used for adjustments when the original claim was accepted.
- 8 (Void): Used when the original claim was accepted but later voided.

Encounters that required resubmission, whether as replacements, voids, or originals, were extracted from the system and prepared for subsequent submission. While there were common elements, the specific steps and systems could vary significantly between ICOs. Each ICO had unique procedures, requirements, and technologies in place.

Collection, Use, and Submission of Provider Data

All ICOs indicated joint responsibility between themselves and their subcontractors for gathering and maintaining provider information. The methods employed to collect, store, and manage these data varied across all ICOs. However, a common thread was that most ICOs received regular updates from subcontractors, State agencies, or other relevant entities to keep provider information current. This was especially relevant for services such as dental, vision, and LTSS, where providers often registered with the State, which could then share these data or updates with the ICOs.

In the ICOs' responses, the provider data were typically stored within their internal systems, facilitating easy access and reference. Each ICO detailed its unique method for linking provider data with claims or encounters, thus ensuring accuracy and completeness during the adjudication process. For instance, **Molina Healthcare of Michigan** described its utilization of a process called Provider Match Logic to link provider data to claims using various criteria for matching.

Collection, Use, and Submission of Enrollment Data

Three ICOs (i.e., **Aetna Better Health of Michigan**, **AmeriHealth Caritas**, and **Meridian Health Plan**) confirmed they manage the enrollment data, while three others ICOs (i.e., **HAP Empowered**, **Molina Healthcare of Michigan**, and **Upper Peninsula Health Plan**) indicated both the ICOs and their subcontractors managed the enrollment data. MDHHS supplied the 834 files and files containing daily Medicaid enrollment updates to the ICOs, which the ICOs could integrate into their systems for claims processing. The ICOs noted that these enrollment details are also shared with their subcontractors, who incorporate them into their claims systems.

Payment Structures of Encounter Data

This section focuses on how the ICOs collected payment-related data and processed claims for payment. Table 3-3 shows the ICOs' primary pricing methodology for inpatient, outpatient, and pharmacy encounters.

Table 3-3—Primary Pricing Methodology, by ICO and Claim Type

Primary Pricing Methodology	Inpatient	Outpatient	Pharmacy
Percent Billed		**UPP**	
Line-by-Line	**HAP, UPP**	**AET, HAP, MER, MOL, UPP**	
Per Diem/Variable Per Diem	**HAP, UPP**	**MER, MOL**	
Capitation	**HAP, MER**	**HAP, MER**	
DRG	**AET, HAP, MOL, UPP**		
Negotiated (Flat) Rate	**HAP, MER**	**HAP, MER, UPP**	
Ingredient Cost			**AET, HAP, MOL, UPP**
Other	**AMI[1], HAP[2], MOL[4]**	**AMI[1]**	**AMI[1], MER[3], UPP[5]**

[1] Percent of allowed.
[2] Ambulatory Payment Classification (APC) and CMS pricing.
[3] Transparent pricing model.
[4] Skilled, short stay, and custodial pricing.
[5] Not specified.
Gray shaded cells indicate no ICO utilized the pricing methodology.

Since the encounter data submission did not include a payment methodology field, some variation in pricing methodology existed among the ICOs.

- For inpatient encounters, all ICOs except **AmeriHealth Caritas** used the DRG methodology for pricing. **AmeriHealth Caritas** exclusively employed the percent of allowed method for claim payments. Additionally, most ICOs utilized various pricing methods as part of their claim payment strategies for inpatient encounters, such as line-by-line; per diem; capitation; negotiated (flat) rate; APC and CMS pricing; or skilled, short stay, and custodial pricing.
- For outpatient encounters, all ICOs, except **AmeriHealth Caritas** used various payment methods such as percent billed, line-by-line, per diem, variable per diem, capitation, or negotiated (flat) rates. **AmeriHealth Caritas,** however, only employed the percent of allowed method for claims payment.

- For pharmacy encounters, most ICOs typically used the ingredient cost methodology for pricing. **AmeriHealth Caritas** used the percent of allowed method, and **Meridian Health Plan** employed the transparent pricing model method for pricing its pharmacy claims.

Bundle Payment Structures

The ICOs were asked if there are any services submitted to the ICO under bundle payment structures. All ICOs except for one (i.e., **Upper Peninsula Health Plan**) indicated that there are services submitted under bundle payment structures.

- **Aetna Better Health of Michigan**, **HAP Empowered**, and **Meridian Health Plan** noted that maternity services were submitted as bundled services.
- **Aetna Better Health of Michigan** noted that bundling also applied to other services, such as dental x-rays and restorations, and vision services also used bundled payments, including specific lens options.
- **AmeriHealth Caritas** noted that services such as inpatient hospital, home health, skilled nursing facility, outpatient hospital, and ambulatory surgery centers were submitted as bundled services.
- **Meridian Health Plan** submitted bundled payments to MDHHS for the following services: inpatient, rehabilitation, and long-term acute care hospitals (LTACHs).
- **Molina Healthcare of Michigan** noted that it adhered to bundle payment methodologies, such as DRG, APC, outpatient prospective payment system (OPPS) for both inpatient and outpatient services, in accordance with both State and federal billing guidelines. Additionally, **Molina Healthcare of Michigan** may have specific agreements with providers for urgent care case rates, adult day care per diems, and dialysis per diem rates.

TPL Data

All ICOs collected and verified insurance coverage information through several combinations of data sources and techniques to identify and manage other insurance coverage for their members. These approaches included:

- 834 files and a weekly TPL resource file from MDHHS.
- Collaborating with external vendors such as Health Management Systems or Council for Affordable Quality Healthcare.
- Members, providers, and the State voluntarily reporting other insurance coverage.
- Claims received with a primary insurance explanation of benefits (EOB).

In general, all ICOs processed claims with TPL based on the collected insurance coverage information. Claims were reviewed during the adjudication process to identify primary insurance. Claims without EOB or prior information were often denied. Cost-avoidance exceptions, such as when Medicaid is the primary payer, were applied. If other insurance information was submitted after the initial processing,

the claim would be reprocessed, reevaluated, and payment adjustments would be made with the new insurance payment details. These methods are broadly used by the ICOs to ensure accurate coordination of benefits when secondary insurance is involved. However, specific processes may vary depending on the ICO's internal procedures and regulations.

Zero-Paid Claims

All ICOs submitted claims with a payment of $0 to MDHHS. The situation leading to zero-dollar payments, as indicated in the ICOs' responses, could be attributed to one of the following scenarios:

- The primary payer covers the entire amount permitted under the member's Medicaid benefit (i.e., paid in full by TPL).
- Claims or service lines that are denied for various reasons, including scenarios such as billed procedures not being covered services, lack of authorization when required, or claims submitted for uncovered services.
- Services under a capitation payment.
- Federally Qualified Health Center (FQHC) claims that are covered under the prospective payment system.
- When all services are bundled and no additional payment is required, which will lead to a zero paid amount.

Services From Providers With ICOs Under Capitation Arrangement

According to MDHHS, providers are required to submit the usual and customary charge or billed amount. It is acceptable to report a value of zero in certain cases:

- If the health plan has a sub-capitated contract arrangement with the provider, as indicated in Loop–2300 Claim Information, Segment CN1, CN101 (Contract Type Code) or Loop–2400 Service Line Number, Segment CN1, CN101 (Contract Type Code), and the contract allows for zero as a charged amount.
- If the service(s) being reported are recognized by MDHHS as having no associated charge(s), such as vaccines.

In the case of a zero-amount submitted for a sub-capitated encounter with a claim's adjustment reason code 24, the value of the service should be reported in the monetary amount field.

All but one ICO (i.e., **Upper Peninsula Health Plan**) indicated having capitated arrangements with their providers and described their processes for submitting payment information on capitated encounters. In general, the ICOs handled capitated encounters by submitting them to MDHHS with specific indicators or segments to denote capitated services. These indicators often included a $0 paid amount and unique codes or segments that conveyed the nature of the capitation agreement. The specifics of how these encounters are submitted may vary slightly between the ICOs, but the common

theme is to clearly communicate that these services are part of a capitation arrangement, typically involving $0 payment directly associated with the encounter.

Encounter Data Quality Monitoring

This section evaluates how the ICOs monitored their encounter data quality from the following questions:

- How do the ICOs monitor encounter data quality for data collected by their subcontractors?
- How do the ICOs monitor encounter data quality for data they collect?
- How do the ICOs address feedback from MDHHS?
- What are the challenges or requests from the ICOs?.

Encounter Data Quality Monitoring by the ICOs' Subcontractors

Table 3-4 presents information about subcontractor involvement in encounter submission; the ICOs' storage, review, and modification of encounters before submission to MDHHS; and subsequent review of encounters by the ICOs after submission. The green dots in the table indicate a "Yes" response, and the red dots indicate a "No" response.

Table 3-4—ICO Processes for Encounters From Subcontractors

ICO	Type of Subcontractor	Submits to MDHHS by Subcontractor	Stored by ICO	Reviewed by ICO Before Submission	Modified by ICO Before Submission	Reviewed by ICO After Submission
AET	BH	●	●	●	●	●
	Dental	●	●	●	●	●
	NEMT	●	●	●	●	●
	Pharmacy	●	●	●	●	●
	Vision	●	●	●	●	●
	Other-Fiscal Intermediary	●	●	●	●	●
AMI	BH	●	●	●	●	●
	Dental	●	●	●	●	●
	NEMT	●	●	●	●	●
	Pharmacy	●	●	●	●	●
	Vision	●	●	●	●	●
	Other- LTSS	●	●	●	●	●
HAP	Dental	●	●	●	●	●
	NEMT	●	●	●	●	●
	Pharmacy	●	●	●	●	●
	Other-Nations Hearing	●	●	●	●	●
MER	BH	●	●	●	●	●
	Dental	●	●	●	●	●
	NEMT	●	●	●	●	●
	Pharmacy	●	●	●	●	●
MOL	BH	●	●	●	●	●
	Dental	●	●	●	●	●
	NEMT	●	●	●	●	●
	Pharmacy	●	●	●	●	●
	Vision	●	●	●	●	●
UPP	BH	●	●	●	●	●
	Dental	●	●	●	●	●
	Pharmacy	●	●	●	●	●

Key Findings: Table 3-4

- Despite subcontractor involvement in encounter collection and processing for most ICOs, the ICOs themselves consistently handled encounter submission to MDHHS, except for:
  - **Meridian Health Plan**.
  - **Upper Peninsula Health Plan**.

- Regarding the different types of subcontractors responsible for processing the data:
  - All ICOs had dental and pharmacy subcontractors, and most ICOs had behavioral health and NEMT subcontractors, except for **HAP Empowered** and **Upper Peninsula Health Plan**, respectively.
  - Three ICOs (i.e., **Aetna Better Health of Michigan**, **AmeriHealth Caritas**, and **Molina Healthcare of Michigan**) had vision subcontractors.
- All ICOs stored their subcontractors' data submitted to MDHHS, except for the following ICOs:
  - **Meridian Health Plan** noted it did not store any of its subcontractors' data.
  - **Molina Healthcare of Michigan** did not store its pharmacy subcontractor's data.
- The ICOs either reviewed the encounter data from subcontractors before or after submission to MDHHS, except for **Molina Healthcare of Michigan**. It did not review its pharmacy data either before or after submission to MDHHS; however, the ICO noted that it meets regularly with its subcontractor to discuss all rejections and that it is satisfied with the quality checks.
- Among the ICOs, four ICOs did not alter encounters before MDHHS submission. However, two ICOs (i.e., **HAP Empowered** and **Molina Healthcare of Michigan**) either edited some subcontractor data or made modifications to each of its subcontractor's data.

HSAG gathered responses from the ICOs regarding the quality checks conducted by both their subcontractors and the ICOs themselves. In order to organize the ICOs' responses, HSAG provided standard data quality checks for them to choose from in their questionnaire responses. Table 3-5 provides a brief description for these checks.

Table 3-5—Description of Data Quality Checks

Data Quality Checks	Description
Claim Volume by Submission Month	Evaluates the number of unique claims based on the month when the claims were submitted to an entity.
Claim Volume PMPM	Evaluates the number of unique claims per member per month based on the month when the services occurred.
Field-Level Completeness	Evaluates whether there are any missing and/or extra values for a specific data element.
Field-Level Validity	Evaluates whether the values for a specific data element are valid.
Timeliness	Evaluates whether the source entity submits claims in a timely manner.
Reconciliation With Financial Reports	Evaluates whether the payment fields in the claims align with the financial reports from an entity.
EDI Compliance Edits	Evaluates whether 837P, 837I, and 837D files pass the EDI compliance edits.
MRR	Evaluates whether some of the data elements in the claims are complete and accurate when comparing to the medical records.

Table 3-6 presents the data quality checks conducted by either the ICOs or their subcontractors on the encounter data collected by the subcontractors. The "Field-Level Completeness and Validity" column included quality checks such as EDI compliance edits, NCPDP edits, field-level completeness, or field-level accuracy. The green dots in the table indicate that there are quality checks, and the red dots indicate that there are no quality checks.

Table 3-6—Data Quality Checks by the ICOs and/or Their Subcontractors

ICO	Type of Subcontractor	Claim Volume by Submission Month/PMPM	Field-Level Completeness and Validity	Timeliness	Reconciliation With Financial Reports
AET	BH	🔴	🟢	🟢	🔴
	Dental	🔴	🟢	🟢	🔴
	NEMT	🔴	🟢	🟢	🔴
	Pharmacy	🔴	🟢	🔴	🟢
	Vision	🔴	🟢	🟢	🔴
	Other-Fiscal Intermediary	🔴	🟢	🔴	🔴
AMI	BH	🟢	🟢	🟢	🟢
	Dental	🟢	🟢	🟢	🟢
	NEMT	🟢	🟢	🟢	🟢
	Pharmacy	🔴	🟢	🟢	🔴
	Vision	🟢	🟢	🟢	🟢
	Other-LTSS	🔴	🟢	🔴	🟢
HAP	Dental	🔴	🟢	🔴	🟢
	NEMT	🟢	🟢	🔴	🟢
	Pharmacy	🟢	🟢	🔴	🟢
	Other-Nations Hearing	🟢	🟢	🔴	🟢
MER	BH	🔴	🟢	🔴	🔴
	Dental	🟢	🟢	🟢	🔴
	NEMT	🟢	🟢	🟢	🔴
	Pharmacy	🔴	🟢	🔴	🔴
MOL	BH	🟢	🟢	🟢	🟢
	Dental	🟢	🟢	🟢	🟢
	NEMT	🟢	🟢	🟢	🟢
	Pharmacy	🔴	🟢	🔴	🟢
	Vision	🟢	🟢	🟢	🟢
UPP	BH	🔴	🟢	🔴	🔴
	Dental	🔴	🟢	🔴	🟢
	Pharmacy	🟢	🟢	🔴	🔴

Key Findings: Table 3-6

- The claim volume by submission month encounter data quality check was not consistently conducted across all ICOs. Except for **Aetna Better Health of Michigan**, all ICOs and their subcontractors performed this check on at least one subcontractor's encounter data.

- The field-level completeness and accuracy quality check for all subcontractors' encounters were performed by either the subcontractors or the ICOs themselves.
- MDHHS used the timeliness report to monitor the minimum monthly requirements for the ICOs, but not all ICOs and their subcontractors performed this check on subcontractor encounters. Specifically, **HAP Empowered** and **Upper Peninsula Health Plan** did not conduct this check on any of their subcontractors' encounters, while the other ICOs performed this check on at least one subcontractor's encounter data.
- **Molina Healthcare of Michigan** and **HAP Empowered** indicated in their responses that they conducted an assessment of the alignment of payment fields in claims with financial reports for all subcontractor data. However, **Meridian Health Plan** did not perform this assessment for all of its subcontractor's data.

Encounter Data Collected by the ICOs

For encounters collected by the ICOs (i.e., not collected by the ICOs' subcontractors), Table 3-7 shows the quality checks reported by the ICOs.

Table 3-7—Data Quality Checks for Encounters Collected by the ICOs

Data Quality Checks	Claim Volume by Submission Month/PMPM	EDI Compliance Edits	Field-Level Completeness and Accuracy	Reconciliation With Financial Reports	Timeliness
AET				✓	
AMI		✓	✓	✓	
HAP	✓	✓		✓	
MER	✓		✓		✓
MOL	✓		✓	✓	✓
UPP			✓		

Key Findings: Table 3-7

- The number and types of data quality checks vary among the ICOs, with "Field-Level Completeness and Accuracy" and "Reconciliation With Financial Reports" being the two most commonly conducted data quality checks by the ICOs.
- Four of the ICOs reported conducting at least three data quality checks, while two ICOs (i.e., **Aetna Better Health of Michigan** and **Upper Peninsula Health Plan**) conducted one quality check.
- Notably, despite MRR being available as a dropdown option in the questionnaire, none of the ICOs opted for MRR as a data quality check method. This is likely due to the labor- and resource-intensive nature of MRR.

Feedback From MDHHS

As noted previously in the "Claims/Encounter Data Flow" section, upon receiving encounters from the ICOs, MDHHS generated a series of response files (e.g., X12 999 response files and ETRR response files) based on EDI compliance edits and additional edits applied within MDHHS' data warehouse. MDHHS sent these files to the ICOs to make corrections. In general, the number of records rejected by MDHHS' edits was higher than the number of records rejected by the EDI translator, with a few exceptions. After receiving and reviewing MDHHS' response files, the ICOs were capable of making corrections for the rejected encounters and then resubmitting them to MDHHS. Based on the ICOs' responses to the questionnaire, Table 3-8 displays the percentage of encounters that were initially rejected and not yet accepted by MDHHS.

Table 3-8—Percentage of Encounters Initially Rejected and Not Yet Accepted by MDHHS

ICO	837I	837P	837D	Pharmacy	Other
AET	0.3%	0.5%	2.7%	0.2%	—
AMI	0.3%	1.5%	6.5%	0.5%	5.5%
HAP	3.4%	0.2%	1.8%	0.0%	1.2%
MER	3.4%	2.3%	26.8%	0.0%	—
MOL	0.6%	0.8%	0.0%	0.2%	—
UPP	0.1%	1.1%	17.3%	0.0%	—

Note: For **HAP Empowered**, the "Other" encounters category encompasses its hearing subcontractor encounters. For **AmeriHealth Caritas**, this category includes its LTSS, NEMT, and vision subcontractor encounters.

Key Findings: Table 3-8

- The rates for pharmacy encounters were generally the lowest (i.e., at or less than 0.5 percent) across all ICOs.
- Among all ICOs, **Meridian Health Plan** had the highest rejection rate for dental encounters with a rate of 26.8 percent, followed by **Upper Peninsula Health Plan** and **AmeriHealth Caritas** with rejection rates of 17.3 percent and 6.5 percent, respectively.
- Overall, all ICOs exhibited relatively low rejection rates for all encounter types, with the exception of dental encounters.

Challenges and Changes Noted by the ICOs

The ICOs were asked about the challenges they encounter or anticipate when submitting encounter data to MDHHS. Responses varied among the ICOs across various topics. Additionally, one ICO provided feedback on upcoming changes in its encounter submission processes. Table 3-9 displays the internal/external challenges and upcoming changes noted by the ICOs in their responses, if any. All ICOs, except for **Meridian Health Plan** and **Molina Healthcare of Michigan**, identified at least one challenge, either internal or external, in submitting encounter data to MDHHS.

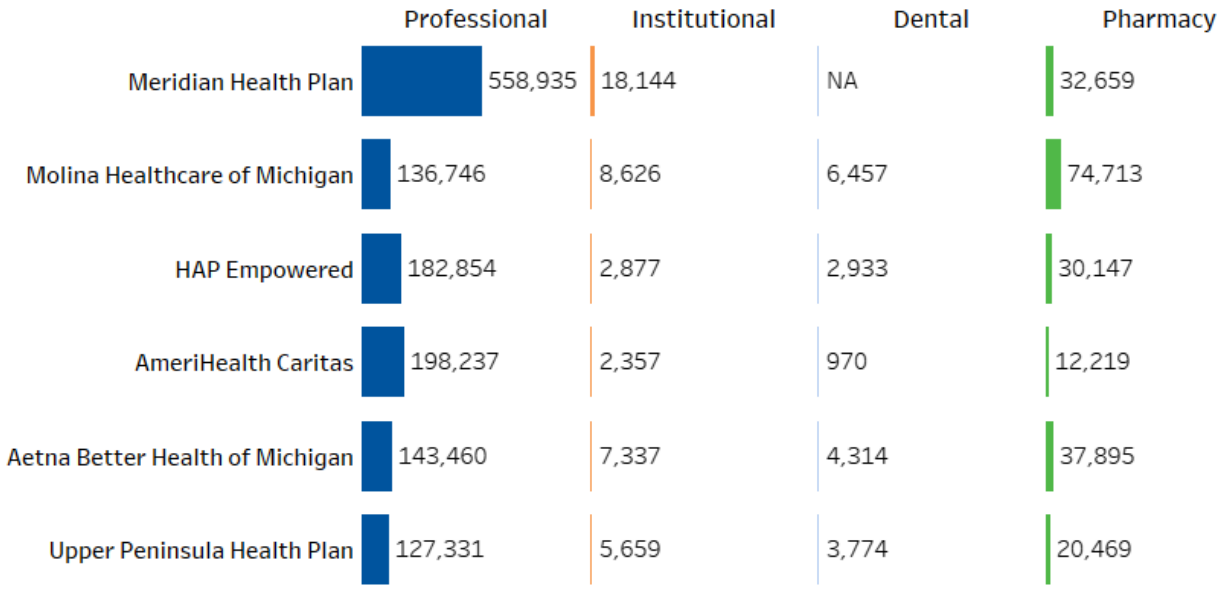
Table 3-9—Internal and External Challenges and Upcoming Changes

ICO	Challenges and/or Upcoming Changes	Description
AET	Internal Challenge	Configuring its claims processing system to align with the State encounter processing system whenever feasible.
	External Challenge	Aligning its encounter processing logic with the State's processing logic is a challenge, as the ICO lacks certain data elements and logic from the State to configure its internal systems accordingly.
AMI	External Challenge	Eligibility: Eligibility data do not match between the State and CMS.
HAP	Internal Challenge	ICO submits 837 files twice a month. Any emergency data submission takes five business days. Building an additional submission in case of pending error/emergency needs.
	External Challenge	ICO experienced Edifecs validation issues with insufficient documentation for 999 response file errors, leading to unclear fix directions. ICO discussed this with MDHHS but could not find guidance on the MDHHS website.
MER	None	Not applicable.
MOL	None	Not applicable.
UPP	Internal Challenge and Upcoming Change	The ICO is reorganizing its 837 file submission to improve processing efficiency and reduce this type of rejection. Following MDHHS guidance, the ICO is placing voids (frequency code 8) at the top, adjustments (frequency code 7) in the middle, and originals (frequency code 1) at the bottom. This ensures voids are processed before originals, minimizing this type of rejection. The changes are expected to be completed by the end of 2023.
	External Challenge	Encounter rejections for members with discrepancy: Encounters are rejected if a member is only active in MARx and not in CHAMPS, or if there are any demographic discrepancies such as date of birth or gender, etc.

Encounter Data Summary

Figure 4-1 displays the total number of paid encounters by ICO and category of service. **Meridian Health Plan** had the largest number of paid professional and institutional encounters of the ICO program at approximately 559,000 and 18,000 encounters, respectively. **Molina Healthcare of Michigan** had the largest number of paid dental and pharmacy encounters of the ICO program at nearly 6,500 and 75,000 encounters, respectively. **AmeriHealth Caritas** had the lowest number of paid encounters for three of the four categories of service: institutional, dental, and pharmacy encounters at approximately 2,300, 970, and 12,200 encounters, respectively. **Meridian Health Plan** submitted its dental data marked as Medicare; therefore, dental encounters for **Meridian Health Plan** were not included in this analysis.

Figure 4-1—Number of Encounters by Claim Status and Category of Service by ICO



Member Composition

Figure 4-2 and Figure 4-3 display MDHHS ICO Medicaid member demographics by ICO. As shown in Figure 4-2, **Molina Healthcare of Michigan** had the highest number of enrolled members in the ICO program at approximately 15,700. This correlates to **Molina Healthcare of Michigan** having the highest number of paid encounters in two of the four categories of service, as seen in Figure 4-1. Moreover, despite **Meridian Health Plan** having the overall highest number of paid encounters, they had the third highest number of enrolled members. **AmeriHealth Caritas** had the lowest number of enrolled members at approximately 4,100, which aligns with **AmeriHealth Caritas** having the lowest number of paid encounters in three of the four categories of service, as seen in Figure 4-1.

Figure 4-2—Enrollment in SFY 2023 by ICO

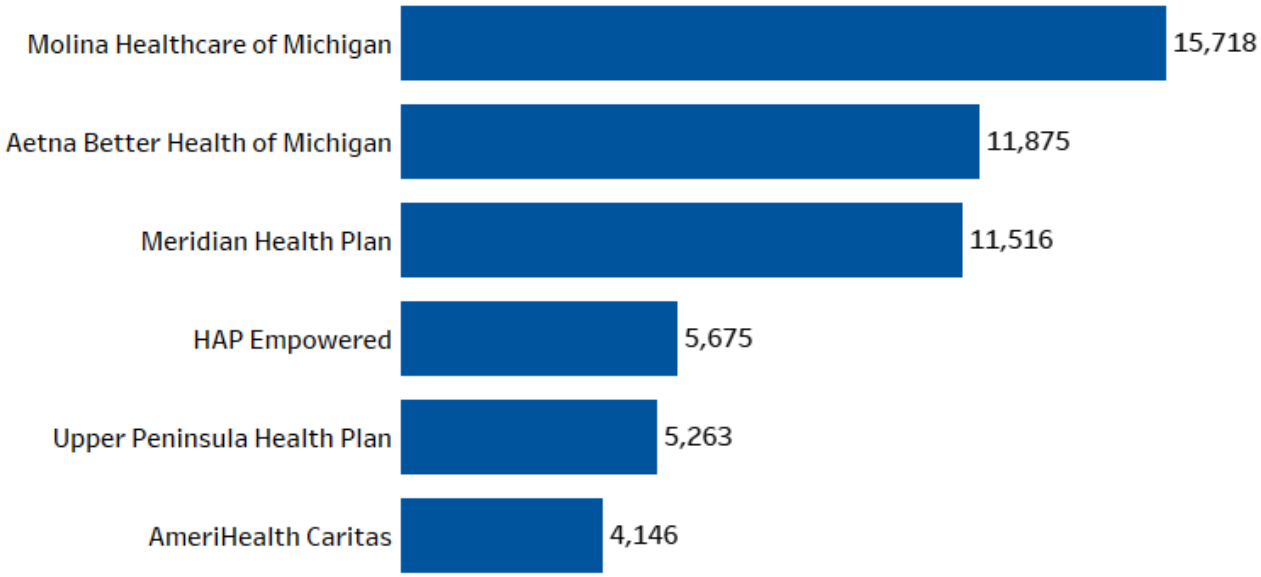
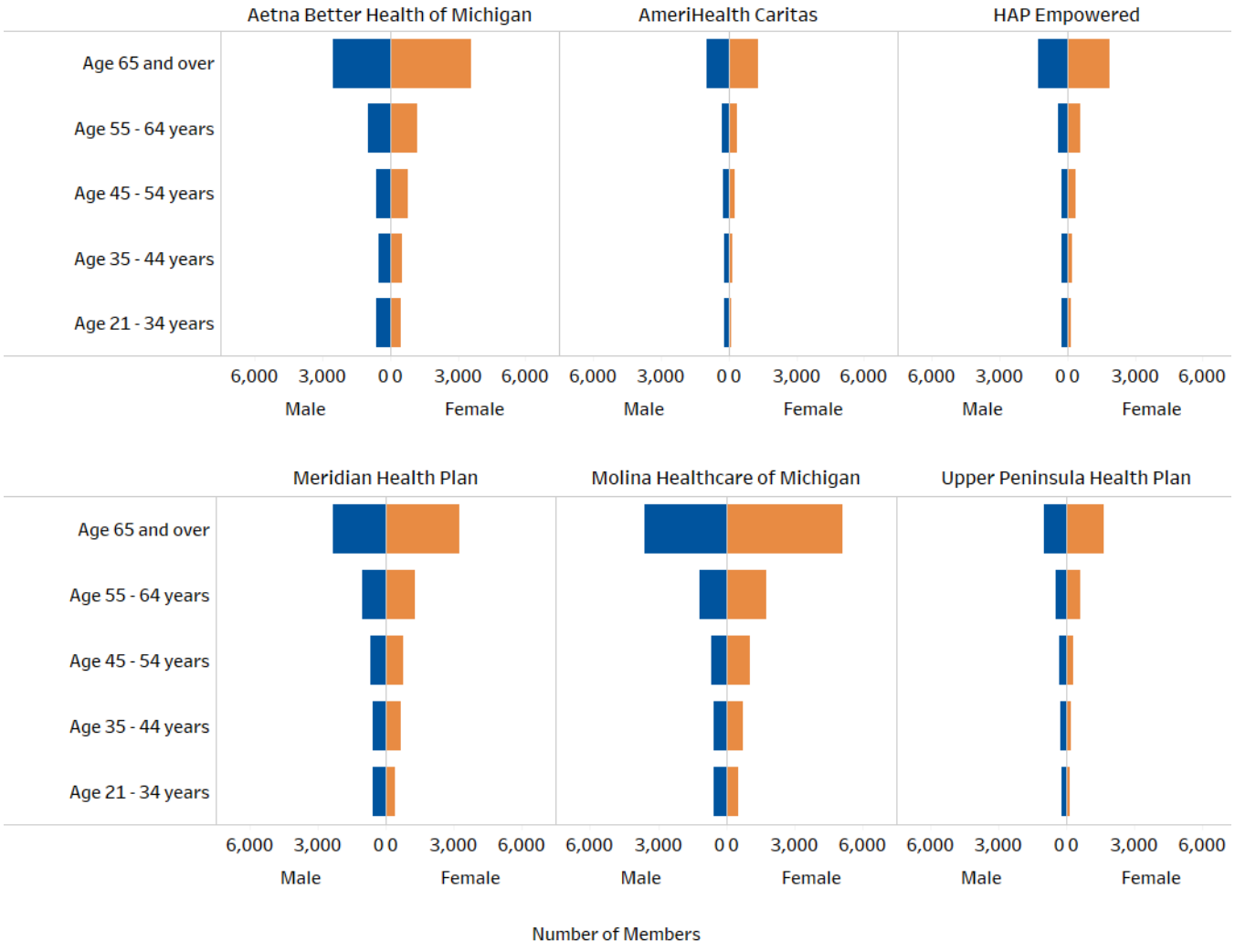


Figure 4-3 displays the age and gender distribution for each ICO. Across all ICOs, the 65 years old and older age category had the largest number of enrolled members. The number of enrolled members within each age category tended to decrease as the age categories got younger. Across all ICOs and age categories, the number of females tended to slightly outweigh the number of males, with the largest variation in the 65 years old and older age category.

Figure 4-3—Age and Gender Distribution by ICO



Encounter Data Completeness

To validate encounter data completeness, HSAG examined encounter data volume through multiple angles across four primary metrics. HSAG stratified each of the following metrics by ICO and category of service (professional, institutional, dental, and pharmacy):

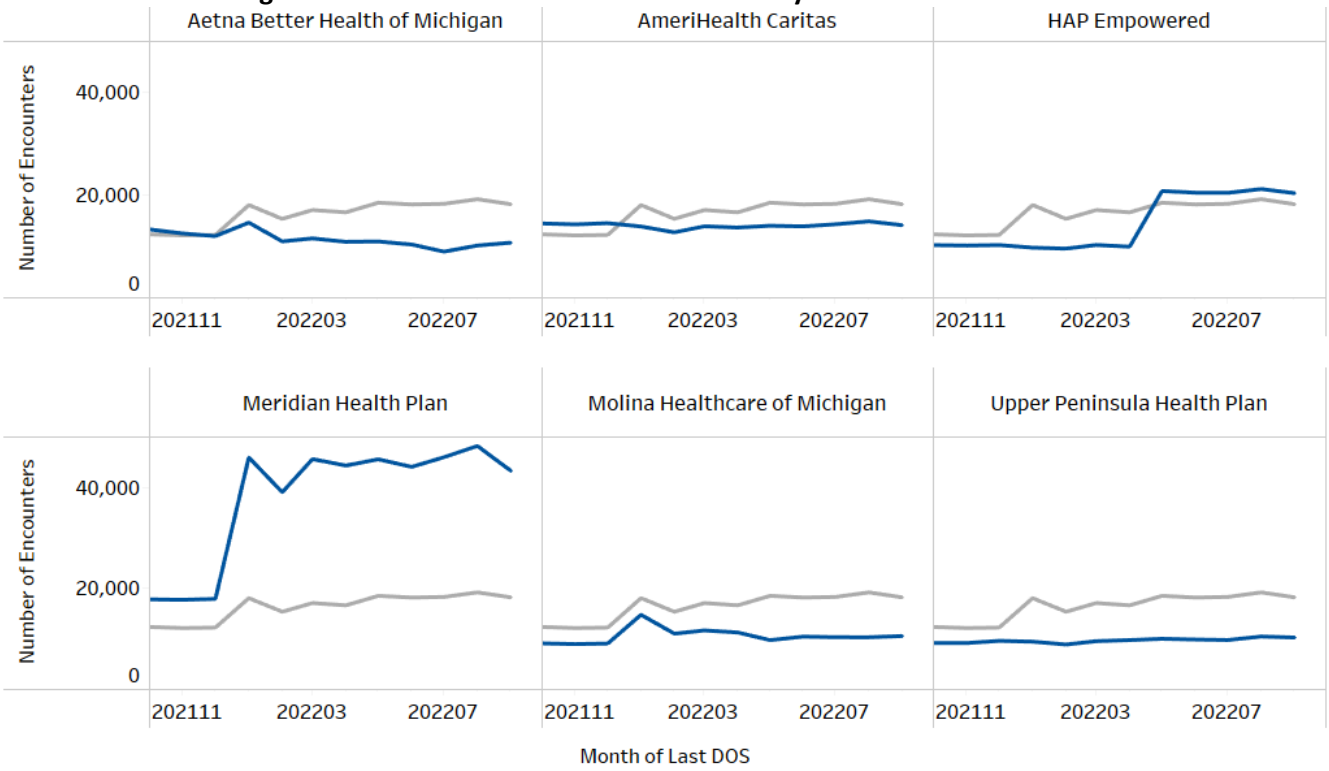
- Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occurred)
- Monthly encounter volume (i.e., visits) per 1,000 MM by service month
- Paid amount PMPM by service month
- Percentage of duplicate encounters

Monthly Encounter Volume by Service Month

Figure 4-4 through Figure 4-7 display the monthly encounter volume by service month and ICO for all encounters that occurred during the measurement year (i.e., October 1, 2021, through September 30, 2022). These figures evaluate the number of encounters that occurred by the month when the service occurred. A higher number of encounters may not indicate that members are having more encounters, but may indicate a higher number of enrolled members, which would therefore increase the number of encounters. Likewise, a lower number of encounters may not indicate that members are not seeking care, but that there are fewer enrolled members.

Figure 4-4 displays the encounter volume by service month and ICO for professional encounters. **AmeriHealth Caritas** and **Upper Peninsula Health Plan** both remained consistent throughout the measurement year, staying below 15,000 encounters a month. **Aetna Better Health of Michigan** and **Molina Healthcare of Michigan** had a small increase in encounters in the beginning of 2022, then remained relatively steady for the remainder of the measurement year. **HAP Empowered** experienced a substantial increase in encounter volume in May 2022, with the number of unique encounters more than doubling, despite the number of lines remaining consistent (not shown). This is likely due to a change in processing personal at-home services, where **HAP Empowered** changed from grouping multiple lines under one unique encounter to a separate encounter for each line. **Meridian Health Plan** had a sharp increase in encounter volume in the beginning of 2022, increasing from approximately 18,000 encounters in December 2021 to approximately 46,000 encounters in January 2022. This large increase was likely due to **Meridian Health Plan** merging with Michigan Complete Health in January 2022.

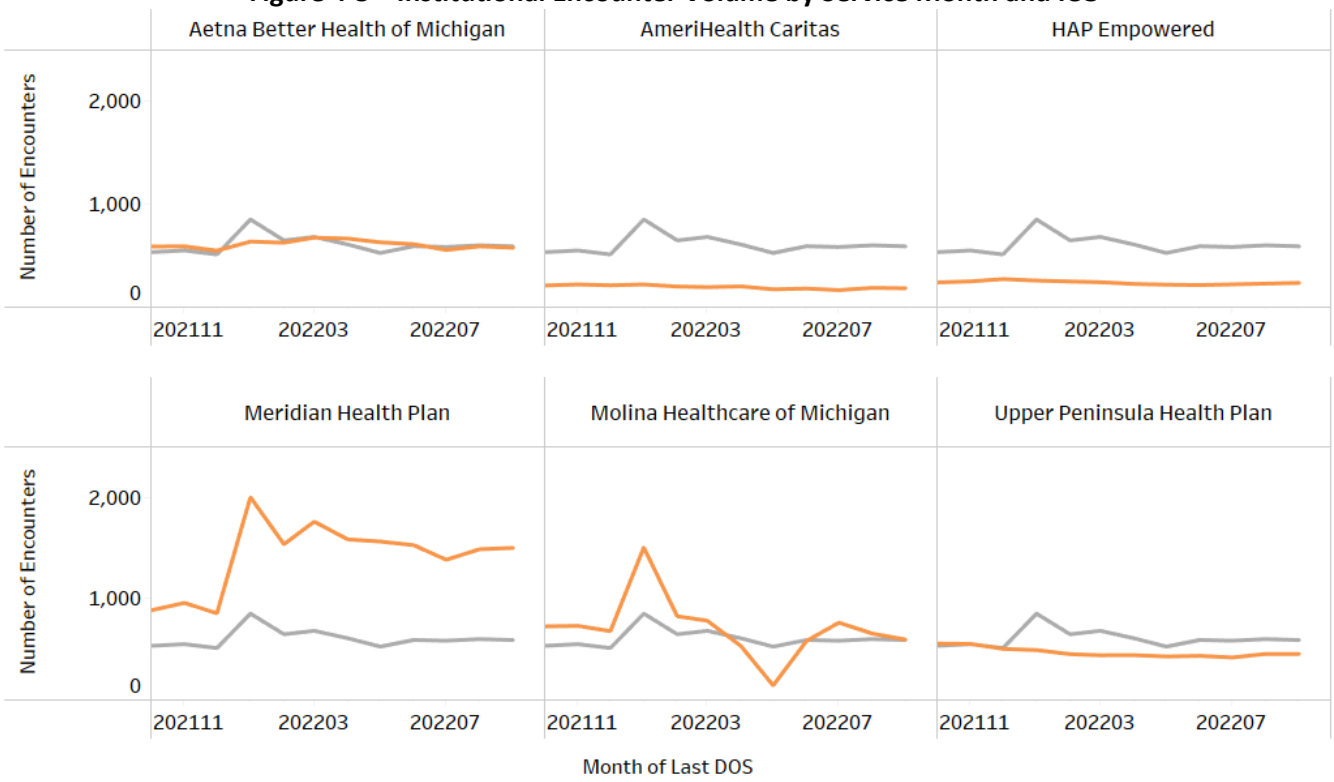
Figure 4-4—Professional Encounter Volume by Service Month and ICO



Note: The grey line indicates the all ICO rate.

Figure 4-5 displays the encounter volume by service month and ICO for institutional encounters. All ICOs, except **Meridian Health Plan** and **Molina Healthcare of Michigan**, demonstrated a relatively unchanging number of encounters throughout the measurement year. Like professional encounters, **Meridian Health Plan** had a lot of variability throughout the measurement year, likely due to the merger with Michigan Complete Health in January 2022. **Molina Healthcare of Michigan** also had variability throughout the measurement year, with a high of approximately 1,500 encounters in January 2022 and a low of approximately 150 encounters in May 2022. Throughout the measurement year, **Meridian Health Plan** had the highest number of institutional encounters and **AmeriHealth Caritas** had the lowest.

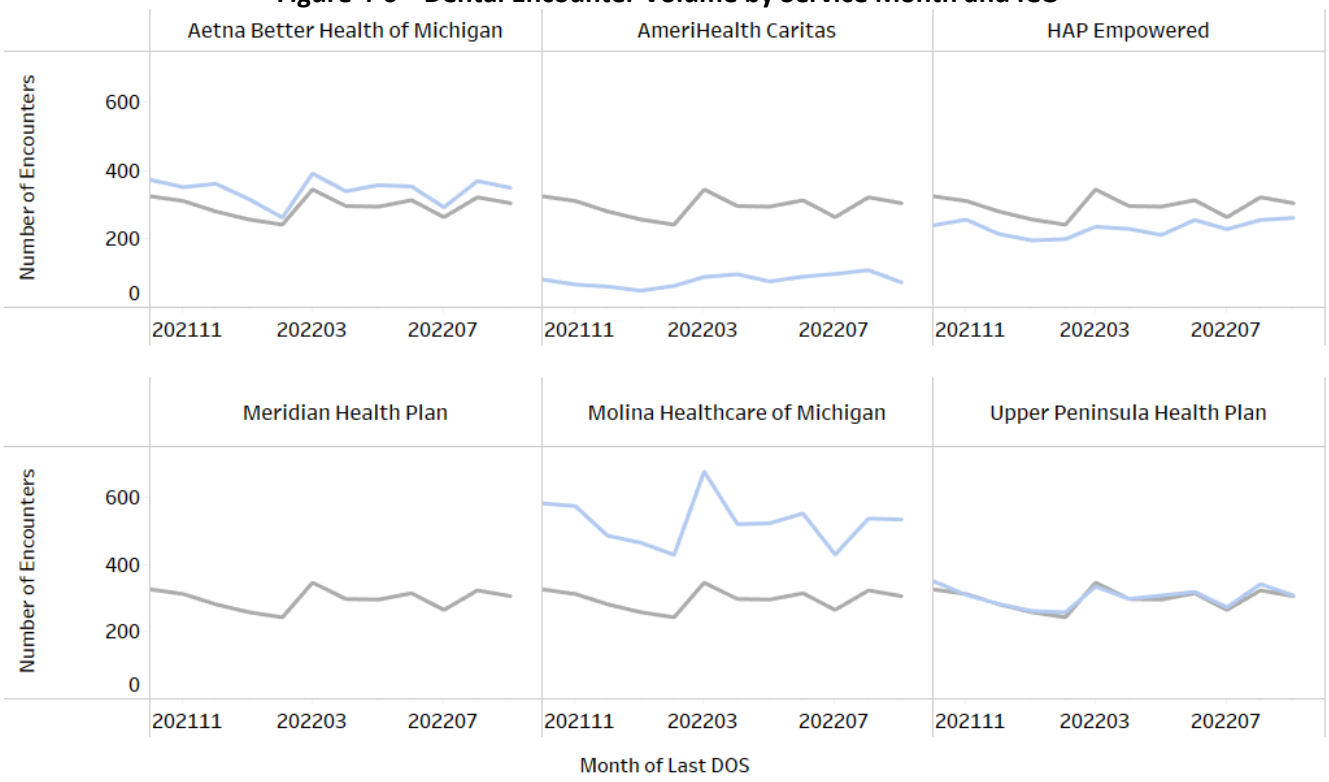
Figure 4-5—Institutional Encounter Volume by Service Month and ICO



Note: The grey line indicates the all ICO rate.

Figure 4-6 displays the encounter volume by service month and ICO for dental encounters. All ICOs showed some level of variability throughout the measurement year. **Molina Healthcare of Michigan** had the highest dental encounter volume throughout the measurement year, which aligns with **Molina Healthcare of Michigan** having the highest number of paid dental encounters out of all ICOs, as seen in Figure 4-1. **Aetna Better Health of Michigan** and **Molina Healthcare of Michigan** also experienced the most variability throughout the measurement year with multiple increases and decreases in dental encounter volume. Additionally, **AmeriHealth Caritas** and **HAP Empowered** consistently stayed below the all ICO rate, with **AmeriHealth Caritas** having the lowest number of dental encounter volume and least variability. Additionally, **Aetna Better Health of Michigan** and **Upper Peninsula Health Plan** remained close to the all ICO rate throughout the measurement year. As mentioned previously, **Meridian Health Plan** did not have dental encounter data included in this analysis due to **Meridian Health Plan** submitting its dental data marked as Medicare.

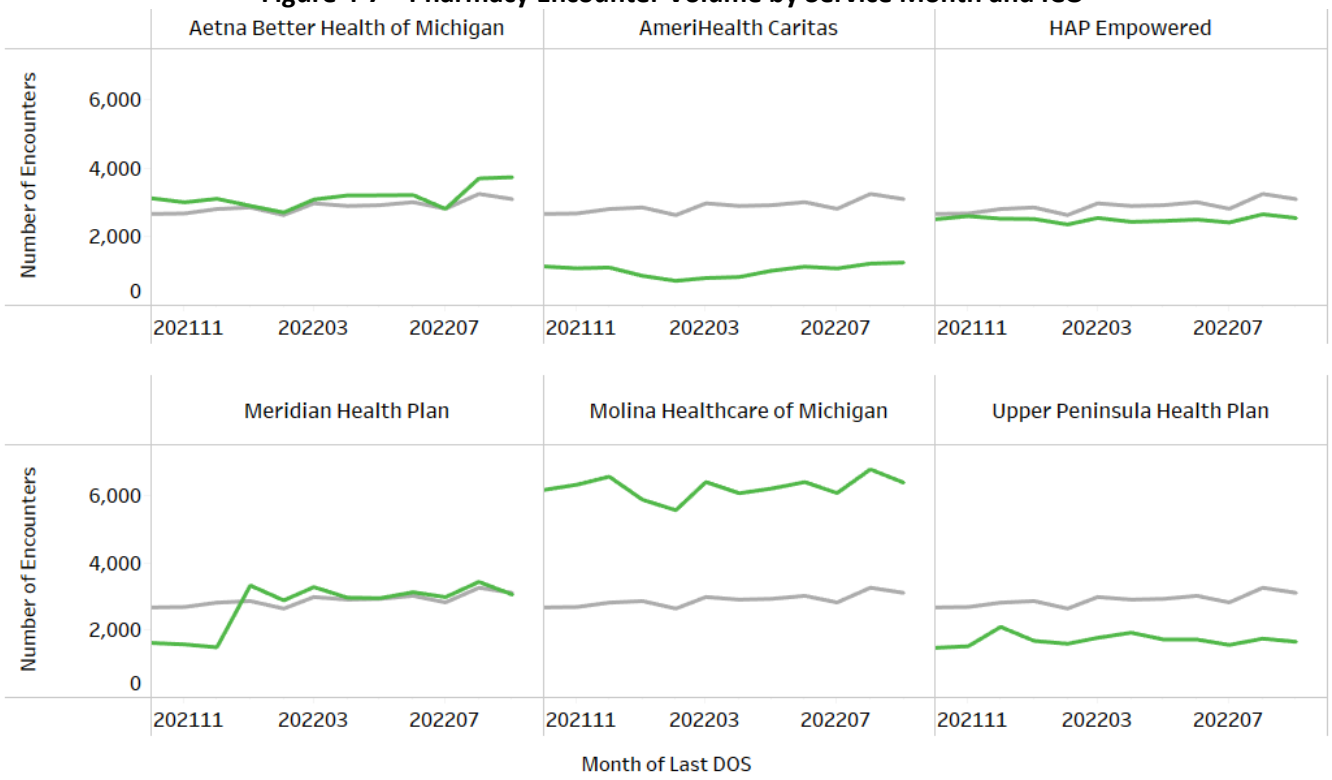
Figure 4-6—Dental Encounter Volume by Service Month and ICO



Note: The grey line indicates the all ICO rate.

Figure 4-7 displays the encounter volume by service month and ICO for pharmacy encounters. Like the dental encounter volume, **Molina Healthcare of Michigan** was consistently above the all ICO rate and had the highest pharmacy encounter volume throughout the measurement year, averaging 6,200 encounters per month. This aligns with **Molina Healthcare of Michigan** having the highest number of paid pharmacy encounters, as seen in Figure 4-1. **AmeriHealth Caritas** and **Upper Peninsula Health Plan** were consistently below the all ICO rate, with **AmeriHealth Caritas** having the lowest number of pharmacy encounter volume, averaging around 1,000 encounters a month. This also aligns with **AmeriHealth Caritas** having the lowest number of paid pharmacy encounters, also seen in Figure 4-1. Like the professional and institutional encounter volume, **Meridian Health Plan** had an increase in encounter volume in January 2022, likely due to the merger with Michigan Complete Health. **Aetna Better Health of Michigan** and **HAP Empowered** remained close to the all ICO rate throughout the measurement year.

Figure 4-7—Pharmacy Encounter Volume by Service Month and ICO



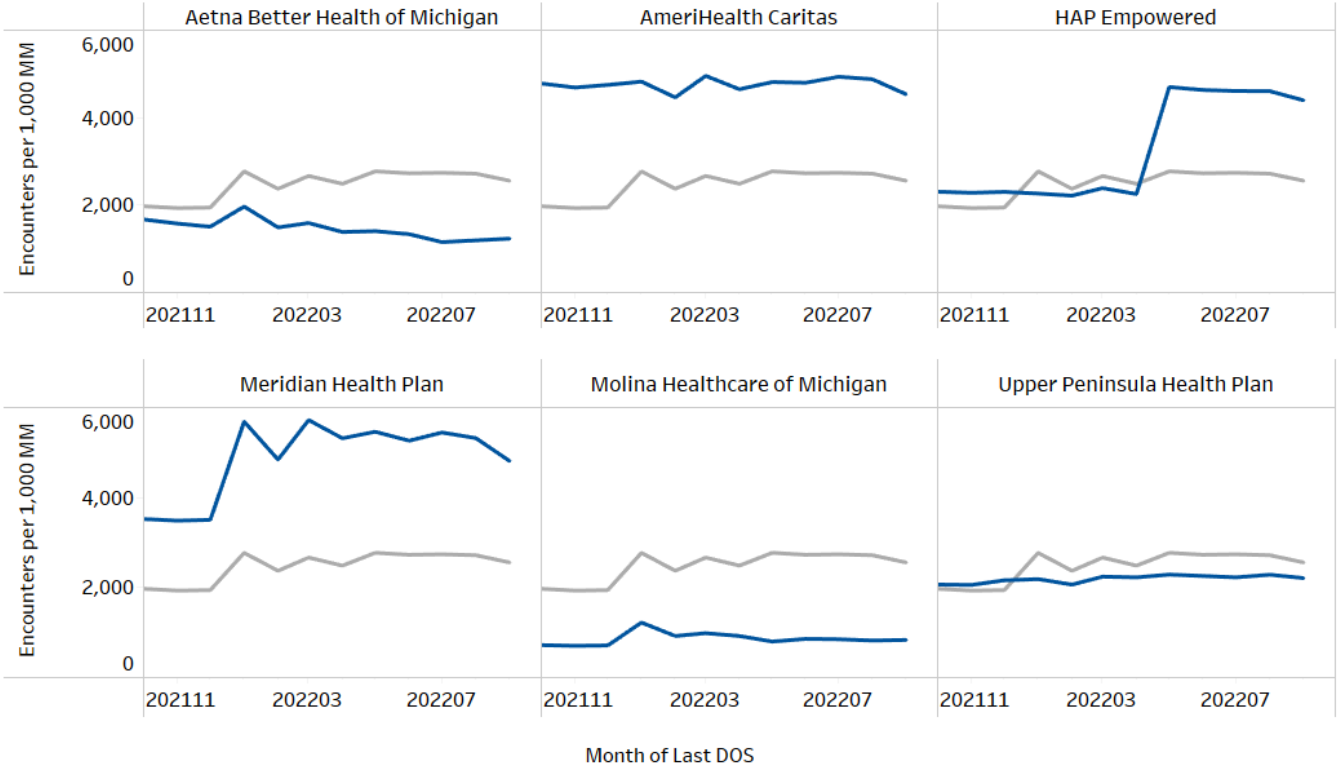
Note: The grey line indicates the all ICO rate.

Monthly Encounter Volume per 1,000 Member Months by Service Month

Figure 4-8 through Figure 4-11 display the monthly encounter volume per 1,000 MM by service month and ICO. Examining the encounter volume per 1,000 MM allows for standardization across all ICOs based on the number of enrolled members during each month.

Figure 4-8 displays the encounter volume per 1,000 MM by ICO for professional encounters. **HAP Empowered** remained consistent between October 2021 and May 2022, averaging around 2,250 encounters per 1,000 MM. However, in May 2022, **HAP Empowered** increased to slightly under 4,700 encounters per 1,000 MM. As previously discussed, this is likely due to a processing change of personal at-home services. Additionally, **Meridian Health Plan** increased in encounter volume per 1,000 MM in January 2022, which is likely due to merging with Michigan Complete Health. After the merger, **Meridian Health Plan** displayed slight variability, with decreases in encounter volume per 1,000 MM in February and April 2022. **Aetna Better Health of Michigan**, **AmeriHealth Caritas**, and **Molina Healthcare of Michigan** had slight variability in encounter volume in the beginning 2022, while **Upper Peninsula Health Plan** remained consistent throughout the measurement year. Overall, **Meridian Health Plan** and **AmeriHealth Caritas** had the highest monthly encounter volume per 1,000 MM, averaging 4,865 encounters per 1,000 MM per month, and 4,755 encounters per 1,000 MM per month, respectively. **Molina Healthcare of Michigan** had the lowest professional encounter volume per 1,000 MM, averaging slightly below 865 encounters per 1,000 MM each month.

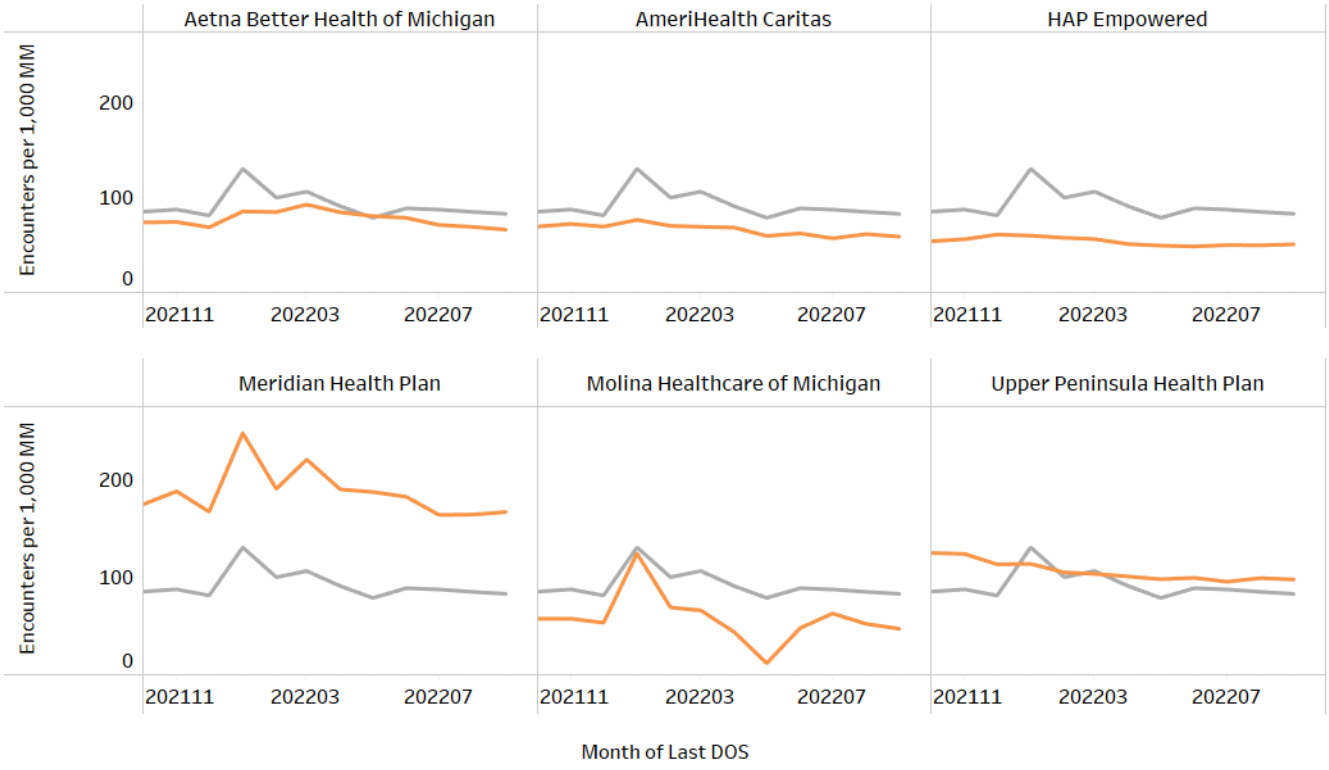
Figure 4-8—Monthly Professional Encounter Volume per 1,000 MM by ICO



Note: The grey line indicates the all ICO rate.

Figure 4-9 displays the encounter volume per 1,000 MM by ICO for institutional encounters. **Aetna Better Health of Michigan**, **AmeriHealth Caritas**, **HAP Empowered**, and **Upper Peninsula Health Plan** were relatively consistent throughout the measurement year in the number of institutional encounters per 1,000 MM per month. Despite a slight increase in the number of encounters per 1,000 MM in January 2022, **Aetna Better Health of Michigan** and **AmeriHealth Caritas** exhibited a downward trend in the number of encounters per 1,000 MM starting in early 2022, while **Upper Peninsula Health** had a slight downward trend throughout the entire measurement year. Additionally, both **Meridian Health Plan** and **Molina Healthcare of Michigan** also had an increase in the number of encounters per 1,000 MM in January 2022; however, **Meridian Health Plan**'s merger with Michigan Complete Health could be driving this increase. Overall, **Meridian Health Plan** had the highest monthly institutional encounter volume per 1,000 MM, reaching a high of nearly 250 encounters per 1,000 MM in January 2022. **Meridian Health Plan** remained, on average, approximately 95 encounters per 1,000 MM per month higher than the all ICO rate. Furthermore, **Molina Healthcare of Michigan** also had a decrease in the number of encounters per 1,000 MM between January 2022 and May 2022, dropping from around 130 encounters per 1,000 MM to 11.8 encounters per 1,000 MM.

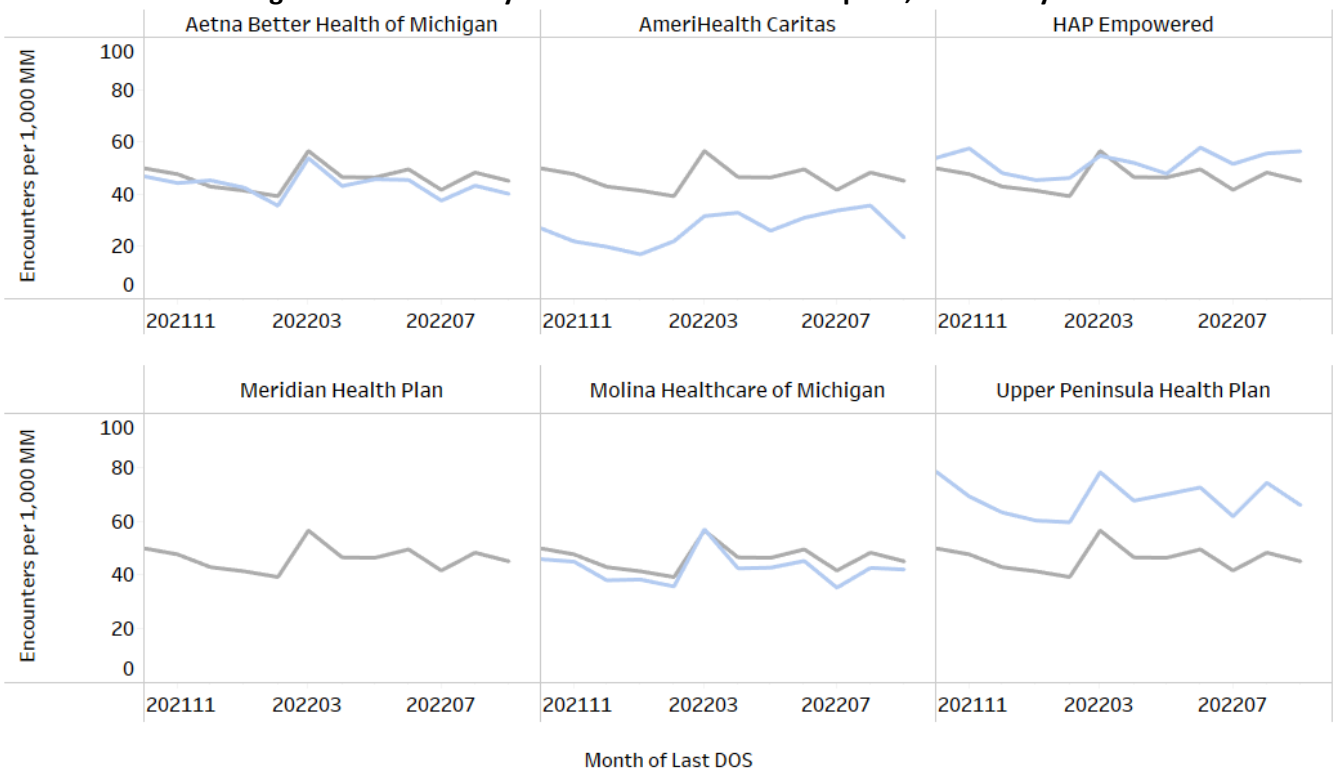
Figure 4-9—Monthly Institutional Encounter Volume per 1,000 MM by ICO



Note: The grey line indicates the all ICO rate.

Figure 4-10 displays the encounter volume per 1,000 MM by ICO for dental encounters. After adjusting for number of enrolled members, **Upper Peninsula Health Plan** had the highest number of dental encounters throughout the measurement year, averaging about 22 encounters per 1,000 MM per month more than the all ICO rate. **AmeriHealth Caritas** had the lowest number of dental encounters and averaged about 19 encounters per 1,000 MM per month less than the all ICO rate. **Aetna Better Health of Michigan**, **HAP Empowered**, and **Molina Healthcare of Michigan** remained about equal to the all ICO rate of 46 encounters per 1,000 MM per month throughout the measurement year. Overall, all ICOs showed variability throughout the measurement year, with increases in March 2022 and slight increases in August 2022.

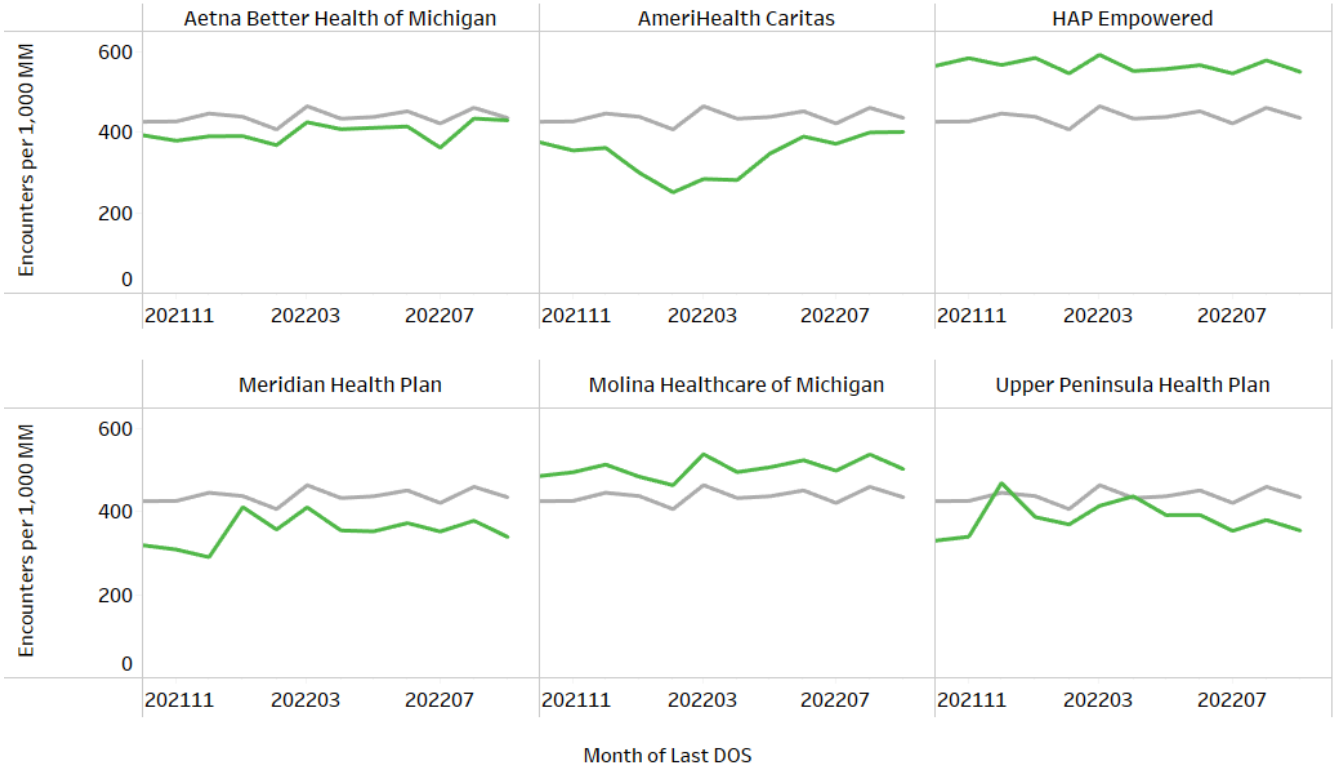
Figure 4-10—Monthly Dental Encounter Volume per 1,000 MM by ICO



Note: The grey line indicates the all ICO rate.

Figure 4-11 displays the encounter volume per 1,000 MM by ICO for pharmacy encounters. Like dental encounters, all ICOs showed variability throughout the measurement year. After adjusting for the number of enrolled members, **HAP Empowered** had the highest number of pharmacy encounters averaging about 565 encounters per 1,000 MM per month. **Molina Healthcare of Michigan** closely followed **HAP Empowered**, with an approximate average of 505 encounters per 1,000 MM per month. **AmeriHealth Caritas** had the lowest number of pharmacy encounters throughout the measurement year, with an average slightly above 340 encounters per 1,000 MM per month, with a notable a decrease in encounters in February 2022.

Figure 4-11—Monthly Pharmacy Encounter Volume per 1,000 MM by ICO



Note: The grey line indicates the all ICO rate.

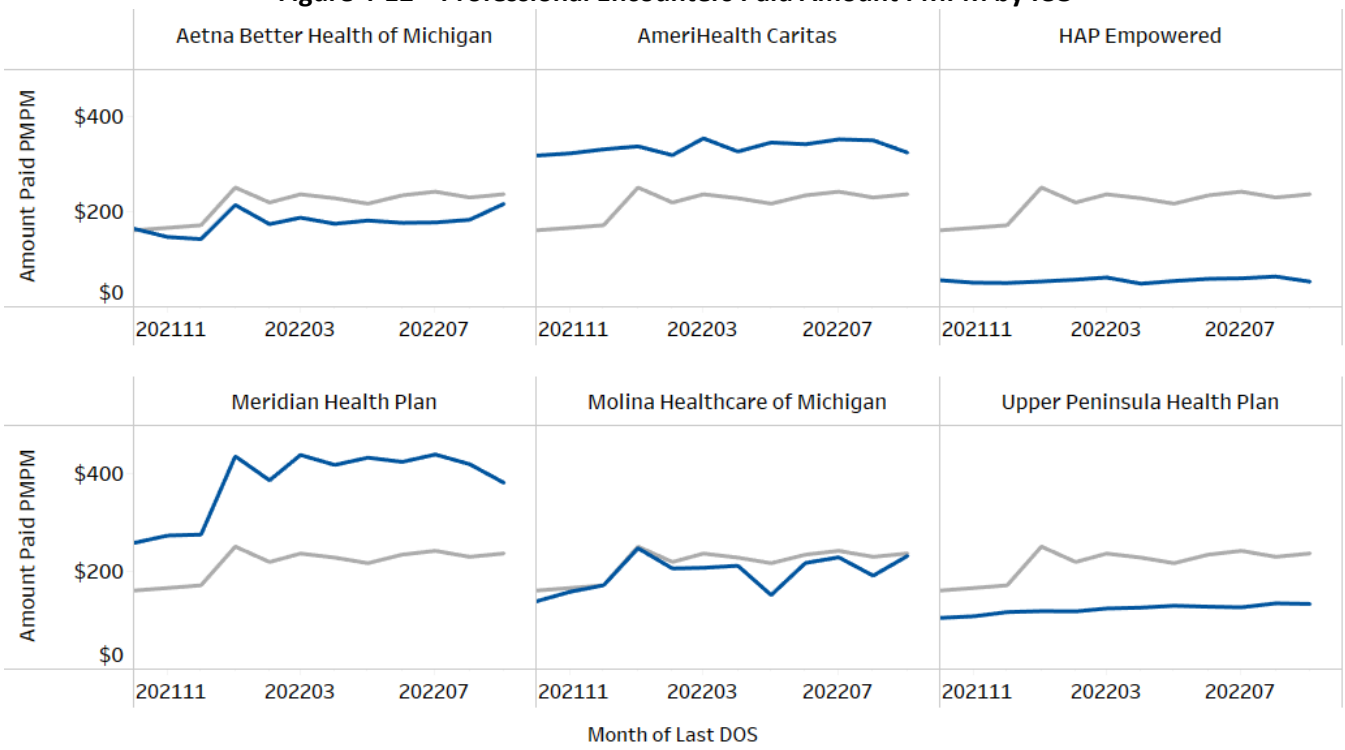
Payment Amounts Per Member Per Month

Figure 4-12 through Figure 4-15 display the monthly payment amounts PMPM by service month and ICO. Examining the paid amount PMPM allows for standardization across all ICOs based on the number of enrolled members during each month.

Figure 4-12 displays the paid amount PMPM for professional encounters across all ICOs. Like the professional volume per 1,000 MM displayed in Figure 4-8, **Meridian Health Plan** exhibited substantial variability in monthly payment amounts PMPM through the measurement year, with a low of approximately $259 in October 2021 and high of approximately $440 in January 2022. As previously mentioned, this variability is likely due to the merger with Michigan Complete Health. **Molina**

Healthcare of Michigan also had considerable variability in payment amounts PMPM ranging from about $139 in October 2021 to $251 in January 2022. **Aetna Better Health of Michigan** and **AmeriHealth Caritas** remained relatively consistent in monthly payment amounts PMPM; however, both ICOs exhibited a spike in the amount paid PMPM. **Aetna Better Health of Michigan** had an increase in January, whereas **AmeriHealth Caritas** exhibited a spike in March 2022. Additionally, **HAP Empowered** and **Upper Peninsula Health Plan** remained consistent throughout the measurement year, averaging at about $55 and $120 PMPM, respectively. Even though **HAP Empowered** experienced an increase in encounter volume in May 2022, as shown in Figure 4-8, the payment amount PMPM remained consistent. Since the increase seen in encounter volume was a result of how claims were reported rather than an increase in the number of encounters from members, **HAP Empowered** did not have an increase in payment amount PMPM.

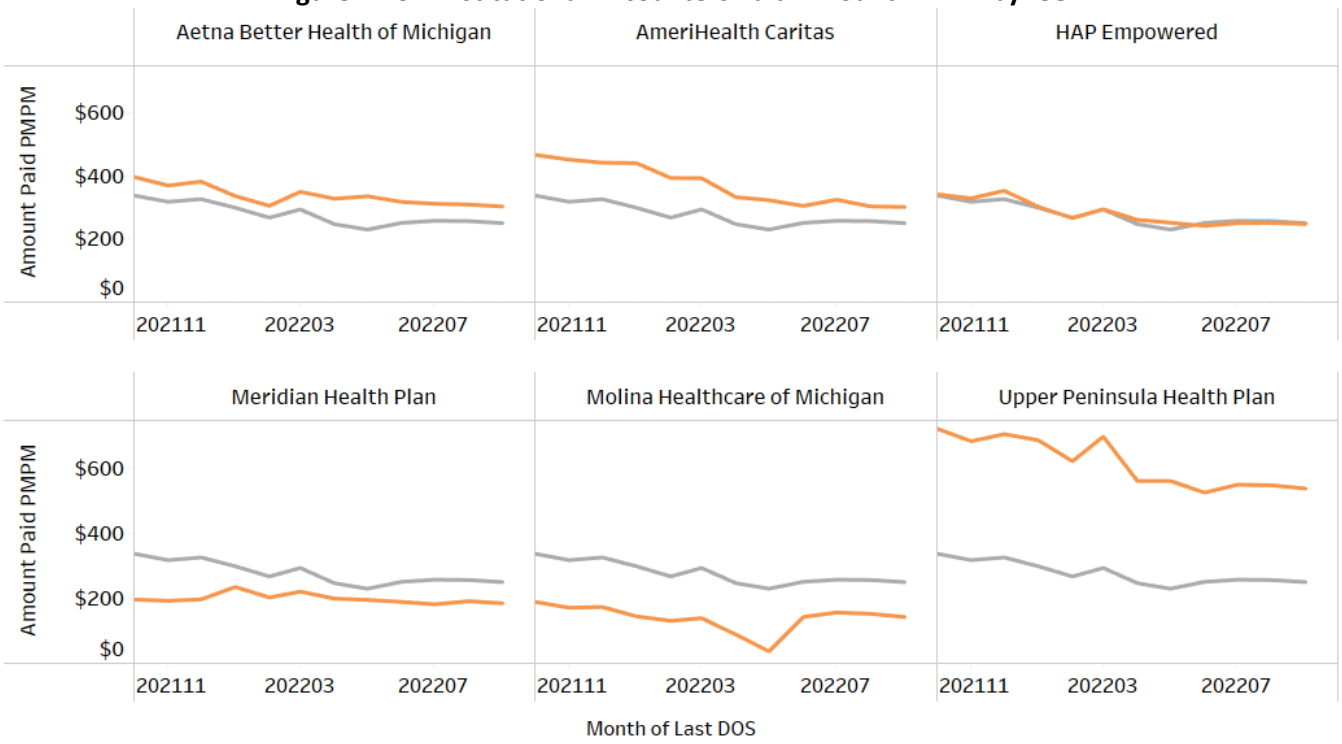
Figure 4-12—Professional Encounters Paid Amount PMPM by ICO



Note: The grey line indicates the all ICO rate.

Figure 4-13 displays the paid amount PMPM for institutional encounters across all ICOs. **Aetna Better Health of Michigan**, **AmeriHealth Caritas**, **HAP Empowered**, and **Upper Peninsula Health Plan** all displayed an overall decrease in the amount paid PMPM throughout the measurement year. From November 2021 to July 2022 the plans decreased from $397 to $304, $467 to $302, $342 to $248, and $725 to $539, respectively. **Meridian Health Plan** remained the most consistent out of all ICOs, averaging approximately $199 PMPM for each month. Additionally, despite having the highest encounter volume per 1,000 MM, **Meridian Health Plan** remained below the all ICO rate throughout the measurement year, indicating that **Meridian Health Plan** had a lower payment amount PMPM compared to other ICOs. **Molina Healthcare of Michigan** had the lowest amount paid PMPM, with a notable decrease between March 2022 and May 2022 from $139 PMPM to $37 PMPM. In June 2022, **Molina Healthcare of Michigan** increased to $143 PMPM, which aligned closely with the amount paid PMPM between October 2021 and March 2022. Interestingly, **Upper Peninsula Health Plan** had the highest amount paid PMPM for institutional encounters, despite having an encounter volume per 1,000 MM near the all ICO rate, indicating that **Upper Peninsula Health Plan** had a higher amount paid PMPM compared to other ICOs.

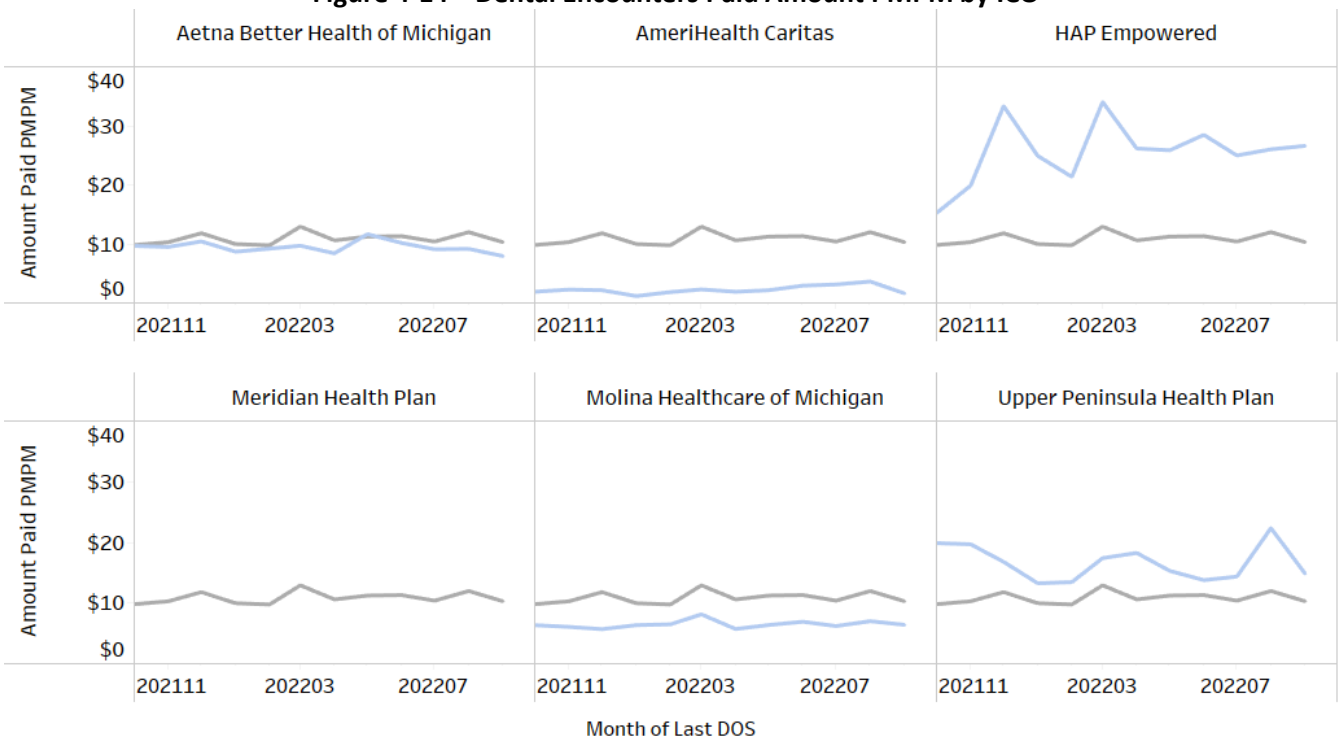
Figure 4-13—Institutional Encounters Paid Amount PMPM by ICO



Note: The grey line indicates the all ICO rate.

Figure 4-14 displays the paid amount PMPM for dental encounters across all ICOs. **Aetna Better Health of Michigan**, **AmeriHealth Caritas**, and **Molina Healthcare of Michigan** all exhibited relatively consistent payment amounts PMPM across the measurement year, averaging at about $9, $2, and $6 PMPM, respectively. Of all ICOs, **HAP Empowered** had the most variability, with fluctuating payment amounts PMPM ranging from around $15 in November 2021 to about $34 in March 2022. **Upper Peninsula Health Plan** also experienced variability throughout the measurement year, with a low of about $13 in January 2022 and a high of about $22 in August 2022.

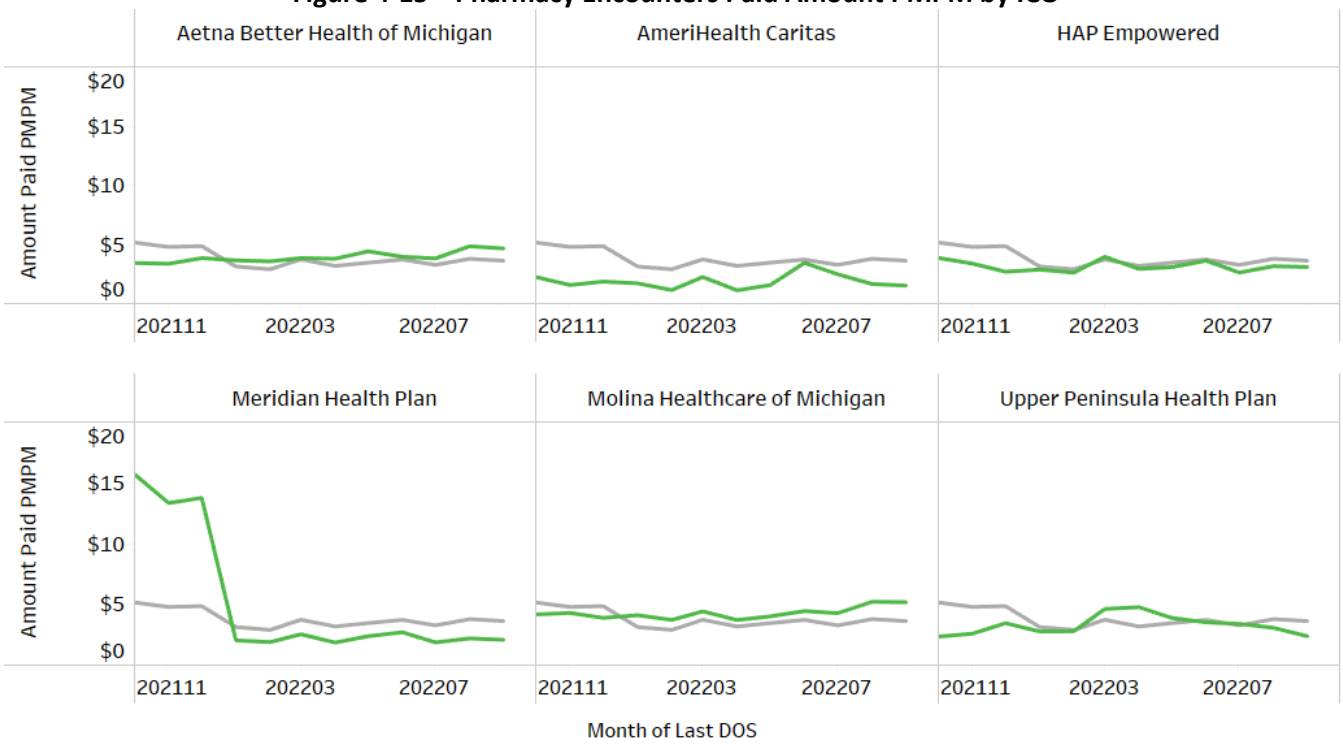
Figure 4-14—Dental Encounters Paid Amount PMPM by ICO



Note: The grey line indicates the all ICO rate.

Figure 4-15 displays the paid amount PMPM for pharmacy encounters across all ICOs. Despite **Meridian Health Plan** merging with Michigan Complete Health in January 2022, **Meridian Health Plan** exhibited a sharp decrease in the payment amounts PMPM, decreasing from approximately $14 PMPM in December 2021 to approximately $2 PMPM in January 2022. **AmeriHealth Caritas** remained below the all ICO rate, whereas **Aetna Better Health of Michigan**, **HAP Empowered**, **Molina Healthcare of Michigan**, and **Upper Peninsula Health Plan** remained about equal to the all ICO rate.

Figure 4-15—Pharmacy Encounters Paid Amount PMPM by ICO



Note: The grey line indicates the all ICO rate.

Percentage of Duplicate Encounters

Duplicate encounters may enter the system for a variety of reasons, such as encounters submitted multiple times to rectify an issue for payment. While most performance metrics used by the State, its ICOs, and its external quality review organization are robust to the presence of duplicate encounters,[4-1] identification and appropriate handling of duplicate encounters is crucial for accurate financial and actuarial calculations. HSAG assessed the percentage of records that were identified as duplicates across the fields presented in Table 4-1.

Table 4-1—Fields Used to Identify Duplicate Encounters

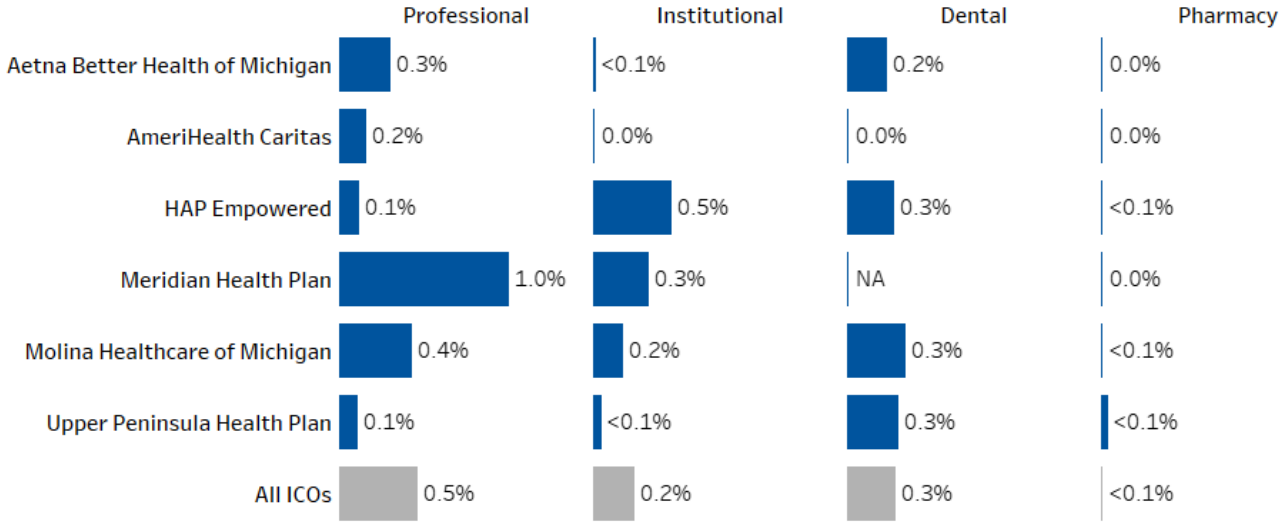
Key Data Element	Professional Encounters (837P)	Institutional Encounters (837I)	Dental Encounters (837D)	Pharmacy Encounters (NCPDP)
Member ID	✓	✓	✓	✓
Header Service From Date	✓	✓	✓	
Header Service To Date	✓	✓	✓	
Header Date of Service				✓
Line Number	✓	✓	✓	✓
Claim Type		✓		
Primary Diagnosis Code	✓	✓	✓	
CPT/HCPCS/CDT Code	✓	✓	✓	
CPT/HCPCS Modifier Codes	✓	✓		
Revenue Code		✓		
Billing Provider NPI	✓	✓	✓	
Rendering Provider NPI	✓		✓	✓
Prescribing Provider NPI				✓
Prescription Number				✓
NDC				✓

[4-1] For example, many HEDIS performance measures count whether or not members had a particular service rather than the number of services. Utilization measures that *do* count the number of services typically count multiple claims for the same service on the same day as a single service, thereby effectively removing duplicate claims.

For this analysis, the original claim in a series of duplicates was not counted as a duplicate. For example, if three encounters were identified as duplicates (i.e., the values of all fields in Table 4-1 matched), then the number of duplicates counted was two, as one was counted for the original claim leaving two duplicates remaining.

Figure 4-16 displays the percentage of duplicate encounters for each ICO and the aggregate result for all ICOs for all categories of service. Across each category of service, professional encounters had the highest rate of duplicates identified, with an all ICO rate of 0.5 percent. **HAP Empowered** and **Upper Peninsula Health Plan** had the lowest percentage of professional duplicate encounters (0.1 percent), whereas **Meridian Health Plan** had the highest (1.0 percent). For institutional encounters, less duplicative encounters were identified, with an all ICO rate of 0.2 percent. **AmeriHealth Caritas** had the lowest percentage of institutional duplicate encounters (0.0 percent), whereas **HAP Empowered** had the highest (0.5 percent). The all ICO rate of duplicate dental encounters was 0.3 percent, and like institutional encounters, **AmeriHealth Caritas** also had the lowest percentage of duplicate encounters (0.0 percent). Lastly, pharmacy encounters had the lowest percentage of duplicate encounters identified, with all ICOs having less than 0.1 percent of encounters identified as duplicative. **Aetna Better Health of Michigan**, **AmeriHealth Caritas**, and **Meridian Health Plan** each had 0.0 percent of pharmacy encounters identified as duplicative.

Figure 4-16—Percentage of Duplicate Encounters by Category of Service and ICO



Encounter Data Timeliness

To validate encounter data timeliness, HSAG examined encounter data volume through multiple angles across two primary metrics. HSAG stratified each of the following metrics by ICO and category of service (professional, institutional, dental, and pharmacy):

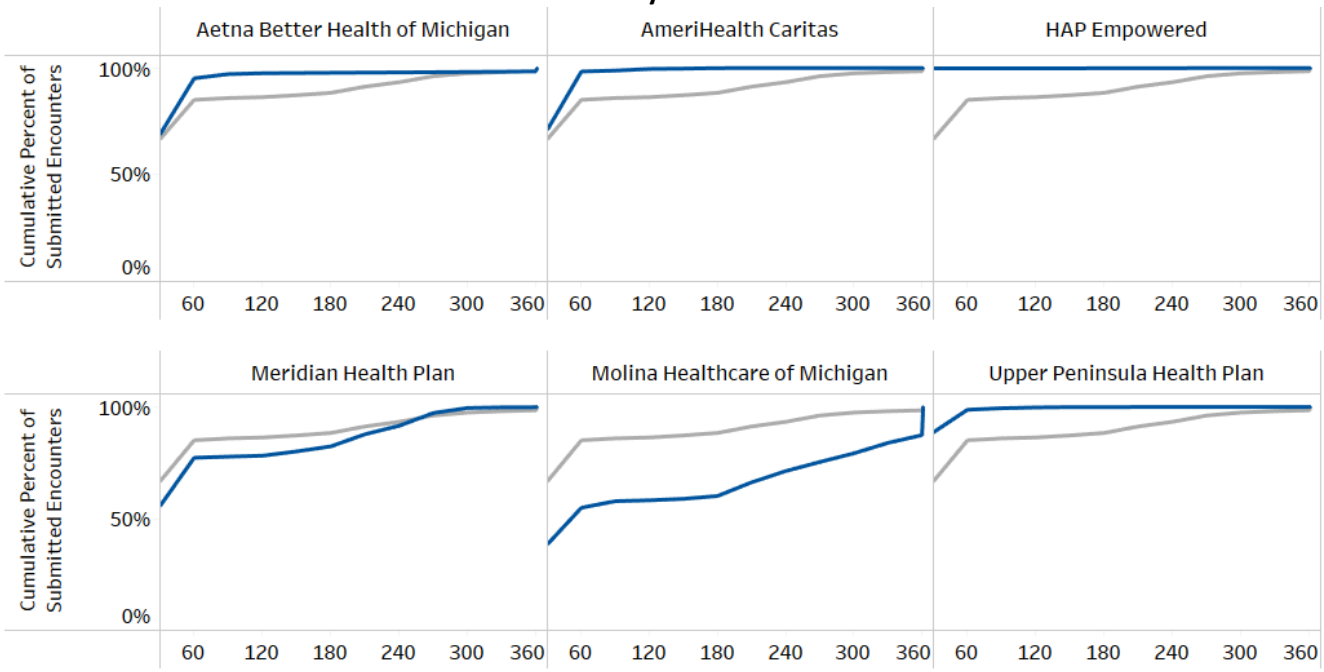
- Percentage of encounters received by MDHHS within 360 days from the ICO payment date, in 30-day increments.
- Claims lag triangle to illustrate the percentage of encounters received by MDHHS two months, three months, …, and such from the service month. For conciseness, lag triangles are presented for each ICO in appendices D through I.

Lag Between ICO Payment Date and Submission to MDHHS

Figure 4-17 through Figure 4-20 as well as Table 4-2 and Table 4-3 show the cumulative percentage of encounters submitted within 360 days to MDHHS from the ICO payment date, in 30-day increments, for each ICO by category of service. Encounters where the submission date was prior to the payment date were not included in the cumulative percentage since the amount of time between payment date and submission date would be a negative value. Additionally, encounters were not included in the cumulative percentage if either the payment date or the submission date were missing since the amount of time between the two dates could not be calculated. If an ICO had any encounters that fell into either criterion, the cumulative percentage would not equal 100 percent. For example, if an ICO had 5 percent of encounters where the submission date occurred prior to the payment date and 3 percent of encounters that were missing either date field, then the cumulative percentage would reach a max of 92 percent (i.e., a total of 8 percent of encounters were not included in the analysis). For any categories of service where an ICO had any encounters that fell into one of the two criteria, a table is displayed to indicate the percentage of encounters that were not included. ICO-specific results can be found in appendices D through I.

Figure 4-17 shows the percentage of professional encounters submitted within 360 days from the ICO payment date, in 30-day increments, by ICO. All ICOs reached 100 percent of professional encounters submitted at varying time frames. **Molina Healthcare of Michigan** had the lowest percentage of encounters submitted (38.4 percent) within 30 days of payment, compared to **HAP Empowered**, which had the highest percentage (99.8 percent). **Aetna Better Health of Michigan**, **AmeriHealth Caritas**, **HAP Empowered**, and **Upper Peninsula** had greater than 95 percent of encounters submitted within 60 days. **Meridian Health Plan** and **Molina Healthcare of Michigan** took substantially longer to process at least 95 percent of encounters submitted (270 days and more than 360 days, respectively).

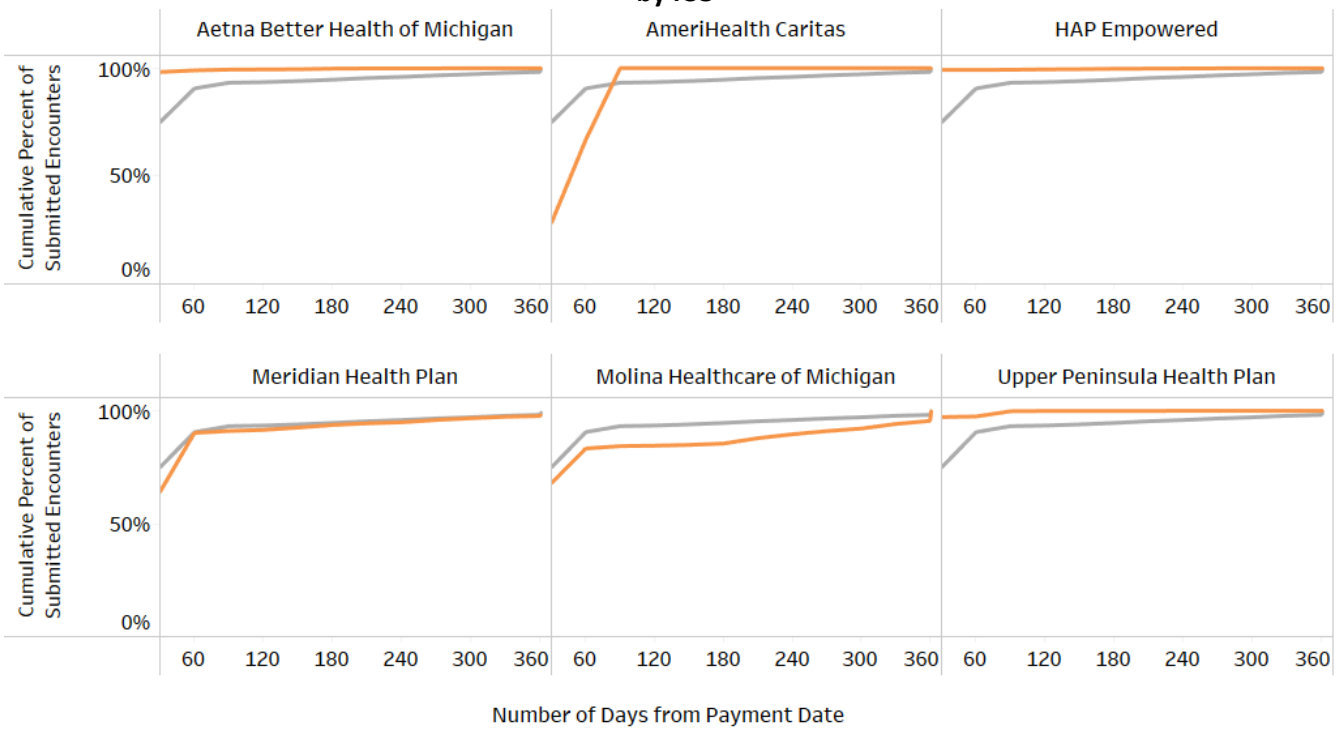
Figure 4-17—Cumulative Percentage of Professional Encounters Submitted to MDHHS From ICO Payment Date by ICO



Note: The grey line indicates the all ICO rate.

Figure 4-18 and Table 4-2 show the percentage of institutional encounters submitted within 360 days from the ICO payment date, in 30-day increments, by ICO. **Aetna Better Health of Michigan**, **HAP Empowered**, and **Upper Peninsula Health Plan** all had above 97 percent of institutional encounters submitted within 30 days of payment, while **AmeriHealth Caritas** had 28.2 percent. However, **AmeriHealth Caritas** quickly increased to 100 percent of submitted institutional encounters within 90 days of payment date. **Meridian Health Plan** and **Molina Healthcare of Michigan** did not reach above 95 percent of encounters submitted until 270 and 360 days, respectively. **Meridian Health Plan** never reached 100 percent of encounters submitted to MDHHS (98.2 percent after 360 days), due to having 1.8 percent of encounters missing a paid or submission date.

Figure 4-18—Cumulative Percentage of Institutional Encounters Submitted to MDHHS From ICO Payment Date by ICO



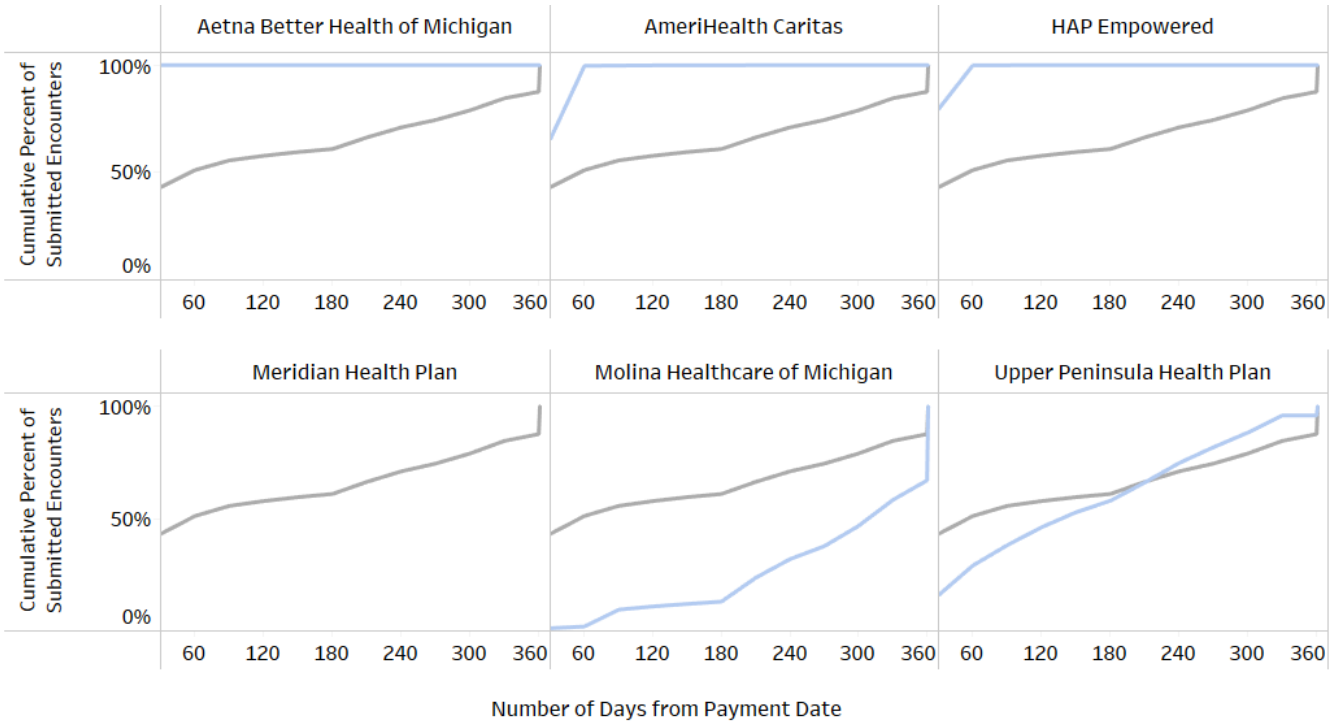
Note: The grey line indicates the all ICO rate.

Table 4-2—Completeness of Institutional Encounters by ICO

ICO	Submitted Prior to Paid Date	Missing Paid or Submission Date
Aetna Better Health of Michigan	0.0%	0.0%
AmeriHealth Caritas	0.0%	0.0%
HAP Empowered	0.0%	0.0%
Meridian Health Plan	0.0%	1.8%
Molina Healthcare of Michigan	0.0%	0.0%
Upper Peninsula Health Plan	0.0%	0.0%

Figure 4-19 shows the percentage of dental encounters submitted within 360 days from the ICO payment date, in 30-day increments, by ICO. **Molina Healthcare of Michigan** had the lowest percentage of dental encounters submitted within 30 days, at 1.2 percent, followed by **Upper Peninsula Health Plan** at 15.9 percent. **Aetna Better Health of Michigan** reached 100 percent of encounters submitted within 30 days and **AmeriHealth Caritas** and **HAP Empowered** both reached greater than 99 percent within 60 days. **Molina Healthcare of Michigan** and **Upper Peninsula Health Plan** took substantially longer to reach 100 percent of encounters submitted (after 360 days).

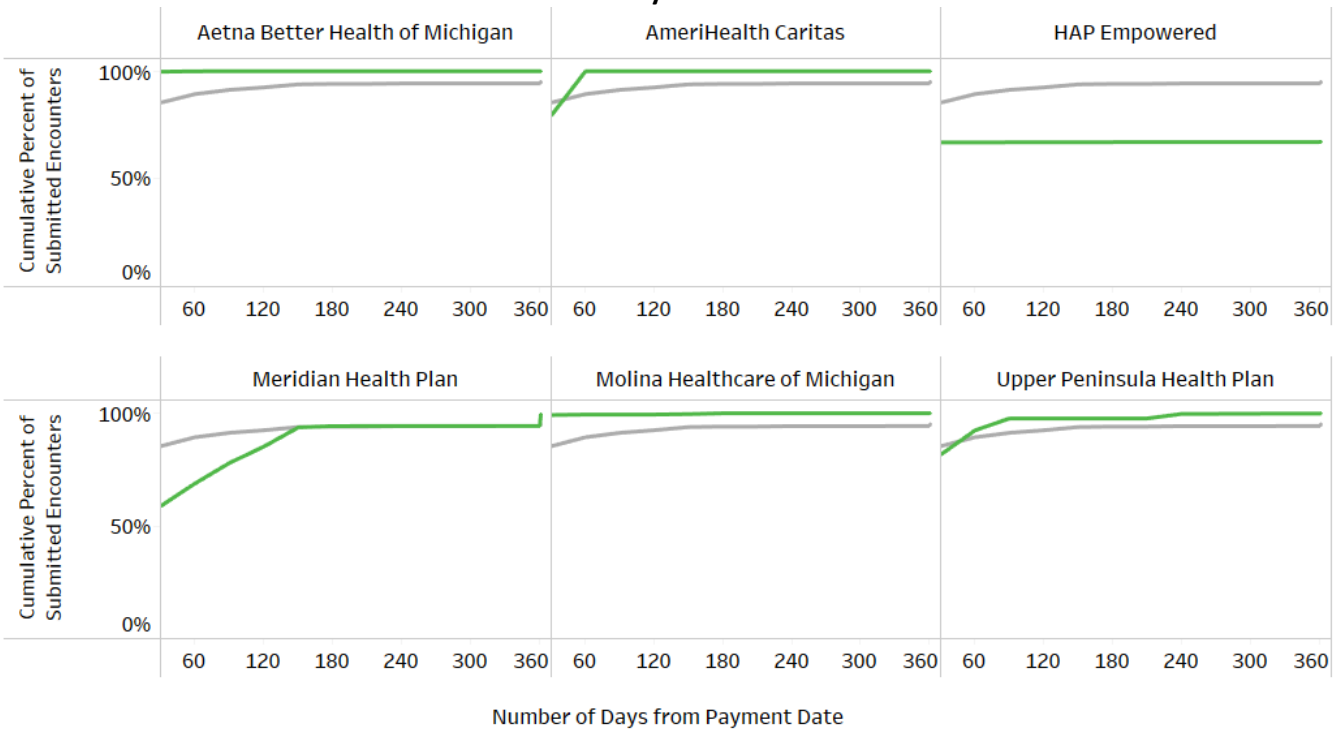
Figure 4-19—Cumulative Percentage of Dental Encounters Submitted to MDHHS From ICO Payment Date by ICO



Note: The grey line indicates the all ICO rate.

Figure 4-20 and Table 4-3 show the percentage of pharmacy encounters submitted within 360 days of the ICO payment date, in 30-day increments, by ICO. **Aetna Better Health of Michigan** and **Molina Healthcare** had over 99 percent of pharmacy encounters submitted within 30 days, with **AmeriHealth Caritas** closely following and reaching 100 percent within 60 days. **Upper Peninsula Health Plan** reached over 97 percent within 90 days. **Meridian Health Plan** had the lowest percentage of encounters submitted within 30 days (58.8 percent) and then remained stationary at approximately 94 percent from 150 days to 360 days. **Meridian Health Plan** reached above 99 percent after 360 days, but did not reach 100 percent due to 0.4 percent of encounters missing a paid or submission date. **HAP Empowered** remained steady throughout the study period, with approximately 67 percent of encounters submitted. **HAP Empowered** never reached 100 percent due to 32.8 percent of encounters being submitted prior to the paid date.

Figure 4-20—Cumulative Percentage of Pharmacy Encounters Submitted to MDHHS From ICO Payment Date by ICO



Note: The grey line indicates the all ICO rate.

Table 4-3—Completeness of Pharmacy Encounters by ICO

ICO	Submitted Prior to Paid Date	Missing Paid or Submission Date
Aetna Better Health of Michigan	0.0%	0.0%
AmeriHealth Caritas	0.0%	0.0%
HAP Empowered	32.8%	0.0%
Meridian Health Plan	0.0%	0.4%
Molina Healthcare of Michigan	0.0%	0.0%
Upper Peninsula Health Plan	0.0%	0.0%

Encounter Data Lag Triangles

To fully assess encounter data completeness and identify any patterns or idiosyncrasies in data submission, HSAG examined lag triangles, which relate the month of service to the month of submission to MDHHS. Separate lag triangles were created for each ICO and category of service, and full results for each ICO and category of service are presented in appendices D through I. These results can be used to provide additional details pertaining to data completeness, encounter volume, and encounters PMPM.

Field-Level Completeness and Accuracy

HSAG evaluated whether the data elements in the final paid encounters are complete and accurate through the two study indicators described in Table 2-2 for the key data elements listed in Table 2-3. In addition, Table 2-3 shows the criteria HSAG used to evaluate the validity for each data element. These criteria are based on standard reference code sets.

Figure 4-21 through Figure 4-24 provide the percentage of encounters that are present and contain valid values for key data elements across all ICOs. ICO-specific results are shown in each ICO-specific appendix. Percent present was calculated only for fields that were applicable to appropriate claim types (e.g., calculations exclude diagnosis codes from pharmacy encounters or attending provider from professional encounters). Similarly, percent valid was only calculated for fields in which values were populated. For instance, Figure 4-21 shows 58.6 percent of all ICO professional encounters contained a billing provider NPI, but 100 percent of those contained valid values. However, CPT/HCPCS codes with PTP edits only apply to a subset of encounters. In this measure, the percent present are the number of present and valid values before applying the PTP edits. For example, since PTP edits can only be applied to valid CPT/HCPCS codes for the applicable subset of the data, the percent present displays the CPT/HCPCS codes which are valid (i.e., the CPT/HCPCS code is in a reference database) for the applicable subset of the data. The percent valid for this measure indicates the percentage of CPT codes that are present and valid via the reference database that also pass the PTP edit criteria.

Figure 4-21 shows the aggregate result of all ICOs for the percent present and percent valid values of key data elements for professional encounters. Over two-thirds (14 of 20) of the key data elements were 100 percent present, and the remaining key data elements are not required to be present on all professional encounters (e.g., Billing Provider NPI, Rendering Provider NPI, Referring Provider NPI, Rendering Provider Taxonomy Code, Secondary Diagnosis Codes, Surgical Procedure Codes, and NDCs). While there is no set requirement for provider NPI data elements to be present, the percentage of NPI fields populated is lower than expected. The Billing Provider NPI had an all ICO rate of 58.6 percent, and results varied across ICOs, ranging from 21.4 percent (**Aetna Better Health of Michigan**) to 94.0 percent (**AmeriHealth Caritas**). However, all data elements that were populated were greater than 96 percent valid, with the majority over 99 percent valid. The Header TPL Paid Amount was slightly lower than the rest of the data elements at 96.2 percent valid, but MDHHS does not expect all header payment amounts to meet the validity requirements outlined in Table 2-3; therefore, these results are expected.

Figure 4-21—Key Professional Encounter Data Elements—All ICOs

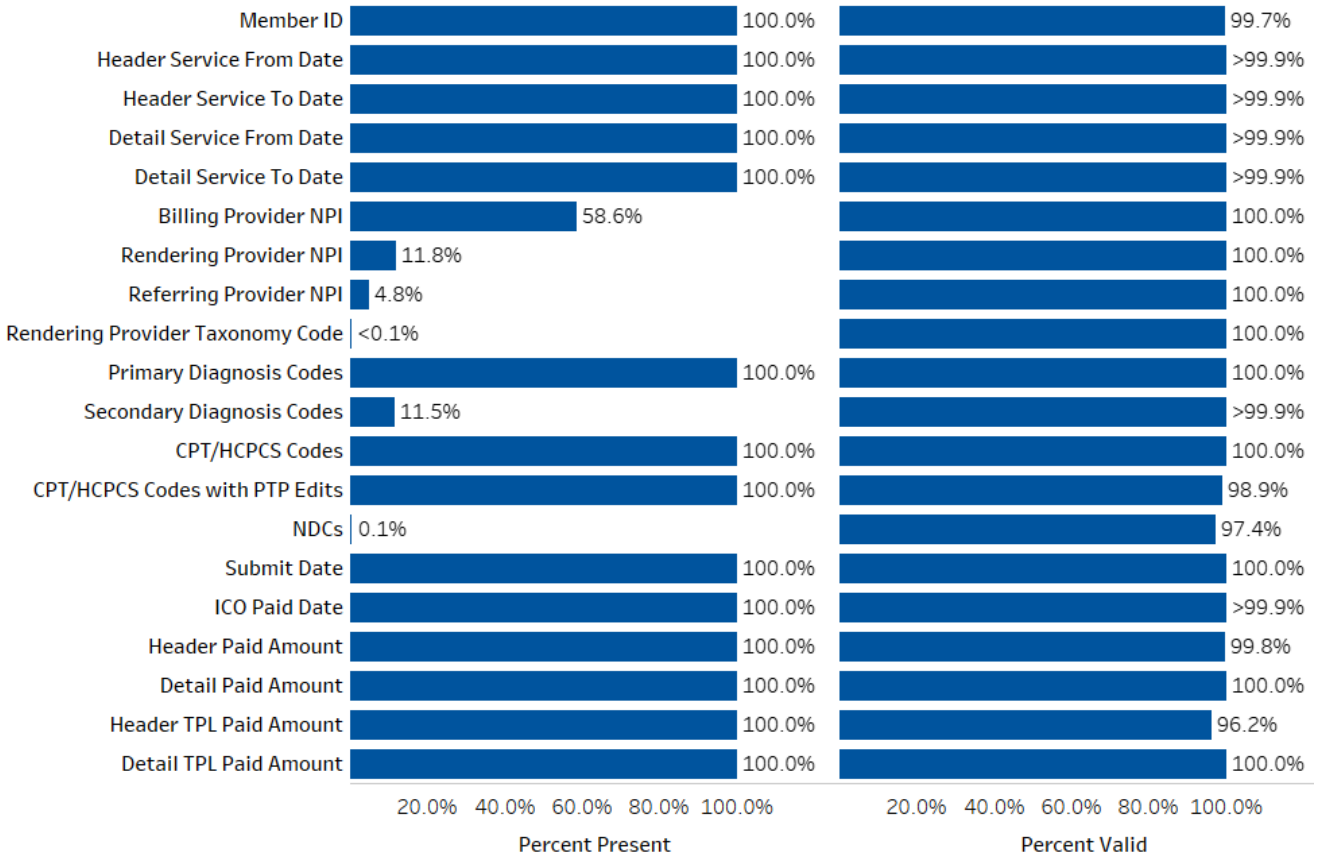


Figure 4-22 shows the aggregate result of all ICOs for the percent present and percent valid values of key data elements for institutional encounters. About two-thirds (17 of 25) of all key data elements were greater than 98 percent populated. All other key data elements were not expected to be present on all institutional encounters (e.g., Referring Provider NPI, Attending Provider Taxonomy Code, Secondary Diagnosis Codes, CPT/HCPCS Codes, Primary And Secondary Surgical Procedure Codes, DRG Codes, and NDCs). CPT/HCPCS Codes were 63.0 percent populated across all ICOs, ranging from 14.5 percent (**HAP Empowered**) to 76.4 percent (**Meridian Health Plan**), which is slightly lower than expected. All data elements that were populated were greater than 97 percent valid, except CPT/HCPCS Codes with PTP Edits, which was valid 93.1 percent of the time.

Figure 4-22—Key Institutional Encounter Data Elements—All ICOs

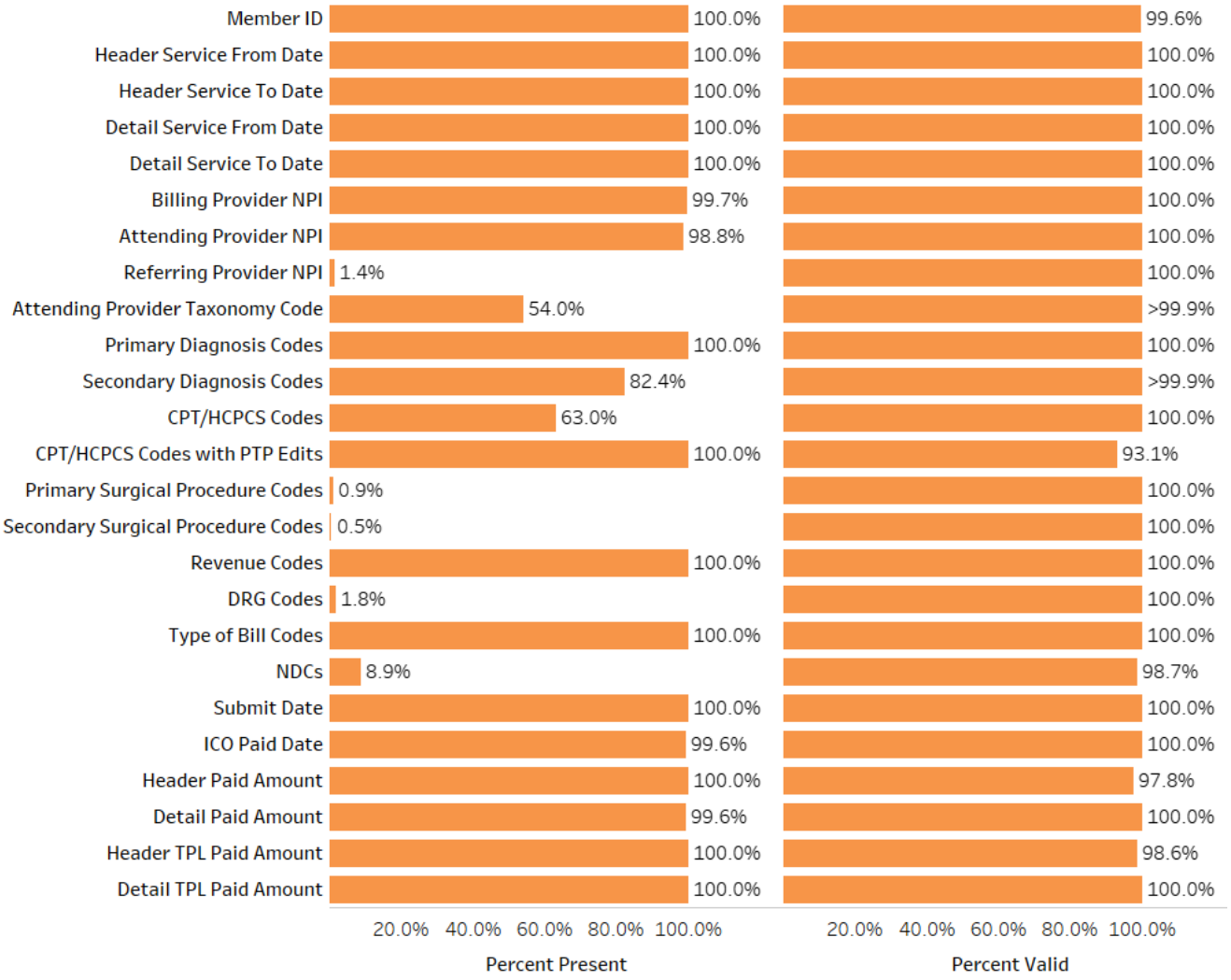


Figure 4-23 shows the aggregate result of all ICOs for the percent present and percent valid values of key data elements for dental encounters. Over half (13 of 20) of all key data elements were greater than 99 percent populated. The other key data elements were not expected to be present on all dental encounters (e.g., Rendering Provider NPI, Referring Provider NPI, Rendering Provider Taxonomy Code, Primary Diagnosis Codes, Tooth Number, Tooth Surface 1–5, and Oral Cavity Code). All data elements that were populated over 99 percent valid.

Figure 4-23—Key Dental Encounter Data Elements—All ICOs

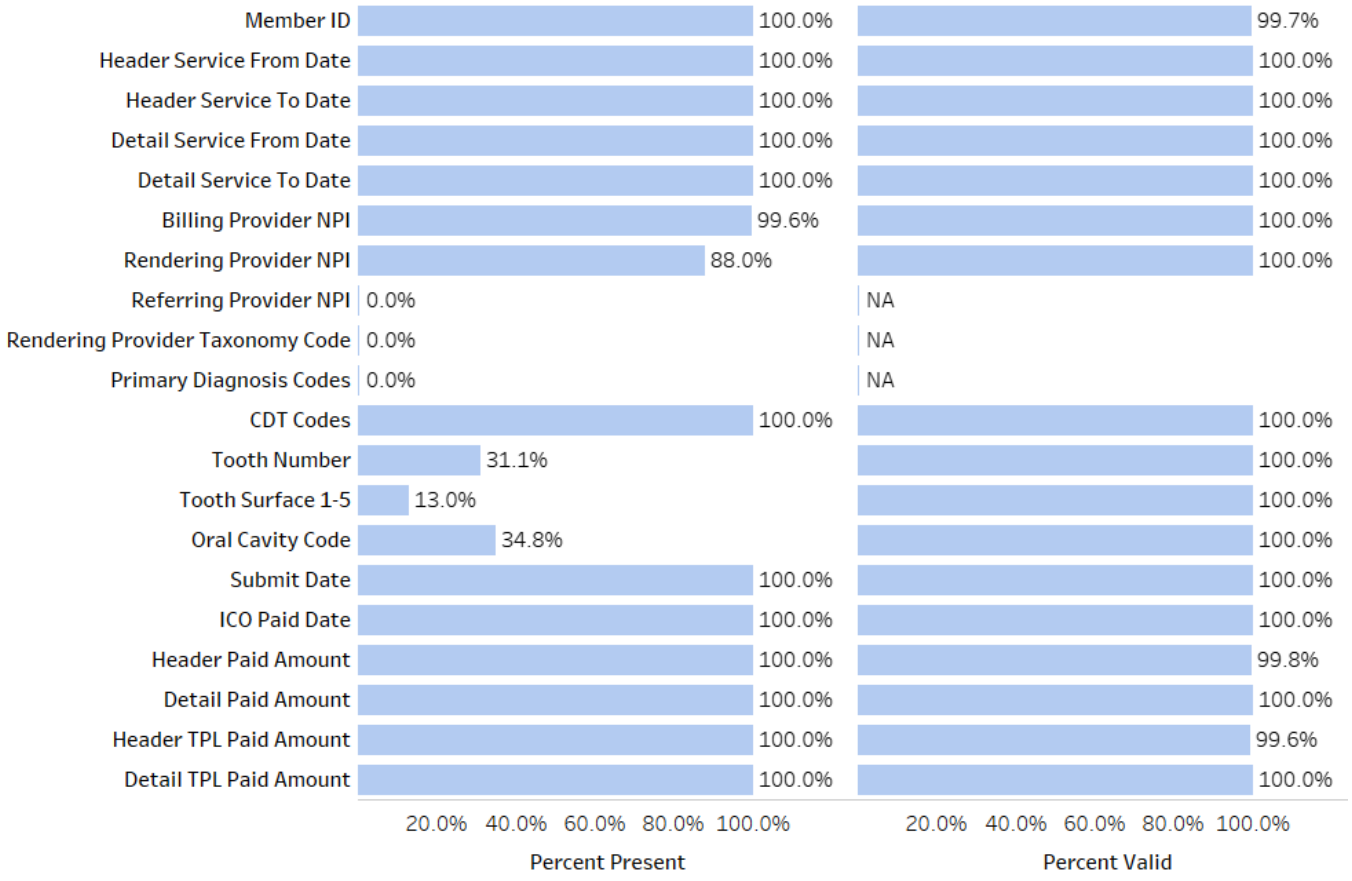
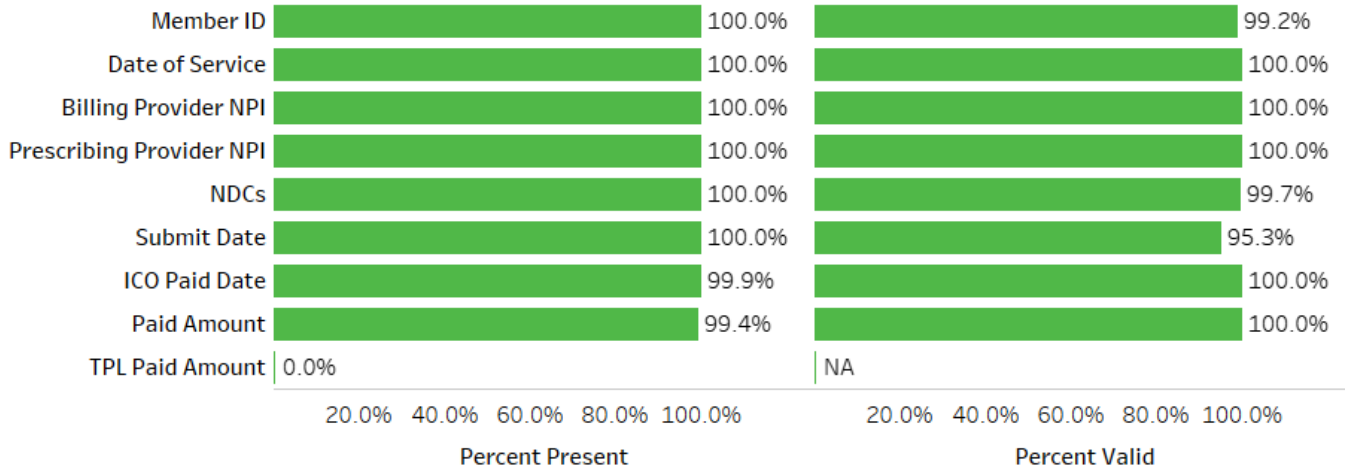


Figure 4-24 shows the aggregate result of all ICOs for the percent present and percent valid values of key data elements for pharmacy encounters. All key data elements expected to be populated were above 99 percent present. TPL Paid Amount, which was populated 0.0 percent of the time, was not expected to be present. All key data elements were over 99 percent valid, except Submit Date, which was 95.3 percent valid.

Figure 4-24—Key Pharmacy Encounter Data Elements—All ICOs



Encounter Referential Integrity

Referential integrity is critical for conducting many analyses involving claims/encounter data, as key identifiers are often joined across multiple tables. For instance, member enrollment data must be joined with encounter data when calculating HEDIS performance measures to ensure members meet continuous enrollment criteria. Likewise, provider data must be joined with encounter data to identify visits with specific provider types (e.g., primary care provider [PCP], obstetrician/gynecologist [OB/GYN], or ophthalmologist).

HSAG examined a bidirectional referential integrity across the files and key identifiers outlined in Table 4-4.

Table 4-4—Referential Integrity Checks

Field	File 1	File 2
Member ID	Medical/Dental Encounters	Enrollment
Member ID	Enrollment	Medical/Dental Encounters
Member ID	Pharmacy Encounters	Enrollment
Member ID	Enrollment	Pharmacy Encounters
Member ID	Medical/Dental Encounters	Pharmacy Encounters
Member ID	Pharmacy Encounters	Medical/Dental Encounters
Provider NPI	Medical/Dental Encounters	Provider

Field	File 1	File 2
Provider NPI	Provider	Medical/Dental Encounters
Prescribing Provider NPI	Pharmacy Encounters	Provider
Prescribing Provider NPI	Provider	Pharmacy Encounters

Figure 4-25 through Figure 4-29 display the referential integrity results by ICO. In each figure, the direction 1 results compare the encounter data to the source file, either the enrollment file or the provider file. Since all member IDs and provider NPIs are expected to be in these files, respectively, the direction 1 results are expected to be 100 percent. The direction 2 results look at the reverse of direction 1, comparing the percentage of members in the enrollment data or providers in the provider file who were in the encounter data. Since it is not expected that all members will have an encounter or all contracted providers actively provide services to Medicaid members, these results are expected to be lower. Across all figures, a medical encounter is defined as either a professional or institutional encounter.

Figure 4-25 displays the referential integrity for member ID between the enrollment and the medical/dental encounter files for each ICO and the aggregate rate for all ICOs. In direction 1, the percentage of members with a medical/dental encounter who were also in the enrollment file, each ICO had strong referential integrity with greater than a 99 percent match. When examining the reverse, **Meridian Health Plan** had the highest number of members who were enrolled with a medical/dental encounter (82.1 percent), while **AmeriHealth Caritas** had the lowest (47.4 percent). About seven in 10 ICO members had either a professional, institutional, or dental encounter.

Figure 4-25—Referential Integrity Comparison Between Enrollment and Medical/Dental Encounter Files

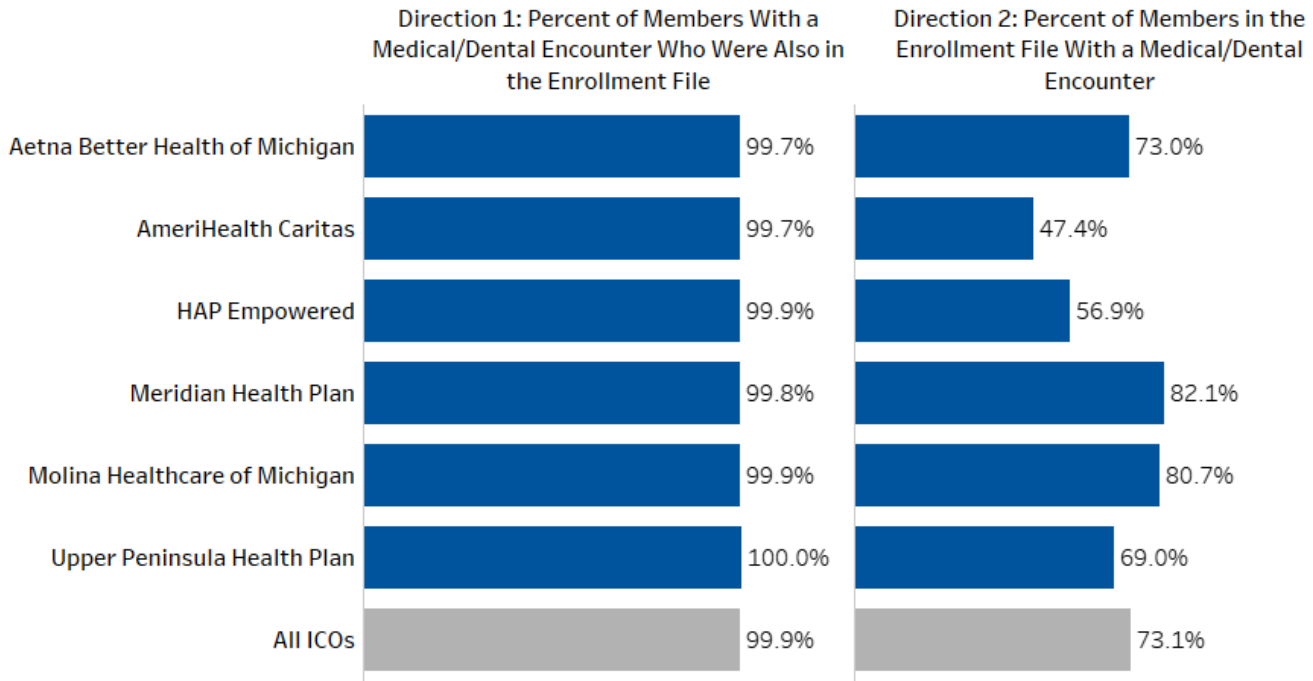


Figure 4-26 compares the referential integrity between the enrollment and pharmacy encounter files. Across all ICOs, more than 99 percent of members with a pharmacy encounter were also in the enrollment file. In direction 2, the percentage of members in the enrollment file with a pharmacy encounter, **HAP Empowered** had the highest percentage (55.0 percent) and **Upper Peninsula Health Plan** had the lowest percentage (44.7 percent). Nearly five in 10 members across all ICOs had a pharmacy encounter throughout the measurement year.

Figure 4-26—Referential Integrity Comparison Between Enrollment and Pharmacy Encounter Files

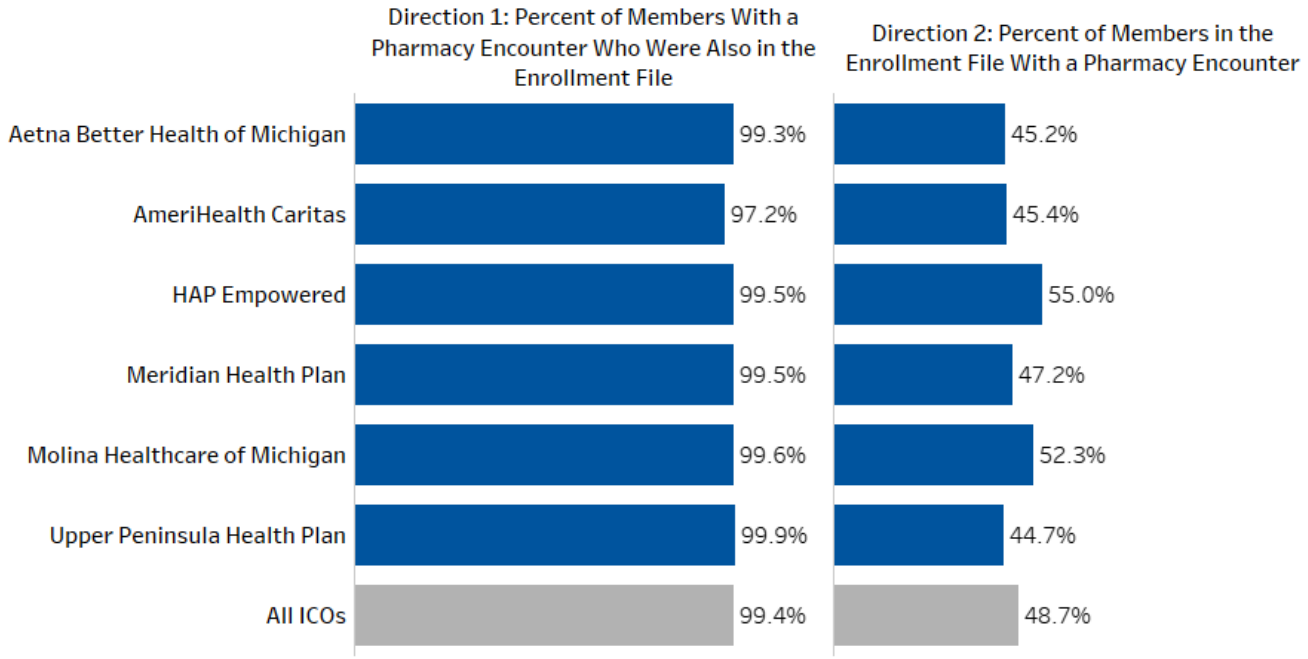


Figure 4-27 examines the comparison between the medical/dental encounter and pharmacy encounter files. ICOs showed variability in the direction 1 rate of members who had a medical/dental encounter who also had a pharmacy encounter, with **Meridian Health Plan** at the high end (95.1 percent) and **AmeriHealth Caritas** at the low end (57 percent). Overall, 84.4 percent of members for all ICOs had both a medical/dental and a pharmacy encounter. When looking at direction 2 for all ICOs, less than six in 10 members in the pharmacy encounter file had a medical/dental encounter, suggesting that just over half of enrolled members received pharmacy services without having a medical/dental encounter. Since these analyses only examined Medicaid paid encounters, it is possible that these members did have a medical/dental encounter that was denied, had not been paid by the time of this analysis, or had a service that was covered by Medicare.

Figure 4-27—Referential Integrity Comparison Between Medical/Dental Encounter and Pharmacy Encounter Files

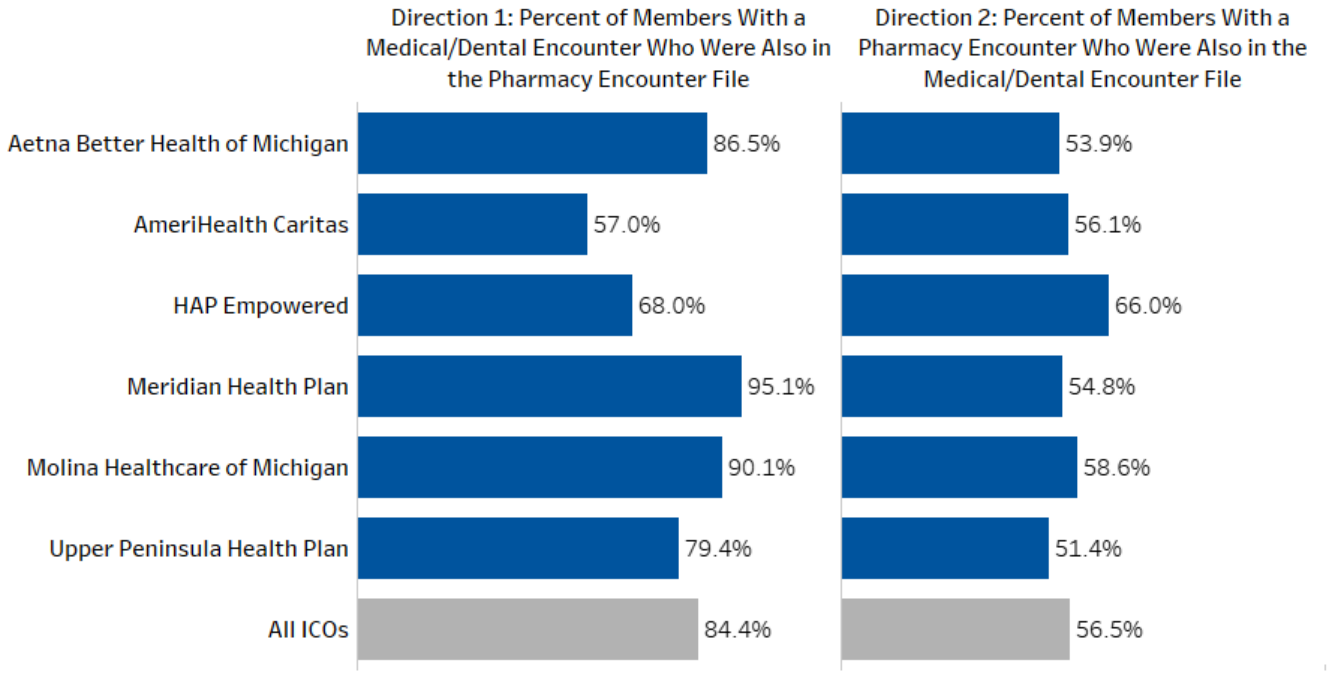


Figure 4-28 displays the referential integrity comparing the providers in the medical/dental encounter file to the provider file. For direction 1, across all ICOs, at least 99.9 percent of identified providers in the medical/dental encounter file were also in the provider file. In direction 2, 71.5 percent of providers in the provider file were also in the medical/dental encounter file; however, there was much variability between ICOs, with results ranging from 29.4 percent **(AmeriHealth Caritas**) to 87.6 percent **(Meridian Health Plan)**.

Figure 4-28—Referential Integrity Comparison Between Medical/Dental Encounter and Provider Files

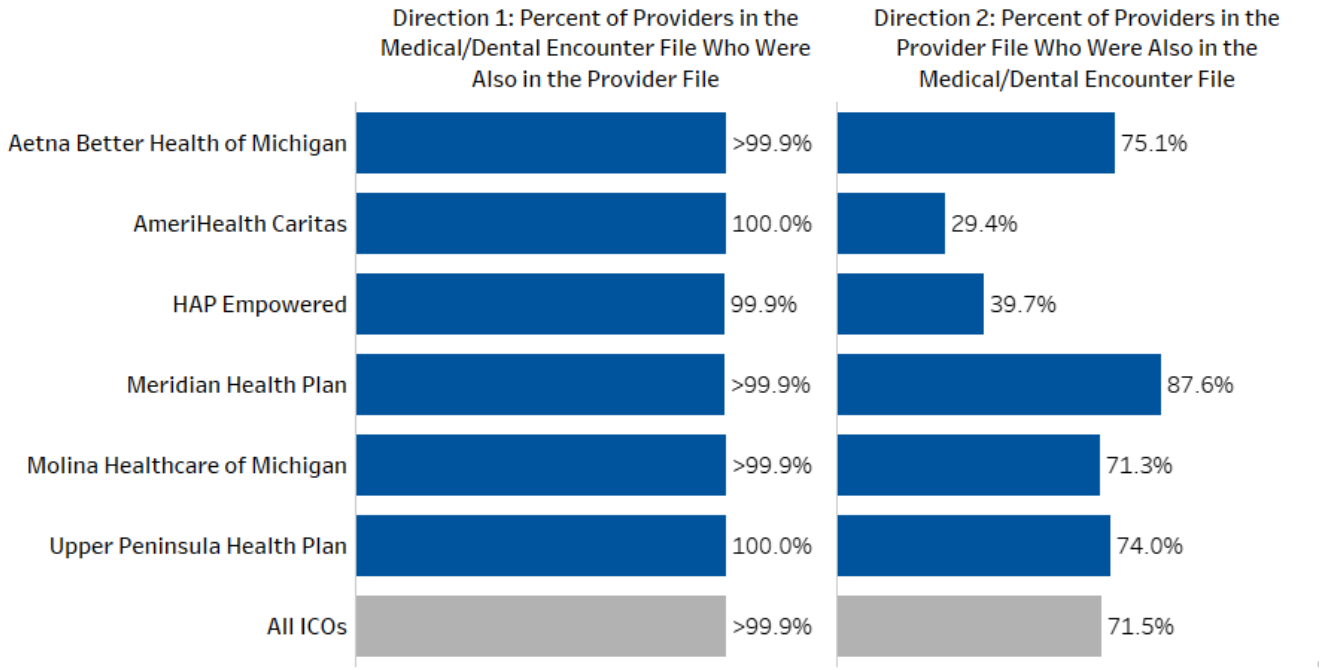
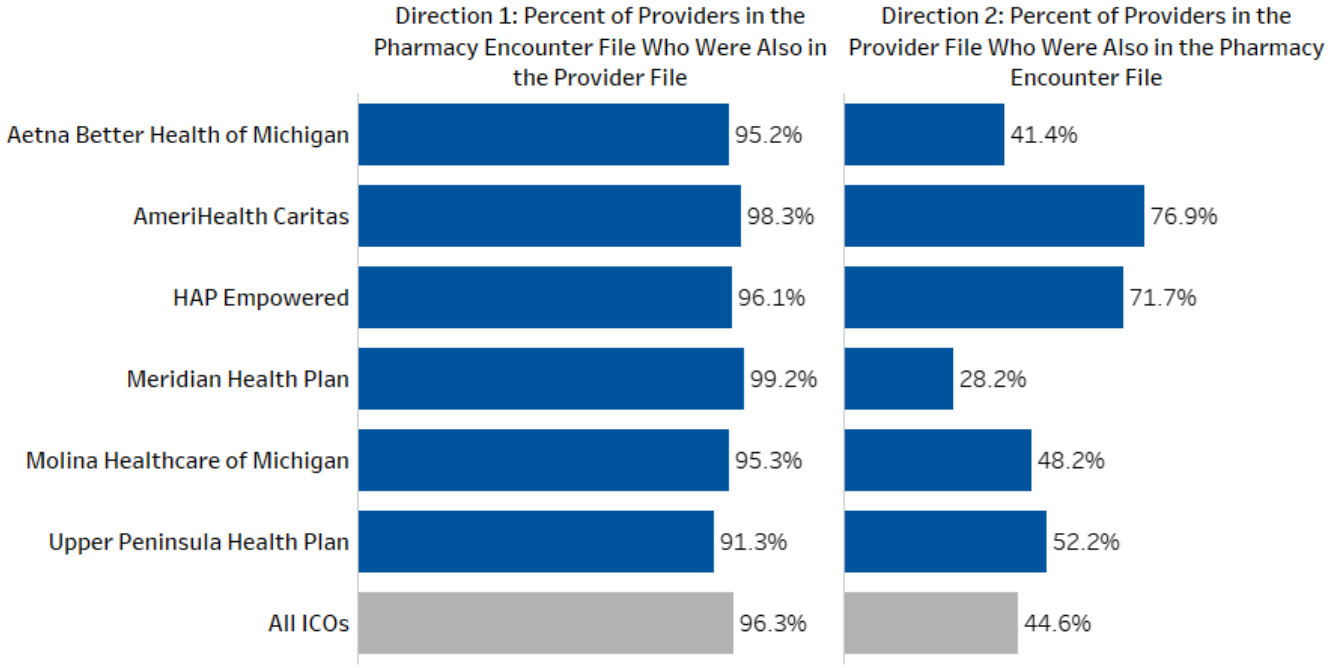


Figure 4-29 displays the referential integrity comparing the providers in the pharmacy encounter file to the provider file. Across all ICOs, 96.3 percent of identified providers in the pharmacy encounter file were also in the provider file, which is slightly lower than the expected rate of 100 percent. **Upper Peninsula Health Plan** had the lowest rate (91.3 percent), and **Meridian Health Plan** had the highest rate (99.2 percent). The reverse, providers in the provider file who were also in the pharmacy encounter file, also had variation across ICOs, with results ranging from 28.2 percent (**Meridian Health Plan**) to 76.9 percent (**AmeriHealth Caritas**). Overall, approximately four in 10 providers in the provider file were also in the pharmacy encounter file.

Figure 4-29—Referential Integrity Comparison Between Pharmacy Encounter and Provider Files



Encounter Data Logic

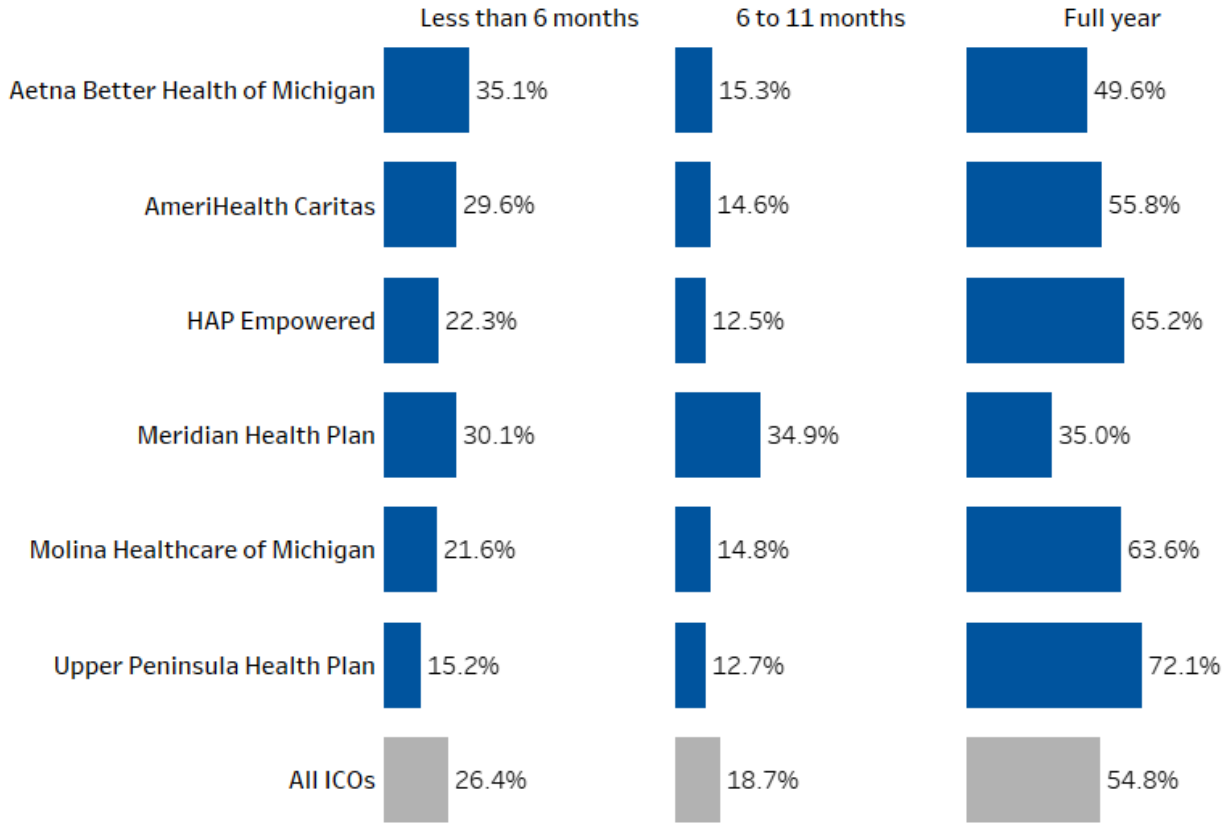
Additional logic checks were conducted to assess member characteristics pertaining to encounter prevalence and enrollment. This assessment provides insights into how well encounter data may be used to support future analyses such as HEDIS performance measure calculations. For instance, many measures require members be enrolled for the full measurement year, allowing only one gap of up to 45 days.

Member Enrollment

As part of its assessment of the MDHHS Medicaid population, HSAG examined enrollment continuity among the ICOs to assess the stability of Medicaid membership over time. Figure 4-30 illustrates the percentage of members continuously enrolled in SFY 2023, those enrolled for a total of six to 11 months, and those enrolled for a total of fewer than six months. Approximately half (54.8 percent) of

members in all ICOs collectively were enrolled for 12 consecutive months throughout the measurement year. Across the ICOs, this ranged from 35.0 percent (**Meridian Health Plan**) to 72.1 percent (**Upper Peninsula Health Plan**). **Aetna Better Health of Michigan** had the highest number of members enrolled for less than six months at 35.1 percent, and **Meridian Health Plan** had the highest number of members enrolled from six to 11 months at 34.9 percent.

Figure 4-30—Percentage of MDHHS Medicaid Members Who Were Continuously Enrolled



5. Discussion

Conclusions

Overall, MDHHS' encounter data should continue to support analyses using encounter data such as HEDIS performance measure calculation and rate setting. Data were largely complete, valid, and reliable. While HSAG identified some gaps and data concerns, this should not preclude the State from conducting further analyses given adequate assessment of encounters prior to analysis.

Information Systems Review Conclusions

The IS review provided self-reported qualitative information from all six ICOs regarding the encounter data process. The questionnaire responses showed that the ICOs and/or their subcontractors have the capability to collect, process, and transmit claims and encounter data to MDHHS that align with established quality specifications. While each ICO had its unique methods to ensure accurate and timely data submission, they all emphasized the significance of their encounter data systems and data warehouses. These systems allowed the ICOs the ability to develop adaptable data review processes to address quality concerns raised by MDHHS promptly. Each ICO discussed their use of software systems and subcontractors for tasks such as claims adjudication, verifying provider and member information, and managing TPL information.

The range and variety of data quality checks applied to the data collected by the ICOs and/or their subcontractors differed among the entities. Regarding encounter data completeness, most ICOs and/or their subcontractors did not consistently conduct a claim volume submission quality check. All ICOs and their subcontractors performed this check on at least one subcontractor's encounter data. MDHHS employed the volume report and the ECR process to oversee completeness. Field-level completeness and accuracy were among the commonly carried out data quality checks by either the ICOs or their subcontractors. Additionally, the ICOs utilized reconciliation with financial reports to ensure alignment between payment fields in the claims and the financial reports for their collected data. While timeliness quality checks were mentioned by some ICOs in their responses, the MDHHS timeliness report was used to monitor the contractual monthly minimum requirements for the ICOs. Notably, while MRR was provided as an option in the questionnaire, none of the ICOs opted for MRR as a data quality check method. This is likely due to the labor- and resource-intensive nature of MRR.

The ICOs are contractually responsible for all of their respective encounter data, which includes subcontractors' encounter data. Based on the information provided by the ICOs, most encounter data were submitted directly by the ICOs, with a few exceptions. Moreover, the ICOs typically stored the data collected by their subcontractors, with data being reviewed either before and/or after submission to MDHHS. These practices underscored each ICO's ability to oversee subcontractor-collected encounters, ensuring data are accurate, complete, and timely in its submission.

While the ICOs largely fulfilled the requirement of submitting accurate, complete, and timely data, there existed areas for enhancement (see the Recommendations section). According to the questionnaire responses, the main aspect needing improvement pertained to the diverse methods of encounter data monitoring used by the ICOs, which varied in scope and depth.

Administrative Profile Conclusions

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Overall, the data were largely complete, timely, and accurate for each ICO. For the number of encounters per 1,000 MM, **Aetna Better Health of Michigan**, **AmeriHealth Caritas**, **Molina Healthcare of Michigan**, and **Upper Peninsula Health Plan** remained relatively consistent in all categories of service throughout the measurement year. **HAP Empowered** stayed relatively consistent besides an increase in professional encounters in May 2022, which was due to a change in how **HAP Empowered** processed personal at-home services encounters. **Meridian Health Plan** showed the most variation in encounter volume on a month-to-month basis out of the ICOs. A likely reason for the variability seen in **Meridian Health Plan** was due to the merger between **Meridian Health Plan** and Michigan Complete Health in January 2022, which resulted in an increase in encounter volume. Additionally, **Meridian Health Plan** submitted its dental data marked as Medicare; therefore, **Meridian Health Plan**'s dental encounters were not included in this analysis. Across all categories of service, professional encounters had the highest volume per 1,000 MM, with an all ICO rate averaging around 2,500 encounters per 1,000 MM. Pharmacy encounters had the second largest volume with an all ICO rate averaging around 450 encounters per 1,000 MM. Institutional and dental encounters both had an average all ICO rate below 100 encounters per 1,000 MM, at about 90 and 45 encounters per 1,000 MM, respectively. Additionally, the amount paid PMPM also represented complete data from the ICOs. Interestingly, despite having an institutional encounter volume per 1,000 MM near the all ICO rate, **Upper Peninsula Health Plan** was well above the all ICO rate for the payment amount PMPM. Conversely, **Meridian Health Plan** had the highest institutional encounter volume per 1,000 MM of the ICOs, yet was below the all ICO rate for the amount paid PMPM. These findings indicate that **Upper Peninsula Health Plan** had a higher amount paid PMPM for institutional encounters compared to other ICOs, whereas **Meridian Health Plan** had a lower amount paid PMPM for institutional encounters compared to the other ICOs. Finally, all ICOs had low percentages of duplicative records, with all four categories of service having an all ICO rate of 0.5 percent or less. **AmeriHealth Caritas** had the lowest percentage of duplicates, with having no duplicative records identified in three of the four categories of service (e.g., institutional, pharmacy, and dental).

The timeliness evaluation of the MDHHS data also suggested that ICOs mostly submitted data in a timely manner to MDHHS after payment date. Both **Aetna Better Health of Michigan** and **AmeriHealth Caritas** had greater than 95 percent of encounters submitted to MDHHS within 90 days from payment in all four categories of service, whereas **HAP Empowered** and **Upper Peninsula**

Health Plan submitted greater than 95 percent of encounters in three of the four categories of service within 90 days from payment date. **HAP Empowered** had a high volume of pharmacy encounters submitted prior to the payment date (32.8 percent), which resulted in these encounters not being included in the analysis. **Meridian Health Plan** took slightly longer to submit its data to MDHHS, reaching 95 percent of professional and institutional encounters submitted within 270 days, and not reaching greater than 95 percent of pharmacy encounters submitted to MDHHS until after 360 days from payment date. Overall, **Molina Healthcare of Michigan** took the longest to submit encounters to MDHHS in three of the four categories of service, not submitting 95 percent of encounters until 360 days for institutional encounters, and after 360 days for professional and dental encounters. Despite this, **Molina Healthcare of Michigan** submitted 99.2 percent of pharmacy encounters within 30 days.

Additionally, the ICOs displayed complete and accurate encounter data, with all expected data elements populated at least 98 percent of the time across all categories of service. While there is no set requirement to be present, the billing provider NPI data element for professional encounters was low, with an all ICO rate of 58.6 percent. All ICOs, except **AmeriHealth Caritas**, had less than 94 percent of the billing provider NPI populated. All data elements that were populated were 90 percent valid or higher, with most data elements valid over 99 percent of the time. CPT/HCPCS codes with PTP edits in institutional encounters had the lowest validity rate at 93.1 percent across all ICOs. Finally, the referential integrity results between the encounter data, pharmacy data, enrollment data, and provider data were all high, indicating that these files can be linked together via the member ID or provider NPI fields. However, when linking the pharmacy data to the provider data, 96.3 percent of providers identified in the pharmacy data were identified in the provider data. This is lower than the >99.9 percent rate when linking the medical/dental data to the provider data and indicates that the provider data may not contain all the providers who provide pharmaceutical services.

Overall, MDHHS' encounter data were largely complete, timely, and accurate. Although there are some areas that MDHHS can collaborate with the ICOs on improving (see Recommendations section), the high levels of completeness, timeliness, and accuracy suggest that the encounter data can be used in subsequent analyses with a high degree of reliability.

Recommendations

Information Systems Review

To improve the quality of encounter data submissions from the ICOs, HSAG offers the following recommendations to assist MDHHS and the ICOs in addressing opportunities for improvement:

- **Meridian Health Plan** noted that it did not store any of its subcontractor data, while **Molina Health Care of Michigan** did not store its pharmacy subcontractor's data. HSAG recommends both ICOs consider storing data from their subcontractors for several reasons. Storing subcontractor encounter data within the ICOs' claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

- **HAP Empowered** and **Molina Health Care of Michigan** performed edits on encounters from some or all of their subcontractors before sending them to MDHHS. These ICOs should collaborate with MDHHS to verify that such modifications do not necessitate returning the data to the subcontractors.
- Although the ICOs conducted timeliness checks on at least one subcontractor's encounters, the ICOs should consider building or enhancing their monitoring reports for encounters collected by each of their subcontractors to comprehensively assess encounter data timeliness:
  - **Aetna Better Health of Michigan** (i.e., pharmacy and fiscal intermediary)
  - **AmeriHealth Caritas** (i.e., LTSS)
  - **HAP Empowered** (i.e., all encounters)
  - **Meridian Health Plan** (i.e., behavioral health and pharmacy encounters)
  - **Molina Health Care of Michigan** (i.e., pharmacy encounters)
  - **Upper Peninsula Health Plan** (i.e., all encounters)
- **Aetna Better Health of Michigan** and **Upper Peninsula Health Plan** each indicated that they perform only one quality check for claims/encounters stored in their data warehouses. Considering this, these ICOs should explore the possibility of constructing or improving monitoring reports to assess the claim volume submission, accuracy, completeness, and/or timeliness of these claims/encounters.
- Three ICOs reported that their dental subcontractor's encounters had been rejected and remained unaccepted by MDHHS when the questionnaire responses were submitted. Rejection rates varied from 6.5 percent to 26.8 percent. MDHHS may consider conducting an assessment to identify any common root causes for these rejections.
- HSAG recommends MDHHS continue its collaboration with the ICOs to address challenges highlighted in the ICOs' responses noted in Table 3-9, such as aligning its encounter processing logic with MDHHS' due to lack of essential data elements and processing rules, eligibility data discrepancies between the State and CMS, and insufficient documentation for resolving 999 response file errors.

Administrative Profile

To improve the quality of encounter data submissions from the ICOs, HSAG offers the following recommendations to assist MDHHS and the ICOs in addressing opportunities for improvement:

- **HAP Empowered** had a high percentage of pharmacy encounters where the submit date was prior to the payment date. Accurate dates for these fields are essential for assessing the timeliness and accuracy of the data. Additionally, subsequent analyses may rely on these fields to subset the data. MDHHS should collaborate with **HAP Empowered** to help improve the accuracy of these fields.
- Timely data are crucial to subsequent analyses, and if data are not submitted in a timely manner, then subsequent analyses may not include complete information and results may not reflect accurate encounter volume. Therefore, **Molina Healthcare of Michigan** should evaluate the delay between submitting professional, institutional, and dental encounters to MDHHS after payment; **Meridian Health Plan** should evaluate the delay between submitting professional, institutional, and pharmacy

encounters to MDHHS after payment; and **Upper Peninsula Health Plan** should evaluate the delay between submitting dental encounters to MDHHS after payment.

- All ICOs demonstrated lower than expected rates when examining the referential integrity of the provider NPIs in the pharmacy data compared to the provider NPIs in the provider data. Since subsequent analyses may require the ability to link these datasets together, MDHHS should collaborate with ICOs to determine if the MDHHS provider data accurately reflects each ICO's current contracted provider network.
- All ICOs demonstrated lower than 95 percent validity rates on CPT/HCPCS codes with PTP edits in institutional data. MDHHS should collaborate with the ICOs to ensure CPT/HCPCS codes pass PTP edit checks to help prevent improper payments.
- Dental services should be covered by Medicaid, and **Meridian Health Plan** submitted these services marked as Medicare. MDHHS should collaborate with the ICOs to ensure Medicaid and Medicare cover appropriate services and that these services are submitted to MDHHS appropriately.

Study Limitations

Information Systems Review

When evaluating the findings outlined in the IS review section, it is important to understand the limitations to the execution of the EDV study:

- The information from MDHHS' and the ICOs' questionnaire responses was self-reported, and HSAG did not validate the responses for accuracy.
- The findings from this assessment were based on questionnaire responses submitted to HSAG in mid-May 2023. As such, findings may not reflect system or process changes implemented after May 2023.

Administrative Profile

The list below displays study limitations for the reader to consider:

- The impact of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) on the data is unclear. Members may have changed how frequently they accessed care from providers, which could have had an impact on the encounter volume trends. Additionally, it is unclear how the COVID-19 PHE directly affected the trends explored in institutional encounters.
- The findings from the administrative profile were associated with encounters with dates of service between October 1, 2021, and September 30, 2022. As such, results may not reflect the current quality of MDHHS' encounter data or changes implemented since the data extraction.

- Reference tables that HSAG utilized to determine valid values for certain data elements may differ from the reference tables MDHHS utilizes for its data warehouse edits. As a result, the percentage of valid values may not exactly reflect what would be captured through MDHHS' data warehouse edits.
- The findings from the administrative profile were limited to Medicaid encounters. Since ICO enrolled members are also enrolled with Medicare, it is possible that members received services that were paid through Medicare. Therefore, these services were not included in this analysis.
- **Meridian Health Plan** submitted its dental data marked as Medicare; therefore, dental encounters for **Meridian Health Plan** were not included in this analysis.
- **Meridian Health Plan** merged with Michigan Complete Health in January 2022, impacting **Meridian Health Plan**'s encounter volume throughout the measurement year. However, it is unclear how the merger directly affected trends explored throughout the analysis.
- Primary diagnosis codes are not required on dental encounters and ICOs did not submit this data element to MDHHS. Therefore, diagnosis codes were not evaluated for completeness and accuracy in the ICOs' data.

Appendix A. ICOs Included in This Report

Table A-1 presents the names, abbreviations, and IDs for the ICOs associated with the MI Health Link Program included in this report for the EDV study.

Table A-1—ICOs Included in the Study

Name	Abbreviation	ID
Aetna Better Health Premier Plan (Aetna Better Health of Michigan)	AET	2836392
AmeriHealth Caritas VIP Care Plus (AmeriHealth Caritas)	AMI	2836401
HAP Empowered[1]	HAP	2836404
MeridianComplete (Meridian Health Plan)	MER	2836394
Molina Dual Options MI Health Link (Molina Healthcare of Michigan)	MOL	2836399
Upper Peninsula Health Plan MI Health Link (Upper Peninsula Health Plan)	UPP	2836390

[1] HAP Empowered will transition to HAP CareSource on January 1, 2024.

Appendix B. Blank Questionnaire for MDHHS

HSAG HEALTH SERVICES ADVISORY GROUP

SFY 2023 Encounter Data Validation Questionnaire for MDHHS

Overview

Pursuant to Title 42 of the Code of Federal Regulations (42 CFR) §438.242, the Michigan Department of Health and Human Services (MDHHS) must ensure that each of its contracted Medicaid managed care entities (MCEs) maintains a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. MDHHS must also review and validate encounter data collected, maintained, and submitted by the MCEs to ensure that it is a complete and accurate representation of the services provided to its Medicaid members. Accurate and complete encounter data are critical to the success of a managed care program. Therefore, MDHHS requires its contracted Medicaid MCEs to submit high-quality encounter data. MDHHS relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During state fiscal year (SFY) 2023, MDHHS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct an encounter data validation (EDV) study. In alignment with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5)[1], HSAG will conduct the following activities for the EDV study:

1. Information systems (IS) review—assessment of MDHHS' and the MCEs' information systems and processes. The goal of this activity is to examine the extent to which MDHHS' and the MCEs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5.
2. Administrative profile—analysis of MDHHS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity is to evaluate the extent to which the encounter data in MDHHS' encounter data warehouse are complete, accurate, and submitted by the MCEs in a timely manner for encounters with dates of service from October 1, 2021, through September 30, 2022. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 5 Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan.* Protocol 5. February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html

This document pertains to the IS review activity. In general, the IS review will include an evaluation of the MCEs' processes for collecting, maintaining, and submitting encounter data to MDHHS and on the strengths and limitations of the MCEs' information systems in promoting and maintaining quality encounter data. Similarly, HSAG will also evaluate MDHHS' processes for collecting and managing the MCE-submitted encounter data. In alignment with Activity 1: Review State Requirements in the CMS EQR Protocol 5, HSAG has developed the following EDV focused questionnaire to gather information regarding MDHHS' information systems and data processing procedures. This IS review will enable HSAG to understand how various systems interact to determine whether such interactions have an impact on MDHHS' ability to receive and maintain complete and accurate data.

HSAG will conduct the EDV study for 47 MCEs. Table 1 displays the programs, MCE types, and number of MCEs[2] included in the study.

Table 1—Michigan Medicaid Managed Programs

Program	MCE Type	Number of MCEs
Comprehensive Health Care Program (CHCP)	Medicaid Health Plans (MHPs)	9
Healthy Kids Dental Program	Prepaid Ambulatory Health Plans (PAHPs)	2
MI Health Link Program	Integrated Care Organizations (ICOs)	6
Behavioral Health Managed Care Program	Prepaid Inpatient Health Plans (PIHPs)	10
MI Choice Waiver Program	Waiver Agencies	20

General Instructions

HSAG developed the following questionnaire to gather both general information and specific procedures for data processing, personnel, and data acquisition capabilities. The questionnaire is divided into the following four domains:

Section A: *Encounter Data Sources and Systems*

Section B: *Data Exchange Policies and Procedures*

Section C: *Management of Encounter Data: Collection, Storage, and Processing*

Section D: *Encounter Data Quality Monitoring and Reporting*

[2] Refer to Appendix A for a list of MCEs included in this study.

Please provide comprehensive answers to the questions in each section of the questionnaire and attach supporting documentation (e.g., policies and procedures, data layouts, data flow diagrams, sample reports, sample data, etc.), where applicable. If different staff members within MDHHS are responsible for different aspects of the processes, please distribute multiple copies of the questionnaire and ensure that each group provides answers to the applicable questions in each section. **Responses do not need to be merged into a single final version; uploading multiple sections and documents is acceptable.**

Upon receiving answers to the questionnaire and additional documentation, HSAG's EDV team may conduct additional follow-up with MDHHS via email or conference calls.

Submission of Questionnaire and Documentation

1. MDHHS should upload the completed questionnaire and supporting documentation electronically to HSAG's Secure Access File Exchange (SAFE) site, https://safe.hsag.com/ in MDHHS' root folder *MI EQRO/MI MDHHS/*
2. Please contact Brittani Alley via e-mail at BAlley@hsag.com for assistance with access to HSAG's SAFE site.
3. HSAG requests that MDHHS upload the completed questionnaire, and any attachments, to HSAG's SAFE site no later than **May 9, 2023**. Upon completion of upload, please notify Krithiga Gopi via e-mail at KGopi@hsag.com.
4. Please provide the descriptions for the acronyms used in your responses in the table below or spell them out when using the acronyms for the first time.

Acronym	Description
BH	Behavioral health
EDI	Electronic data interchange
NEMT	Non-emergency medical transportation

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Acronym	Description

SFY 2023 Encounter Data Validation—MDHHS Focused Questionnaire

Section A: Encounter Data Sources and Systems

Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename(s) in your response. In the case of file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to the question. It is not required to resubmit the file(s).

1. Describe the process flows and system architecture used to import, process, and store encounter data submitted by the MCEs. Please submit any supporting documentation available including, but not limited to, information system schemas, processing diagrams, and file/table layouts. If the process differs by encounter type (e.g., medical, vision, pharmacy), provide separate updates for each encounter type and scenario. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Claim Type	Process Flow	Supporting Document
837 Professional	*After MCEs upload 837 professional files to the sFTP site, MDHHS downloads them daily and then passes them through the EDI translator for compliance checks and generates X12 999 response files to the MCEs. Encounters passing the EDI compliance checks are saved in CHAMPS and then go through additional MDHHS edits. Any records failing the edits are flagged with a pending status in the data warehouse and also saved in the response files for the MCEs to submit corrections.*	*Encounter_Process.docx*
837 Professional		
837 Institutional		
837 Dental		
Pharmacy		
<insert claim type>		

2. Using the table below, list and describe the function and role of any organizational units responsible for processing and monitoring encounters. *Note: The table can be expanded if additional rows are required.*

	Department	Function/ Role	# of Staff
1			
2			
3			
4			
5			

3. Describe all system/processing edits conducted on incoming encounters prior to accepting/loading the data into MDHHS' final database for MDHHS' end-users. For example, please provide details on the encounter data interchange (EDI) compliance edits and the state-specific edits, or how MDHHS assesses whether the encounter is for the appropriate program (e.g., MHP versus ICO).

4. How does MDHHS process data exceptions? For example, when an encounter is not in a valid format, contains invalid values, or includes erroneous field logic, describe the processes (manual or automatic) used to process the submission.

5. Does MDHHS provide any type of response file or feedback to the MCEs submitting the encounters?
   - ☐ Yes (If yes, please describe the process used to provide feedback to the MCEs including any process flows and report layouts.)
   - ☐ No

6. Please describe in the table below the process used by the MCEs to resubmit updated, modified, or corrected encounters. Provide any documentation or policies and procedures related to the resubmission of encounter files or records.

Question	Response
6a. How are updated records flagged in MDHHS' system?	
6b. Are the original encounters stored in the encounter data system or deleted?	
6c. Provide details on how replacement transactions are processed when target transaction is in active failed validation status.	

7. The following questions address the collection, use, and maintenance of provider data and member enrollment data.

Provider Data	
7a. Outline the path MDHHS' Medicaid provider data follow from collection to maintenance.	
7b. Describe MDHHS' procedures for overseeing and ensuring the completeness of provider data.	
7c. Describe MDHHS' procedures for overseeing and ensuring the accuracy of provider data.	
7d. Describe the process for cross-checking encounters with provider data (e.g., list any procedures for reconciling differences between provider information submitted on the encounter and MDHHS' provider data).	
7e. Describe how MDHHS uses provider data submitted by the MCEs to conduct evaluations on the encounter data, if applicable.	

Member Enrollment data	
7f. Outline the path MDHHS' Medicaid enrollment data follow from collection to maintenance.	
7g. Describe MDHHS' procedures for overseeing and ensuring the completeness of enrollment data.	
7h. Describe MDHHS' procedures for overseeing and ensuring the accuracy of enrollment data.	
7i. How often is Medicaid enrollment information updated for MDHHS and the MCEs?	
7j. Describe the process for crosschecking encounters with enrollment data (e.g., list any procedures for reconciling differences between member information submitted on the encounter and MDHHS' member enrollment data).	

Section B: Data Exchange Policies and Procedures

Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response. In the case of file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to the question. It is not required to resubmit the file(s).

1. Please describe the data exchange process between the MCEs and MDHHS. Include details outlining the organizational and operational policies and procedures related to the MCEs' encounter data submissions. Provide copies of all policies and procedures, manuals, file specifications, etc., that outline the procedures that govern the transmission of data between the MCEs and MDHHS.

2. Are Medicaid encounters audited regularly?
   - ☐ Yes (If yes, please provide MDHHS' policy regarding Medicaid encounter audits and the audit frequency.)
   - ☐ No

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3. Describe the process MDHHS has in place to ensure that updates to MDHHS' requirements for data submission are implemented and communicated to each MCE. Please provide any documentation, if available.

4. Describe the testing policies and processes MDHHS has in place when MCEs have any major changes affecting the encounter data (e.g., a new subcontractor or a new software). Please provide any documentation, if available, to describe the testing process from the time when the MCE notifies MDHHS of the change to the time when MDHHS approves the MCE to submit the encounter data to the production environment.

5. Describe in the table below how information systems failure affects encounters and the measures taken to prevent failure.

Question	Response
5a. Describe how the loss of Medicaid encounters and other related data is prevented when systems fail.	
5b. How frequently are system back-ups performed?	
5c. How are the back-ups tested to make sure the back-ups are functional?	
5d. How often are back-ups tested for functionality?	
5e. How is Medicaid data corruption prevented when there is a system failure or program error?	
5f. Describe the controls used to ensure all data entered in the system are fully accounted for (e.g., batch control sheets)?	

Section C: Management of Encounter Data: Collection, Storage, and Processing

Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response. In the case of file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to the question. It is not required to resubmit the file(s).

1. Please attach a flowchart outlining the structure of your complete management information systems. Provide any documentation regarding data integration policies and procedures.

2. For each database described in Question 1, please highlight all internal and external data inputs and processes. Identify any processes in place that modify the data as it moves from one database to another.

Input Data	Output Data	Processes that Modify Data

3. Describe in the table below the procedure for consolidating Medicaid claims/encounter, member, and provider data for reporting (whether it is a relational database or file extracts).

Question	Response
3a. How many different data sources are merged to create reports?	

Question	Response
3b. What control processes are in place to ensure data merges are accurate and complete?	
3c. What control processes are in place to ensure that no extraneous data are captured (e.g., lack of specificity in patient identifiers may lead to inclusion of non-eligible members or double counting)?	

4. Describe the algorithms used to check the reasonableness of data integrated for purposes of reporting or creating data marts.

5. Do your current system documentation and file layouts clearly delineate derived and non-derived data fields?
   - ☐ Yes (If yes, please describe the fields that are derived and the point in the encounter data process at which they are created. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*)
   - ☐ No

Derived Field	Point in Process When Field is Calculated	Algorithm for Calculating the Field
Final_Ind indicating final adjudicated encounters	*Created when applying MDHHS-specific edits*	*The most recently submitted records based on the unique claim identifier from MCEs*

6. Describe the policies and procedures used to identify duplicate or missing records in the MCEs' regular encounter submissions.

Question	Response
6a. List policies and procedures used to identify duplicates.	
6b. When duplicates are identified, how are the affected records processed and what information is returned to the MCEs?	
6c. List policies and procedures used to identify missing records.	
6d. When missing records are identified, what information is returned to the MCEs?	

7. During the processing of the MCEs' encounter data submissions, describe the modifications or reformatting using specific data field names and specific examples (e.g., zeros are added to the beginning of values in any specific field to pad the results to a length of a specific number of characters). *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Field Name	Modifications/ Reformatting (include examples)	Encounter Types Affected (e.g., All, Pharmacy, Medical)
Rendering Provider NPI	*When the rendering provider NPI is missing, fill in with billing provider NPI.*	*837P*

8. Explain the code and/or field mapping processes performed during data processing and provide reference table(s) and/or source of the reference table(s), as appropriate. How often are each of the reference table(s) updated? Monthly, quarterly, annually, never, etc.? *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Field	Description of Mapping	Source of Reference Table	Frequency of Updating Reference Table
Rendering Provider NPI	*Map to reference table*	*Provider enrollment file*	*Quarterly*

Field	Description of Mapping	Source of Reference Table	Frequency of Updating Reference Table

9. Describe the documentation used to train staff within MDHHS regarding MDHHS' information systems and encounter data processing protocols.

Section D: Encounter Data Quality Monitoring and Reporting

Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response. In the case of file(s)/document(s) that have already been submitted to HSAG, please provide the filename(s) that are applicable to the question. It is not required to resubmit the file(s).

1. Describe how MDHHS monitors encounter data submitted by the MCEs for accuracy, completeness, and timeliness. Please include metrics in place including defined error thresholds and standards. If regular reports are used, submit a recent report example.

Measure	Description	Metrics
Accuracy		
Completeness		
Timeliness		

2. Does MDHHS have performance standards, beyond what is described in the MCE contract requirements, in place regarding the submission, accuracy, and timeliness of encounter data?
   ☐ Yes (If yes, provide documentation of the performance standards and describe how the performance standards are communicated to the MCEs.)
   ☐ No

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3. Are the MCEs required to submit reports on encounter data submission activities (e.g., submission statistics) to MDHHS?
   ☐ Yes (If yes, please describe the reporting process and submit a recent example of these reports for each MCE and other applicable documents.)
   ☐ No

4. Does MDHHS use a specific format to provide feedback to the MCEs on their submissions?
   ☐ Yes (If yes, please describe the files used to provide feedback to the MCEs.)
   ☐ No

5. What is the average percentage of encounters (by MCE) submitted to MDHHS that get rejected by MDHHS? *Note: The first row of the table is provided as an example. The table can be expanded if additional columns are required.*

MCE Type	MCE	Professional	Institutional	Dental	Pharmacy
MHP	*Aetna Better Health of Michigan*	*5%*	*10%*	*7%*	*3%*

6. Describe how data in MDHHS' encounter data system/data warehouse are used (e.g., rate-setting, HEDIS reporting, etc.)

7. Please answer the questions in the table below regarding MDHHS' collection of capitated encounters (e.g., encounters submitted by the MCEs' capitated providers/provider groups) from its MCEs.

Question	Response
7a. What are MDHHS' requirements for submitting pricing information on capitated encounters?	
7b. Does MDHHS monitor capitated encounters for unallowable services? If YES, describe the type of reporting that is available.	
7c. If NO, does MDHHS maintain a list of allowable/unallowable services? If MDHHS maintains a list of allowable/unallowable services, please provide supporting document(s).	

Attestation Statement

I hereby certify that I have reviewed the information entered on this questionnaire and that, to the best of my knowledge, the information is complete and accurate as of the date below.

_____ _____

Signature of responsible individual Date

_____

Print name and title

Appendix A: Managed Care Entities Included in the Study

Table A-1 presents the programs, MCE types, MCE names and abbreviations for the MCEs included in the EDV study.

Table A-1—Medicaid Managed Care Programs and MCEs Included in the Study

Program	MCE Type	MCE Name	MCE Abbreviation
CHCP	MHPs	Aetna Better Health of Michigan	AET
		Blue Cross Complete of Michigan	BCC
		HAP Empowered Health Plan, Inc.	HAP
		McLaren Health Plan	MCL
		Meridian Health Plan of Michigan	MER
		Molina Healthcare of Michigan	MOL
		Priority Health Choice	PRI
		UnitedHealthcare Community Plan	UNI
		Upper Peninsula Health Plan	UPP
Healthy Kids Dental Program	PAHPs	Blue Cross Complete of Michigan	BCBSM
		Delta Dental of Michigan	DDMI
MI Health Link Program	ICOs/PIHPs	Aetna Better Health Premier Plan	Aetna
		AmeriHealth Caritas VIP Care Plus	AmeriHealth
		HAP Empowered	HAP
		MeridianComplete	Meridian
		Molina Dual Options MI Health Link	Molina
		Upper Peninsula Health Plan MI Health Link	UPHP
Behavioral Health Managed Care Program	PIHPs	NorthCare Network	NCN
		Northern Michigan Regional Entity (NMRE)	NMRE
		Lakeshore Regional Entity	LRE
		Southwest Michigan Behavioral Health	SWMBH
		Mid-State Health Network	MSHN
		Community Mental Health Partnership of Southeast Michigan	CMHPSM
		Detroit Wayne Integrated Health Network	DWIHN
		Oakland Community Health Network	OCHN
		Macomb County Community Mental Health	MCCMH
		Region 10 PIHP	Region 10 PIHP

Program	MCE Type	MCE Name	MCE Abbreviation
MI Choice Waiver Program	Waiver Agencies	A&D Home Health Care	AD
		Area Agency on Aging 1B	AAA1B
		Area Agency on Aging of Northwest Michigan	AAANWMI
		Area Agency on Aging of Western Michigan	AAAWMI
		Detroit Area Agency on Aging	Detroit AAA
		easterseals|MORC	MORC
		Region 9 Area Agency on Aging/ Northeast MI Community Service Agency	NEMCSA
		Northern Health Care Management	NHCM
		Region 2 Area Agency on Aging	R2AAA
		Region 3B Area Agency on Aging/Carewell Services	R3BAAA
		Region IV Area Agency on Aging	RIVAAA
		Region VII Area Agency on Aging	Region VII
		Reliance Community Care Partners	Reliance
		Senior Resources	Senior Resources
		Milestone Senior Services	Senior Services
		Tri-County Office on Aging	Tri-County
		The Information Center	The Information Ctr
		The Senior Alliance	Senior Alliance
		Upper Peninsula Commission for Area Progress (UPCAP)	UPCAP
		Valley Area Agency on Aging	Valley AAA

Appendix C. Blank Questionnaire for ICOs

HSAG HEALTH SERVICES ADVISORY GROUP

SFY 2023 Encounter Data Validation Questionnaire for ICOs

Overview

Pursuant to Title 42 of the Code of Federal Regulations (42 CFR) §438.242, the Michigan Department of Health and Human Services (MDHHS) must ensure that each of its contracted Medicaid managed care entities (MCEs) maintains a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. MDHHS must also review and validate encounter data collected, maintained, and submitted by the MCEs to ensure that it is a complete and accurate representation of the services provided to its Medicaid members. Accurate and complete encounter data are critical to the success of a managed care program. Therefore, MDHHS requires its contracted Medicaid MCEs to submit high-quality encounter data. MDHHS relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During state fiscal year (SFY) 2023, MDHHS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct an encounter data validation (EDV) study. In alignment with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5)[1], HSAG will conduct the following activities for the EDV study:

- Information systems (IS) review—assessment of MDHHS' and the MCEs' information systems and processes. The goal of this activity is to examine the extent to which MDHHS' and the MCEs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5.
- Administrative profile—analysis of MDHHS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity is to evaluate the extent to which the encounter data in MDHHS' encounter data warehouse are complete, accurate, and submitted by the MCEs in a timely manner for encounters with dates of service from October 1, 2021, through September 30, 2022. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 5 Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan.* Protocol 5. February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html

This document pertains to the IS review activity. In general, the IS review will include an evaluation of the MCEs' processes for collecting, maintaining, and submitting encounter data to MDHHS and on the strengths and limitations of the MCEs' information systems in promoting and maintaining quality encounter data. Similarly, HSAG will also evaluate MDHHS' processes for collecting and managing the MCE-submitted encounter data. In alignment with Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5, HSAG has developed the following EDV focused questionnaire to gather information regarding each MCE's information systems and data processing procedures. The IS review will enable HSAG to understand how various systems interact to determine whether such interactions have an impact on the MCEs' ability to submit complete and accurate data.

HSAG will conduct the EDV study for 47 MCEs. Table 1 displays the programs, MCE types, and number of MCEs[2] included in the study.

Table 1—Michigan Medicaid Managed Programs

Program	MCE Type	Number of MCEs
Comprehensive Health Care Program (CHCP)	Medicaid Health Plans (MHPs)	9
Healthy Kids Dental Program	Prepaid Ambulatory Health Plans (PAHPs)	2
MI Health Link Program	Integrated Care Organizations (ICOs)	6
Behavioral Health Managed Care Program	Prepaid Inpatient Health Plans (PIHPs)	10
MI Choice Waiver Program	Waiver Agencies	20

This questionnaire pertains to the Integrated Care Organizations (ICOs) associated with the MI Health Link Program.

General Instructions

HSAG developed the following questionnaire customized in collaboration with MDHHS to gather both general information and specific procedures for data processing, personnel, and data acquisition capabilities. The questionnaire is divided into the following four domains:

- **Section A**: Encounter Data Sources and Systems
- **Section B**: Payment Structures of Encounter Data
- **Section C**: Encounter Data Quality Monitoring by Subcontractors
- **Section D**: Encounter Data Quality Monitoring by ICOs

[2] Refer to Appendix A for a list of MCEs included in this study.

Each participating ICO must complete all sections of the following questionnaire, providing comprehensive answers to the questions and attaching supporting documentation (e.g., policies and procedures, data layouts, data flow diagrams, sample reports, sample data, etc.), where applicable. Please provide responses specific to procedures related to the processing of MDHHS claims and encounters. If different staff members within your ICO are responsible for different aspects of the processes, please distribute multiple copies of the questionnaire and ensure that each group provides answers to the applicable questions in each section.

Upon evaluating answers to the questionnaire and additional documentation, HSAG's EDV team may conduct additional follow-up with the ICOs via email or conference calls.

Submission of Questionnaire and Documentation

- HSAG requests that ICOs complete the questionnaires no later than **May 9, 2023**. Upon completion of the questionnaires, please notify Krithiga Gopi via e-mail at KGopi@hsag.com.
- Please provide the descriptions for the acronyms used in your responses in the table below or spell them out when using the acronyms for the first time.

Acronym	Description
BH	Behavioral health
EDI	Electronic data interchange
NEMT	Non-emergency medical transportation

Acronym	Description

SFY 2023 Encounter Data Validation ICO Questionnaire

Section A: Encounter Data Sources and Systems

ICO Name	
Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If your ICO uses the same data system for multiple clients or lines of business, please limit your responses to specific procedures related to the processing of MDHHS' claims and encounters. If supplemental files or supporting documents are provided, please note the filename(s) in your response.

This section provides an overview regarding the data sources and systems for your ICO's claims/encounter data.

1. Using the table below and data flow diagrams (i.e., supporting documents listed in the last column), outline the path your ICO's encounter data follow from the time a member receives a service(s) until the encounter is submitted to MDHHS and your ICO processes MDHHS' feedback. If the data path differs by or within a claim type, provide a separate list or data flow diagram for each claim type and scenario. Be sure to identify any subcontractors responsible for processing the data and the associated processes with the subcontractors. *Note: The first section of the table is provided as an example. The table can be expanded if additional rows are required.*

   Total number of subcontractors: Choose an item.

Data Source[1]	Data Flow	Supporting Document
Paper Claims	*All paper claims are received via mail. Paper claims are date stamped upon receipt and scanned with optical character recognition (OCR) software and converted to 837 files for electronic processing. The remaining process is the same as the claims in electronic format.*	*<insert file name>*
Medical		
Behavioral Health (BH)		

Data Source[1]	Data Flow	Supporting Document
Pharmacy		
Dental		
Vision		
Non-Emergency Medical Transportation (NEMT)		
<insert other data sources[2]>		

[1] These sources represent claims/encounter submissions from the rendering provider to your ICO or subcontractor.
[2] Examples include hearing, chiropractic, laboratory, etc.

2. For each key data source (i.e., all data your ICO receives that are included in the encounter data submissions to MDHHS), provide a description of the files received, the frequency of receipt, and the approximate percentage of claims submitted by capitated versus fee-for-service (FFS) providers. *Note: The first section of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Source[1]	Description of Data Received (Including Format)	Frequency	Approximate Percentage of Claims from Capitated Providers
Pharmacy	*We receive point of service claims submitted by retail pharmacies from our subcontractor, Express Scripts. Files are submitted using the NCPDP D.0 format.*	*Weekly*	*30%*
Medical in 837 Professional Format		Choose an item.	
Medical in 837 Institutional Format		Choose an item.	
Dental in 837 Dental Format		Choose an item.	
BH		Choose an item.	
Pharmacy		Choose an item.	
Vision		Choose an item.	
NEMT		Choose an item.	
<insert other sources[2]>		Choose an item.	

[1] These sources represent claims/encounter submissions from the rendering provider to your ICO or subcontractor.
[2] Examples include hearing, chiropractic, laboratory, etc.

3. For each key data source, provide a description of the software used to receive data, validate data, prepare outbound encounters for submission to MDHHS, and frequency for submission. *Note: The first section of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Source[1]	Software Used to Receive Data	Software Used to Validate Data	Software Used to Generate Encounters for MDHHS	Frequency for Submission to MDHHS
Paper claims	*Convert to 837 format through an optical character recognition (OCR) software by <insert name>*	*Facets*	*Encounter Data Manager*	*Weekly*
Medical in 837 Professional Format				Choose an item.
Medical in 837 Institutional Format				Choose an item.
Dental in 837 Dental Format				Choose an item.
BH				Choose an item.
Pharmacy				Choose an item.
Vision				Choose an item.
NEMT				Choose an item.
<insert other data sources[2]>				Choose an item.

[1] These sources represent claims/encounter submissions from the rendering provider to your ICO or subcontractor.
[2] Examples include hearing, chiropractic, laboratory, etc.

4. For encounters submitted to MDHHS through 837 professional and institutional formats, please describe the software used for the Electronic Data Interchange (EDI) compliance checks and the Workgroup for Electronic Data Interchange Strategic National Implementation Process (WEDI SNIP) levels that are used in the EDI compliance checks.

Data Source[1]	Software for EDI Compliance Check	WEDI SNIP Level
Vision claims		*Levels 1 and 2*
Medical in 837 Professional Format		
Medical in 837 Institutional Format		
Dental in 837 Dental Format		
BH		
Vision		
NEMT		
<insert other data sources[2]>		

[1] These sources represent claims/encounter submissions from the rendering provider to your ICO or subcontractor.
[2] Examples include hearing, chiropractic, laboratory, etc.

5. Please specify the modifications, reformatting or changes made to the claims/encounter data to accommodate MDHHS' encounter data submission standards. Describe the modifications or reformatting using specific data field names and examples. If a subcontractor prepares the encounter data submission for your ICO, please specify the modifications made by the subcontractor and additional modifications made by the ICO separately. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Type	Field	Modification Details	Modification Made By
Vision Claims	*Provider ID*	*Zeros are added to the beginning of values in the Provider ID field to pad the results to a standard length of characters (e.g., 00003126).*	*ICO*

6. Please specify how your ICO prepares/enriches data elements that are not on the claims from providers but required by MDHHS. Describe the source of the data and process to create these data elements. If a subcontractor prepares the encounter data submission for your ICO, please specify the modifications made by the subcontractor and additional modifications made by the ICO separately.

Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.

Data Type	Field	Source Data and Creation Process	Modification Made By
Professional Claims	*VBP Indicator*	*Check whether the encounter is for value-based payments (VBP) by linking with reference table via data fields variable 1, variable 2, and variable 3.*	*ICO*

7. Describe the process to identify duplicate claims. Provide details on the fields used to identify duplicates, where in the process the duplicates are identified and how they are handled.

8. Describe the types of claims/encounters that are not submitted to MDHHS (e.g., paid, denied, voided, adjusted claims, or a specific service provided to members).

9. Describe the process to submit denied or partially denied claims/encounters to MDHHS. List measures taken to ensure that denied claims/encounters do not include paid service lines.

10. Using the following table, describe the process to submit adjustments/replacement/void/corrections (collectively referred to as adjustments) to encounters that have previously been submitted to MDHHS.

Question	Response
10a. What is the process to identify encounters for which adjustments are required?	
10b. Describe the process to submit adjustments.	
10c. How long does it take from identification to re-submission for encounters needing adjustments?	
10d. If adjustments are not submitted, describe why these encounters were not submitted.	

11. The following questions address the collection, use, and submission of provider data and member enrollment data.

Provider Data	
11a. Provider data collected and maintained by?	☐ By the ICO ☐ By a subcontractor ☐ Both
11b. List name of subcontractor and type of provider data maintained (e.g., Subcontractor X maintains provider data for vision services)	
11c. List subcontractor's responsibilities in collecting and maintaining the data	
11d. Describe flow of provider data from collection to maintenance including processes associated with the subcontractor	
11e. Describe the process for linking provider data to claims/encounters including any procedures for	

reconciling differences between data submitted on the claim/encounter and your provider data	
Member Enrollment data	
11f. Data maintained by?	☐ By the ICO ☐ By a subcontractor ☐ Both
11g. List subcontractor's responsibilities in maintaining the member enrollment data	
11h. Describe flow of member enrollment data from collection to maintenance including processes associated with the subcontractor	
11i. Describe the process for linking member enrollment data to claims/encounters including any procedures for reconciling differences between data submitted on the claim/encounter and your member enrollment data	

Section B: Payment Structures of Encounter Data

ICO Name	
Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response.

1. How are claims paid (e.g., percent of billed, line-by-line, case rate, etc.)? If different methods exist, please add to the table below and then list them by percentage of claim dollars for each payment type.

Payment Type	Inpatient	Outpatient	Pharmacy
Percent of Billed			
Line-by-line			
Per-diem			
Variable Per Diem			
Capitation			
DRG			
Negotiated (Flat) Rate			
Ingredient Cost (for Pharmacy)			
Other (Please describe)			
Other (Please describe)			
Total	**100%**	**100%**	**100%**

2. Are any services submitted to the ICO under a bundled-payment structures? If so, what services are submitted for a bundled-payment? For example, if delivery services are considered a bundled payment, please specify whether encounters on both delivery and all prenatal/postpartum services are collected and submitted to MDHHS by your ICO.

3. Describe in the table below the process for collecting coordination of benefits (COB)/third party liability (TPL) data and submitting encounters with TPL and TPL payments. Provide separate responses for different types of claims including pharmacy encounters.

Question	Response
3a. How is other insurance data collected? Are your ICO's subcontractors required to collect other insurance data?	
3b. How are claims processed with TPL, including the scenario when other insurance is submitted after the initial claim processing?	
3c. What source data is used to verify the accuracy of the TPL information? Where does your ICO store payment information and the source data? How is TPL information populated onto encounters submitted to MDHHS?	
3d. What are the measures taken to ensure accuracy of the TPL payment amount?	

4. Describe in the table below the process to capture, monitor accuracy, and submit zero-pay claims to MDHHS.

Question	Response
4a. Describe scenarios creating zero-pay amounts for your ICO (e.g., full payment by TPL, denied	

Question	Response
claims/claim lines, services under capitated arrangement).	
4b. How are zero-pay claims reflected in the encounter data to MDHHS?	
4c. Are zero-pay claims for capitated providers processed and submitted to MDHHS? If so, describe how the completeness and accuracy of the claims are assessed.	

5. Describe the process for submitting payment information on capitated encounters (e.g., encounters for services paid to providers per member per month by your ICO or subcontractor).

Section C: Encounter Data Quality Monitoring by Subcontractors

ICO Name	
Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response.

This section focuses on the quality checks **performed by your ICO's subcontractors** (not by your ICO). Please answer the following questions for each subcontractor that submits claims/encounter data to your ICO. Currently, pharmacy, dental, vision, NEMT, and BH are the potential subcontractors listed in this section. If your ICO has a subcontractor that is not listed, please add a new question after Question 5 based on the questions for the subcontractor listed. To help organize the responses, this section includes some standard data quality checks in the drop-down list. The table below shows a brief description for these checks. If the checks from the drop-down list are not appropriate for your entity, please choose "Other" and then include the details in the "Description" column.

Data Quality Checks in Drop-Down List	Description
Claim Volume by Submission Month	Evaluates the number of unique claims based on the month when the claims were submitted to your entity. Please describe the specifications for the counts and any stratifications you may use.
Claim Volume per Member per Month (PMPM)	Evaluates the number of unique claims per member per month based on the month when the services occurred. Please describe the specifications for the counts and any stratifications you may use.
Field-Level Completeness	Evaluates whether there are any missing and/or extra values for a specific data element. Please provide a list of variables and specifications for the evaluation.
Field-Level Validity	Evaluates whether the values for a specific data element are valid. Please provide a list of variables and specifications for the evaluation.
Timeliness	Evaluates whether the source entity submits claims to your entity in a timely manner.
Reconciliation with Financial Reports	Evaluates whether the payment fields in the claims align with the financial reports from your entity.

Data Quality Checks in Drop-Down List	Description
EDI Compliance Edits	Evaluates whether 837 professional and 837 institutional files pass the EDI compliance edits. Please describe the Workgroup for Electronic Data Interchange Strategic National Implementation Process (WEDI SNIP) levels that are used in the EDI compliance checks.
Medical Record Review	Evaluates whether some of the data elements in the claims are complete and accurate when comparing to the medical records.

1. Does your **pharmacy** subcontractor perform data quality checks and validation on the claims/encounter data before it submits to your ICO?
   ☐ Yes
   ☐ No (If No, please provide an explanation why the quality checks were not performed in the box below.)
   ☐ Don't know (If you don't know, please provide an explanation in the box below.)
   ☐ Not applicable. Our ICO does not have a pharmacy subcontractor

Click or tap here to enter text.

If Yes, list the specific checks and validation the subcontractor performs on the data, describe them briefly, provide the frequency of the checks/validation, and provide example reports to support the listed quality checks. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2022Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

2. Does your **dental** subcontractor perform data quality checks and validation on the claims/encounter data before it submits to your ICO?
   ☐ Yes
   ☐ No (If No, please provide an explanation why the quality checks are not performed in the box below.)
   ☐ Don't know (If you don't know, please provide an explanation in the box below.)

☐ Not applicable. Our ICO does not have a dental subcontractor

Click or tap here to enter text.

If Yes, list the specific checks and validation the subcontractor performs on the data, describe them briefly, provide the frequency of the checks/validation, and provide example reports to support the listed quality checks. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2022Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

3. Does your **vision** subcontractor perform data quality checks and validation on the claims/encounter data before it submits to your ICO?

☐ Yes

☐ No (If No, please provide an explanation why the quality checks are not performed in the box below.)

☐ Don't know (If you don't know, please provide an explanation in the box below.)

☐ Not applicable. Our ICO does not have a vision subcontractor

Click or tap here to enter text.

If Yes, list the specific checks and validation the subcontractor performs on the data, describe them briefly, provide the frequency of the checks/validation, and provide example reports to support the listed quality checks. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2022Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

4. Does your **NEMT** subcontractor perform data quality checks and validation on the claims/encounter data before it submits to your ICO?

☐ Yes

☐ No (If No, please provide an explanation why the quality checks are not performed in the box below.)

☐ Don't know (If you don't know, please provide an explanation in the box below.)

☐ Not applicable. Our ICO does not have a NEMT subcontractor

Click or tap here to enter text.

If Yes, list the specific checks and validation the subcontractor performs on the data, describe them briefly, provide the frequency of the checks/validation, and provide example reports to support the listed quality checks. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2022Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

5. Does your **BH** subcontractor perform data quality checks and validation on the claims/encounter data before it submits to your ICO?

☐ Yes

☐ No (If No, please provide an explanation why the quality checks are not performed in the box below.)

☐ Don't know (If you don't know, please provide an explanation in the box below.)

☐ Not applicable. Our ICO does not have a BH subcontractor

Click or tap here to enter text.

If Yes, list the specific checks and validation the subcontractor performs on the data, describe them briefly, provide the frequency of the checks/validation, and provide example reports to support the listed quality checks. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2022Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

SECTION D: ENCOUNTER DATA QUALITY MONITORING BY ICOS

ICO Name	
Contact person for this section (Name and Title)	
Contact Information (Phone Number and E-mail)	

Please note that if your staff uses an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If your ICO uses the same data system for multiple clients or lines of business, please limit your responses to specific procedures related to the processing of MDHHS' claims and encounters. If supplemental files or supporting documents are provided, please note the filename(s) in your response.

This section focuses on the quality checks **performed by your ICO** regarding the claims/encounter data in your ICO's data warehouse, as well as claims/encounter data submitted to MDHHS. Currently, pharmacy, dental, vision, NEMT, and BH are the potential subcontractors listed in this section. If your ICO has a subcontractor that is not listed, please add a new question after Question 6 based on the questions for the subcontractor listed. Lastly, to help organize the responses, this section includes some standard data quality checks in the drop-down list. The table below shows a brief description for these checks. If the checks from the drop-down list are not appropriate for your ICO, please choose "Other" and then include the details in the "Description" column.

Data Quality Checks in Drop-Down List	Description
Claim Volume by Submission Month	Evaluates the number of unique claims based on the month when the claims were submitted to your entity. Please describe the specifications for the counts and any stratifications you may use.
Claim Volume PMPM	Evaluates the number of unique claims per member per month based on the month when the services occurred. Please describe the specifications for the counts and any stratifications you may use.
Field-Level Completeness	Evaluates whether there are any missing and/or extra values for a specific data element. Please provide a list of variables and specifications for the evaluation.
Field-Level Validity	Evaluates whether the values for a specific data element are valid. Please provide a list of variables and specifications for the evaluation.
Timeliness	Evaluates whether the source entity submits claims to your ICO in a timely manner.

Data Quality Checks in Drop-Down List	Description
Reconciliation with Financial Reports	Evaluates whether the payment fields in the claims align with the financial reports from your ICO.
EDI Compliance Edits	Evaluates whether 837 professional and 837 institutional files pass the EDI compliance edits. Please describe the WEDI SNIP levels that are used in the EDI compliance checks.
Medical Record Review	Evaluates whether some of the data elements in the claims are complete and accurate when comparing to the medical records.

1. Upon receiving claims/encounter files from your subcontractors, please use the table below to indicate the following for each subcontractor:

- Column 2: Does subcontractor submit encounter files to MDHHS?
- Column 3: Does your ICO store the claims/encounter files from subcontractors in your data warehouse?
- Column 4: Does your ICO perform any quality checks on the claims/encounter files from subcontractors **before** submitting them to MDHHS? If not, please provide an explanation why the quality checks are not performed in the second box below.
- Column 5: Does your ICO modify the claims/encounter files from subcontractors **before** submitting them to MDHHS?
- Column 6: Does your ICO perform any quality checks on the claims/encounter data from subcontractors **after** submitting them to MDHHS?

Subcontractor	Submits to MDHHS by Subcontractor	Stored by ICO	Reviewed by ICO Before Submission	Modified by ICO Before Submission	Reviewed by ICO After Submission
Pharmacy	*Yes*	*Yes*	*No*	*No*	*Yes*
BH	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
NEMT	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Pharmacy	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Dental	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Vision	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Other (*list and describe*)	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

Subcontractor	Explanation Why Claims/Encounter Data are Not Reviewed by ICO Before Submission to MDHHS
Pharmacy	*ICO is satisfied with the quality checks that the subcontractor has in place.*
BH	
NEMT	
Pharmacy	
Dental	
Vision	
Other (*list and describe*)	

2. If your ICO performs quality checks on the claims/encounter data from a **pharmacy** subcontractor, please list the specific checks and validation your ICO performs on the data, describe them briefly, provide the frequency of the checks/validation, and provide example reports to support the listed quality checks. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2022Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

3. If your ICO does not have a **dental** subcontractor, please mark the check box below. If your ICO performs quality checks on the claims/encounter data from a **dental** subcontractor, please list the specific checks and validation your ICO performs on the data, describe them briefly, provide the frequency of the checks/validation, and provide example reports to support the listed quality checks. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

☐ Our ICO does not have a dental subcontractor

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2022Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

4. If your ICO does not have a **vision** subcontractor, please mark the check box below. If your ICO performs quality checks on the claims/encounter data from a **vision** subcontractor, please list the specific checks and validation your ICO performs on the data, describe them briefly, provide the frequency of the checks/validation, and provide example reports to support the listed quality checks. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

☐ Our ICO does not have a vision subcontractor

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2022Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

5. If your ICO does not have a **NEMT** subcontractor, please mark the check box below. If your ICO performs quality checks on the claims/encounter data from a **NEMT** subcontractor, please list the specific checks and validation your ICO performs on the data, describe them briefly, provide the frequency of the checks/validation, and provide example reports to support the listed quality checks. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

☐ Our ICO does not have a NEMT subcontractor

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2022Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

Data Quality Checks	Description	Frequency	Supporting Documents
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

6. If your ICO does not have a **BH** subcontractor, please mark the check box below. If your ICO performs quality checks on the claims/encounter data from a **BH** subcontractor, please list the specific checks and validation your ICO performs on the data, describe them briefly, provide the frequency of the checks/validation, and provide example reports to support the listed quality checks. *Note: You can select from the drop-down list. The grey shaded rows in the table are provided as an example. The table can be expanded if additional rows are required.*

☐ Our ICO does not have a BH subcontractor

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2022Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

7. Does your ICO perform any quality checks on the claims/encounter data that are stored in your data warehouse but **NOT** submitted by the subcontractors?
   ☐ Yes
   ☐ No (If No, please provide an explanation why the quality checks are not performed in the box below.)
   ☐ Don't know (If you don't know, please provide an explanation in the box below.)

Click or tap here to enter text.

If Yes, please list the specific checks and validation your ICO performs on the data, describe them briefly, provide the frequency of the checks/validation, and provide example reports to support the listed quality checks. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2022Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

8. Please describe how your ICO ensures that the National Correct Coding Initiative (NCCI) edits have been applied to the encounter data submitted to MDHHS.

9. Using the table below, please identify which transaction response files are used to support your encounter data submission activities and how the responses are tracked in your data system. If the transaction response files are used to support encounter data submission activities ("YES"), describe how the data are used in the last column and whether the transaction responses are stored in your ICO's data system. If the transaction responses are not used to support encounter data submission activities ("NO"), explain the reason why in the last column and whether the transaction responses are stored in your ICO's data system. *Note: The table can be expanded if additional rows are required.*

Transaction Response	Used to Support Encounter Data Submission?	Explanation of Transaction Response Use and Storage in your ICO's Data System
277	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

10. List the number of encounters submitted, initially denied, initially denied but later accepted on resubmission, and initially denied but not accepted yet as of the date when the responses are prepared. Please stratify the counts by claim/encounter type.

Claim/Encounter Type	Submitted	Initially Denied Due to MDHHS' EDI Translator	Initially Denied Due to Additional MDHHS Specific Edits	Initially Denied, Accepted on Resubmission	Initially Denied, Not Yet Accepted
837 Institutional					
837 Professional					
837 Dental					
Pharmacy					
<Insert Claim/Encounter Type>					

11. What are the top five reasons for the initial denials by MDHHS for each claim/encounter type?

Claim/Encounter	Reason 1	Reason 2	Reason 3	Reason 4	Reason 5
837 Institutional					
837 Professional					
837 Dental					
Pharmacy					
<Insert Claim/Encounter Type>					

12. Describe your ICO's process for reconciling files rejected by MDHHS' EDI translator, including key policies and procedures for the identification, correction, and subsequent resubmission of encounters to MDHHS.

13. Describe your ICO's process for reconciling transactions that fail additional state-specific edits, including key policies and procedures for the identification, correction, and subsequent resubmission of these encounters to MDHHS.

14. Describe how data in your ICO's encounter data system/data warehouse are used (e.g., rate-setting, HEDIS reporting, etc.)

15. What internal challenges do you face in submitting encounter data to MDHHS?

16. What external challenges do you face in submitting encounter data to MDHHS? For example, are there challenges with MDHHS' EDI translator or the Community Health Automated Medicaid Processing System (CHAMPS).

17. What changes in processes or additional resources and support from MDHHS would you find most helpful in overcoming your challenges with successfully submitting encounter data to MDHHS?

18. Do you have any upcoming changes to your encounter submission process that may impact your answers to the questions above? If yes, what changes are expected and when are they likely to become effective?

Attestation Statement

I hereby certify that I have reviewed the information entered on this questionnaire and that, to the best of my knowledge, the information is complete and accurate as of the date below.

_____ _____

Signature of CEO or responsible individual Date

_____

Print name and title

Appendix A: Managed Care Entities Included in the Study

Table A-1 presents the programs, MCE types, MCE names and abbreviations for the MCEs included in the EDV study.

Table A-1—Medicaid Managed Care Programs and MCEs Included in the Study

Program	MCE Type	MCE Name	MCE Abbreviation
CHCP	MHPs	Aetna Better Health of Michigan	AET
		Blue Cross Complete of Michigan	BCC
		HAP Empowered Health Plan, Inc.	HAP
		McLaren Health Plan	MCL
		Meridian Health Plan of Michigan	MER
		Molina Healthcare of Michigan	MOL
		Priority Health Choice	PRI
		UnitedHealthcare Community Plan	UNI
		Upper Peninsula Health Plan	UPP
Healthy Kids Dental Program	PAHPs	Blue Cross Blue Shield of Michigan Healthy Kids Dental	BCBSM
		Delta Dental of Michigan	DDMI
MI Health Link Program	ICOs/PIHPs	Aetna Better Health Premier Plan	Aetna
		AmeriHealth Caritas VIP Care Plus	AmeriHealth
		HAP Empowered	HAP
		MeridianComplete	Meridian
		Molina Dual Options MI Health Link	Molina
		Upper Peninsula Health Plan MI Health Link	UPHP
Behavioral Health Managed Care Program	PIHPs	NorthCare Network	NCN
		Northern Michigan Regional Entity (NMRE)	NMRE
		Lakeshore Regional Entity	LRE
		Southwest Michigan Behavioral Health	SWMBH
		Mid-State Health Network	MSHN
		Community Mental Health Partnership of Southeast Michigan	CMHPSM
		Detroit Wayne Integrated Health Network	DWIHN
		Oakland Community Health Network	OCHN
		Macomb County Community Mental Health	MCCMH

Program	MCE Type	MCE Name	MCE Abbreviation
		Region 10 PIHP	Region 10 PIHP
MI Choice Waiver Program	Waiver Agencies	A&D Home Health Care	AD
		Area Agency on Aging 1B	AAA1B
		Area Agency on Aging of Northwest Michigan	AAANWMI
		Area Agency on Aging of Western Michigan	AAAWMI
		Detroit Area Agency on Aging	Detroit AAA
		easterseals|MORC	MORC
		Region 9 Area Agency on Aging/ Northeast MI Community Service Agency	NEMCSA
		Northern Health Care Management	NHCM
		Region 2 Area Agency on Aging	R2AAA
		Region 3B Area Agency on Aging/Carewell Services	R3BAAA
		Region IV Area Agency on Aging	RIVAAA
		Region VII Area Agency on Aging	Region VII
		Reliance Community Care Partners	Reliance
		Senior Resources	Senior Resources
		Milestone Senior Services	Senior Services
		Tri-County Office on Aging	Tri-County
		The Information Center	The Information Ctr
		The Senior Alliance	Senior Alliance
		Upper Peninsula Commission for Area Progress (UPCAP)	UPCAP
		Valley Area Agency on Aging	Valley AAA

Appendix D. Results for Aetna Better Health of Michigan

Appendix D contains the IS review and administrative profile results, strengths, weaknesses, and recommendations, as applicable, that HSAG identified from the EDV study for **Aetna Better Health of Michigan**.

IS Review Findings

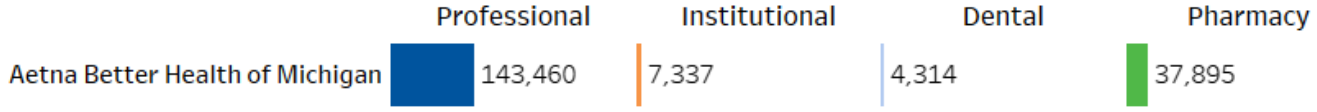
Please refer to Section 3: Information Systems Review Findings for **Aetna Better Health of Michigan**'s specific findings, if any.

Administrative Profile Results

Encounter Data Summary

Figure D-1 displays the number of encounters by category of service.

Figure D-1—Number of Encounters by Category of Service—Aetna Better Health of Michigan

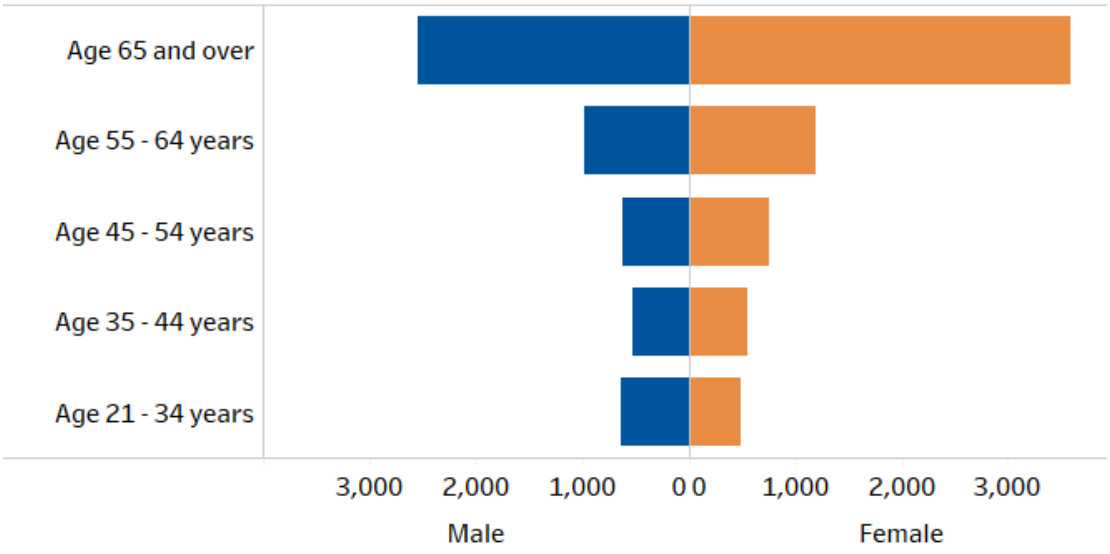


Member Composition

Figure D-2 and Figure D-3 display member demographics.

Figure D-2—Enrollment in SFY 2023—Aetna Better Health of Michigan

Figure D-3—Age and Gender Distribution—Aetna Better Health of Michigan

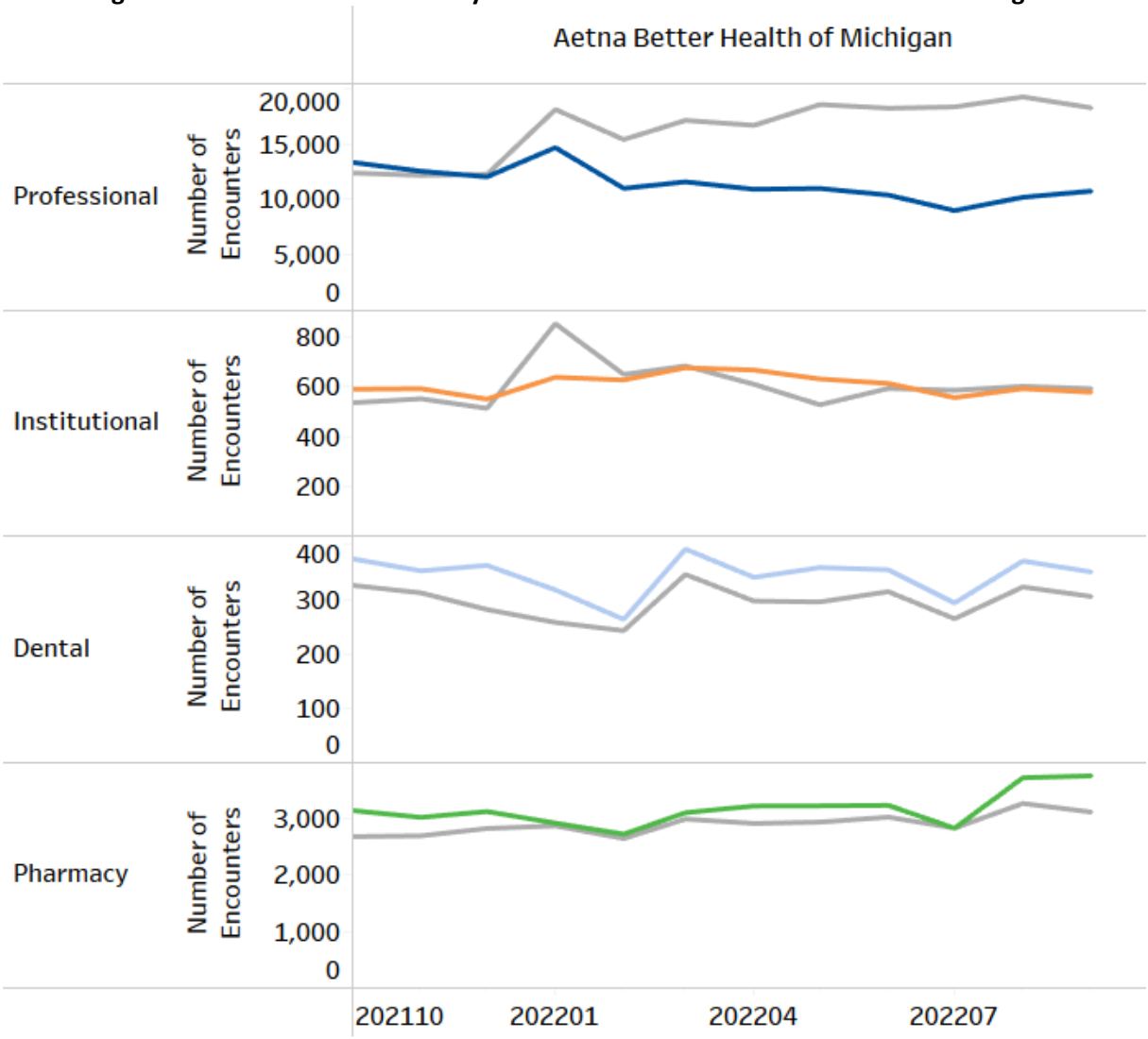


Encounter Data Completeness

Encounter Volume by Service Month

Figure D-4 displays the monthly encounter volume by service month and category of service.

Figure D-4—Encounter Volume by Service Month—Aetna Better Health of Michigan

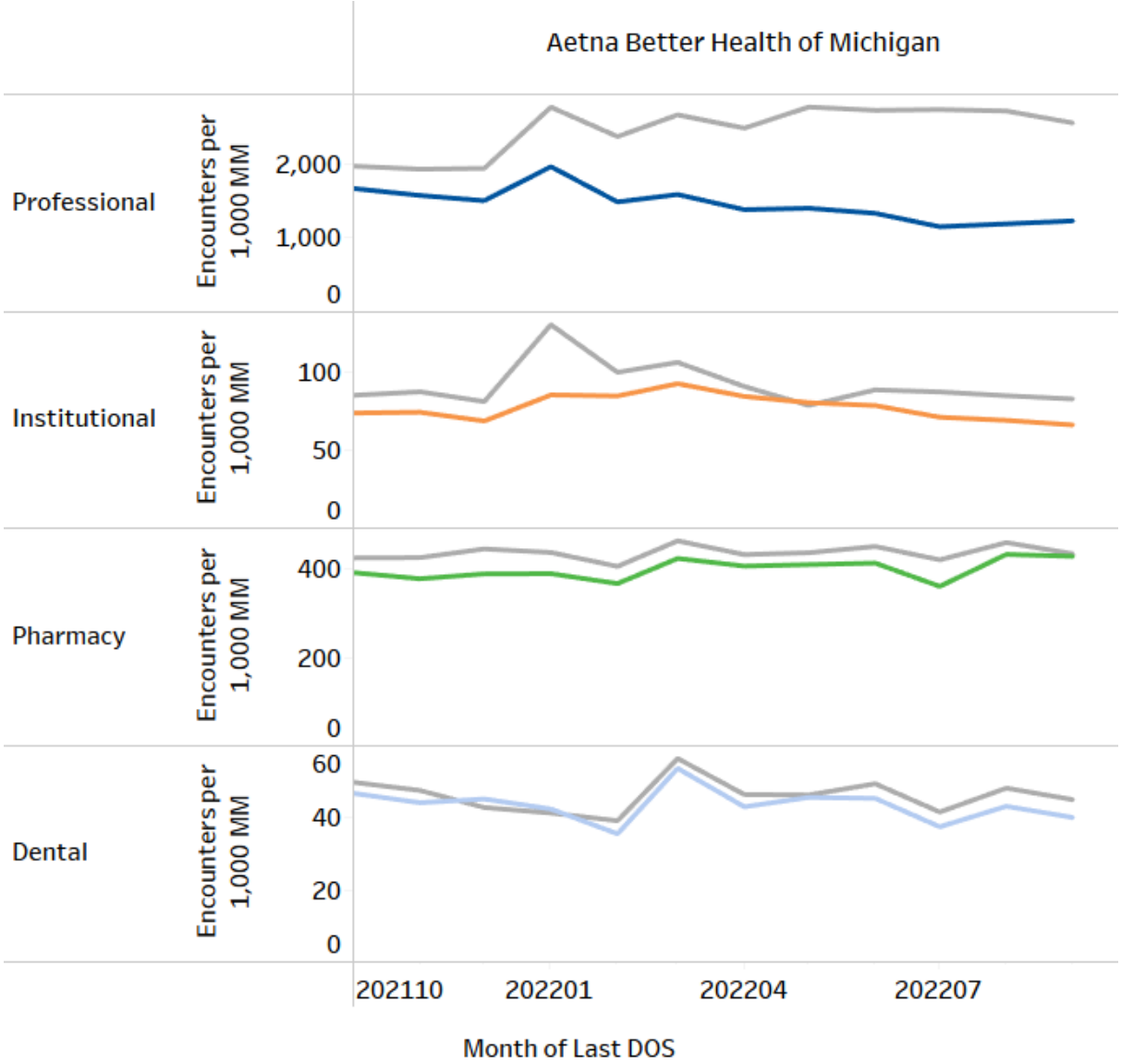


Note: The grey line indicates the all ICO rate.

Encounter Volume Per 1,000 Member Months

Figure D-5 displays the monthly encounter volume per 1,000 MM by service month and category of service.

Figure D-5—Encounter Volume per 1,000 MM—Aetna Better Health of Michigan

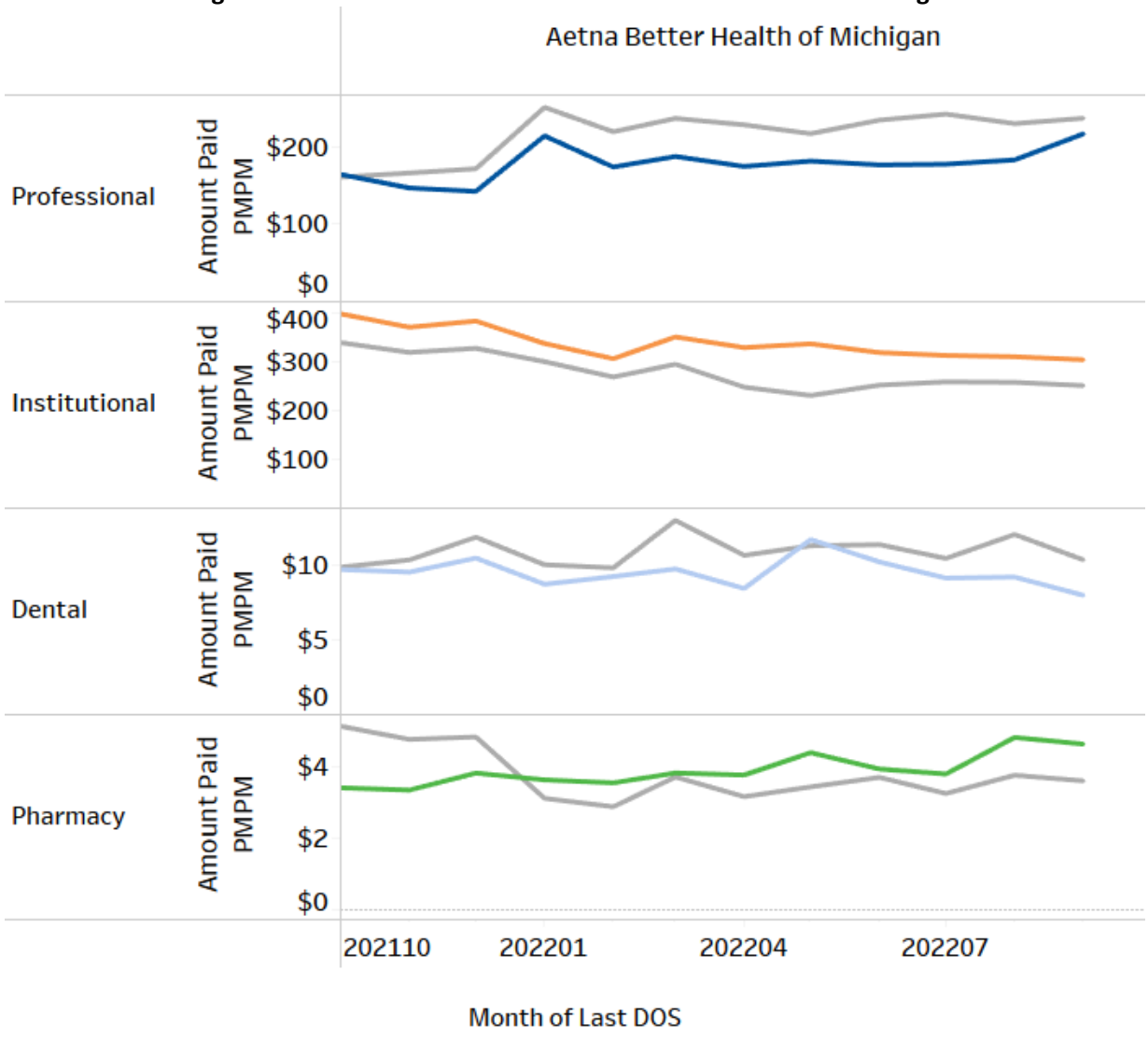


Note: The grey line indicates the all ICO rate.

Payment Amounts Per Member Per Month

Figure D-6 displays the monthly payment amounts PMPM by service month and category of service.

Figure D-6—Paid Amount PMPM—Aetna Better Health of Michigan

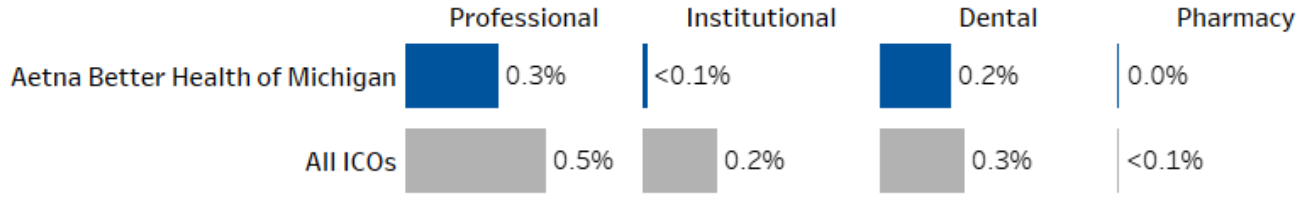


Note: The grey line indicates the all ICO rate.

Percentage of Duplicate Encounters

Figure D-7 displays the percentage of duplicate encounters.

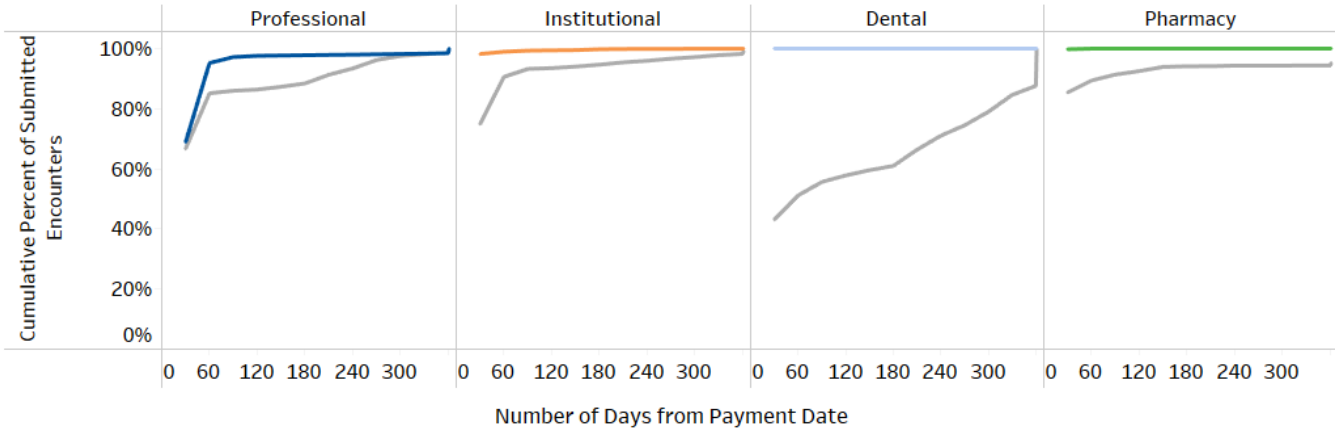
Figure D-7—Percentage of Duplicate Encounters—Aetna Better Health of Michigan



Encounter Data Timeliness

Figure D-8 and Table D-1 show the cumulative percentage of encounters submitted to MDHHS from the payment date by category of service.

Figure D-8—Cumulative Percentage of Encounters Submitted to MDHHS From ICO Payment Date by Category of Service—Aetna Better Health of Michigan



Note: The grey line indicates the all ICO rate.

Table D-1—Completeness of Encounters by Category of Service—Aetna Better Health of Michigan

Number of Days From Payment Date	Cumulative Percentage of Submitted Professional Encounters	Cumulative Percentage of Submitted Institutional Encounters	Cumulative Percentage of Submitted Dental Encounters	Cumulative Percentage of Submitted Pharmacy Encounters
Submitted Within 30 Days	68.9%	98.2%	100.0%	99.8%
Submitted Within 60 Days	95.2%	98.9%	100.0%	>99.9%
Submitted Within 90 Days	97.2%	99.3%	100.0%	>99.9%
Submitted Within 120 Days	97.6%	99.4%	100.0%	>99.9%
Submitted Within 150 Days	97.7%	99.5%	100.0%	>99.9%
Submitted Within 180 Days	97.8%	99.8%	100.0%	>99.9%
Submitted Within 210 Days	97.9%	99.8%	100.0%	>99.9%
Submitted Within 240 Days	98.0%	99.9%	100.0%	>99.9%
Submitted Within 270 Days	98.1%	99.9%	100.0%	100.0%
Submitted Within 300 Days	98.2%	99.9%	100.0%	100.0%
Submitted Within 330 Days	98.3%	99.9%	100.0%	100.0%
Submitted Within 360 Days	98.5%	99.9%	100.0%	100.0%
Submitted After 360 Days	100.0%	100.0%	100.0%	100.0%
Missing Paid or Submission Date	0.0%	0.0%	0.0%	0.0%
Submitted Prior to Paid Date	0.0%	0.0%	0.0%	0.0%

Field-Level Completeness and Accuracy

Figure D-9 through Figure D-12 provide the percentage of encounters that are present and contain valid values for key data elements.

Figure D-9—Key Professional Encounter Data Elements—Aetna Better Health of Michigan

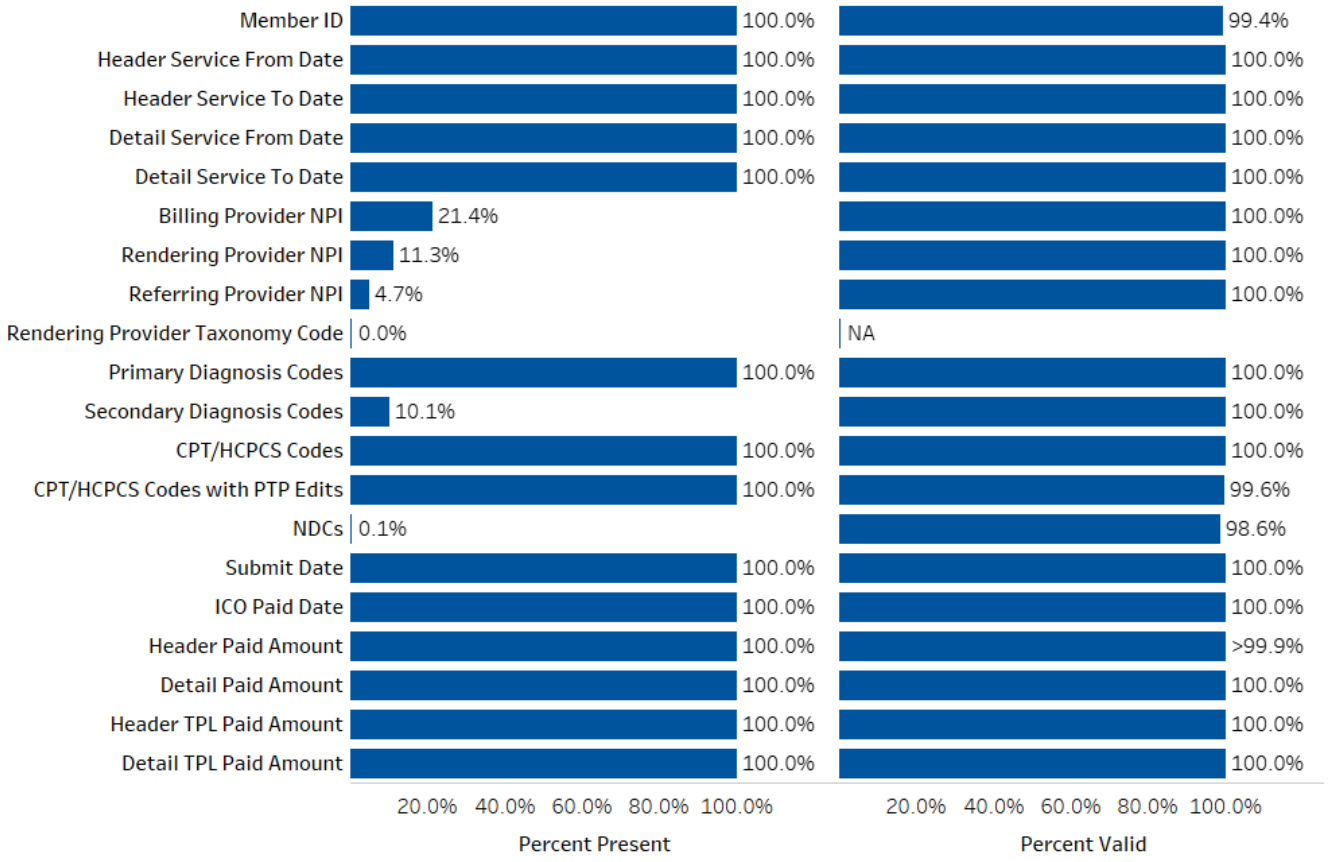


Figure D-10—Key Institutional Encounter Data Elements—Aetna Better Health of Michigan

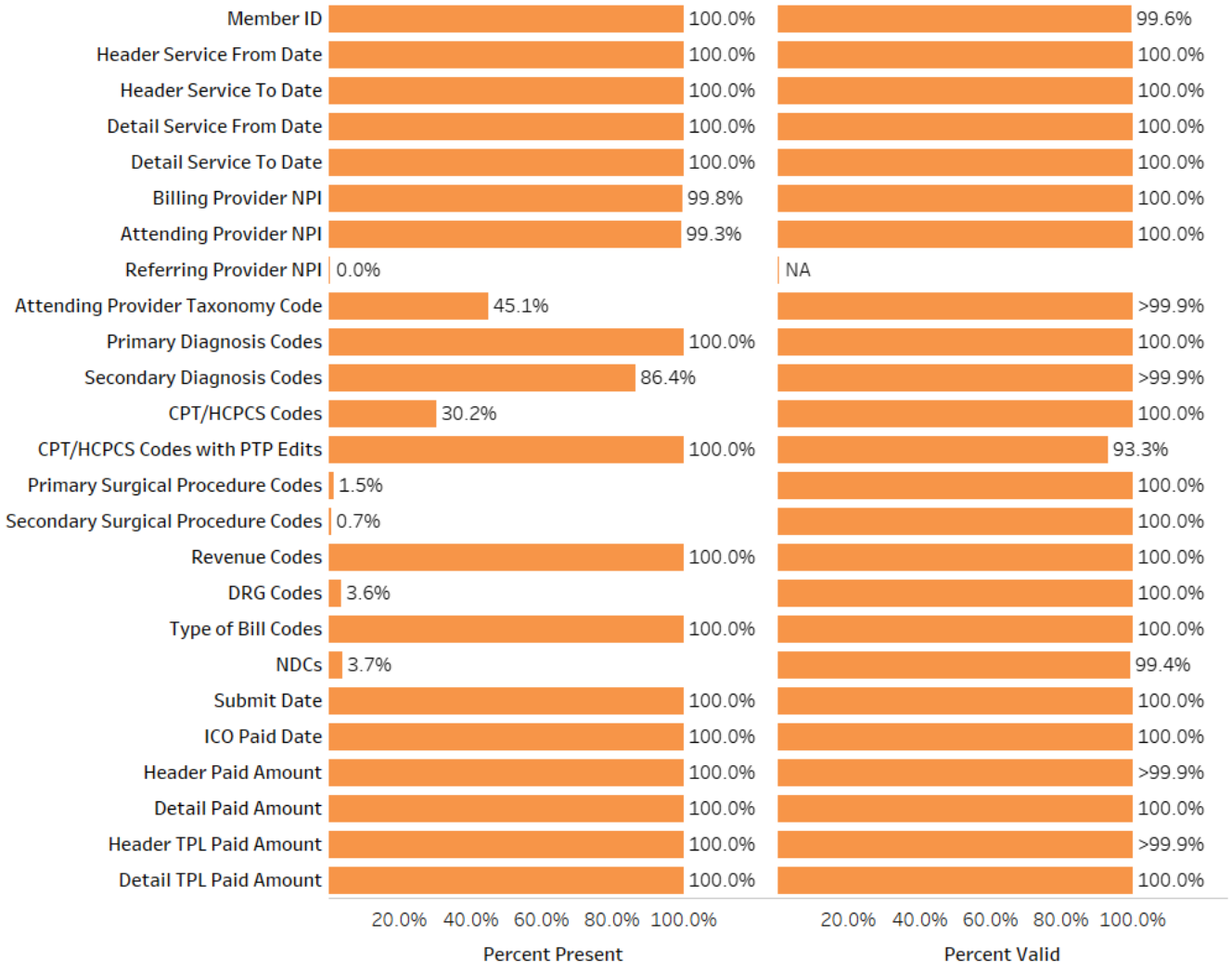


Figure D-11—Key Dental Encounter Data Elements—Aetna Better Health of Michigan

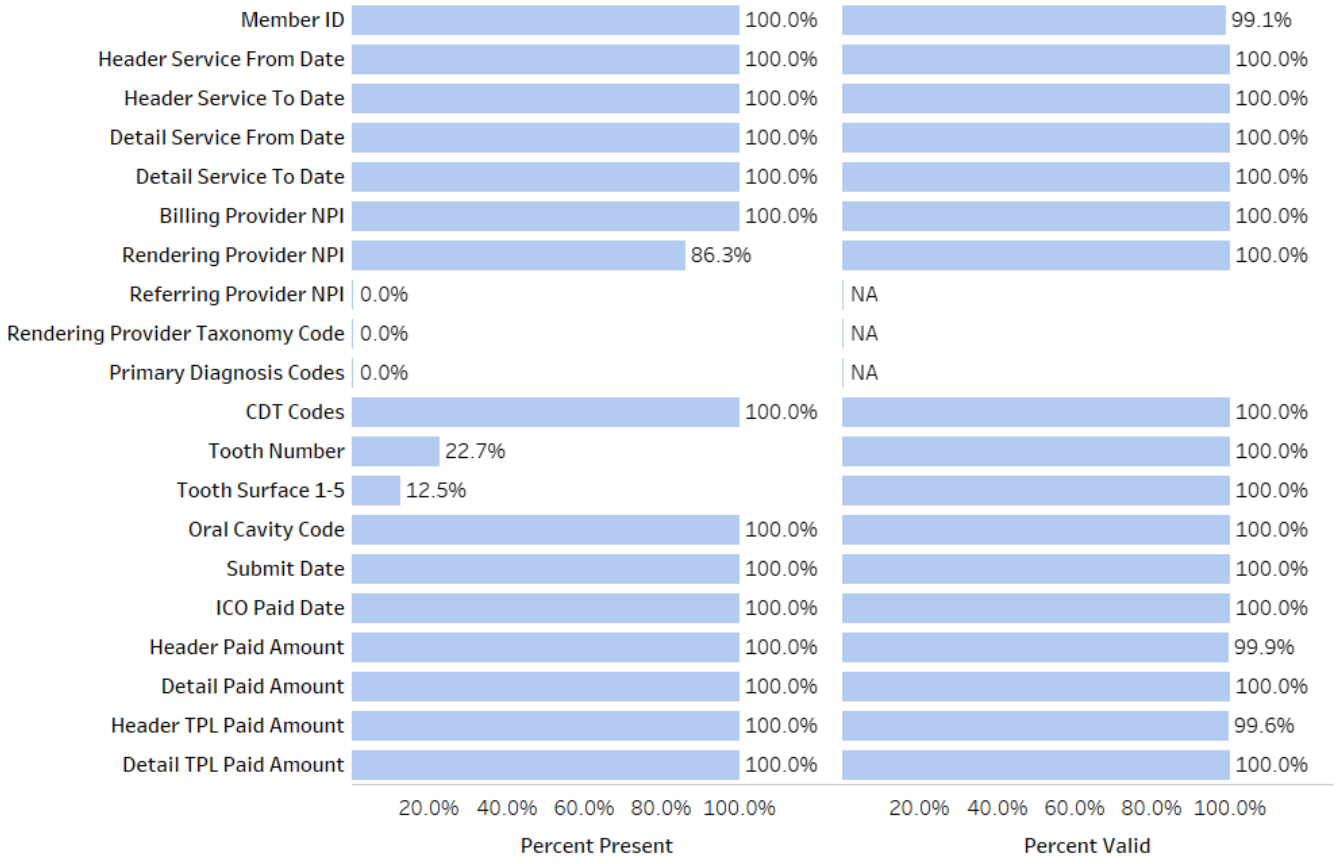
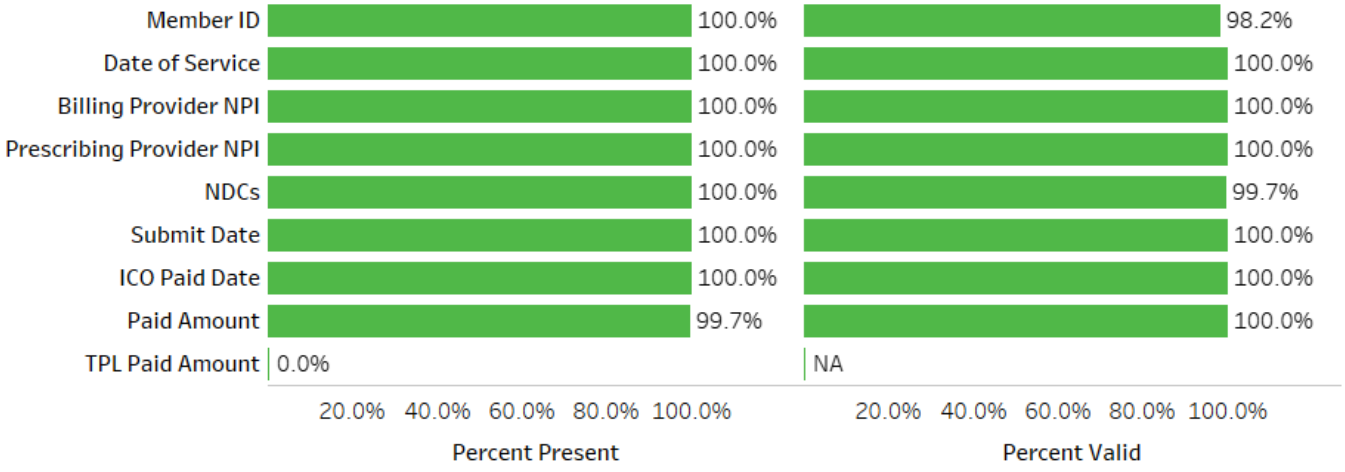


Figure D-12—Key Pharmacy Encounter Data Elements—Aetna Better Health of Michigan



Encounter Data Referential Integrity

Figure D-13 through Figure D-17 display the referential integrity results.

Figure D-13—Referential Integrity Comparison Between Enrollment and Medical/Dental Encounter Files—Aetna Better Health of Michigan

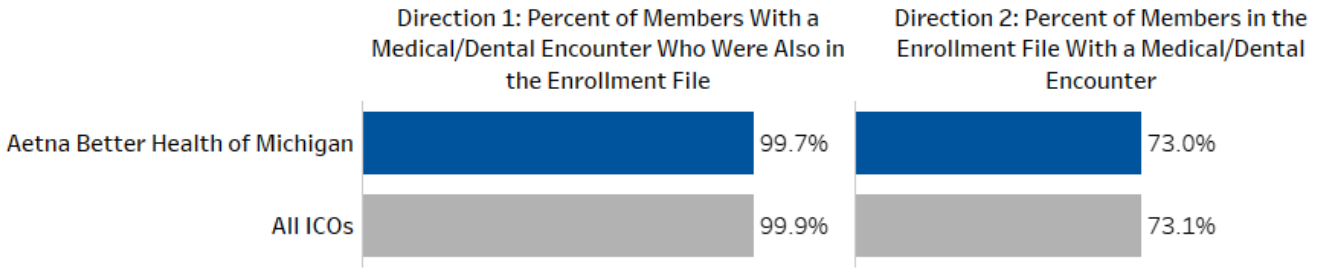


Figure D-14—Referential Integrity Comparison Between Enrollment and Pharmacy Encounter Files—Aetna Better Health of Michigan

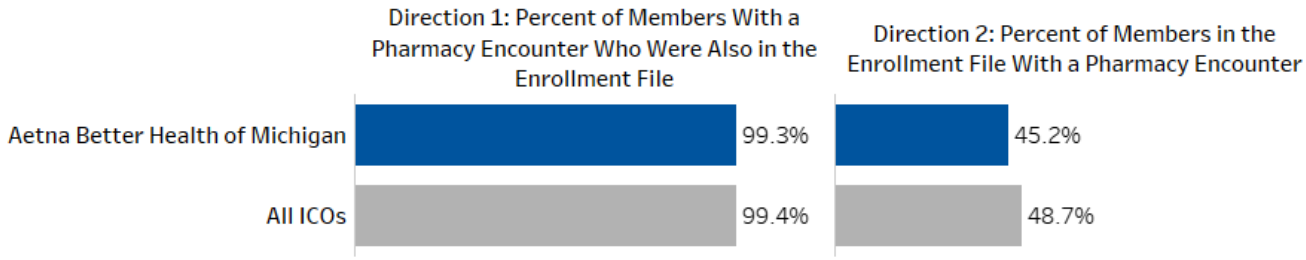


Figure D-15—Referential Integrity Comparison Between Medical/Dental Encounter and Pharmacy Encounter Files—Aetna Better Health of Michigan

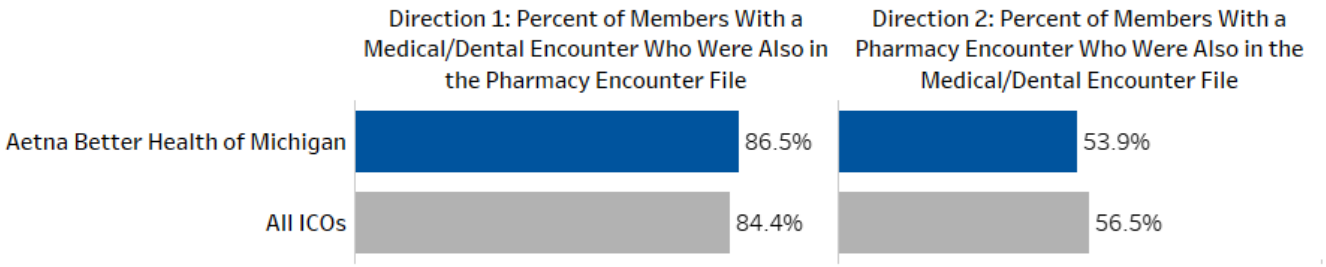


Figure D-16—Referential Integrity Comparison Between Medical/Dental Encounter and Provider Files—Aetna Better Health of Michigan

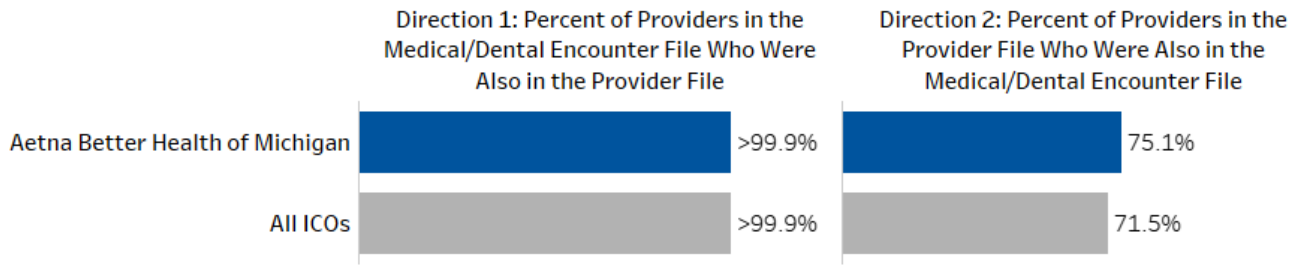
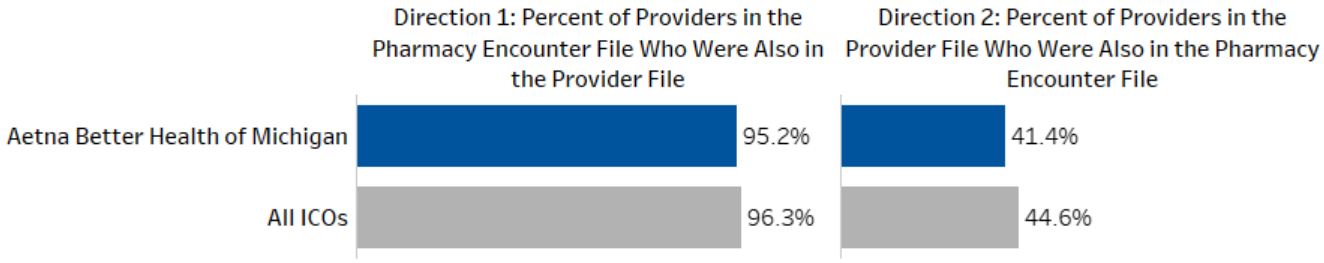


Figure D-17—Referential Integrity Comparison Between Pharmacy Encounter and Provider Files—Aetna Better Health of Michigan

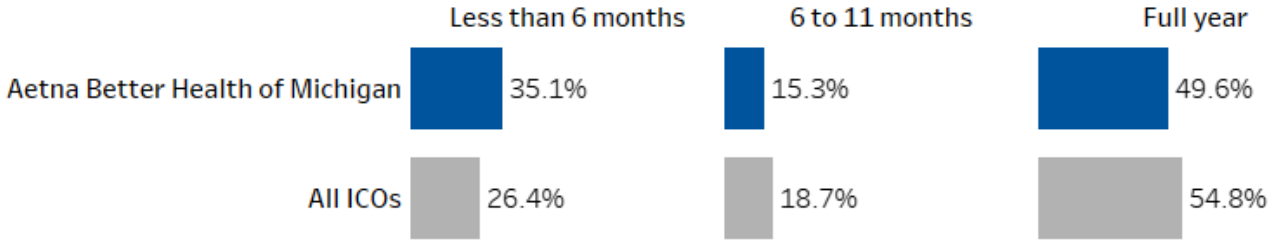


Encounter Data Logic

Member Enrollment

Figure D-18 displays the percentage of members who were continuously enrolled.

Figure D-18—Percentage of Members Who Were Continuously Enrolled—Aetna Better Health of Michigan



Conclusions

Based on the examination of the IS review and administrative profile outcomes in Section 3 and Section 4, respectively, for **Aetna Better Health of Michigan**, HSAG identified the following areas of strength and opportunities for improvement. Along with each opportunity for improvement, HSAG has also provided a recommendation to help target improvement efforts.

IS Review Conclusions

Strengths

Strength #1: Aetna Better Health of Michigan demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The ICO has also established data review and correction processes that efficiently address quality concerns identified by MDHHS.

Opportunities for Improvement

Weakness #1: Aetna Better Health of Michigan did not indicate timeliness quality checks were performed for claims/encounters originating from its pharmacy and fiscal intermediary subcontractors.

Why the weakness exists: Timeliness quality checks are crucial to ensuring that claims and encounters are submitted within the stipulated time frames.

Recommendation: Aetna Better Health of Michigan should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

Weakness #2: Aetna Better Health of Michigan reported only conducting one quality check for claims/encounters stored in its data warehouses.

Why the weakness exists: Only the reconciliation with the financial report was listed as being conducted, and no other checks for accuracy, completeness, or timeliness were mentioned.

Recommendation: Aetna Better Health of Michigan should build a comprehensive set of monitoring reports to evaluate encounter data accuracy, completeness, and timeliness for encounters collected and stored by **Aetna Better Health of Michigan**.

Administrative Profile Conclusions

Strengths

Strength #1: Aetna Better Health of Michigan submitted professional, institutional, dental, and pharmacy encounters in a timely manner from the payment date, with greater than 95 percent of all encounters submitted within 60 days of the payment date.

Strength #2: Across all categories of service, all key data elements for **Aetna Better Health of Michigan** were populated at high rates, and all but one was greater than 98 percent valid.

Opportunities for Improvement

Weakness #1: Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 95.2 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data.

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: Aetna Better Health of Michigan should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Weakness #2: Although not required to be populated, 21.4 percent of professional encounters contained a billing provider NPI, and 11.3 percent contained a rendering provider NPI.

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Aetna Better Health of Michigan should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Administrative Profile Results—Tabular Data

Encounter Data Summary

Member Composition

Table D-2 presents the member composition.

Table D-2—Age and Gender Distribution—Aetna Better Health of Michigan

Age Category	Number of Females	Number of Males
Age 21–34 years	493	639
Age 35–44 years	542	524
Age 45–54 years	756	630
Age 55–64 years	1,186	977
Age 65 and over	3,586	2,547
Total	**6,563**	**5,317**

Encounter Data Completeness

Encounter Volume by Service Month

Table D-3 through Table D-6 display the encounter volume by service month.

Table D-3—Encounter Volume: Professional Encounters—Aetna Better Health of Michigan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	13,341	7,983	1,671.2
November 2021	12,550	7,957	1,577.2
December 2021	12,041	7,997	1,505.7
January 2022	14,674	7,461	1,966.8
February 2022	11,004	7,389	1,489.2
March 2022	11,590	7,289	1,590.1
April 2022	10,923	7,888	1,384.8
May 2022	10,995	7,833	1,403.7
June 2022	10,402	7,789	1,335.5
July 2022	9,007	7,806	1,153.9
August 2022	10,205	8,555	1,192.9
September 2022	10,755	8,725	1,232.7

Table D-4—Encounter Volume: Institutional Encounters—Aetna Better Health of Michigan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	590	7,983	73.9
November 2021	592	7,957	74.4
December 2021	550	7,997	68.8
January 2022	638	7,461	85.5
February 2022	627	7,389	84.9
March 2022	676	7,289	92.7
April 2022	667	7,888	84.6
May 2022	631	7,833	80.6
June 2022	613	7,789	78.7
July 2022	556	7,806	71.2
August 2022	592	8,555	69.2
September 2022	578	8,725	66.2

Table D-5—Encounter Volume: Dental Encounters—Aetna Better Health of Michigan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	374	7,983	46.8
November 2021	352	7,957	44.2
December 2021	362	7,997	45.3
January 2022	317	7,461	42.5
February 2022	263	7,389	35.6
March 2022	392	7,289	53.8
April 2022	340	7,888	43.1
May 2022	358	7,833	45.7
June 2022	354	7,789	45.4
July 2022	293	7,806	37.5
August 2022	370	8,555	43.2
September 2022	350	8,725	40.1

Table D-6—Encounter Volume: Pharmacy Encounters—Aetna Better Health of Michigan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	3,131	7,983	392.2
November 2021	3,011	7,957	378.4
December 2021	3,114	7,997	389.4
January 2022	2,909	7,461	389.9
February 2022	2,715	7,389	367.4
March 2022	3,094	7,289	424.5
April 2022	3,211	7,888	407.1
May 2022	3,215	7,833	410.4
June 2022	3,223	7,789	413.8
July 2022	2,819	7,806	361.1
August 2022	3,709	8,555	433.5
September 2022	3,744	8,725	429.1

Payment Amounts Per Member Per Month

Table D-7 through Table D-10 display the monthly payment amounts PMPM by service month.

Table D-7—Paid Amount PMPM: Professional Encounters—Aetna Better Health of Michigan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	7,983	$164.71
November 2021	7,957	$147.10
December 2021	7,997	$142.70
January 2022	7,461	$214.52
February 2022	7,389	$174.19
March 2022	7,289	$187.89
April 2022	7,888	$174.97
May 2022	7,833	$181.84
June 2022	7,789	$176.97
July 2022	7,806	$177.83
August 2022	8,555	$183.43
September 2022	8,725	$217.09

Table D-8—Paid Amount PMPM: Institutional Encounters—Aetna Better Health of Michigan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	7,983	$397.41
November 2021	7,957	$370.07
December 2021	7,997	$382.64
January 2022	7,461	$336.73
February 2022	7,389	$305.64
March 2022	7,289	$350.21
April 2022	7,888	$328.39
May 2022	7,833	$336.11
June 2022	7,789	$318.14
July 2022	7,806	$312.40
August 2022	8,555	$309.67
September 2022	8,725	$303.52

Table D-9—Paid Amount PMPM: Dental Encounters—Aetna Better Health of Michigan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	7,983	$9.65
November 2021	7,957	$9.48
December 2021	7,997	$10.41
January 2022	7,461	$8.68
February 2022	7,389	$9.19
March 2022	7,289	$9.69
April 2022	7,888	$8.40
May 2022	7,833	$11.65
June 2022	7,789	$10.16
July 2022	7,806	$9.09
August 2022	8,555	$9.15
September 2022	8,725	$7.94

Table D-10—Paid Amount PMPM: Pharmacy Encounters—Aetna Better Health of Michigan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	7,983	$3.43
November 2021	7,957	$3.37
December 2021	7,997	$3.84
January 2022	7,461	$3.65
February 2022	7,389	$3.57
March 2022	7,289	$3.85
April 2022	7,888	$3.79
May 2022	7,833	$4.42
June 2022	7,789	$3.96
July 2022	7,806	$3.82
August 2022	8,555	$4.84
September 2022	8,725	$4.66

Percentage of Duplicate Encounters

Table D-11 displays the percentage of duplicate encounters by category of service.

Table D-11—Percentage of Duplicate Encounters by Category of Service—Aetna Better Health of Michigan

Category of Service	Number of Duplicate Records	Percentage of Duplicate Records
Professional	824	0.3%
Institutional	3	<0.1%
Dental	20	0.2%
Pharmacy	0	0.0%

Encounter Data Timeliness

Encounter Data Lag Triangles

Table D-12 through Table D-15 display the lag triangles between service month and submission month to MDHHS. For conciseness, lag triangles only include encounters submitted through April 2023 (a minimum of a seven-month lag); therefore, counts displayed in the total line may not equal counts displayed in encounter volume figures.

Table D-12—Encounter Data Lag Triangle: Professional Encounters—Aetna Better Health of Michigan

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	576												576
202111	4,656	515											5,171
202112	5,049	4,343	376										9,768
202201	603	5,133	6,830	413									12,979
202202	524	1,545	3,817	6,392	130								12,408
202203	142	439	536	3,908	4,995	253							10,273
202204	69	163	238	695	3,847	5,601	328						10,941
202205	85	69	179	2,900	1,507	4,137	2,775	487					12,139
202206	457	199	190	318	389	1,143	6,647	4,438	553				14,334
202207	16	12	35	81	100	278	478	3,993	3,558	373			8,924
202208	5	5	14	52	93	68	200	477	4,536	5,547	316		11,313
202209	195	127	53	127	98	136	439	1,322	1,478	2,444	4,573	234	11,226
202210	9	9	5	30	23	21	39	86	169	357	4,230	3,729	8,707
202211	7	15	5	16	23	23	25	53	37	224	662	3,460	4,550
202212	1	3	7	4	7	41	47	67	71	106	380	3,161	3,895
202301	33	72	180	188	159	199	179	157	131	150	196	279	1,923
202302	10	11	25	39	36	62	37	42	50	49	46	79	486
202303	17	16	17	19	26	30	23	28	41	39	46	70	372
202304	3	5	1	9	20	36	20	30	70	65	77	64	400
Total	12,457	12,681	12,508	15,191	11,453	12,028	11,237	11,180	10,694	9,354	10,526	11,076	140,385
MM	7,983	7,957	7,997	7,461	7,389	7,289	7,888	7,833	7,789	7,806	8,555	8,725	94,672
PMPM	1.56	1.59	1.56	2.04	1.55	1.65	1.42	1.43	1.37	1.20	1.23	1.27	1.48

Table D-13—Encounter Data Lag Triangle: Institutional Encounters—Aetna Better Health of Michigan

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	0												0
202111	21	1											22
202112	32	36	1										69
202201	21	48	32	0									101
202202	13	7	19	7	1								47
202203	15	8	9	79	81	27							219
202204	16	4	9	13	38	91	8						179
202205	6	4	8	50	33	35	83	6					225
202206	17	9	12	5	6	15	49	96	17				226
202207	9	12	8	9	8	19	16	34	109	10			234
202208	7	6	5	7	10	3	13	11	31	111	10		214
202209	12	12	12	15	12	5	5	8	17	35	97	0	230
202210	2	4	2	0	2	3	3	7	5	8	38	75	149
202211	4	2	4	4	4	8	11	11	9	29	25	57	168
202212	1	5	5	19	16	23	27	16	11	13	22	30	188
202301	7	9	13	366	333	353	385	353	337	271	332	334	3,093
202302	1	7	5	5	6	12	6	6	3	18	13	25	107
202303	4	5	4	3	6	1	1	1	5	6	4	9	49
202304	9	5	0	6	6	6	12	23	11	12	12	8	110
Total	197	184	148	588	562	601	619	572	555	513	553	538	5,630
MM	7,983	7,957	7,997	7,461	7,389	7,289	7,888	7,833	7,789	7,806	8,555	8,725	94,672
PMPM	0.02	0.02	0.02	0.08	0.08	0.08	0.08	0.07	0.07	0.07	0.06	0.06	0.06

Table D-14—Encounter Data Lag Triangle: Dental Encounters—Aetna Better Health of Michigan

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	219												219
202111	151	239											390
202112	10	105	257										372
202201	4	19	92	161									276
202202	4	6	18	150	195								373
202203	1	1	8	6	67	252							335
202204	1	0	1	3	7	111	188						311
202205	2	1	3	4	1	12	124	251					398
202206	0	0	0	1	4	9	14	90	224				342
202207	0	0	0	0	3	3	5	7	118	148			284
202208	0	0	0	1	2	7	13	14	10	128	232		407
202209	2	0	0	0	0	5	3	2	5	5	87	201	310
202210	0	1	0	4	1	5	0	3	2	4	15	129	164
202211	0	1	0	0	1	1	5	1	6	13	25	9	62
202212	0	0	2	1	0	0	1	1	0	2	4	7	18
202301	0	0	0	1	0	0	0	1	0	3	3	3	11
202302	0	0	0	0	0	0	2	1	2	1	1	3	10
202303	0	0	0	0	0	1	0	1	1	0	1	0	4
202304	0	0	0	0	0	0	0	0	0	2	3	1	6
Total	394	373	381	332	281	406	355	372	368	306	371	353	4,292
MM	7,983	7,957	7,997	7,461	7,389	7,289	7,888	7,833	7,789	7,806	8,555	8,725	94,672
PMPM	0.05	0.05	0.05	0.04	0.04	0.06	0.05	0.05	0.05	0.04	0.04	0.04	0.05

Table D-15—Encounter Data Lag Triangle: Pharmacy Encounters—Aetna Better Health of Michigan

	Month of Service												
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	1,137												1,137
202111	1,693	945											2,638
202112	164	1,818	1,394										3,376
202201	18	81	1,435	1,002									2,536
202202	14	22	113	1,542	744								2,435
202203	0	7	6	59	1,446	1,239							2,757
202204	5	2	3	41	156	1,277	1,054						2,538
202205	45	67	96	10	29	67	1,452	888					2,654
202206	6	9	10	20	92	173	247	1,734	1,299				3,590
202207	12	15	11	84	94	130	198	300	1,547	1,050			3,441
202208	3	6	2	15	30	33	62	78	136	1,539	1,741		3,645
202209	5	1	3	35	24	33	40	43	52	66	1,568	1,446	3,316
202210	1	4	8	28	33	24	35	30	27	29	142	1,854	2,215
202211	0	3	0	19	11	22	20	28	33	14	75	211	436
202212	3	6	6	13	14	13	21	27	28	31	52	93	307
202301	3	1	5	9	12	7	11	17	14	8	34	24	145
202302	3	4	4	6	9	54	44	43	45	42	46	56	356
202303	0	0	0	5	4	2	4	3	4	5	9	8	44
202304	11	5	7	7	6	6	5	8	8	10	14	16	103
Total	3,123	2,996	3,103	2,895	2,704	3,080	3,193	3,199	3,193	2,794	3,681	3,708	37,669
MM	7,983	7,957	7,997	7,461	7,389	7,289	7,888	7,833	7,789	7,806	8,555	8,725	94,672
PMPM	0.39	0.38	0.39	0.39	0.37	0.42	0.40	0.41	0.41	0.36	0.43	0.42	0.40

Field-Level Completeness and Accuracy

Table D-16 through Table D-19 provide the percentage of encounters that are present and contain valid values for key data elements for all categories of service.

Table D-16—Key Encounter Data Elements: Professional Encounters—Aetna Better Health of Michigan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	143,460	143,460	100.0%	143,460	142,664	99.4%
Header Service From Date	143,460	143,460	100.0%	143,460	143,460	100.0%
Header Service To Date	143,460	143,460	100.0%	143,460	143,460	100.0%
Detail Service From Date	277,597	277,597	100.0%	277,597	277,597	100.0%
Detail Service To Date	277,597	277,597	100.0%	277,597	277,597	100.0%
Billing Provider NPI	143,460	30,657	21.4%	30,657	30,657	100.0%
Rendering Provider NPI	143,460	16,148	11.3%	16,148	16,148	100.0%
Referring Provider NPI	143,460	6,783	4.7%	6,783	6,783	100.0%
Rendering Provider Taxonomy Code	143,460	0	0.0%	0	0	NA
Primary Diagnosis Codes	143,460	143,460	100.0%	143,460	143,460	100.0%
Secondary Diagnosis Codes	143,460	14,428	10.1%	30,107	30,107	100.0%
CPT/HCPCS Codes	277,597	277,597	100.0%	277,597	277,597	100.0%
CPT/HCPCS Codes with PTP Edits	274,228	274,228	100.0%	274,228	273,214	99.6%
NDCs	277,597	368	0.1%	368	363	98.6%
Submit Date	277,597	277,597	100.0%	277,597	277,597	100.0%
ICO Paid Date	277,597	277,597	100.0%	277,597	277,597	100.0%
Header Paid Amount	143,460	143,460	100.0%	143,460	143,435	>99.9%
Detail Paid Amount	277,597	277,597	100.0%	277,597	277,597	100.0%
Header TPL Paid Amount	143,460	143,460	100.0%	143,460	143,460	100.0%
Detail TPL Paid Amount	277,597	277,597	100.0%	277,597	277,597	100.0%

Table D-17—Key Encounter Data Elements: Institutional Encounters—Aetna Better Health of Michigan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	7,337	7,337	100.0%	7,337	7,311	99.6%
Header Service From Date	7,337	7,337	100.0%	7,337	7,337	100.0%
Header Service To Date	7,337	7,337	100.0%	7,337	7,337	100.0%
Detail Service From Date	17,939	17,939	100.0%	17,939	17,939	100.0%
Detail Service To Date	17,939	17,939	100.0%	17,939	17,939	100.0%
Billing Provider NPI	7,337	7,323	99.8%	7,323	7,323	100.0%
Attending Provider NPI	7,337	7,285	99.3%	7,285	7,285	100.0%
Referring Provider NPI	7,337	0	0.0%	0	0	NA
Attending Provider Taxonomy Code	7,337	3,308	45.1%	3,308	3,307	>99.9%
Primary Diagnosis Codes	7,337	7,337	100.0%	7,337	7,337	100.0%
Secondary Diagnosis Codes	7,337	6,340	86.4%	88,150	88,149	>99.9%
CPT/HCPCS Codes	17,939	5,425	30.2%	5,425	5,425	100.0%
CPT/HCPCS Codes with PTP Edits	3,090	3,090	100.0%	3,090	2,883	93.3%
Primary Surgical Procedure Codes	7,337	110	1.5%	110	110	100.0%
Secondary Surgical Procedure Codes	7,337	53	0.7%	125	125	100.0%
Revenue Codes	17,939	17,939	100.0%	17,939	17,939	100.0%
DRG Codes	7,337	266	3.6%	266	266	100.0%
Type of Bill Codes	7,337	7,337	100.0%	7,337	7,337	100.0%
NDCs	17,939	667	3.7%	667	663	99.4%
Submit Date	17,939	17,939	100.0%	17,939	17,939	100.0%
ICO Paid Date	17,939	17,939	100.0%	17,939	17,939	100.0%
Header Paid Amount	7,337	7,337	100.0%	7,337	7,334	>99.9%
Detail Paid Amount	17,939	17,939	100.0%	17,939	17,939	100.0%
Header TPL Paid Amount	7,337	7,337	100.0%	7,337	7,335	>99.9%
Detail TPL Paid Amount	17,939	17,939	100.0%	17,939	17,939	100.0%

Table D-18—Key Encounter Data Elements: Dental Encounters—Aetna Better Health of Michigan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	4,314	4,314	100.0%	4,314	4,277	99.1%
Header Service From Date	4,314	4,314	100.0%	4,314	4,314	100.0%
Header Service To Date	4,314	4,314	100.0%	4,314	4,314	100.0%
Detail Service From Date	8,724	8,724	100.0%	8,724	8,724	100.0%
Detail Service To Date	8,724	8,724	100.0%	8,724	8,724	100.0%
Billing Provider NPI	4,314	4,314	100.0%	4,314	4,314	100.0%
Rendering Provider NPI	4,314	3,722	86.3%	3,722	3,722	100.0%
Referring Provider NPI	4,314	0	0.0%	0	0	NA
Rendering Provider Taxonomy Code	4,314	0	0.0%	0	0	NA
Primary Diagnosis Codes	4,314	0	0.0%	0	0	NA
CDT Codes	8,724	8,724	100.0%	8,724	8,724	100.0%
Tooth Number	8,724	1,983	22.7%	1,983	1,983	100.0%
Tooth Surface 1-5	8,724	1,089	12.5%	2,407	2,407	100.0%
Oral Cavity Code	8,724	8,724	100.0%	8,724	8,724	100.0%
Submit Date	8,724	8,724	100.0%	8,724	8,724	100.0%
ICO Paid Date	8,724	8,724	100.0%	8,724	8,724	100.0%
Header Paid Amount	4,314	4,314	100.0%	4,314	4,308	99.9%
Detail Paid Amount	8,724	8,724	100.0%	8,724	8,724	100.0%
Header TPL Paid Amount	4,314	4,314	100.0%	4,314	4,297	99.6%
Detail TPL Paid Amount	8,724	8,724	100.0%	8,724	8,724	100.0%

Table D-19—Key Encounter Data Elements: Pharmacy Encounters—Aetna Better Health of Michigan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	37,895	37,895	100.0%	37,895	37,222	98.2%
Date of Service	37,895	37,895	100.0%	37,895	37,895	100.0%
Billing Provider NPI	37,895	37,895	100.0%	37,895	37,895	100.0%
Prescribing Provider NPI	37,895	37,895	100.0%	37,895	37,895	100.0%
NDCs	37,895	37,895	100.0%	37,895	37,765	99.7%
Submit Date	37,895	37,895	100.0%	37,895	37,895	100.0%
ICO Paid Date	37,895	37,895	100.0%	37,895	37,895	100.0%
Paid Amount	37,895	37,800	99.7%	37,800	37,800	100.0%
TPL Paid Amount	37,895	0	0.0%	0	0	NA

Appendix E. Results for AmeriHealth Caritas

Appendix E contains the IS review and administrative profile results, strengths, weaknesses, and recommendations, as applicable, that HSAG identified from the EDV study for **AmeriHealth Caritas**.

IS Review Findings

Please refer to Section 3: Information Systems Review Findings for **AmeriHealth Caritas**' specific findings, if any.

Administrative Profile Results

Encounter Data Summary

Figure E-1 displays the number of encounters by category of service.

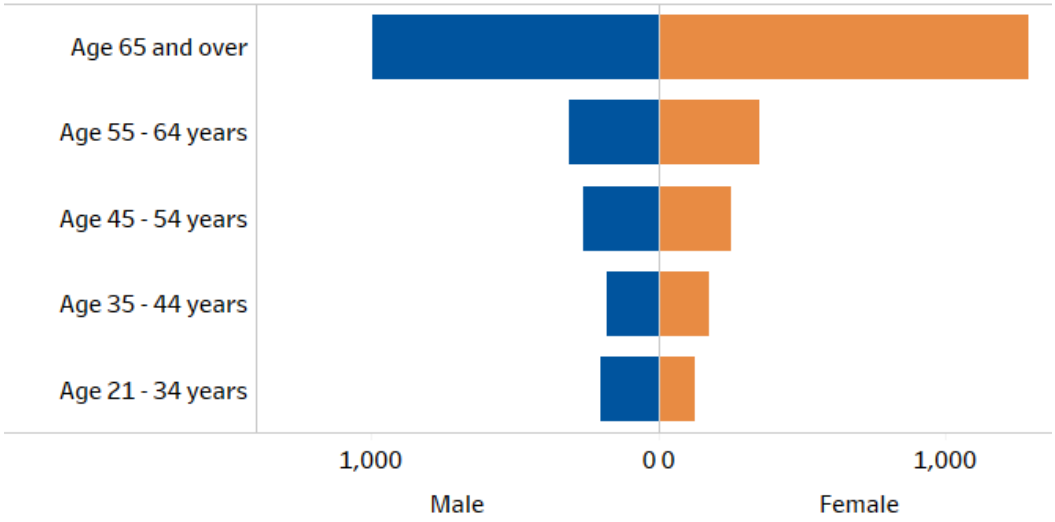
Figure E-1—Number of Encounters by Category of Service—AmeriHealth Caritas

Member Composition

Figure E-2 and Figure E-3 display member demographics.

Figure E-2—Enrollment in SFY 2023—AmeriHealth Caritas

Figure E-3—Age and Gender Distribution—AmeriHealth Caritas

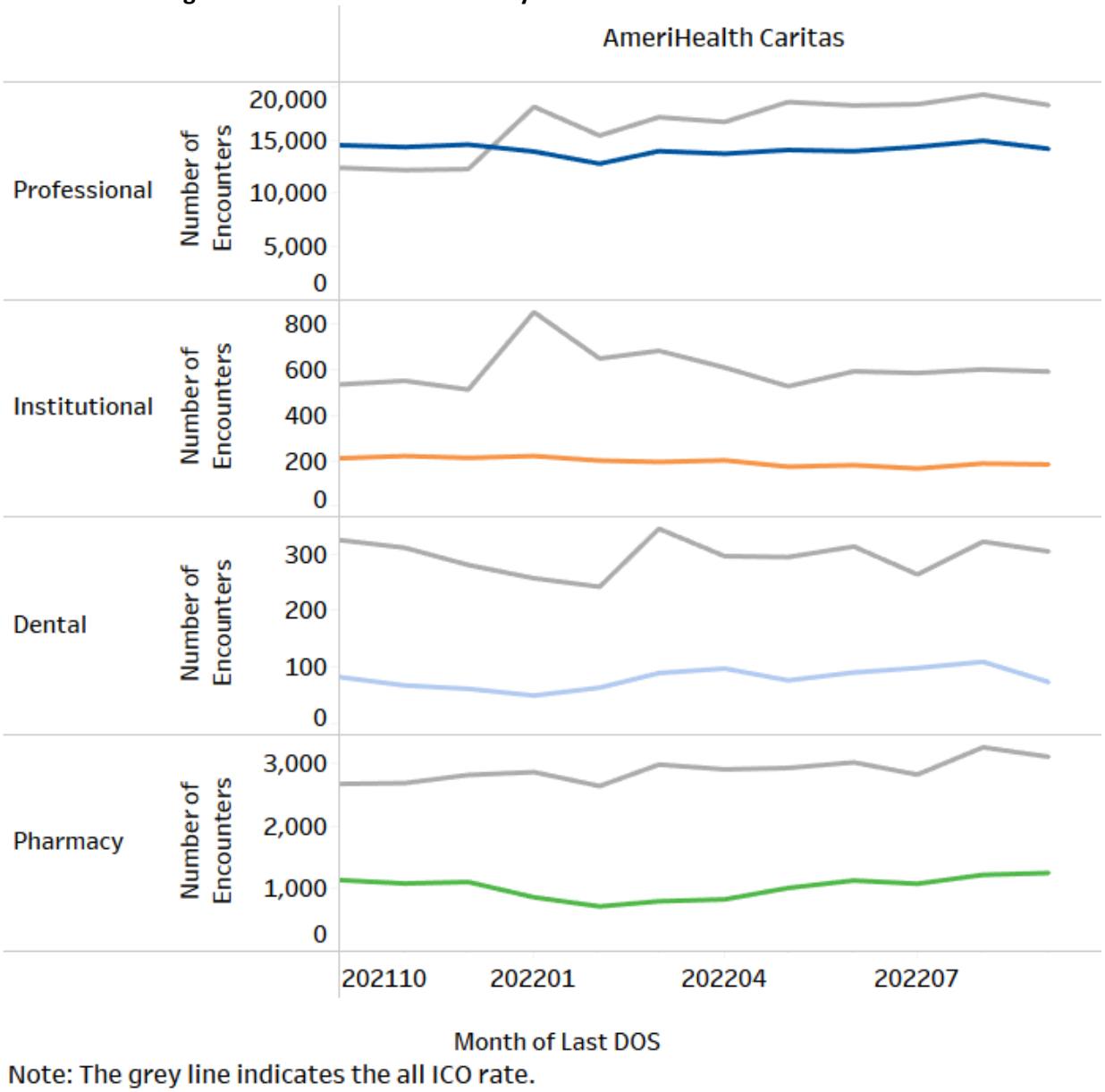


Encounter Data Completeness

Encounter Volume by Service Month

Figure E-4 displays the monthly encounter volume by service month and category of service.

Figure E-4—Encounter Volume by Service Month—AmeriHealth Caritas

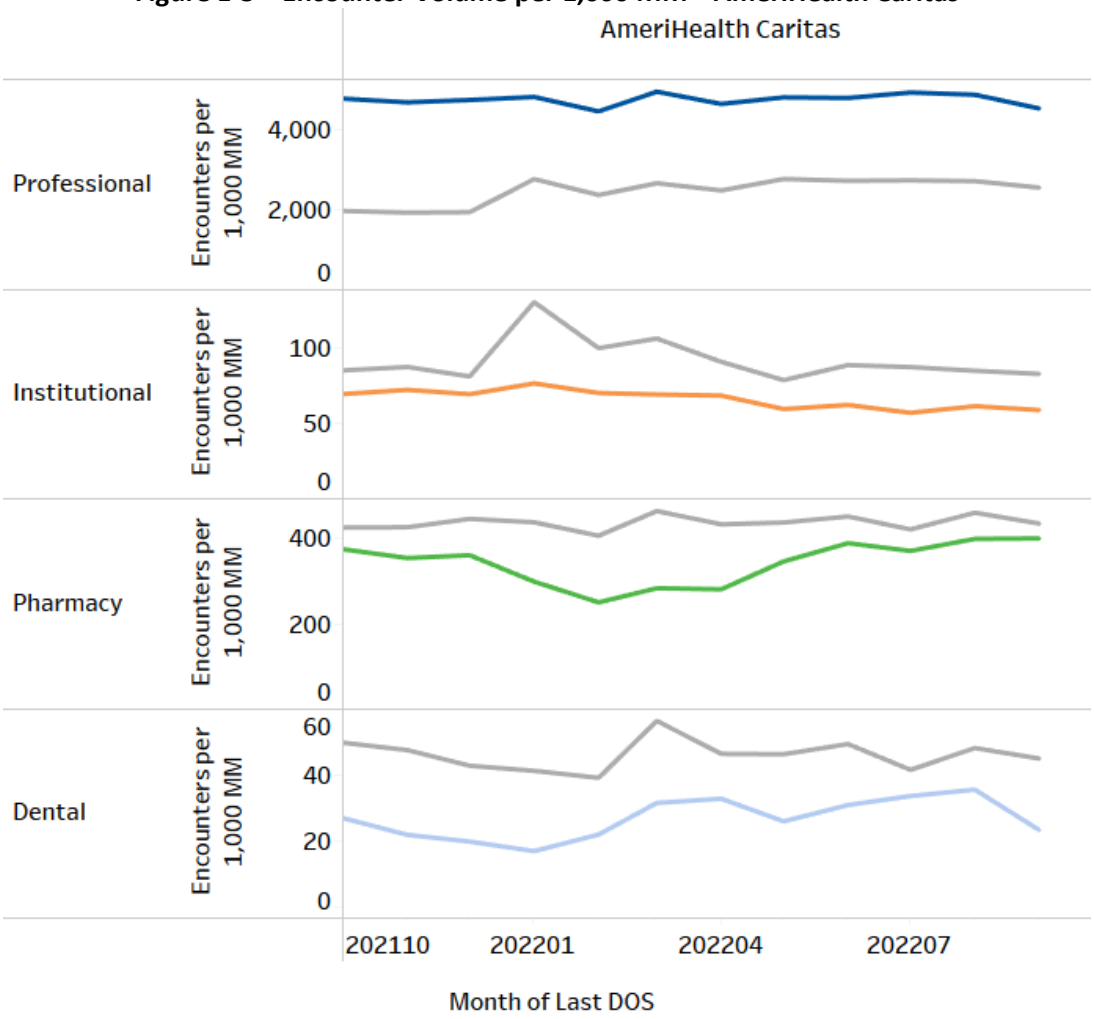


Note: The grey line indicates the all ICO rate.

Encounter Volume Per 1,000 Member Months

Figure E-5 displays the monthly encounter volume per 1,000 MM by service month and category of service.

Figure E-5—Encounter Volume per 1,000 MM—AmeriHealth Caritas

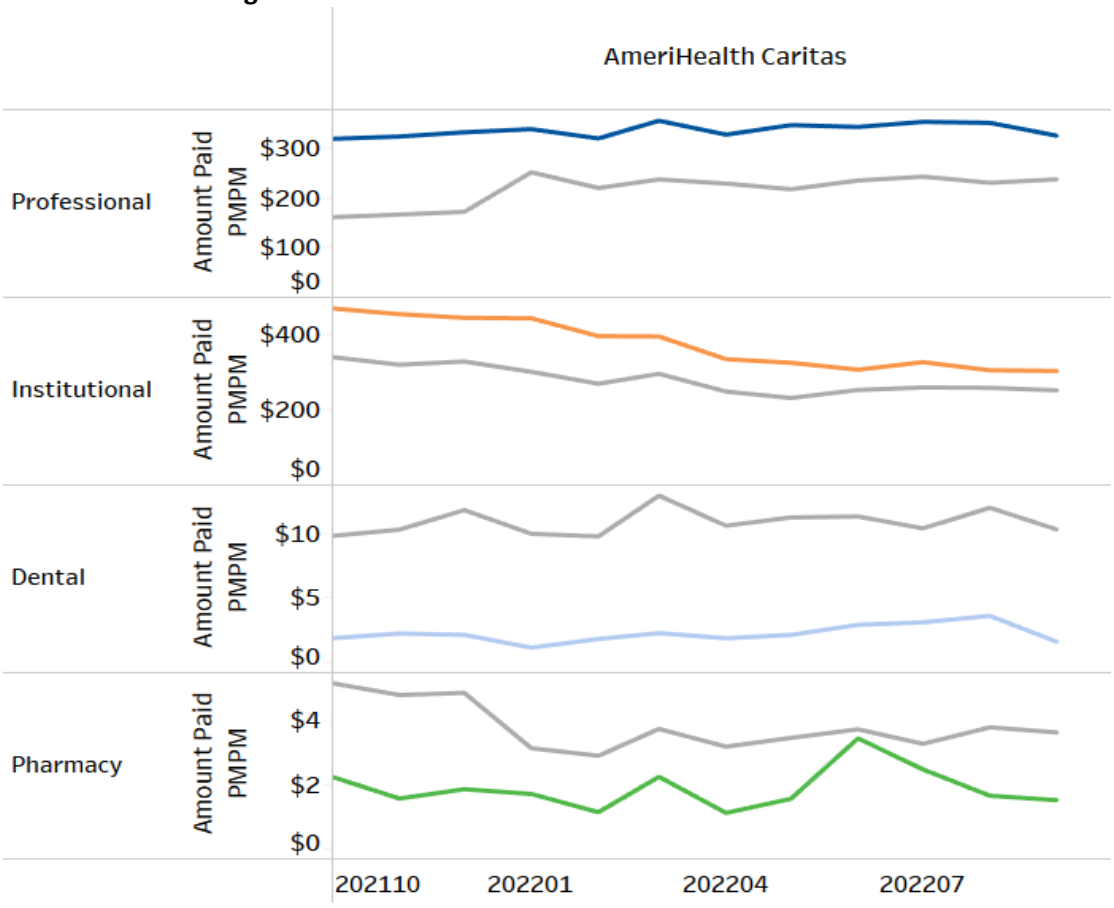


Note: The grey line indicates the all ICO rate.

Payment Amounts Per Member Per Month

Figure E-6 displays the monthly payment amounts PMPM by service month and category of service.

Figure E-6—Paid Amount PMPM—AmeriHealth Caritas

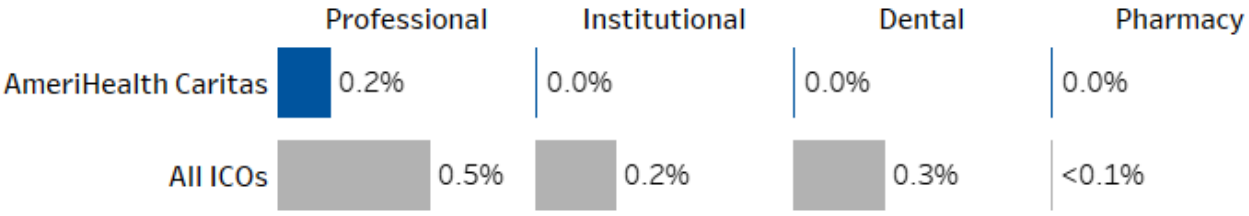


Note: The grey line indicates the all ICO rate.

Percentage of Duplicate Encounters

Figure E-7 displays the percentage of duplicate encounters.

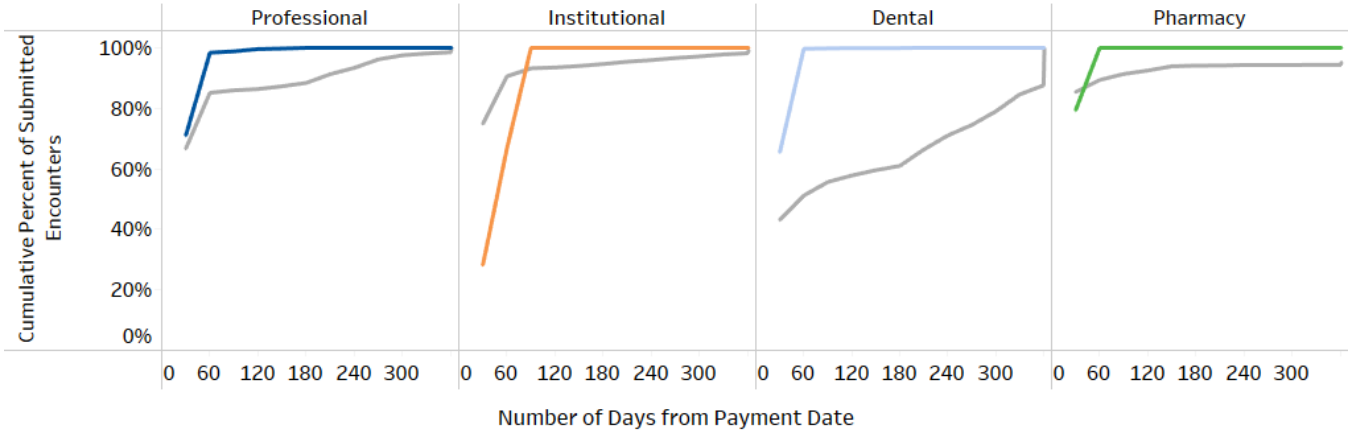
Figure E-7—Percentage of Duplicate Encounters—AmeriHealth Caritas



Encounter Data Timeliness

Figure E-8 and Table E-1 show the cumulative percentage of encounters submitted to MDHHS from the payment date by category of service.

Figure E-8—Cumulative Percentage of Encounters Submitted to MDHHS From ICO Payment Date by Category of Service—AmeriHealth Caritas



Note: The grey line indicates the all ICO rate.

Table E-1—Completeness of Encounters by Category of Service—AmeriHealth Caritas

Number of Days From Payment Date	Cumulative Percentage of Submitted Professional Encounters	Cumulative Percentage of Submitted Institutional Encounters	Cumulative Percentage of Submitted Dental Encounters	Cumulative Percentage of Submitted Pharmacy Encounters
Submitted Within 30 Days	71.1%	28.2%	65.5%	79.4%
Submitted Within 60 Days	98.4%	66.8%	99.7%	100.0%
Submitted Within 90 Days	98.8%	100.0%	99.8%	100.0%
Submitted Within 120 Days	99.6%	100.0%	99.9%	100.0%
Submitted Within 150 Days	99.7%	100.0%	99.9%	100.0%
Submitted Within 180 Days	>99.9%	100.0%	99.9%	100.0%
Submitted Within 210 Days	>99.9%	100.0%	100.0%	100.0%
Submitted Within 240 Days	>99.9%	100.0%	100.0%	100.0%
Submitted Within 270 Days	>99.9%	100.0%	100.0%	100.0%
Submitted Within 300 Days	>99.9%	100.0%	100.0%	100.0%
Submitted Within 330 Days	>99.9%	100.0%	100.0%	100.0%
Submitted Within 360 Days	>99.9%	100.0%	100.0%	100.0%
Submitted After 360 Days	100.0%	100.0%	100.0%	100.0%
Missing Paid or Submission Date	0.0%	0.0%	0.0%	0.0%
Submitted Prior to Paid Date	0.0%	0.0%	0.0%	0.0%

Field-Level Completeness and Accuracy

Figure E-9 through Figure E-12 provide the percentage of encounters that are present and contain valid values for key data elements.

Figure E-9—Key Professional Encounter Data Elements—AmeriHealth Caritas

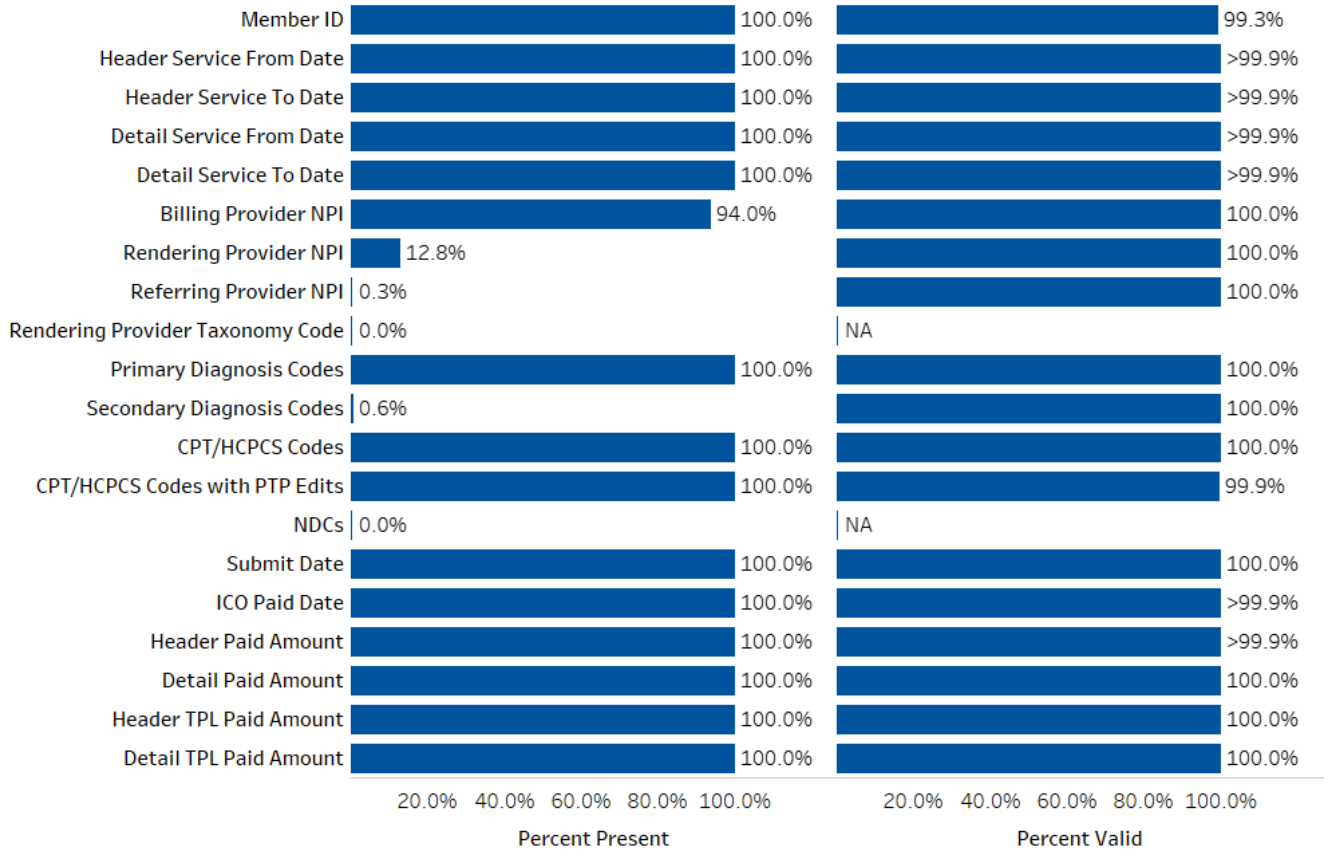


Figure E-10—Key Institutional Encounter Data Elements—AmeriHealth Caritas

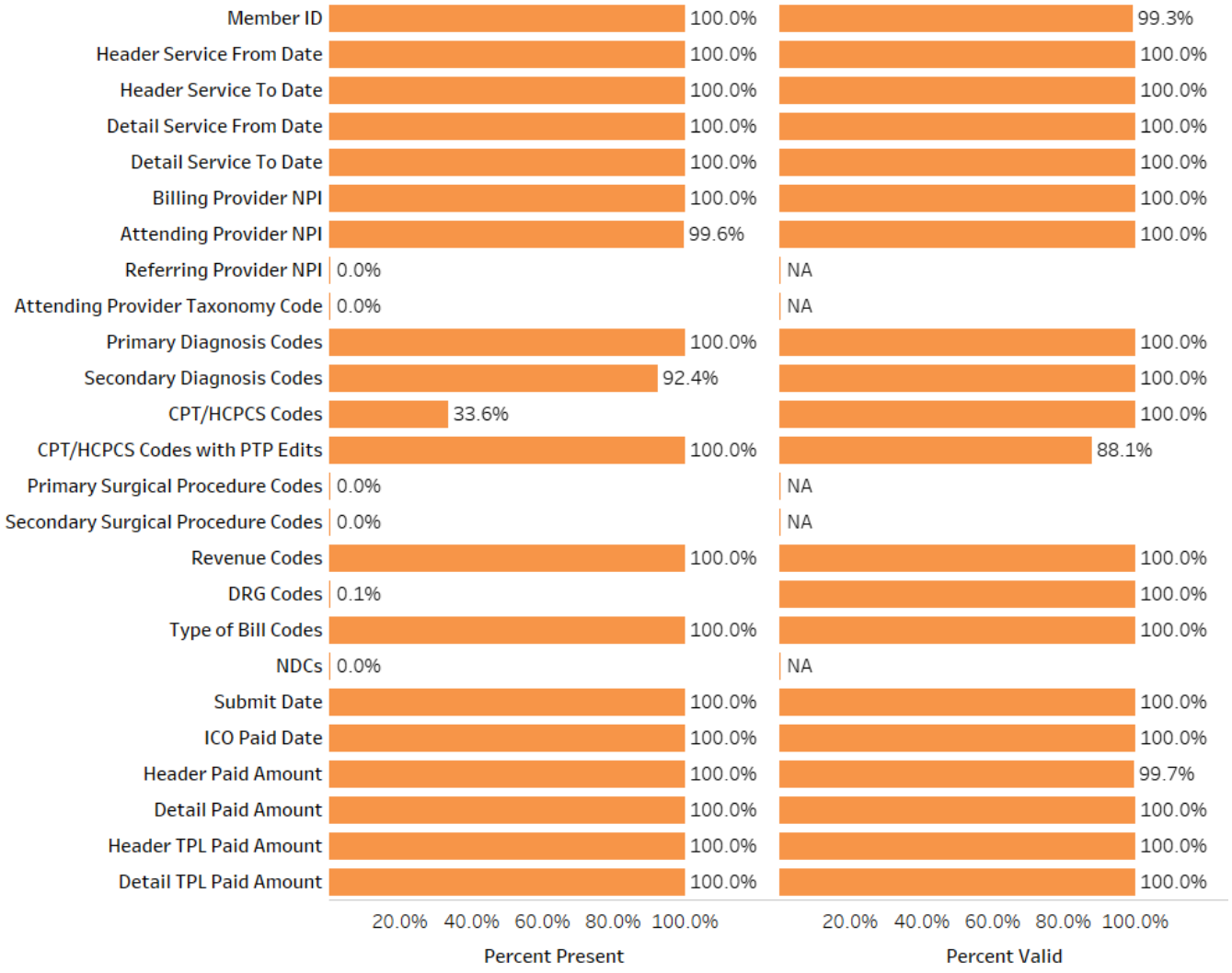


Figure E-11—Key Dental Encounter Data Elements—AmeriHealth Caritas

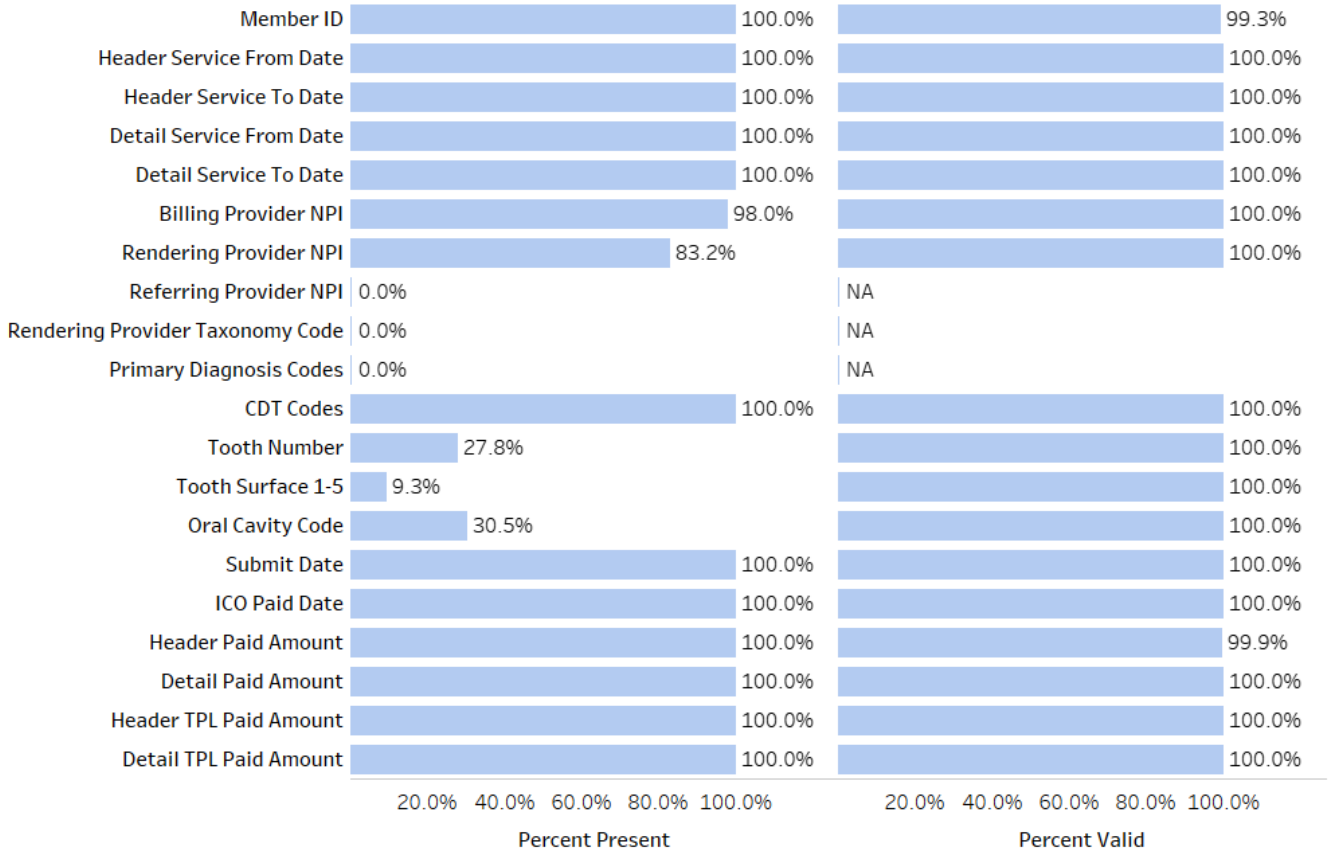
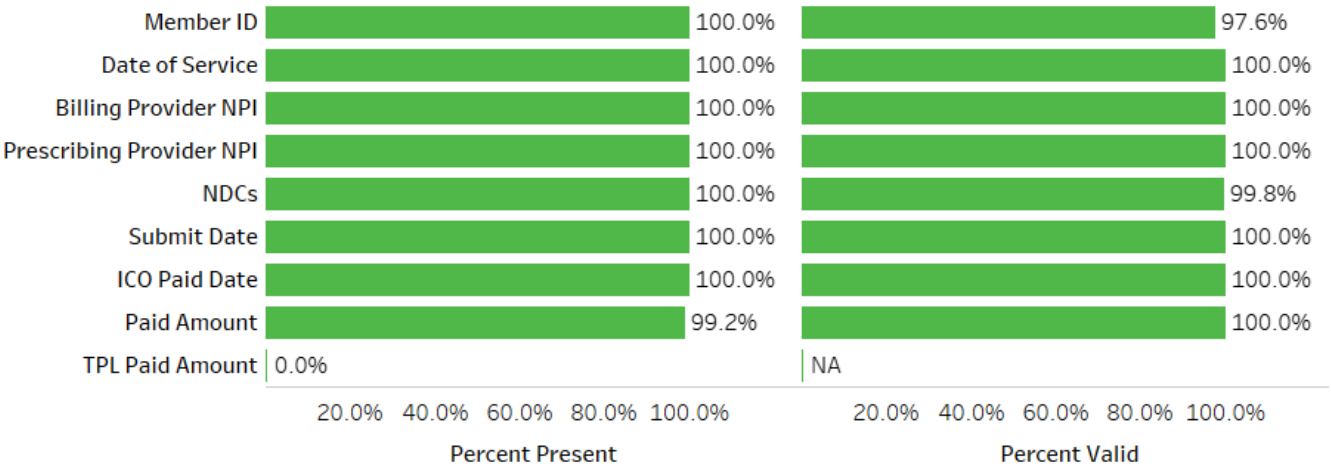


Figure E-12—Key Pharmacy Encounter Data Elements—AmeriHealth Caritas



Encounter Data Referential Integrity

Figure E-13 through Figure E-17 display the referential integrity results.

Figure E-13—Referential Integrity Comparison Between Enrollment and Medical/Dental Encounter Files—AmeriHealth Caritas

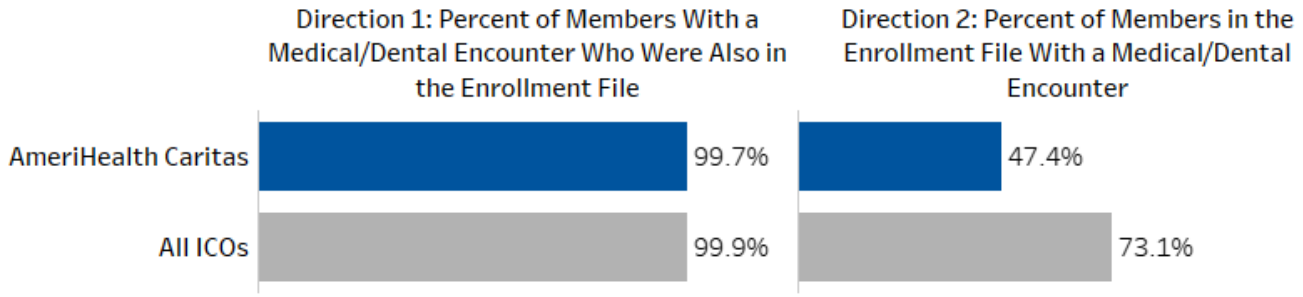


Figure E-14—Referential Integrity Comparison Between Enrollment and Pharmacy Encounter Files—AmeriHealth Caritas

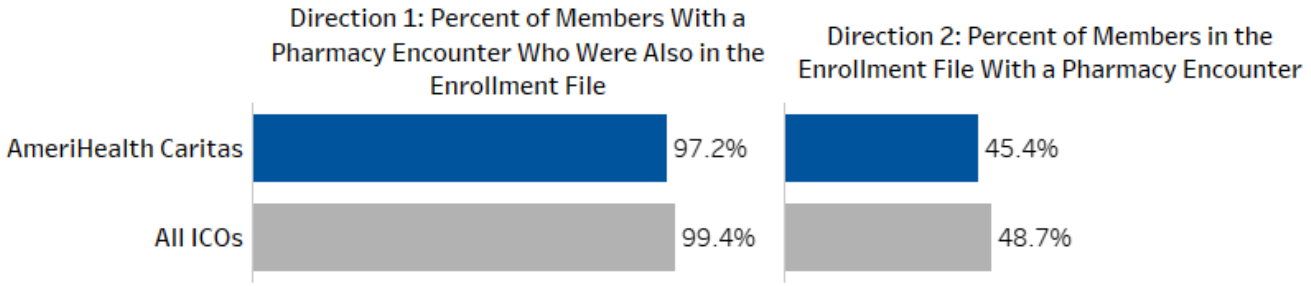


Figure E-15—Referential Integrity Comparison Between Medical/Dental Encounter and Pharmacy Encounter Files—AmeriHealth Caritas

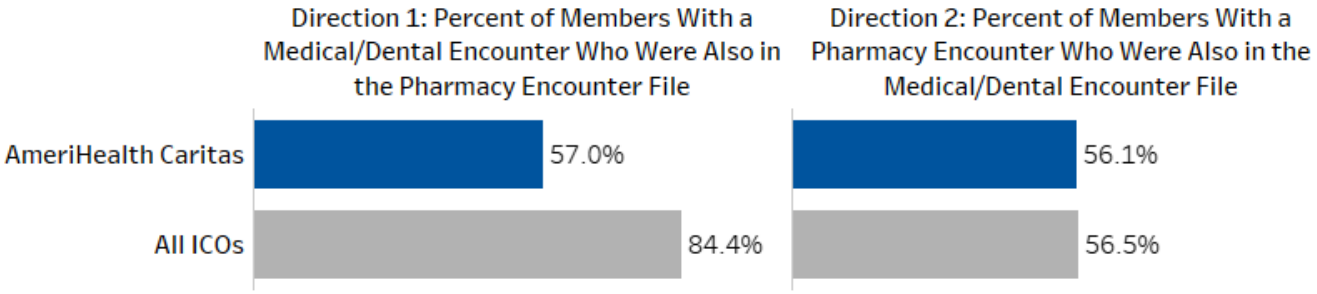


Figure E-16—Referential Integrity Comparison Between Medical/Dental Encounter and Provider Files—AmeriHealth Caritas

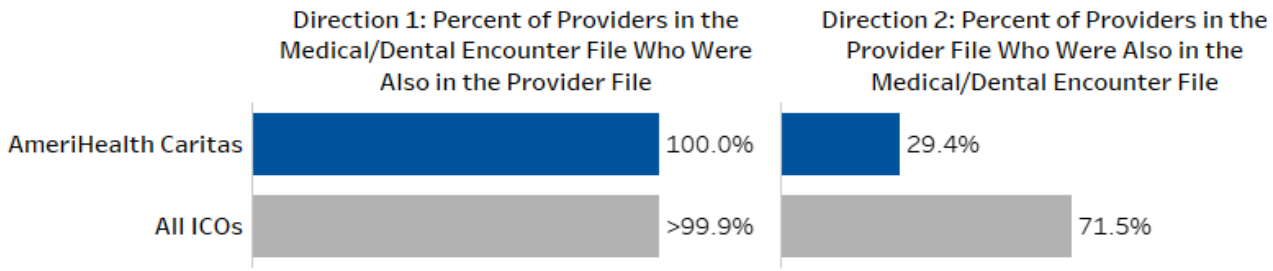
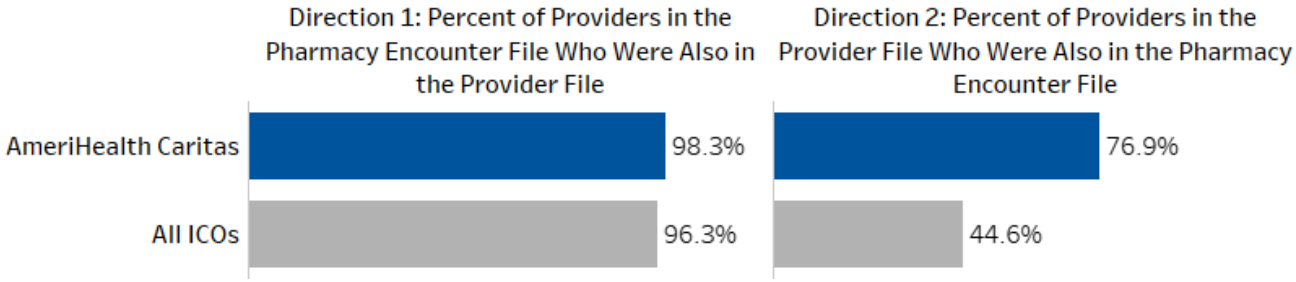


Figure E-17—Referential Integrity Comparison Between Pharmacy Encounter and Provider Files—AmeriHealth Caritas

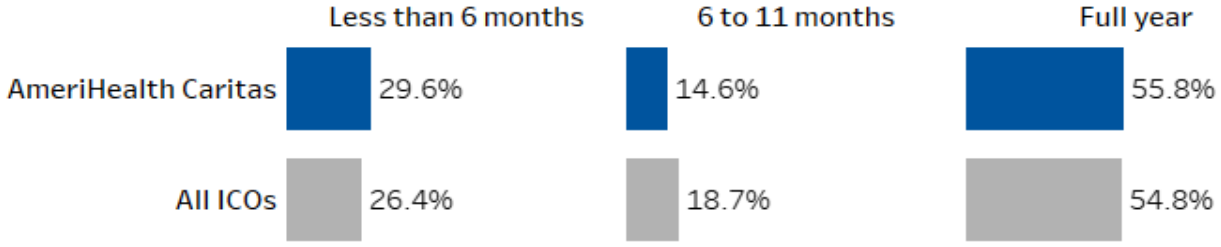


Encounter Data Logic

Member Enrollment

Figure E-18 displays the percentage of members who were continuously enrolled.

Figure E-18—Percentage of Members Who Were Continuously Enrolled—AmeriHealth Caritas



Conclusions

Based on the examination of the IS review and administrative profile outcomes in Section 3 and Section 4, respectively, for **AmeriHealth Caritas**, HSAG identified the following areas of strength and

opportunities for improvement. Along with each opportunity for improvement, HSAG has also provided a recommendation to help target improvement efforts.

IS Review Conclusions

Strengths

Strength #1: AmeriHealth Caritas demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The ICO has also established data review and correction processes that efficiently address quality concerns identified by MDHHS.

Opportunities for Improvement

Weakness #1: AmeriHealth Caritas did not indicate timeliness quality checks were performed for claims/encounters originating from its LTSS subcontractors.

Why the weakness exists: Timeliness quality checks are crucial to ensuring that claims and encounters are submitted within the stipulated time frames.

Recommendation: AmeriHealth Caritas should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

Administrative Profile Conclusions

Strengths

Strength #1: AmeriHealth Caritas submitted professional, institutional, dental, and pharmacy encounters in a timely manner from the payment date, with greater than 98 percent of all encounters submitted within 90 days of the payment date.

Strength #2: AmeriHealth Caritas had no duplicative records identified in institutional, dental, or pharmacy encounters.

Strength #3: Across all categories of service, all key data elements for **AmeriHealth Caritas** were populated at high rates, and all but one was greater than 97 percent valid.

Opportunities for Improvement

Weakness #1: Although nearly all key data elements had high validity rates across all categories of service, CPT/HCPCS codes with PTP edits was valid 88.1 percent of the time in institutional data.

Why the weakness exists: Incorrectly reported pairs of CPT/HCPCS codes may cause improper payments.

Recommendation: AmeriHealth Caritas should continue to evaluate its data for accuracy and evaluate CPT/HCPCS codes with PTP edit checks to ensure proper payment.

Administrative Profile Results—Tabular Data

Encounter Data Summary

Member Composition

Table E-2 presents the member composition.

Table E-2—Age and Gender Distribution—AmeriHealth Caritas

Age Category	Number of Females	Number of Males
Age 21–34 years	126	203
Age 35–44 years	175	182
Age 45–54 years	250	263
Age 55–64 years	350	311
Age 65 and over	1,292	995
Total	**2,193**	**1,954**

Encounter Data Completeness

Encounter Volume by Service Month

Table E-3 through Table E-6 display the encounter volume by service month.

Table E-3—Encounter Volume: Professional Encounters—AmeriHealth Caritas

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	14,507	3,034	4,781.5
November 2021	14,326	3,055	4,689.4
December 2021	14,560	3,066	4,748.9
January 2022	13,913	2,884	4,824.2
February 2022	12,770	2,861	4,463.5
March 2022	13,949	2,815	4,955.2
April 2022	13,708	2,948	4,649.9
May 2022	14,057	2,920	4,814.0
June 2022	13,941	2,905	4,799.0

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
July 2022	14,346	2,907	4,935.0
August 2022	14,917	3,057	4,879.6
September 2022	14,169	3,124	4,535.5

Table E-4—Encounter Volume: Institutional Encounters—AmeriHealth Caritas

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	211	3,034	69.5
November 2021	221	3,055	72.3
December 2021	213	3,066	69.5
January 2022	221	2,884	76.6
February 2022	201	2,861	70.3
March 2022	195	2,815	69.3
April 2022	202	2,948	68.5
May 2022	174	2,920	59.6
June 2022	181	2,905	62.3
July 2022	166	2,907	57.1
August 2022	188	3,057	61.5
September 2022	184	3,124	58.9

Table E-5—Encounter Volume: Dental Encounters—AmeriHealth Caritas

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	82	3,034	27.0
November 2021	67	3,055	21.9
December 2021	61	3,066	19.9
January 2022	49	2,884	17.0
February 2022	63	2,861	22.0
March 2022	89	2,815	31.6
April 2022	97	2,948	32.9
May 2022	76	2,920	26.0
June 2022	90	2,905	31.0
July 2022	98	2,907	33.7

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
August 2022	109	3,057	35.7
September 2022	73	3,124	23.4

Table E-6—Encounter Volume: Pharmacy Encounters—AmeriHealth Caritas

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	1,137	3,034	374.8
November 2021	1,082	3,055	354.2
December 2021	1,106	3,066	360.7
January 2022	862	2,884	298.9
February 2022	716	2,861	250.3
March 2022	798	2,815	283.5
April 2022	828	2,948	280.9
May 2022	1,011	2,920	346.2
June 2022	1,130	2,905	389.0
July 2022	1,078	2,907	370.8
August 2022	1,220	3,057	399.1
September 2022	1,250	3,124	400.1

Payment Amounts Per Member Per Month

Table E-7 through Table E-10 display the monthly payment amounts PMPM by service month.

Table E-7—Paid Amount PMPM: Professional Encounters—AmeriHealth Caritas

Month of Service	Number of MM	Paid Amount PMPM
October 2021	3,034	$318.67
November 2021	3,055	$323.43
December 2021	3,066	$331.88
January 2022	2,884	$338.18
February 2022	2,861	$319.59
March 2022	2,815	$355.09
April 2022	2,948	$327.20
May 2022	2,920	$346.33
June 2022	2,905	$342.60

Month of Service	Number of MM	Paid Amount PMPM
July 2022	2,907	$352.88
August 2022	3,057	$350.89
September 2022	3,124	$324.99

Table E-8—Paid Amount PMPM: Institutional Encounters—AmeriHealth Caritas

Month of Service	Number of MM	Paid Amount PMPM
October 2021	3,034	$467.44
November 2021	3,055	$452.25
December 2021	3,066	$442.60
January 2022	2,884	$441.32
February 2022	2,861	$394.08
March 2022	2,815	$393.25
April 2022	2,948	$333.14
May 2022	2,920	$323.58
June 2022	2,905	$305.38
July 2022	2,907	$325.18
August 2022	3,057	$303.80
September 2022	3,124	$302.04

Table E-9—Paid Amount PMPM: Dental Encounters—AmeriHealth Caritas

Month of Service	Number of MM	Paid Amount PMPM
October 2021	3,034	$1.90
November 2021	3,055	$2.26
December 2021	3,066	$2.16
January 2022	2,884	$1.16
February 2022	2,861	$1.84
March 2022	2,815	$2.29
April 2022	2,948	$1.89
May 2022	2,920	$2.15
June 2022	2,905	$2.93
July 2022	2,907	$3.12
August 2022	3,057	$3.63
September 2022	3,124	$1.61

Table E-10—Paid Amount PMPM: Pharmacy Encounters—AmeriHealth Caritas

Month of Service	Number of MM	Paid Amount PMPM
October 2021	3,034	$2.24
November 2021	3,055	$1.57
December 2021	3,066	$1.86
January 2022	2,884	$1.71
February 2022	2,861	$1.14
March 2022	2,815	$2.25
April 2022	2,948	$1.12
May 2022	2,920	$1.56
June 2022	2,905	$3.44
July 2022	2,907	$2.48
August 2022	3,057	$1.66
September 2022	3,124	$1.52

Percentage of Duplicate Encounters

Table E-11 displays the percentage of duplicate encounters by category of service.

Table E-11—Percentage of Duplicate Encounters by Category of Service—AmeriHealth Caritas

Category of Service	Number of Duplicate Records	Percentage of Duplicate Records
Professional	317	0.2%
Institutional	0	0.0%
Dental	0	0.0%
Pharmacy	0	0.0%

Encounter Data Timeliness

Encounter Data Lag Triangles

Table E-12 through Table E-15 display the lag triangles between service month and submission month to MDHHS. For conciseness, lag triangles only include encounters submitted through April 2023 (a minimum of a seven-month lag); therefore, counts displayed in the total line may not equal counts displayed in encounter volume figures.

Table E-12—Encounter Data Lag Triangle: Professional Encounters—AmeriHealth Caritas

	Month of Service												
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	0												0
202111	489	0											489
202112	9,442	784	0										10,226
202201	4,298	11,640	1,031	0									16,969
202202	196	1,944	11,890	957	0								14,987
202203	907	1,498	3,110	12,922	1,478	115							20,030
202204	190	252	310	1,918	11,842	772	0						15,284
202205	521	187	105	96	1,160	13,391	1,240	0					16,700
202206	25	56	77	241	401	1,997	13,526	9,042	159				25,524
202207	46	16	27	148	179	80	959	5,395	5,830	0			12,680
202208	2	30	43	37	76	147	210	1,379	7,104	838	0		9,866
202209	3	2	14	4	16	9	102	558	3,166	12,538	985	0	17,397
202210	7	5	4	10	33	2	30	165	245	2,788	14,506	837	18,632
202211	1	5	4	1	51	71	89	47	65	669	1,625	14,104	16,732
202212	2	1	4	1	5	3	2	1	7	19	420	1,656	2,121
202301	0	0	1	1	1	1	1	6	7	31	67	250	366
202302	0	0	1	1	3	4	4	1	1	2	7	14	38
202303	0	0	0	1	1	2	1	0	39	8	11	9	72
202304	1	0	0	0	0	0	4	5	2	2	5	3	22
Total	16,130	16,420	16,621	16,338	15,246	16,594	16,168	16,599	16,625	16,895	17,626	16,873	198,135
MM	3,034	3,055	3,066	2,884	2,861	2,815	2,948	2,920	2,905	2,907	3,057	3,124	35,576
PMPM	5.32	5.37	5.42	5.67	5.33	5.89	5.48	5.68	5.72	5.81	5.77	5.40	5.57

Table E-13—Encounter Data Lag Triangle: Institutional Encounters—AmeriHealth Caritas

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	0												0
202111	0	0											0
202112	0	0	0										0
202201	22	1	0	0									23
202202	3	19	1	1	0								24
202203	1	15	48	6	0	0							70
202204	0	10	8	104	3	0	0						125
202205	10	6	10	15	131	7	0	0					179
202206	31	44	45	30	11	146	20	0	0				327
202207	2	0	0	8	4	12	21	12	1	0			60
202208	127	105	67	33	28	9	3	20	4	0	0		396
202209	0	2	1	0	2	1	0	2	32	32	2	0	74
202210	4	12	13	7	6	7	5	2	0	0	20	0	76
202211	4	3	2	6	6	3	1	3	4	3	20	26	81
202212	6	2	4	2	2	2	0	1	4	4	3	8	38
202301	0	1	8	1	1	2	3	4	6	2	9	33	70
202302	1	0	3	6	5	4	143	127	122	115	123	106	755
202303	0	1	0	0	0	0	1	0	1	3	3	2	11
202304	0	0	0	0	0	1	2	1	1	1	3	5	14
Total	211	221	210	219	199	194	199	172	175	160	183	180	2,323
MM	3,034	3,055	3,066	2,884	2,861	2,815	2,948	2,920	2,905	2,907	3,057	3,124	35,576
PMPM	0.07	0.07	0.07	0.08	0.07	0.07	0.07	0.06	0.06	0.06	0.06	0.06	0.07

Table E-14—Encounter Data Lag Triangle: Dental Encounters—AmeriHealth Caritas

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	0												0
202111	37	0											37
202112	31	35	0										66
202201	3	22	42	0									67
202202	2	2	10	30	0								44
202203	4	4	6	13	34	0							61
202204	0	0	2	2	23	44	0						71
202205	1	1	0	1	2	31	60	0					96
202206	1	0	0	0	0	5	22	48	0				76
202207	2	2	1	1	1	3	5	22	37	0			74
202208	1	2	0	0	1	4	3	3	46	60	0		120
202209	0	0	0	0	2	0	2	0	2	27	58	0	91
202210	0	0	0	1	0	1	0	0	0	1	46	40	89
202211	0	0	0	0	1	0	0	0	3	0	1	22	27
202212	1	2	0	2	0	1	4	1	3	2	2	5	23
202301	0	0	0	0	0	0	0	0	1	3	0	0	4
202302	0	0	0	0	0	2	2	1	0	4	0	2	11
202303	0	0	0	0	0	0	1	0	0	0	0	1	2
202304	0	0	0	0	0	0	0	1	0	1	1	1	4
Total	83	70	61	50	64	91	99	76	92	98	108	71	963
MM	3,034	3,055	3,066	2,884	2,861	2,815	2,948	2,920	2,905	2,907	3,057	3,124	35,576
PMPM	0.03	0.02	0.02	0.02	0.02	0.03	0.03	0.03	0.03	0.03	0.04	0.02	0.03

Table E-15—Encounter Data Lag Triangle: Pharmacy Encounters—AmeriHealth Caritas

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	0												0
202111	838	0											838
202112	283	880	0										1,163
202201	9	192	1,078	27									1,306
202202	0	2	13	14	0								29
202203	0	0	0	0	10	0							10
202204	0	0	0	0	0	6	0						6
202205	0	0	0	0	0	0	18	0					18
202206	0	0	0	0	0	0	13	583	0				596
202207	7	3	5	0	0	0	1	10	851	0			877
202208	0	0	0	0	0	0	0	0	8	936	0		944
202209	0	0	0	0	0	0	0	0	4	7	1,215	0	1,226
202210	0	0	0	469	302	375	366	90	0	2	5	1,244	2,853
202211	0	0	0	15	30	22	25	72	108	58	0	5	335
202212	1	0	0	334	371	390	400	255	159	75	0	0	1,985
202301	0	0	0	0	1	0	0	1	0	0	0	0	2
202302	0	0	0	0	1	1	0	0	0	0	0	0	2
202303	0	0	0	0	0	0	0	0	0	0	0	0	0
202304	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	1,138	1,077	1,096	859	715	794	823	1,011	1,130	1,078	1,220	1,249	12,190
MM	3,034	3,055	3,066	2,884	2,861	2,815	2,948	2,920	2,905	2,907	3,057	3,124	35,576
PMPM	0.38	0.35	0.36	0.30	0.25	0.28	0.28	0.35	0.39	0.37	0.40	0.40	0.34

Field-Level Completeness and Accuracy

Table E-16 through Table E-19 provide the percentage of encounters that are present and contain valid values for key data elements for all categories of service.

Table E-16—Key Encounter Data Elements: Professional Encounters—AmeriHealth Caritas

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	198,237	198,237	100.0%	198,237	196,762	99.3%
Header Service From Date	198,237	198,237	100.0%	198,237	198,189	>99.9%
Header Service To Date	198,237	198,237	100.0%	198,237	198,189	>99.9%
Detail Service From Date	201,114	201,114	100.0%	201,114	201,066	>99.9%
Detail Service To Date	201,114	201,114	100.0%	201,114	201,066	>99.9%
Billing Provider NPI	198,237	186,245	94.0%	186,245	186,245	100.0%
Rendering Provider NPI	198,237	25,394	12.8%	25,394	25,394	100.0%
Referring Provider NPI	198,237	644	0.3%	644	644	100.0%
Rendering Provider Taxonomy Code	198,237	0	0.0%	0	0	NA
Primary Diagnosis Codes	198,237	198,237	100.0%	198,237	198,237	100.0%
Secondary Diagnosis Codes	198,237	1,228	0.6%	1,939	1,939	100.0%
CPT/HCPCS Codes	201,114	201,114	100.0%	201,114	201,114	100.0%
CPT/HCPCS Codes with PTP Edits	201,021	201,021	100.0%	201,021	200,802	99.9%
NDCs	201,114	0	0.0%	0	0	NA
Submit Date	201,114	201,114	100.0%	201,114	201,114	100.0%
ICO Paid Date	201,114	201,114	100.0%	201,114	201,066	>99.9%
Header Paid Amount	198,237	198,237	100.0%	198,237	198,235	>99.9%
Detail Paid Amount	201,114	201,114	100.0%	201,114	201,114	100.0%
Header TPL Paid Amount	198,237	198,237	100.0%	198,237	198,237	100.0%
Detail TPL Paid Amount	201,114	201,114	100.0%	201,114	201,114	100.0%

Table E-17—Key Encounter Data Elements: Institutional Encounters—AmeriHealth Caritas

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	2,357	2,357	100.0%	2,357	2,340	99.3%
Header Service From Date	2,357	2,357	100.0%	2,357	2,357	100.0%
Header Service To Date	2,357	2,357	100.0%	2,357	2,357	100.0%
Detail Service From Date	3,755	3,755	100.0%	3,755	3,755	100.0%

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Detail Service To Date	3,755	3,755	100.0%	3,755	3,755	100.0%
Billing Provider NPI	2,357	2,357	100.0%	2,357	2,357	100.0%
Attending Provider NPI	2,357	2,348	99.6%	2,348	2,348	100.0%
Referring Provider NPI	2,357	0	0.0%	0	0	NA
Attending Provider Taxonomy Code	2,357	0	0.0%	0	0	NA
Primary Diagnosis Codes	2,357	2,357	100.0%	2,357	2,357	100.0%
Secondary Diagnosis Codes	2,357	2,177	92.4%	32,850	32,850	100.0%
CPT/HCPCS Codes	3,755	1,260	33.6%	1,260	1,260	100.0%
CPT/HCPCS Codes with PTP Edits	218	218	100.0%	218	192	88.1%
Primary Surgical Procedure Codes	2,357	0	0.0%	0	0	NA
Secondary Surgical Procedure Codes	2,357	0	0.0%	0	0	NA
Revenue Codes	3,755	3,755	100.0%	3,755	3,755	100.0%
DRG Codes	2,357	2	0.1%	2	2	100.0%
Type of Bill Codes	2,357	2,357	100.0%	2,357	2,357	100.0%
NDCs	3,755	0	0.0%	0	0	NA
Submit Date	3,755	3,755	100.0%	3,755	3,755	100.0%
ICO Paid Date	3,755	3,755	100.0%	3,755	3,755	100.0%
Header Paid Amount	2,357	2,357	100.0%	2,357	2,350	99.7%
Detail Paid Amount	3,755	3,755	100.0%	3,755	3,755	100.0%
Header TPL Paid Amount	2,357	2,357	100.0%	2,357	2,357	100.0%
Detail TPL Paid Amount	3,755	3,755	100.0%	3,755	3,755	100.0%

Table E-18—Key Encounter Data Elements: Dental Encounters—AmeriHealth Caritas

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	970	970	100.0%	970	963	99.3%
Header Service From Date	970	970	100.0%	970	970	100.0%
Header Service To Date	970	970	100.0%	970	970	100.0%
Detail Service From Date	2,824	2,824	100.0%	2,824	2,824	100.0%
Detail Service To Date	2,824	2,824	100.0%	2,824	2,824	100.0%
Billing Provider NPI	970	951	98.0%	951	951	100.0%
Rendering Provider NPI	970	807	83.2%	807	807	100.0%

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Referring Provider NPI	970	0	0.0%	0	0	NA
Rendering Provider Taxonomy Code	970	0	0.0%	0	0	NA
Primary Diagnosis Codes	970	0	0.0%	0	0	NA
CDT Codes	2,824	2,824	100.0%	2,824	2,824	100.0%
Tooth Number	2,824	786	27.8%	786	786	100.0%
Tooth Surface 1-5	2,824	264	9.3%	495	495	100.0%
Oral Cavity Code	2,824	860	30.5%	860	860	100.0%
Submit Date	2,824	2,824	100.0%	2,824	2,824	100.0%
ICO Paid Date	2,824	2,824	100.0%	2,824	2,824	100.0%
Header Paid Amount	970	970	100.0%	970	969	99.9%
Detail Paid Amount	2,824	2,824	100.0%	2,824	2,824	100.0%
Header TPL Paid Amount	970	970	100.0%	970	970	100.0%
Detail TPL Paid Amount	2,824	2,824	100.0%	2,824	2,824	100.0%

Table E-19—Key Encounter Data Elements: Pharmacy Encounters—AmeriHealth Caritas

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	12,219	12,219	100.0%	12,219	11,931	97.6%
Date of Service	12,219	12,219	100.0%	12,219	12,219	100.0%
Billing Provider NPI	12,219	12,219	100.0%	12,219	12,219	100.0%
Prescribing Provider NPI	12,219	12,219	100.0%	12,219	12,219	100.0%
NDCs	12,219	12,219	100.0%	12,219	12,199	99.8%
Submit Date	12,219	12,219	100.0%	12,219	12,219	100.0%
ICO Paid Date	12,219	12,219	100.0%	12,219	12,219	100.0%
Paid Amount	12,219	12,118	99.2%	12,118	12,118	100.0%
TPL Paid Amount	12,219	0	0.0%	0	0	NA

Appendix F. Results for HAP Empowered

Appendix F contains the IS review and administrative profile results, strengths, weaknesses, and recommendations, as applicable, that HSAG identified from the EDV study for **HAP Empowered**.

IS Review Findings

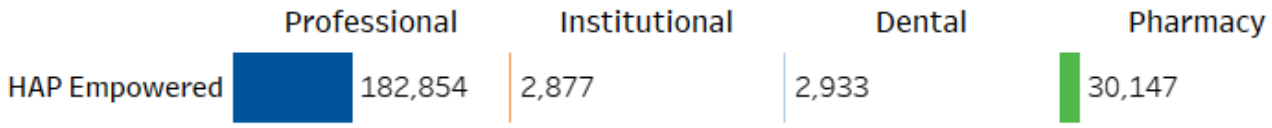
Please refer to Section 3: Information Systems Review Findings for **HAP Empowered**'s specific findings, if any.

Administrative Profile Results

Encounter Data Summary

Figure F-1 displays the number of encounters by category of service.

Figure F-1—Number of Encounters by Category of Service—HAP Empowered

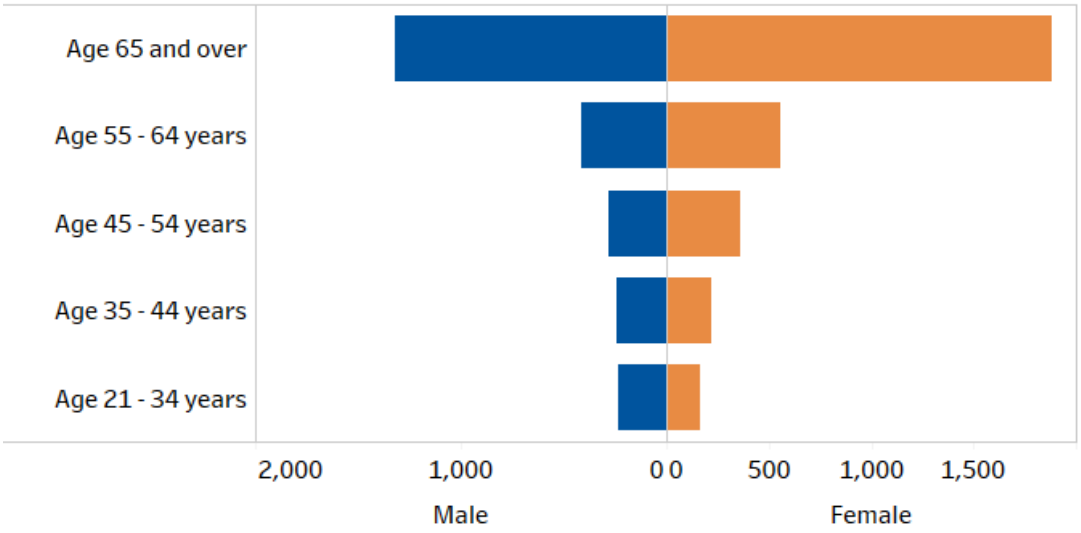


Member Composition

Figure F-2 and Figure F-3 display member demographics.

Figure F-2—Enrollment in SFY 2023—HAP Empowered

Figure F-3—Age and Gender Distribution—HAP Empowered

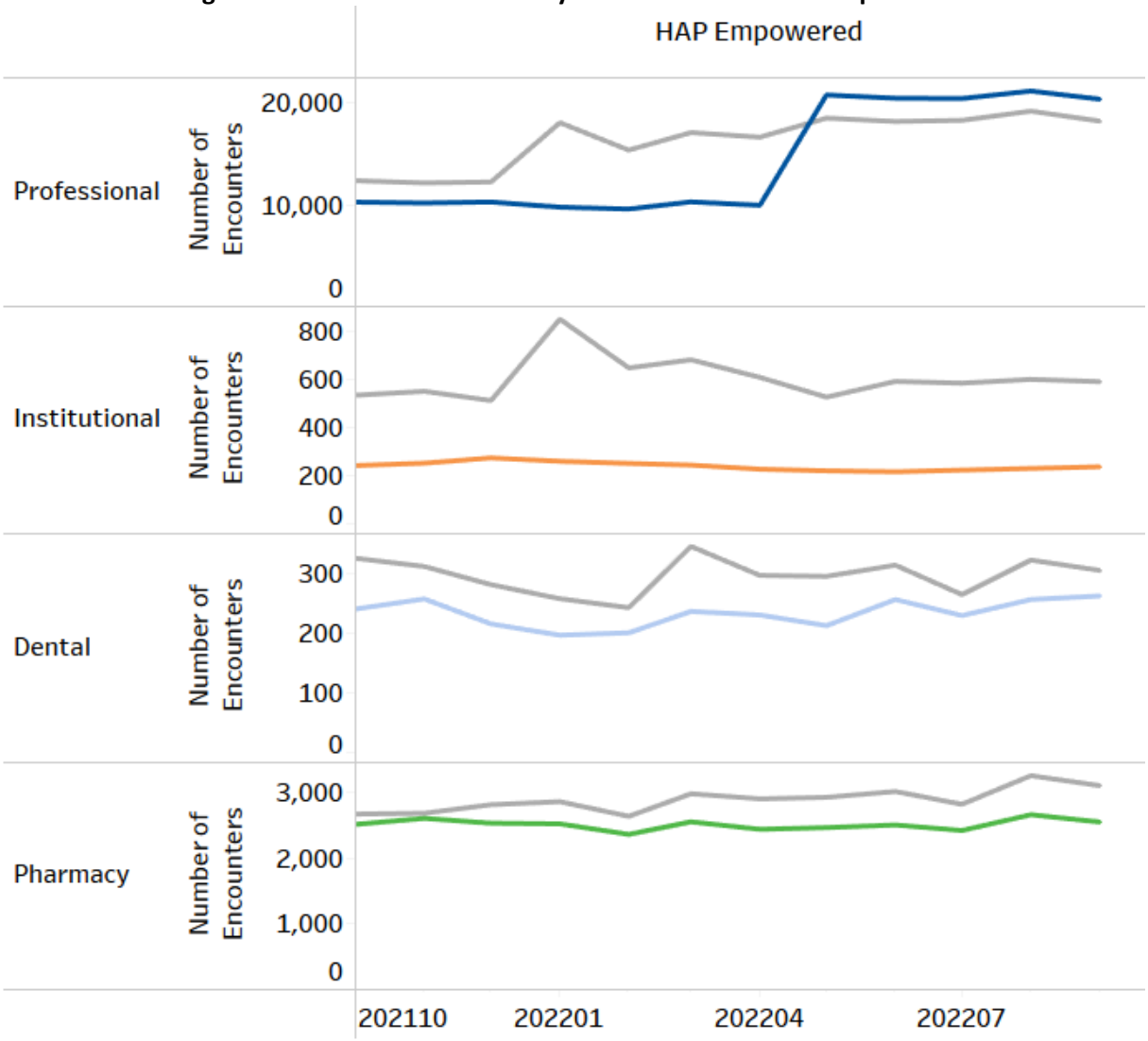


Encounter Data Completeness

Encounter Volume by Service Month

Figure F-4 displays the monthly encounter volume by service month and category of service.

Figure F-4—Encounter Volume by Service Month—HAP Empowered

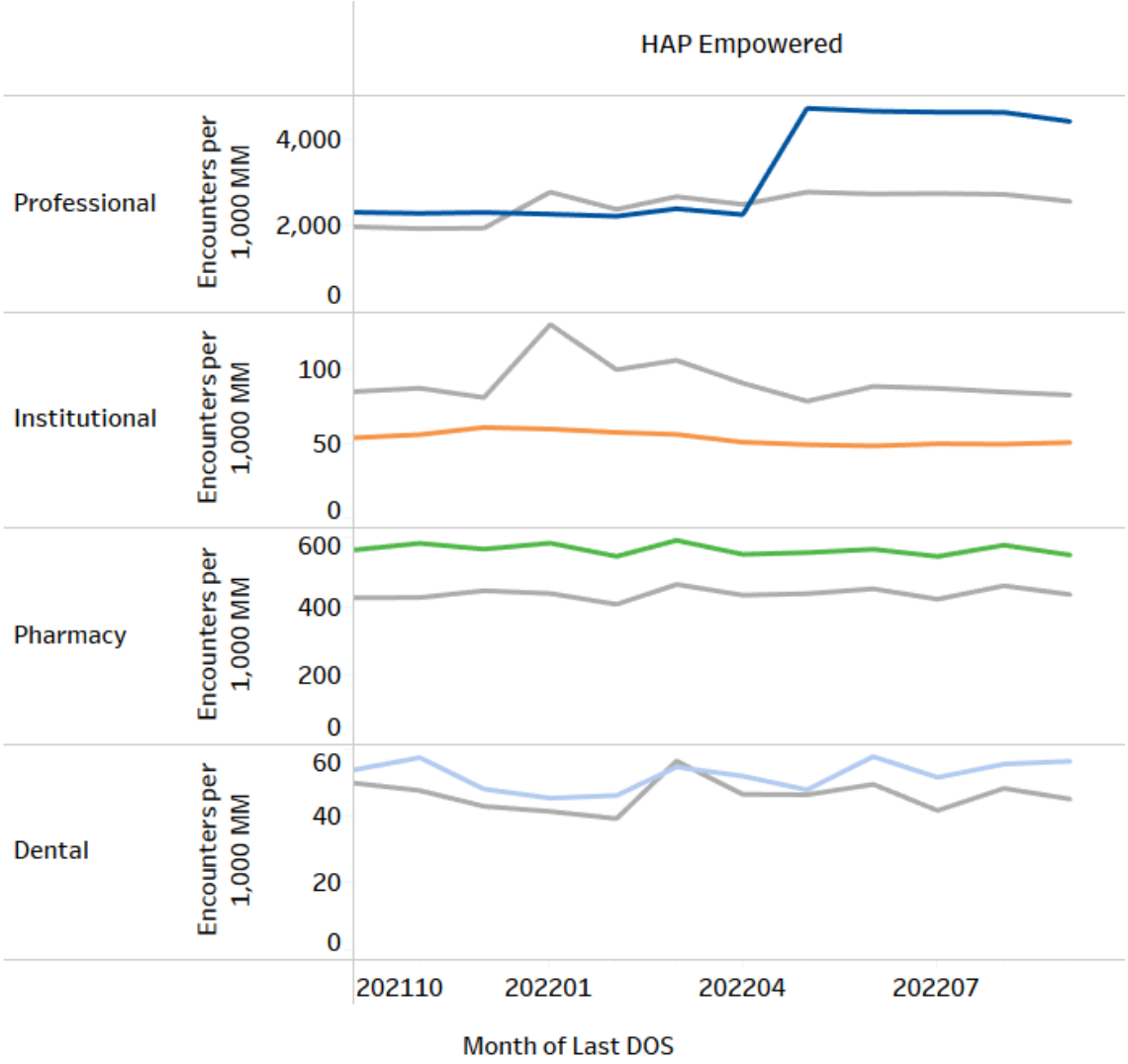


Note: The grey line indicates the all ICO rate.

Encounter Volume Per 1,000 Member Months

Figure F-5 displays the monthly encounter volume per 1,000 MM by service month and category of service.

Figure F-5—Encounter Volume per 1,000 MM—HAP Empowered

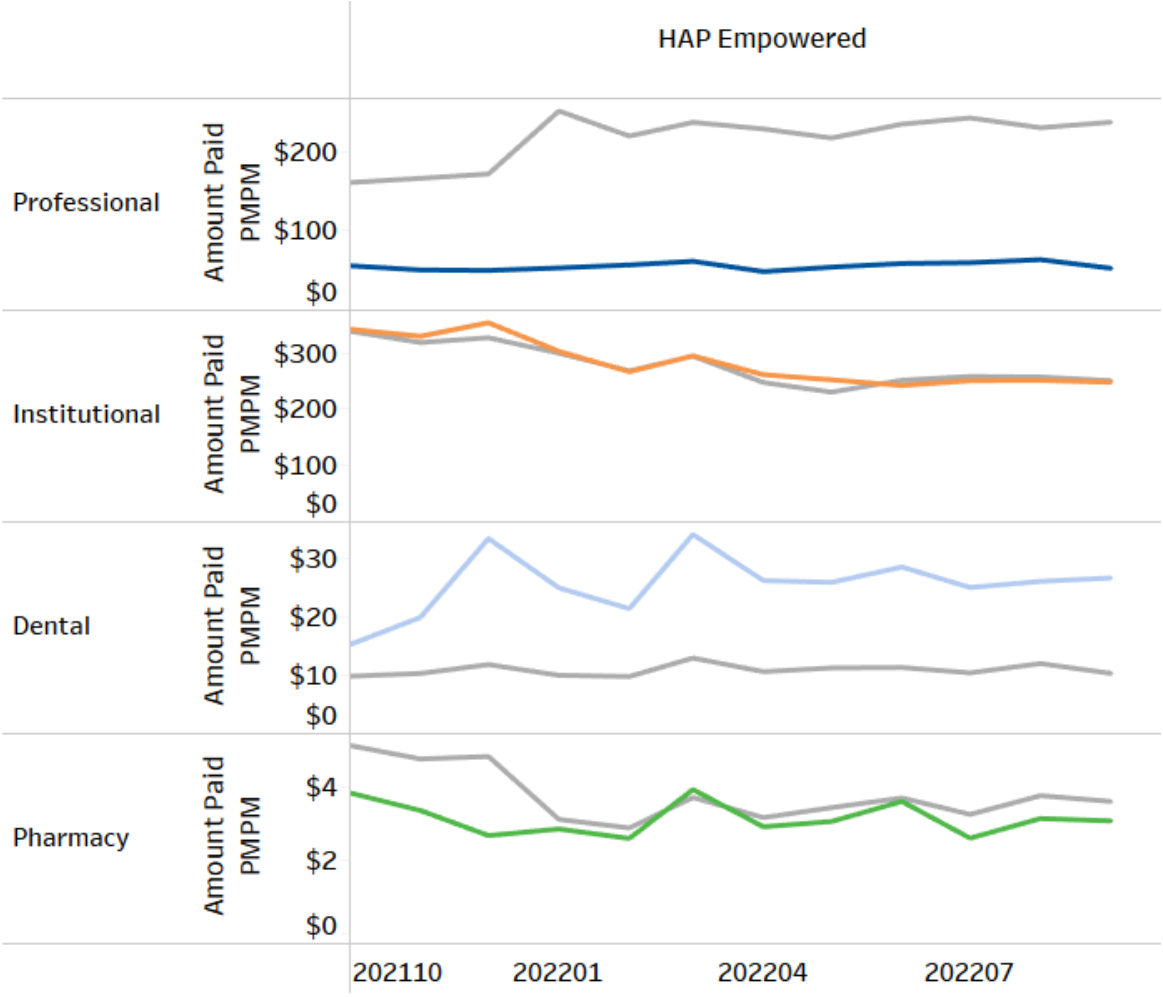


Note: The grey line indicates the all ICO rate.

Payment Amounts Per Member Per Month

Figure F-6 displays the monthly payment amounts PMPM by service month and category of service.

Figure F-6—Paid Amount PMPM—HAP Empowered

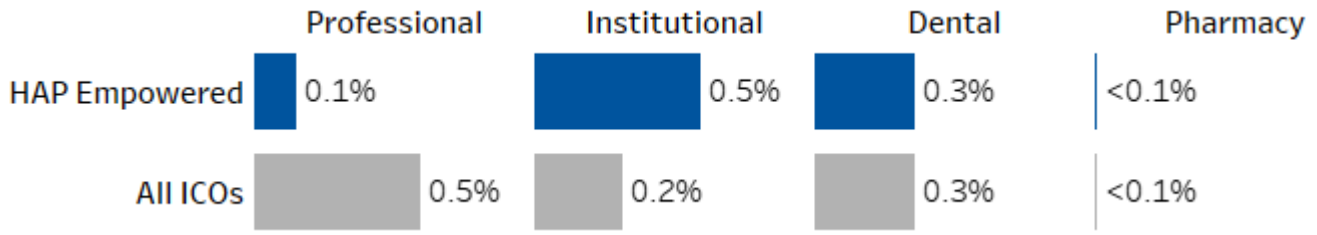


Note: The grey line indicates the all ICO rate.

Percentage of Duplicate Encounters

Figure F-7 displays the percentage of duplicate encounters.

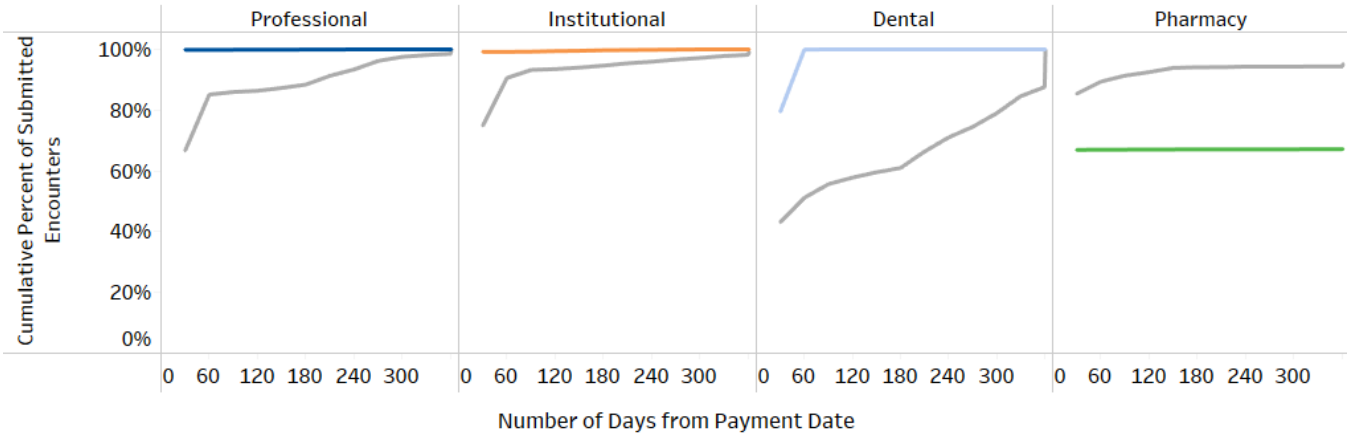
Figure F-7—Percentage of Duplicate Encounters—HAP Empowered



Encounter Data Timeliness

Figure F-8 and Table F-1 show the cumulative percentage of encounters submitted to MDHHS from the payment date by category of service.

Figure F-8—Cumulative Percentage of Encounters Submitted to MDHHS From ICO Payment Date by Category of Service—HAP Empowered



Note: The grey line indicates the all ICO rate.

Table F-1—Completeness of Encounters by Category of Service—HAP Empowered

Number of Days From Payment Date	Cumulative Percentage of Submitted Professional Encounters	Cumulative Percentage of Submitted Institutional Encounters	Cumulative Percentage of Submitted Dental Encounters	Cumulative Percentage of Submitted Pharmacy Encounters
Submitted Within 30 Days	99.8%	99.2%	79.5%	66.9%
Submitted Within 60 Days	99.8%	99.2%	99.9%	67.0%
Submitted Within 90 Days	99.8%	99.2%	>99.9%	67.0%
Submitted Within 120 Days	99.8%	99.4%	100.0%	67.0%
Submitted Within 150 Days	99.9%	99.5%	100.0%	67.0%
Submitted Within 180 Days	99.9%	99.7%	100.0%	67.1%
Submitted Within 210 Days	99.9%	99.8%	100.0%	67.1%
Submitted Within 240 Days	>99.9%	99.8%	100.0%	67.1%
Submitted Within 270 Days	>99.9%	99.9%	100.0%	67.1%
Submitted Within 300 Days	>99.9%	>99.9%	100.0%	67.1%
Submitted Within 330 Days	>99.9%	>99.9%	100.0%	67.1%
Submitted Within 360 Days	100.0%	>99.9%	100.0%	67.1%
Submitted After 360 Days	100.0%	100.0%	100.0%	67.2%
Missing Paid or Submission Date	0.0%	0.0%	0.0%	0.0%
Submitted Prior to Paid Date	0.0%	0.0%	0.0%	32.8%

Field-Level Completeness and Accuracy

Figure F-9 through Figure F-12 provide the percentage of encounters that are present and contain valid values for key data elements.

Figure F-9—Key Professional Encounter Data Elements—HAP Empowered

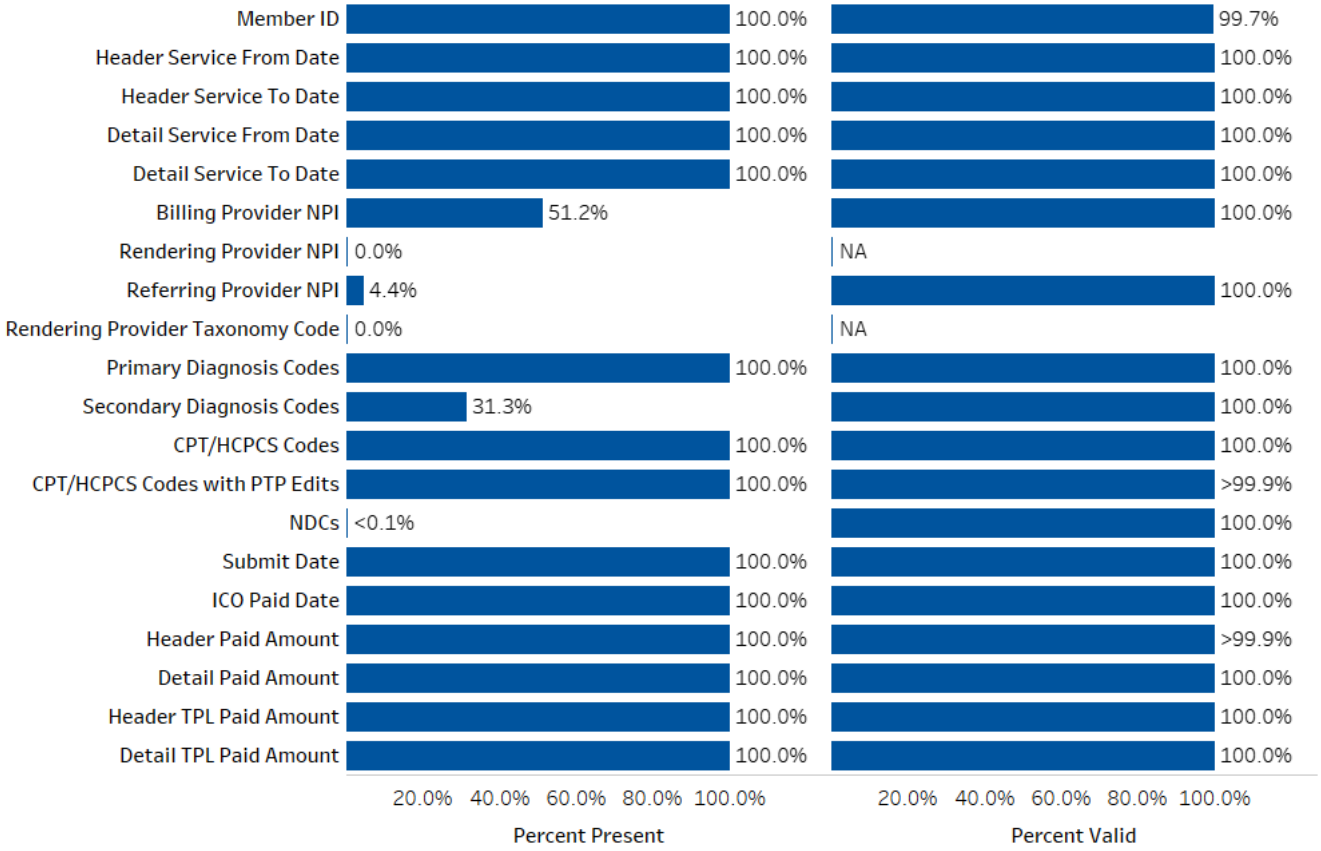


Figure F-10—Key Institutional Encounter Data Elements—HAP Empowered

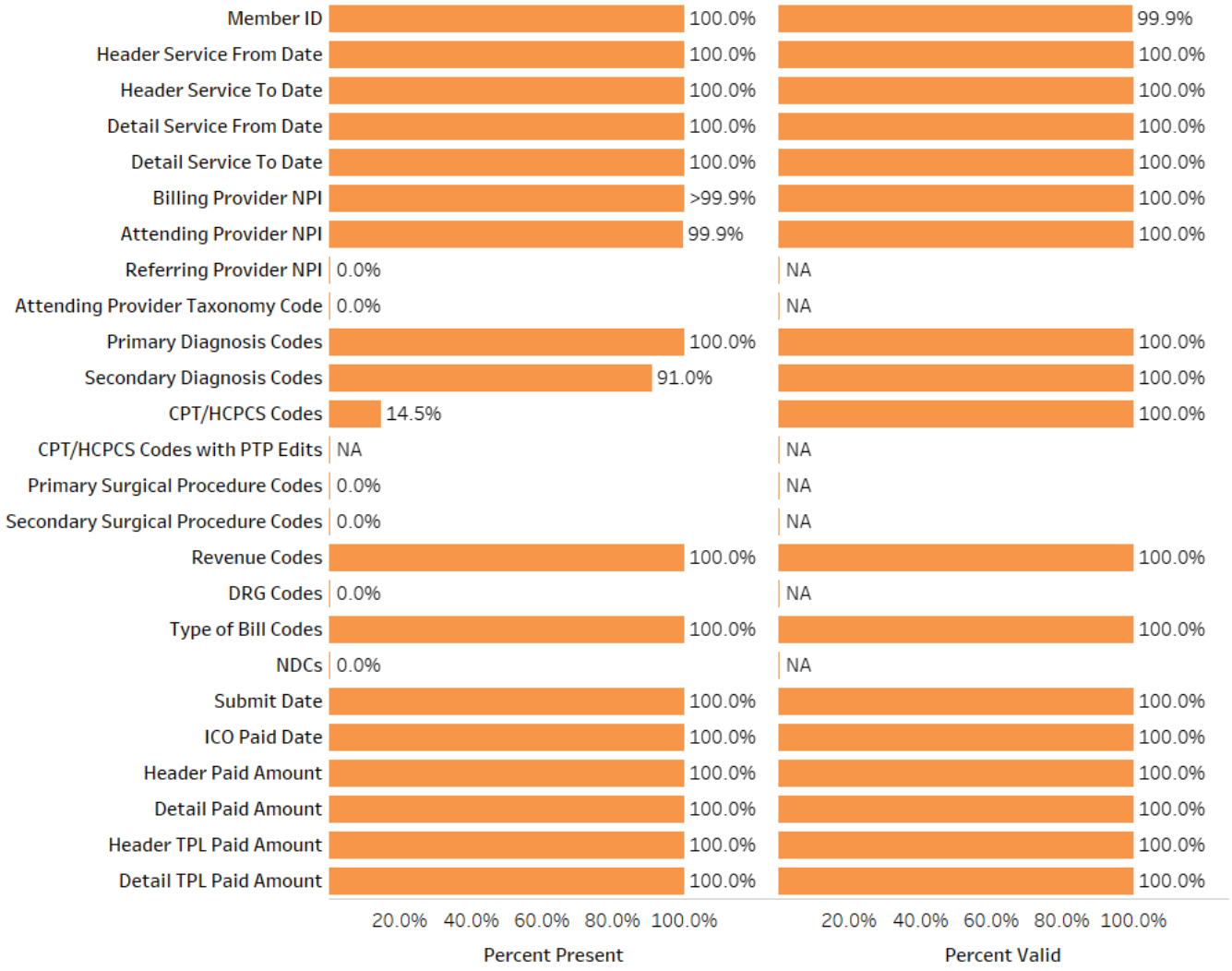


Figure F-11—Key Dental Encounter Data Elements—HAP Empowered

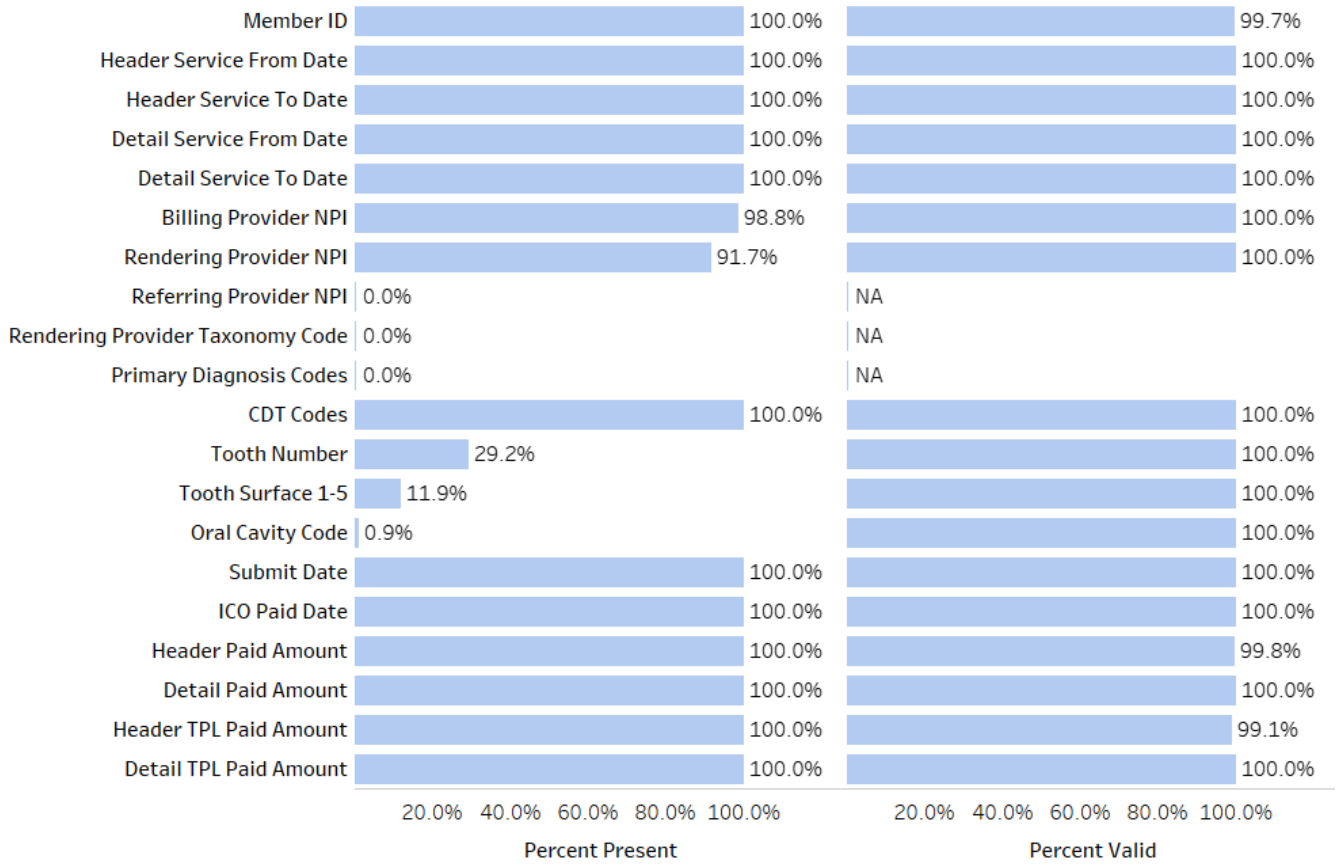
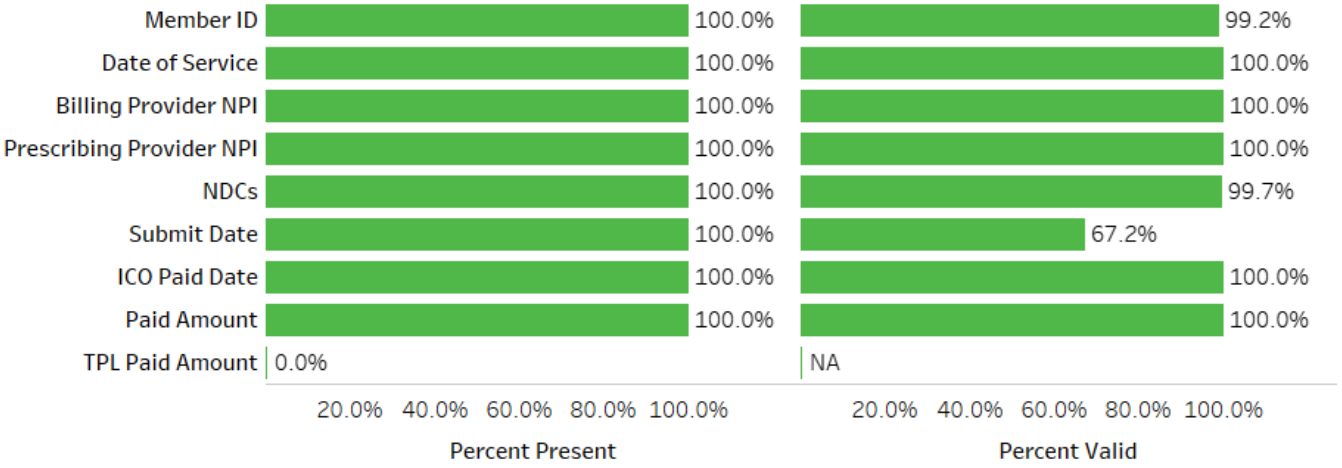


Figure F-12—Key Pharmacy Encounter Data Elements—HAP Empowered



Encounter Data Referential Integrity

Figure F-13 through Figure F-17 display the referential integrity results.

Figure F-13—Referential Integrity Comparison Between Enrollment and Medical/Dental Encounter Files—HAP Empowered

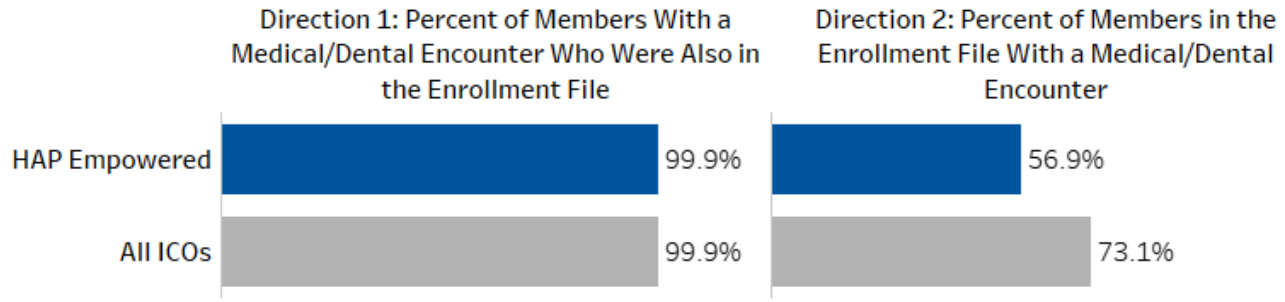


Figure F-14—Referential Integrity Comparison Between Enrollment and Pharmacy Encounter Files—HAP Empowered

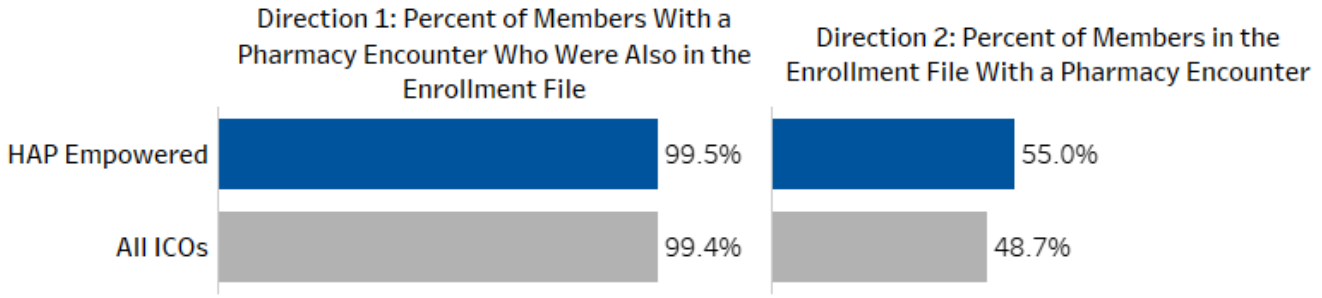


Figure F-15—Referential Integrity Comparison Between Medical/Dental Encounter and Pharmacy Encounter Files—HAP Empowered

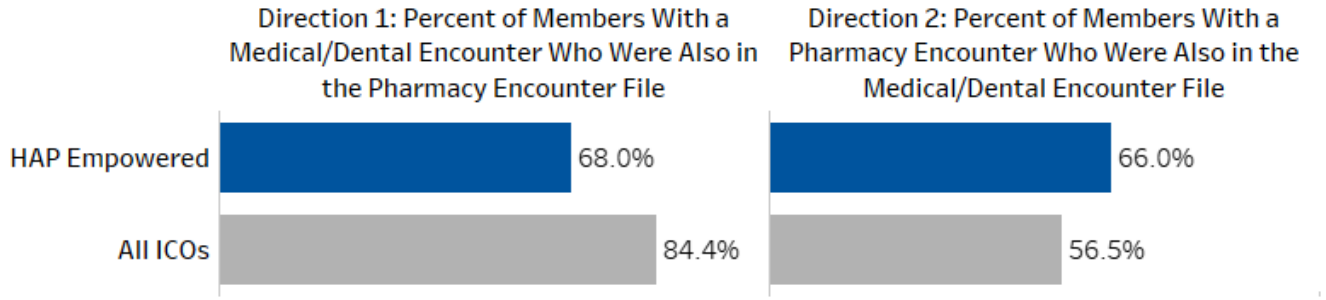


Figure F-16—Referential Integrity Comparison Between Medical/Dental Encounter and Provider Files—HAP Empowered

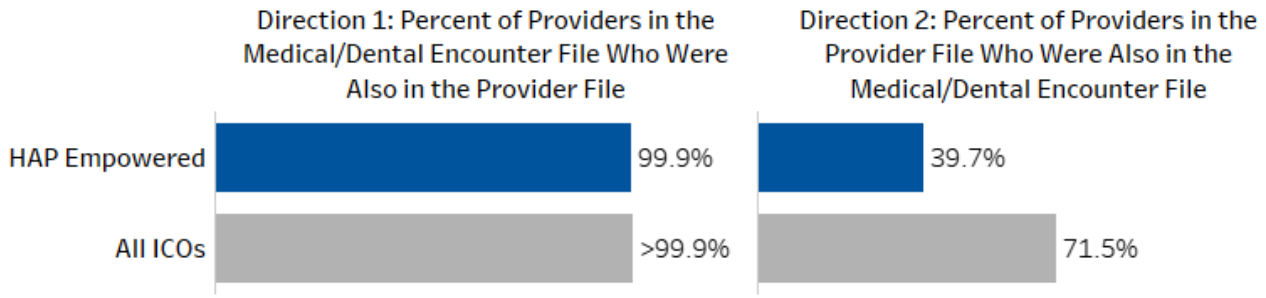
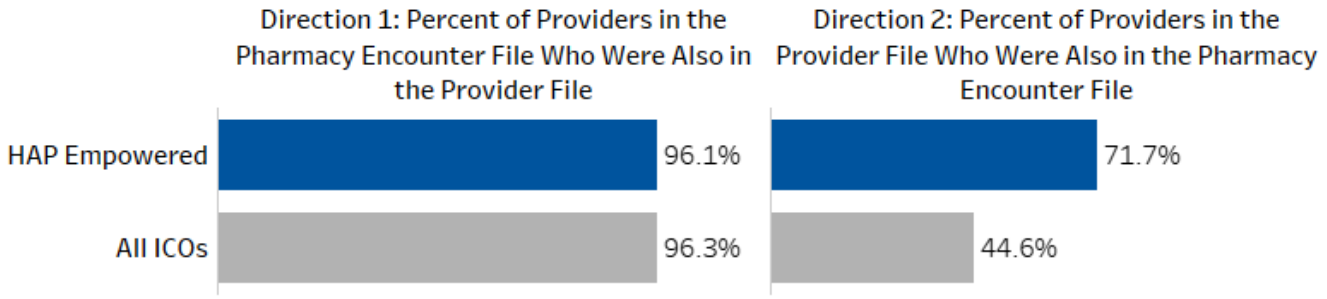


Figure F-17—Referential Integrity Comparison Between Pharmacy Encounter and Provider Files—HAP Empowered

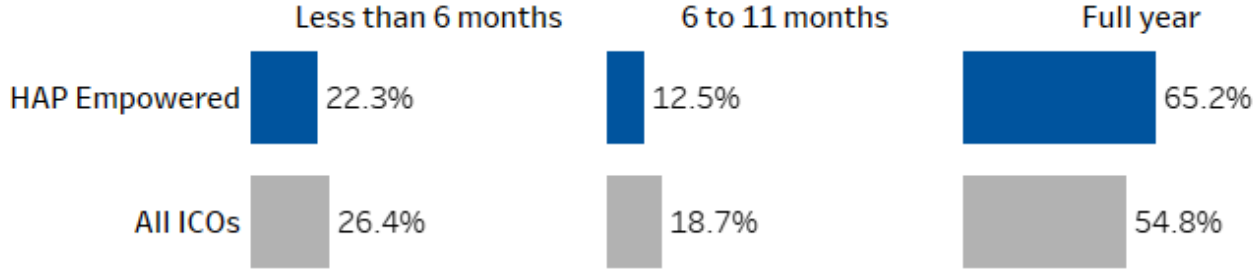


Encounter Data Logic

Member Enrollment

Figure F-18 displays the percentage of members who were continuously enrolled.

Figure F-18—Percentage of Members Who Were Continuously Enrolled—HAP Empowered



Conclusions

Based on the examination of the IS review and administrative profile outcomes in Section 3 and Section 4, respectively, for **HAP Empowered**, HSAG identified the following areas of strength and opportunities for improvement. Along with each opportunity for improvement, HSAG has also provided a recommendation to help target improvement efforts.

IS Review Conclusions

Strengths

Strength #1: HAP Empowered demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The ICO has also established data review and correction processes that efficiently address quality concerns identified by MDHHS.

Opportunities for Improvement

Weakness #1: HAP Empowered modified encounters from its subcontractors before submitting them to MDHHS.

Why the weakness exists: Since modifications were made to the subcontractors' encounters, it is essential to communicate these changes to each entity involved to maintain data integrity.

Recommendation: HAP Empowered should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

Weakness #2: HAP Empowered did not indicate timeliness quality checks were performed for claims/encounters originating from all of its subcontractors.

Why the weakness exists: Timeliness quality checks are crucial to ensuring that claims and encounters are submitted within the stipulated time frames.

Recommendation: HAP Empowered should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

Administrative Profile Conclusions

Strengths

Strength #1: HAP Empowered submitted professional, institutional, and dental encounters in a timely manner from the payment date, with greater than 99 percent of all encounters submitted within 60 days of the payment date.

Strength #2: Across all categories of service, all key data elements for **HAP Empowered** were populated at high rates, and all but one was greater than 99 percent valid.

Opportunities for Improvement

Weakness #1: Although 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, 96.1 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data.

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: HAP Empowered should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Weakness #2: Approximately 33 percent of **HAP Empowered** pharmacy encounters had a submit date prior to the payment date.

Why the weakness exists: Inaccurate date fields can lead to inaccurate timeliness metrics.

Recommendation: HAP Empowered should determine the accuracy of the payment and submission date fields and implement quality checks to ensure the submission date field is after the payment date field.

Weakness #3: Although not required to be populated, 51.2 percent of professional encounters contained a billing provider NPI, and 0.0 percent contained a rendering provider NPI.

Why the weakness exists: Billing and rendering provider information are important for proper provider identification.

Recommendation: HAP Empowered should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Administrative Profile Results—Tabular Data

Encounter Data Summary

Member Composition

Table F-2 presents the member composition.

Table F-2—Age and Gender Distribution—HAP Empowered

Age Category	Number of Females	Number of Males
Age 21–34 years	167	233
Age 35–44 years	218	246
Age 45–54 years	362	282
Age 55–64 years	554	416
Age 65 and over	1,881	1,317
Total	**3,182**	**2,494**

Encounter Data Completeness

Encounter Volume by Service Month

Table F-3 through Table F-6 display the encounter volume by service month.

Table F-3—Encounter Volume: Professional Encounters—HAP Empowered

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	10,281	4,460	2,305.2
November 2021	10,198	4,469	2,281.9
December 2021	10,294	4,472	2,301.9
January 2022	9,783	4,321	2,264.1
February 2022	9,600	4,332	2,216.1
March 2022	10,306	4,315	2,388.4
April 2022	9,971	4,426	2,252.8
May 2022	20,830	4,432	4,699.9
June 2022	20,510	4,427	4,632.9
July 2022	20,479	4,442	4,610.3
August 2022	21,217	4,606	4,606.4
September 2022	20,414	4,644	4,395.8

Table F-4—Encounter Volume: Institutional Encounters—HAP Empowered

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	241	4,460	54.0
November 2021	251	4,469	56.2
December 2021	273	4,472	61.0
January 2022	259	4,321	59.9
February 2022	250	4,332	57.7
March 2022	243	4,315	56.3
April 2022	226	4,426	51.1
May 2022	219	4,432	49.4
June 2022	215	4,427	48.6
July 2022	222	4,442	50.0
August 2022	229	4,606	49.7
September 2022	236	4,644	50.8

Table F-5—Encounter Volume: Dental Encounters—HAP Empowered

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	240	4,460	53.8
November 2021	257	4,469	57.5
December 2021	215	4,472	48.1
January 2022	196	4,321	45.4
February 2022	200	4,332	46.2
March 2022	236	4,315	54.7
April 2022	230	4,426	52.0
May 2022	212	4,432	47.8
June 2022	256	4,427	57.8
July 2022	229	4,442	51.6
August 2022	256	4,606	55.6
September 2022	262	4,644	56.4

Table F-6—Encounter Volume: Pharmacy Encounters—HAP Empowered

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	2,515	4,460	563.9
November 2021	2,607	4,469	583.4
December 2021	2,533	4,472	566.4
January 2022	2,523	4,321	583.9
February 2022	2,363	4,332	545.5
March 2022	2,554	4,315	591.9
April 2022	2,440	4,426	551.3
May 2022	2,466	4,432	556.4
June 2022	2,506	4,427	566.1
July 2022	2,422	4,442	545.2
August 2022	2,662	4,606	577.9
September 2022	2,551	4,644	549.3

Payment Amounts Per Member Per Month

Table F-7 through Table F-10 display the monthly payment amounts PMPM by service month.

Table F-7—Paid Amount PMPM: Professional Encounters—HAP Empowered

Month of Service	Number of MM	Paid Amount PMPM
October 2021	4,460	$56.12
November 2021	4,469	$50.81
December 2021	4,472	$50.20
January 2022	4,321	$53.41
February 2022	4,332	$57.14
March 2022	4,315	$61.77
April 2022	4,426	$48.74
May 2022	4,432	$54.38
June 2022	4,427	$58.96
July 2022	4,442	$60.05
August 2022	4,606	$63.83
September 2022	4,644	$52.95

Table F-8—Paid Amount PMPM: Institutional Encounters—HAP Empowered

Month of Service	Number of MM	Paid Amount PMPM
October 2021	4,460	$342.09
November 2021	4,469	$329.54
December 2021	4,472	$353.63
January 2022	4,321	$302.91
February 2022	4,332	$266.58
March 2022	4,315	$294.83
April 2022	4,426	$261.40
May 2022	4,432	$252.29
June 2022	4,427	$242.23
July 2022	4,442	$250.76
August 2022	4,606	$251.30
September 2022	4,644	$248.04

Table F-9—Paid Amount PMPM: Dental Encounters—HAP Empowered

Month of Service	Number of MM	Paid Amount PMPM
October 2021	4,460	$15.22
November 2021	4,469	$19.86
December 2021	4,472	$33.34
January 2022	4,321	$24.91
February 2022	4,332	$21.36
March 2022	4,315	$34.03
April 2022	4,426	$26.15
May 2022	4,432	$25.85
June 2022	4,427	$28.47
July 2022	4,442	$24.97
August 2022	4,606	$26.02
September 2022	4,644	$26.60

Table F-10—Paid Amount PMPM: Pharmacy Encounters—HAP Empowered

Month of Service	Number of MM	Paid Amount PMPM
October 2021	4,460	$3.86
November 2021	4,469	$3.38
December 2021	4,472	$2.69
January 2022	4,321	$2.87
February 2022	4,332	$2.61
March 2022	4,315	$3.95
April 2022	4,426	$2.93
May 2022	4,432	$3.08
June 2022	4,427	$3.63
July 2022	4,442	$2.62
August 2022	4,606	$3.16
September 2022	4,644	$3.09

Percentage of Duplicate Encounters

Table F-11 displays the percentage of duplicate encounters by category of service.

Table F-11—Percentage of Duplicate Encounters by Category of Service—HAP Empowered

Category of Service	Number of Duplicate Records	Percentage of Duplicate Records
Professional	422	0.1%
Institutional	19	0.5%
Dental	21	0.3%
Pharmacy	2	<0.1%

Encounter Data Timeliness

Encounter Data Lag Triangles

Table F-12 through Table F-15 display the lag triangles between service month and submission month to MDHHS. For conciseness, lag triangles only include encounters submitted through April 2023 (a minimum of a seven-month lag); therefore, counts displayed in the total line may not equal counts displayed in encounter volume figures.

Table F-12—Encounter Data Lag Triangle: Professional Encounters—HAP Empowered

	Month of Service												
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	14												14
202111	1,860	6											1,866
202112	2,888	1,551	54										4,493
202201	4,081	6,522	1,693	5									12,301
202202	1,035	1,344	3,974	1,475	35								7,863
202203	652	473	4,657	2,763	1,373	50							9,968
202204	29	28	79	5,758	5,504	1,243	14						12,655
202205	9	17	26	117	2,939	3,394	1,355	3					7,860
202206	6	16	25	48	421	5,720	8,325	1,917	47				16,525
202207	5	7	11	27	27	148	373	8,840	1,991	29			11,458
202208	44	512	42	36	9	18	55	54	5,040	1,194	7		7,011
202209	159	151	155	32	31	45	50	10,766	14,141	5,200	1,944	22	32,696
202210	23	34	33	2	10	17	15	56	181	14,790	4,782	1,655	21,598
202211	72	37	83	93	46	254	69	52	39	91	15,121	8,386	24,343
202212	0	2	3	4	5	7	9	19	20	39	116	10,987	11,211
202301	12	18	16	5	0	1	3	3	4	4	27	33	126
202302	4	0	0	2	3	2	2	3	3	18	41	87	165
202303	1	0	1	0	0	0	0	2	4	4	10	34	56
202304	0	0	0	0	16	0	2	0	2	2	6	8	36
Total	10,894	10,718	10,852	10,367	10,419	10,899	10,272	21,715	21,472	21,371	22,054	21,212	182,245
MM	4,460	4,469	4,472	4,321	4,332	4,315	4,426	4,432	4,427	4,442	4,606	4,644	53,346
PMPM	2.44	2.40	2.43	2.40	2.41	2.53	2.32	4.90	4.85	4.81	4.79	4.57	3.42

Table F-13—Encounter Data Lag Triangle: Institutional Encounters—HAP Empowered

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	0												0
202111	0	0											0
202112	11	0	0										11
202201	2	20	5	0									27
202202	33	39	53	14	0								139
202203	121	81	99	14	31	0							346
202204	48	34	24	14	18	22	0						160
202205	5	9	9	78	75	94	1	0					271
202206	8	44	61	102	89	87	183	3	0				577
202207	5	3	1	4	9	18	20	11	0	0			71
202208	3	6	6	5	2	5	3	13	56	2	0		101
202209	1	11	15	12	12	1	5	178	131	176	0	0	542
202210	2	2	1	2	3	5	2	2	3	18	183	0	223
202211	1	2	0	3	5	3	3	1	3	6	17	177	221
202212	0	1	0	2	0	1	1	0	11	11	10	24	61
202301	1	0	1	5	3	6	3	5	3	5	4	9	45
202302	0	0	0	5	2	2	2	4	6	6	2	10	39
202303	0	0	0	0	0	0	2	0	1	2	7	5	17
202304	0	0	0	0	1	0	1	1	0	1	3	5	12
Total	241	252	275	260	250	244	226	218	214	227	226	230	2,863
MM	4,460	4,469	4,472	4,321	4,332	4,315	4,426	4,432	4,427	4,442	4,606	4,644	53,346
PMPM	0.05	0.06	0.06	0.06	0.06	0.06	0.05	0.05	0.05	0.05	0.05	0.05	0.05

Table F-14—Encounter Data Lag Triangle: Dental Encounters—HAP Empowered

	Month of Service												
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	0												0
202111	174	0											174
202112	55	188	0										243
202201	5	47	186	0									238
202202	5	12	27	153	0								197
202203	7	7	3	39	137	0							193
202204	2	6	3	7	54	180	0						252
202205	1	3	1	3	5	48	166	0					227
202206	1	2	0	1	7	7	31	170	0				219
202207	1	0	1	0	3	4	8	31	206	0			254
202208	0	1	1	1	0	4	9	6	31	190	0		243
202209	0	2	4	0	2	3	9	3	15	28	201	0	267
202210	0	0	0	1	0	5	0	5	5	9	40	198	263
202211	2	1	1	1	0	1	1	0	3	1	5	37	53
202212	2	0	0	0	0	0	4	0	1	4	7	17	35
202301	0	0	1	0	3	0	5	0	5	0	3	7	24
202302	0	0	0	1	0	1	0	1	1	4	4	7	19
202303	0	0	0	0	0	0	1	1	0	1	0	0	3
202304	0	0	0	0	0	1	0	2	2	0	1	1	7
Total	255	269	228	207	211	254	234	219	269	237	261	267	2,911
MM	4,460	4,469	4,472	4,321	4,332	4,315	4,426	4,432	4,427	4,442	4,606	4,644	53,346
PMPM	0.06	0.06	0.05	0.05	0.05	0.06	0.05	0.05	0.06	0.05	0.06	0.06	0.05

Table F-15—Encounter Data Lag Triangle: Pharmacy Encounters—HAP Empowered

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	1,343												1,343
202111	1,157	1,780											2,937
202112	11	806	1,532										2,349
202201	0	16	988	1,808									2,812
202202	0	0	7	693	1,024								1,724
202203	0	0	1	16	1,315	1,567							2,899
202204	0	0	0	2	10	958	1,286						2,256
202205	0	0	0	0	2	14	1,137	1,709					2,862
202206	0	0	1	2	10	3	8	743	1,486				2,253
202207	0	0	0	1	0	3	1	2	1,003	1,272			2,282
202208	1	3	1	1	1	6	3	6	15	1,141	1,771		2,949
202209	0	0	0	0	1	0	0	0	0	1	875	1,436	2,313
202210	0	0	1	0	0	0	0	0	0	3	4	1,105	1,113
202211	3	2	3	0	0	0	0	0	0	0	1	3	12
202212	0	0	0	0	0	0	0	0	0	0	2	0	2
202301	0	0	0	0	0	0	1	0	0	1	4	2	8
202302	0	0	0	0	0	0	0	0	0	0	3	2	5
202303	0	0	0	0	0	0	0	0	0	0	0	0	0
202304	0	0	0	0	0	0	0	1	0	0	0	0	1
Total	2,515	2,607	2,534	2,523	2,363	2,551	2,436	2,461	2,504	2,418	2,660	2,548	30,120
MM	4,460	4,469	4,472	4,321	4,332	4,315	4,426	4,432	4,427	4,442	4,606	4,644	53,346
PMPM	0.56	0.58	0.57	0.58	0.55	0.59	0.55	0.56	0.57	0.54	0.58	0.55	0.56

Field-Level Completeness and Accuracy

Table F-16 through Table F-19 provide the percentage of encounters that are present and contain valid values for key data elements for all categories of service.

Table F-16—Key Encounter Data Elements: Professional Encounters—HAP Empowered

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	182,854	182,854	100.0%	182,854	182,233	99.7%
Header Service From Date	182,854	182,854	100.0%	182,854	182,854	100.0%
Header Service To Date	182,854	182,854	100.0%	182,854	182,854	100.0%
Detail Service From Date	377,211	377,211	100.0%	377,211	377,211	100.0%
Detail Service To Date	377,211	377,211	100.0%	377,211	377,211	100.0%
Billing Provider NPI	182,854	93,673	51.2%	93,673	93,673	100.0%
Rendering Provider NPI	182,854	0	0.0%	0	0	NA
Referring Provider NPI	182,854	8,027	4.4%	8,027	8,027	100.0%
Rendering Provider Taxonomy Code	182,854	0	0.0%	0	0	NA
Primary Diagnosis Codes	182,854	182,854	100.0%	182,854	182,854	100.0%
Secondary Diagnosis Codes	182,854	57,205	31.3%	58,487	58,487	100.0%
CPT/HCPCS Codes	377,211	377,211	100.0%	377,211	377,211	100.0%
CPT/HCPCS Codes with PTP Edits	377,157	377,157	100.0%	377,157	377,033	>99.9%
NDCs	377,211	1	<0.1%	1	1	100.0%
Submit Date	377,211	377,211	100.0%	377,211	377,211	100.0%
ICO Paid Date	377,211	377,211	100.0%	377,211	377,211	100.0%
Header Paid Amount	182,854	182,854	100.0%	182,854	182,848	>99.9%
Detail Paid Amount	377,211	377,211	100.0%	377,211	377,211	100.0%
Header TPL Paid Amount	182,854	182,854	100.0%	182,854	182,854	100.0%
Detail TPL Paid Amount	377,211	377,211	100.0%	377,211	377,211	100.0%

Table F-17—Key Encounter Data Elements: Institutional Encounters—HAP Empowered

	Percent Present			Percent Valid		
Data Element	**Denominator**	**Numerator**	**Rate**	**Denominator**	**Numerator**	**Rate**
Member ID	2,877	2,877	100.0%	2,877	2,875	99.9%
Header Service From Date	2,877	2,877	100.0%	2,877	2,877	100.0%
Header Service To Date	2,877	2,877	100.0%	2,877	2,877	100.0%
Detail Service From Date	4,220	4,220	100.0%	4,220	4,220	100.0%
Detail Service To Date	4,220	4,220	100.0%	4,220	4,220	100.0%
Billing Provider NPI	2,877	2,876	>99.9%	2,876	2,876	100.0%
Attending Provider NPI	2,877	2,873	99.9%	2,873	2,873	100.0%
Referring Provider NPI	2,877	0	0.0%	0	0	NA
Attending Provider Taxonomy Code	2,877	0	0.0%	0	0	NA
Primary Diagnosis Codes	2,877	2,877	100.0%	2,877	2,877	100.0%
Secondary Diagnosis Codes	2,877	2,619	91.0%	39,006	39,006	100.0%
CPT/HCPCS Codes	4,220	613	14.5%	613	613	100.0%
CPT/HCPCS Codes with PTP Edits	0	0	NA	0	0	NA
Primary Surgical Procedure Codes	2,877	0	0.0%	0	0	NA
Secondary Surgical Procedure Codes	2,877	0	0.0%	0	0	NA
Revenue Codes	4,220	4,220	100.0%	4,220	4,220	100.0%
DRG Codes	2,877	0	0.0%	0	0	NA
Type of Bill Codes	2,877	2,877	100.0%	2,877	2,877	100.0%
NDCs	4,220	0	0.0%	0	0	NA
Submit Date	4,220	4,220	100.0%	4,220	4,220	100.0%
ICO Paid Date	4,220	4,220	100.0%	4,220	4,220	100.0%
Header Paid Amount	2,877	2,877	100.0%	2,877	2,877	100.0%
Detail Paid Amount	4,220	4,220	100.0%	4,220	4,220	100.0%
Header TPL Paid Amount	2,877	2,877	100.0%	2,877	2,877	100.0%
Detail TPL Paid Amount	4,220	4,220	100.0%	4,220	4,220	100.0%

Table F-18—Key Encounter Data Elements: Dental Encounters—HAP Empowered

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	2,933	2,933	100.0%	2,933	2,923	99.7%
Header Service From Date	2,933	2,933	100.0%	2,933	2,933	100.0%
Header Service To Date	2,933	2,933	100.0%	2,933	2,933	100.0%
Detail Service From Date	7,791	7,791	100.0%	7,791	7,791	100.0%
Detail Service To Date	7,791	7,791	100.0%	7,791	7,791	100.0%
Billing Provider NPI	2,933	2,897	98.8%	2,897	2,897	100.0%
Rendering Provider NPI	2,933	2,690	91.7%	2,690	2,690	100.0%
Referring Provider NPI	2,933	0	0.0%	0	0	NA
Rendering Provider Taxonomy Code	2,933	0	0.0%	0	0	NA
Primary Diagnosis Codes	2,933	0	0.0%	0	0	NA
CDT Codes	7,791	7,791	100.0%	7,791	7,791	100.0%
Tooth Number	7,791	2,274	29.2%	2,274	2,274	100.0%
Tooth Surface 1-5	7,791	929	11.9%	2,127	2,127	100.0%
Oral Cavity Code	7,791	68	0.9%	68	68	100.0%
Submit Date	7,791	7,791	100.0%	7,791	7,791	100.0%
ICO Paid Date	7,791	7,791	100.0%	7,791	7,791	100.0%
Header Paid Amount	2,933	2,933	100.0%	2,933	2,928	99.8%
Detail Paid Amount	7,791	7,791	100.0%	7,791	7,791	100.0%
Header TPL Paid Amount	2,933	2,933	100.0%	2,933	2,908	99.1%
Detail TPL Paid Amount	7,791	7,791	100.0%	7,791	7,791	100.0%

Table F-19—Key Encounter Data Elements: Pharmacy Encounters—HAP Empowered

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	30,147	30,147	100.0%	30,147	29,906	99.2%
Date of Service	30,147	30,147	100.0%	30,147	30,147	100.0%
Billing Provider NPI	30,147	30,147	100.0%	30,147	30,147	100.0%
Prescribing Provider NPI	30,147	30,147	100.0%	30,147	30,147	100.0%
NDCs	30,147	30,147	100.0%	30,147	30,057	99.7%
Submit Date	30,147	30,147	100.0%	30,147	20,264	67.2%
ICO Paid Date	30,147	30,147	100.0%	30,147	30,147	100.0%
Paid Amount	30,147	30,147	100.0%	30,147	30,147	100.0%
TPL Paid Amount	30,147	0	0.0%	0	0	NA

Appendix G. Results for Meridian Health Plan

Appendix G contains the IS review and administrative profile results, strengths, weaknesses, and recommendations, as applicable, that HSAG identified from the EDV study for **Meridian Health Plan**.

IS Review Results

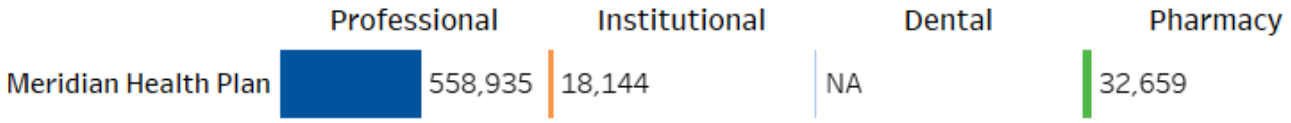
Please refer to Section 3: Information Systems Review Findings for **Meridian Health Plan**'s specific findings, if any.

Administrative Profile Results

Encounter Data Summary

Figure G-1 displays the number of encounters by category of service.

Figure G-1—Number of Encounters by Category of Service—Meridian Health Plan

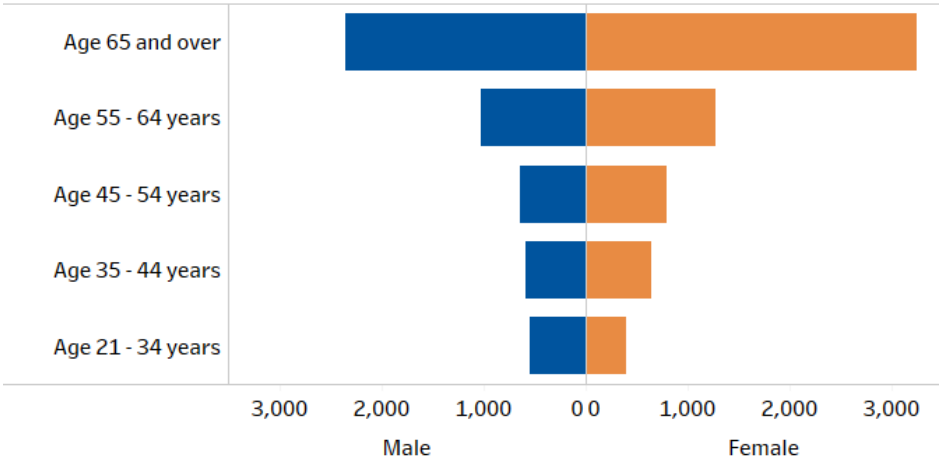


Member Composition

Figure G-2 and Figure G-3 display member demographics.

Figure G-2—Enrollment in SFY 2023—Meridian Health Plan

Figure G-3—Age and Gender Distribution—Meridian Health Plan

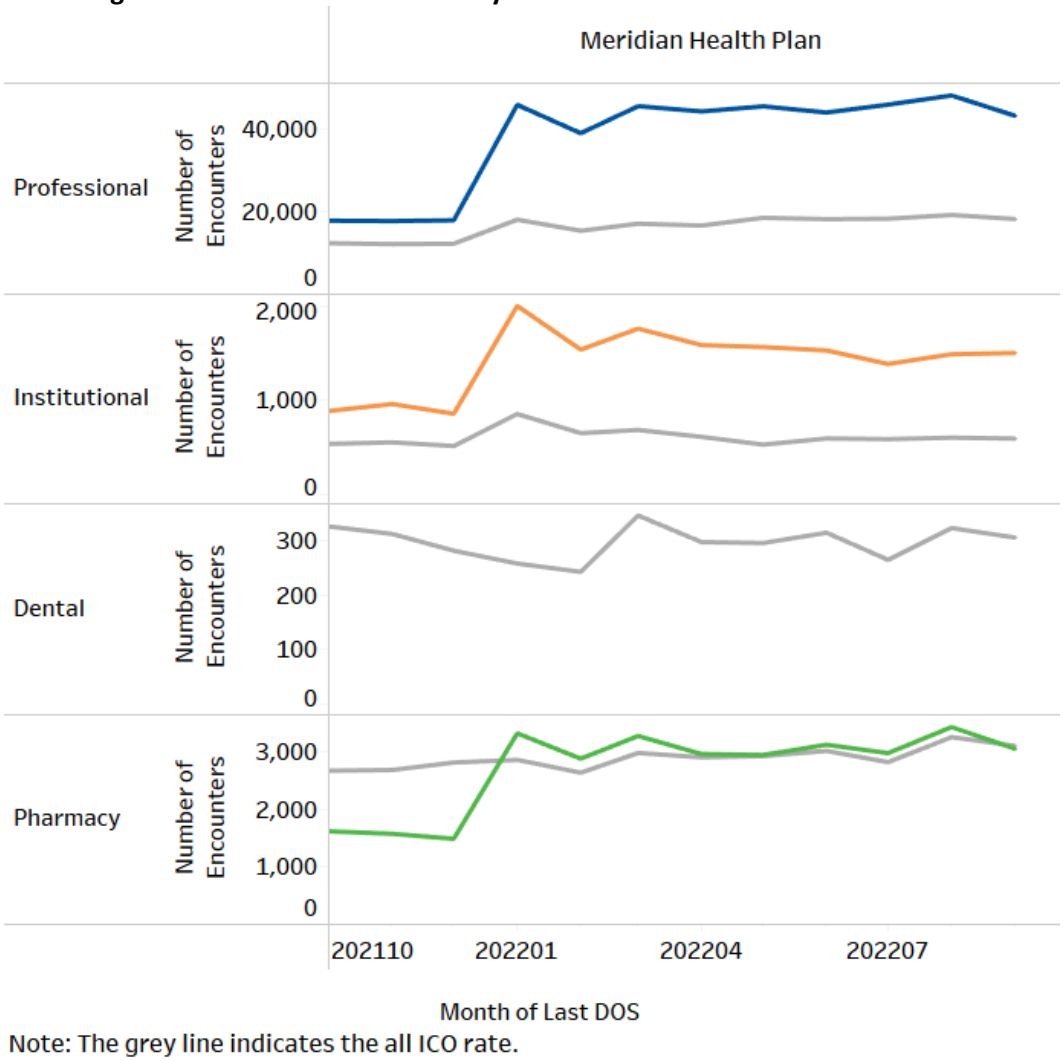


Encounter Data Completeness

Encounter Volume by Service Month

Figure G-4 displays the monthly encounter volume by service month and category of service.

Figure G-4—Encounter Volume by Service Month—Meridian Health Plan

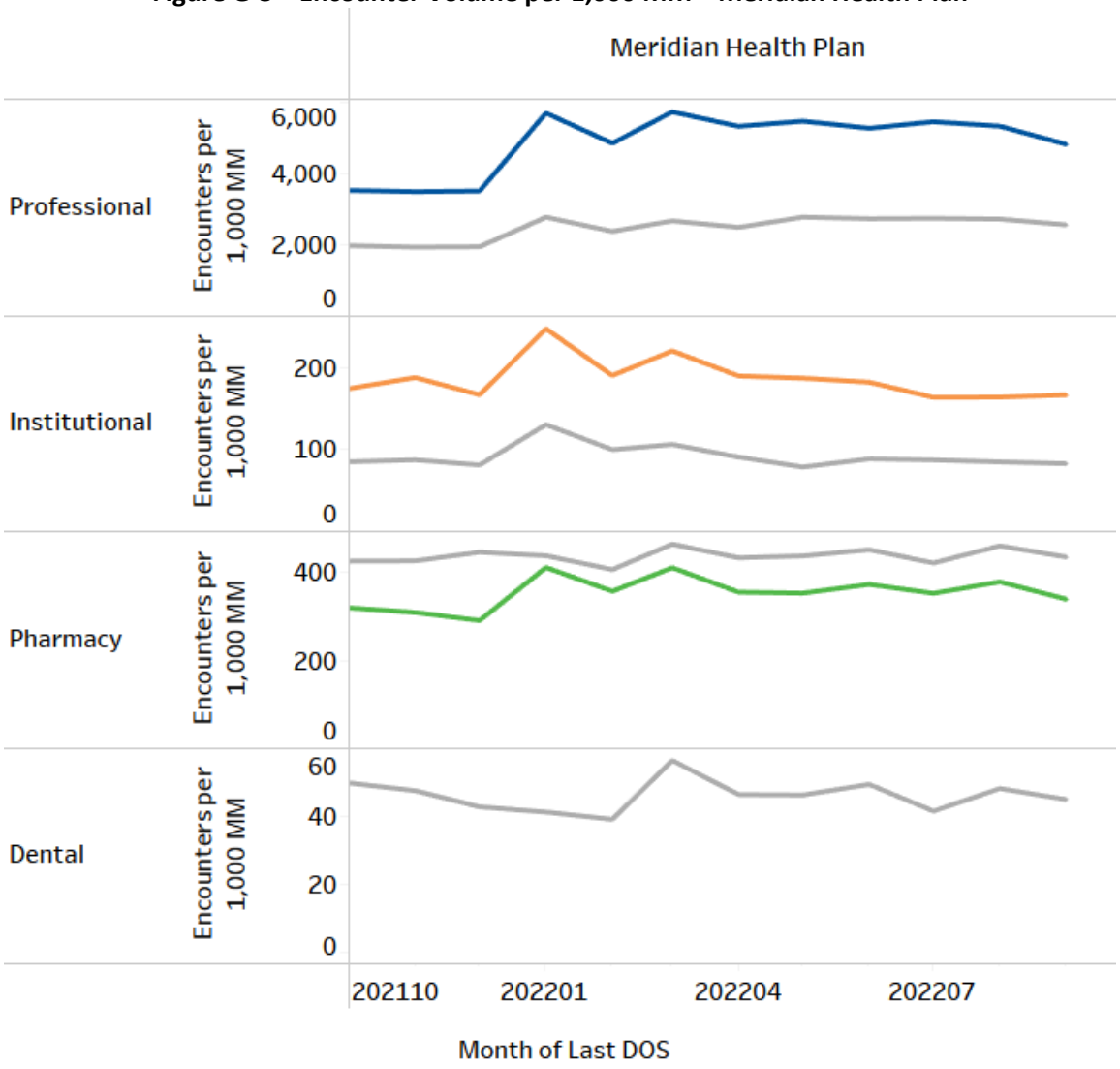


Note: The grey line indicates the all ICO rate.

Encounter Volume Per 1,000 Member Months

Figure G-5 displays the monthly encounter volume per 1,000 MM by service month and category of service.

Figure G-5—Encounter Volume per 1,000 MM—Meridian Health Plan

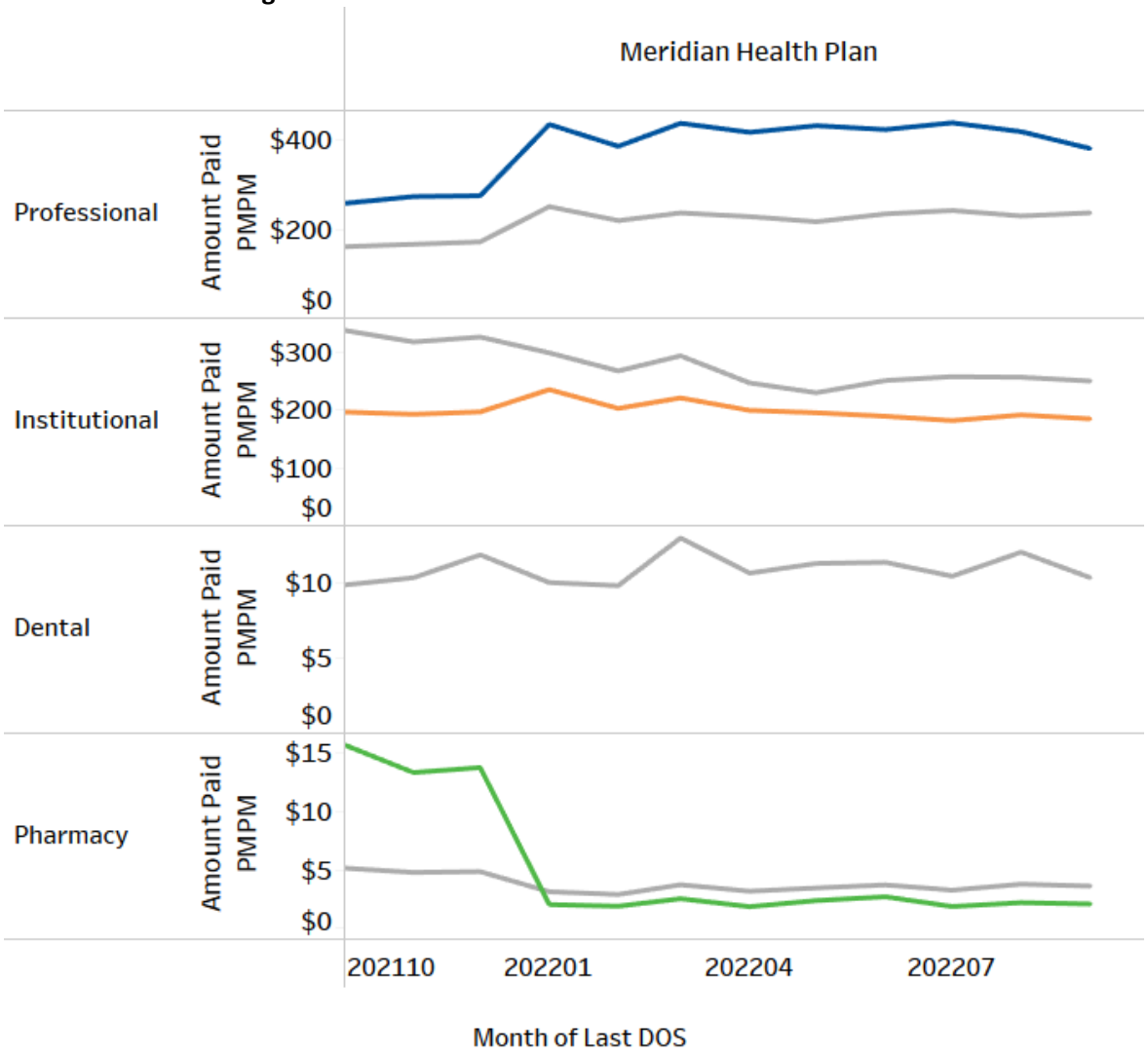


Note: The grey line indicates the all ICO rate.

Payment Amounts Per Member Per Month

Figure G-6 displays the monthly payment amounts PMPM by service month and category of service.

Figure G-6—Paid Amount PMPM—Meridian Health Plan

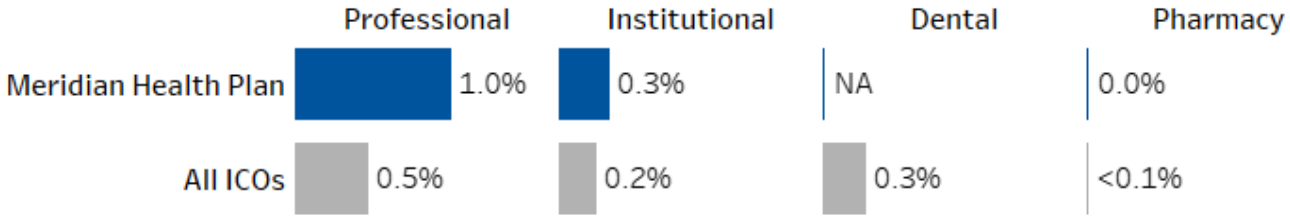


Note: The grey line indicates the all ICO rate.

Percentage of Duplicate Encounters

Figure G-7 displays the percentage of duplicate encounters.

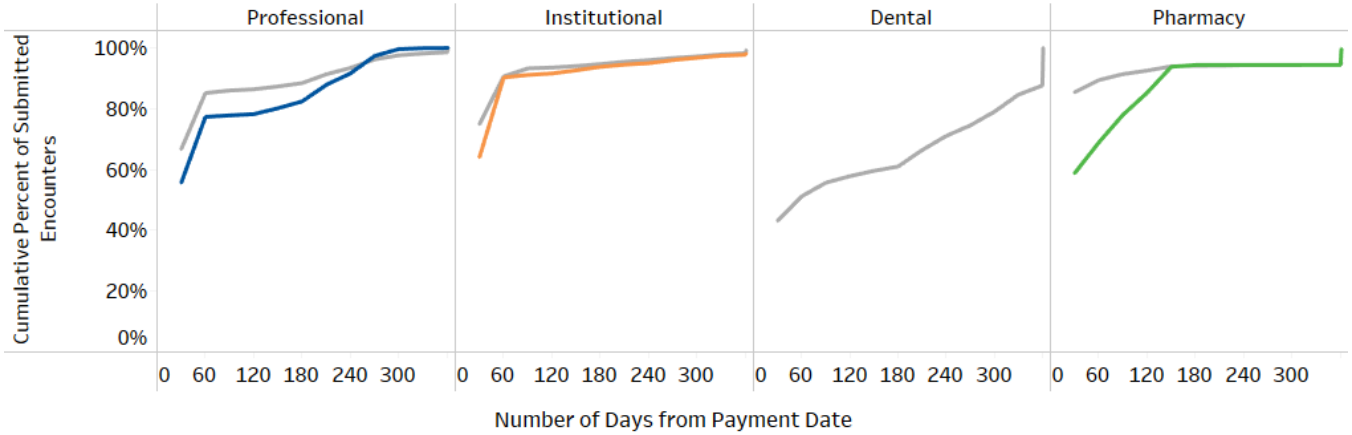
Figure G-7—Percentage of Duplicate Encounters—Meridian Health Plan



Encounter Data Timeliness

Figure G-8 and Table G-1 show the cumulative percentage of encounters submitted to MDHHS from the payment date by category of service.

Figure G-8—Cumulative Percentage of Encounters Submitted to MDHHS From ICO Payment Date by Category of Service—Meridian Health Plan



Note: The grey line indicates the all ICO rate.

Table G-1—Completeness of Encounters by Category of Service—Meridian Health Plan

Number of Days From Payment Date	Cumulative Percentage of Submitted Professional Encounters	Cumulative Percentage of Submitted Institutional Encounters	Cumulative Percentage of Submitted Dental Encounters	Cumulative Percentage of Submitted Pharmacy Encounters
Submitted Within 30 Days	55.6%	64.0%	NA	58.8%
Submitted Within 60 Days	77.3%	90.2%	NA	68.9%
Submitted Within 90 Days	77.8%	91.1%	NA	78.0%
Submitted Within 120 Days	78.2%	91.5%	NA	85.2%
Submitted Within 150 Days	80.1%	92.6%	NA	93.8%
Submitted Within 180 Days	82.4%	93.7%	NA	94.3%
Submitted Within 210 Days	87.8%	94.5%	NA	94.3%
Submitted Within 240 Days	91.6%	94.9%	NA	94.3%
Submitted Within 270 Days	97.3%	95.9%	NA	94.3%
Submitted Within 300 Days	99.6%	96.7%	NA	94.3%
Submitted Within 330 Days	99.8%	97.4%	NA	94.3%
Submitted Within 360 Days	99.9%	97.7%	NA	94.4%
Submitted After 360 Days	100.0%	98.2%	NA	99.6%
Missing Paid or Submission Date	0.0%	1.8%	NA	0.4%
Submitted Prior to Paid Date	0.0%	0.0%	NA	0.0%

Field-Level Completeness and Accuracy

Figure G-9 through Figure G-12 provide the percentage of encounters that are present and contain valid values for key data elements.

Figure G-9—Key Professional Encounter Data Elements—Meridian Health Plan

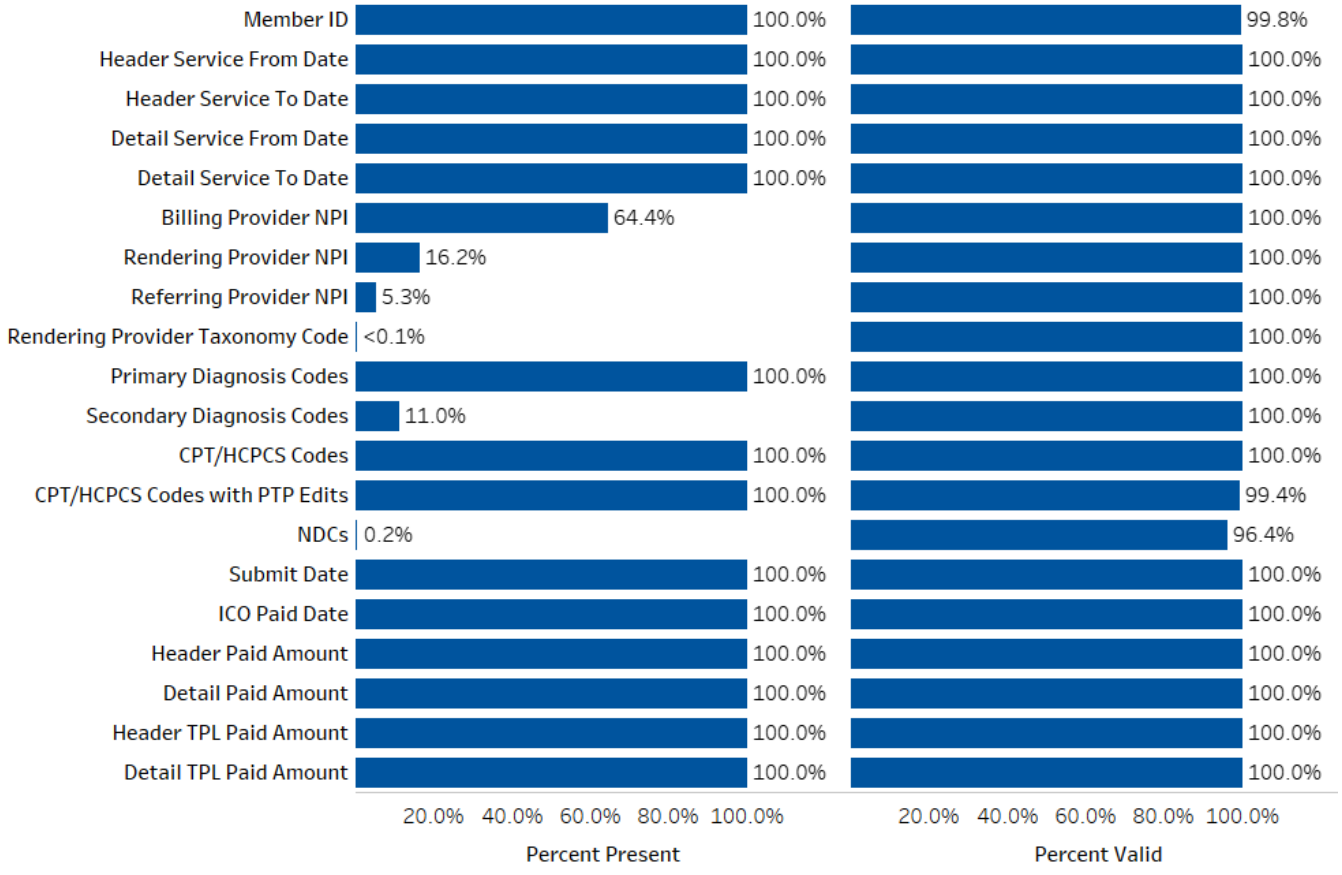


Figure G-10—Key Institutional Encounter Data Elements—Meridian Health Plan

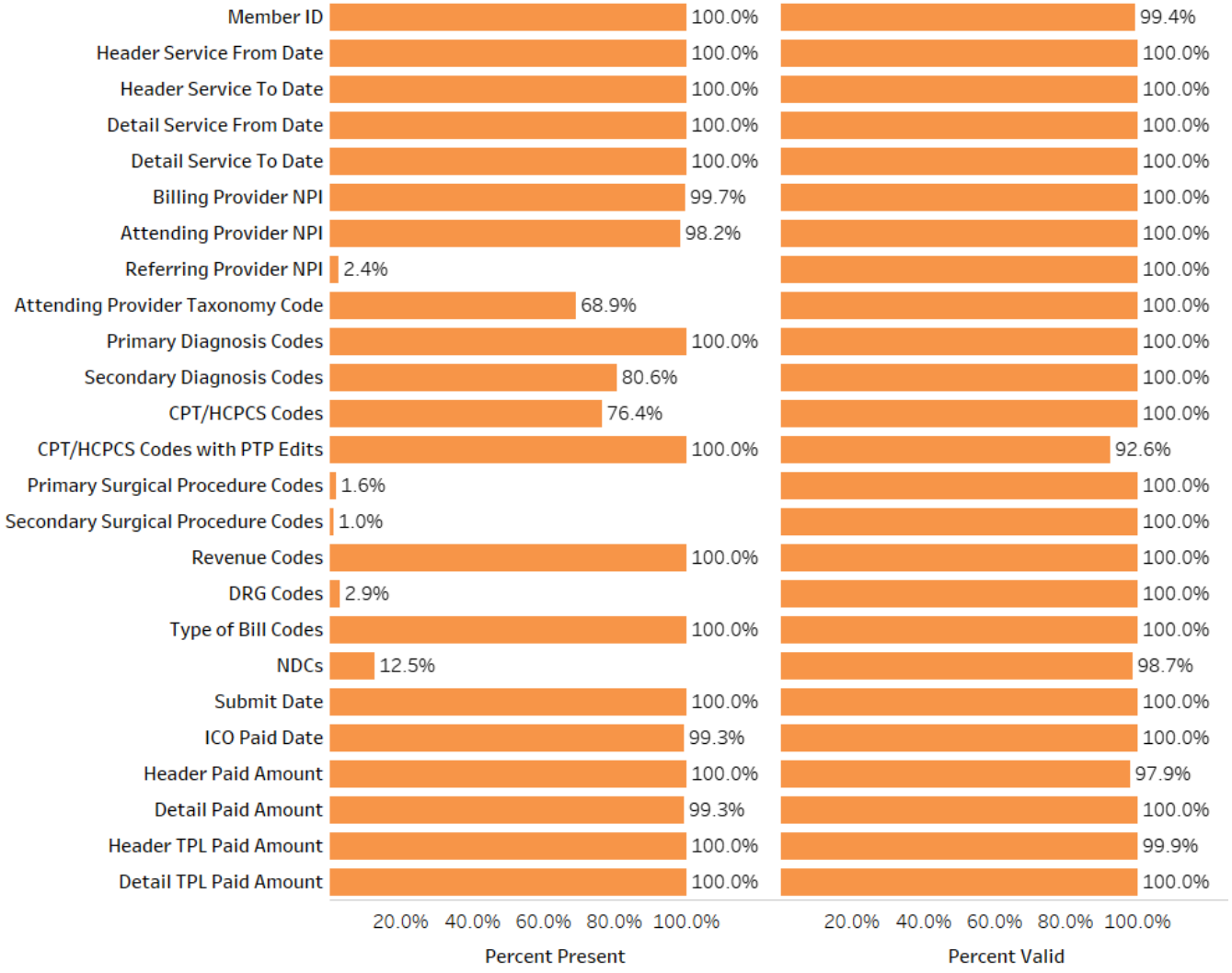


Figure G-11—Key Dental Encounter Data Elements—Meridian Health Plan

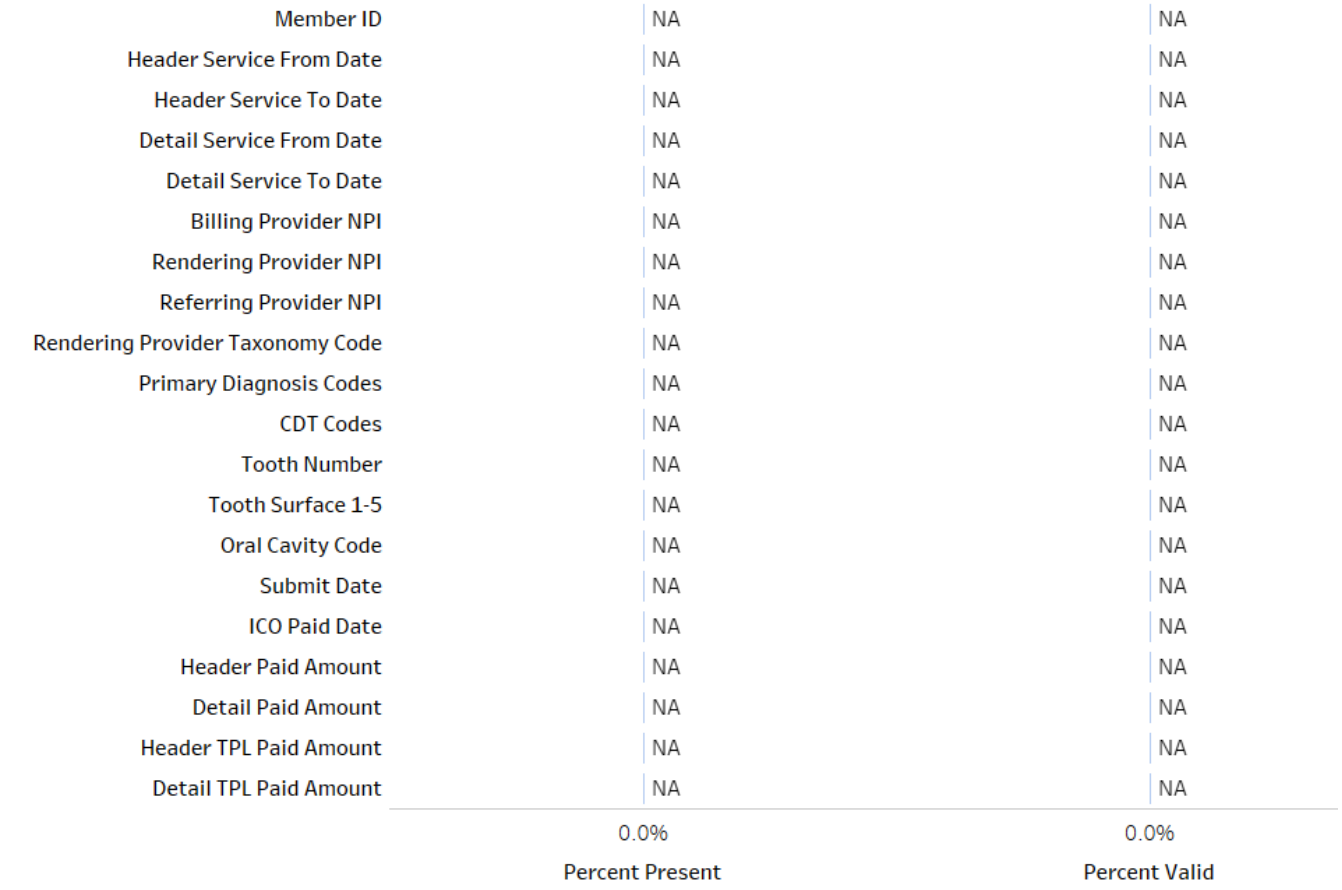
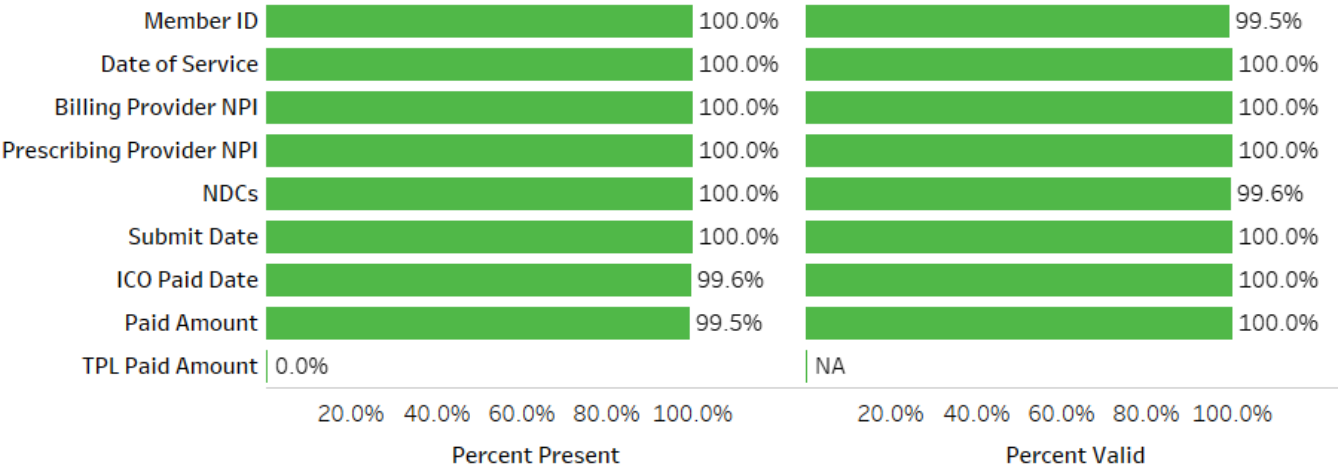


Figure G-12—Key Pharmacy Encounter Data Elements—Meridian Health Plan



Encounter Data Referential Integrity

Figure G-13 through Figure G-17 display the referential integrity results.

Figure G-13—Referential Integrity Comparison Between Enrollment and Medical/Dental Encounter Files—Meridian Health Plan

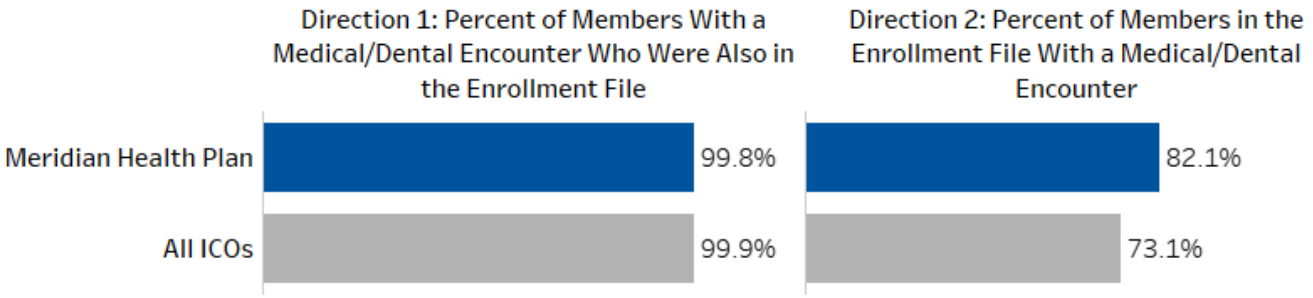


Figure G-14—Referential Integrity Comparison Between Enrollment and Pharmacy Encounter Files—Meridian Health Plan

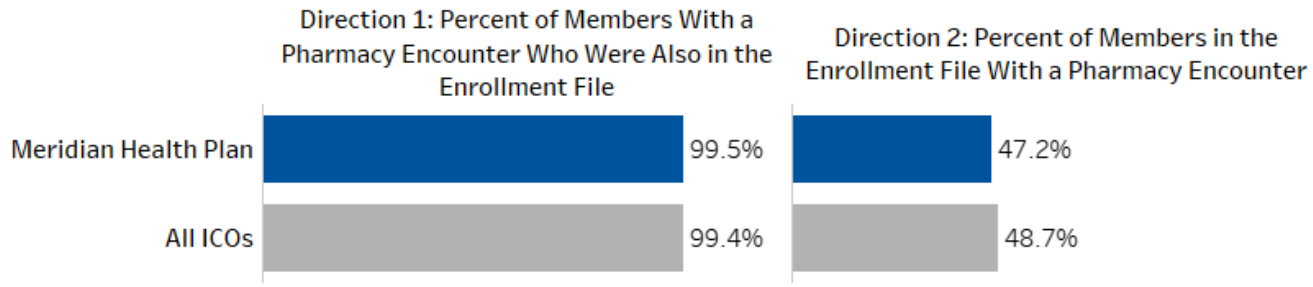


Figure G-15—Referential Integrity Comparison Between Medical/Dental Encounter and Pharmacy Encounter Files—Meridian Health Plan

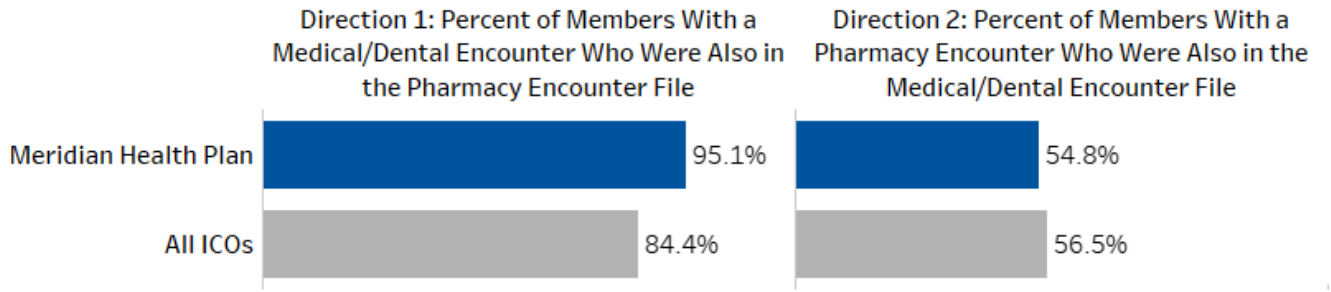


Figure G-16—Referential Integrity Comparison Between Medical/Dental Encounter and Provider Files—Meridian Health Plan

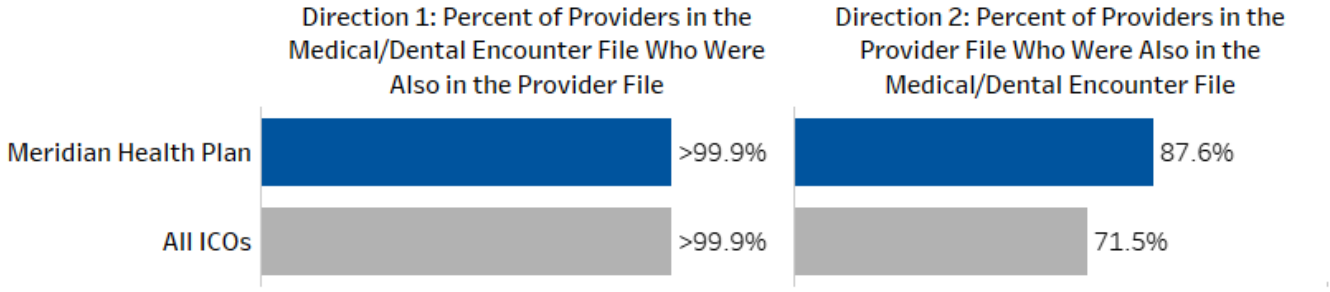
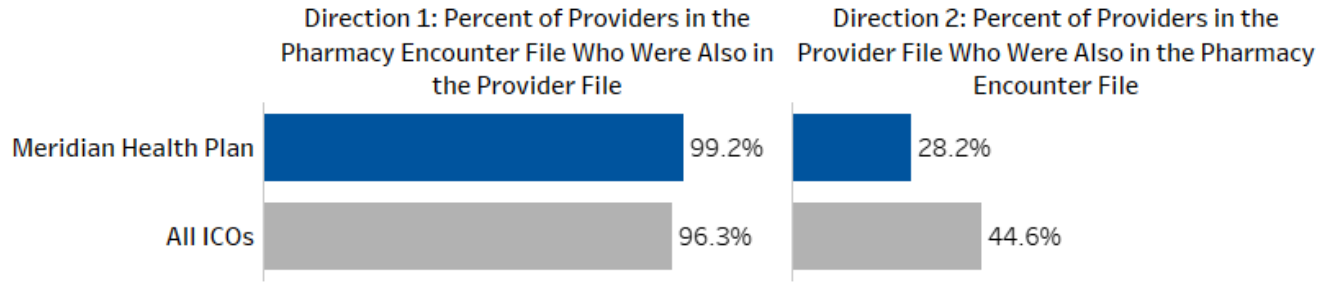


Figure G-17—Referential Integrity Comparison Between Pharmacy Encounter and Provider Files—Meridian Health Plan

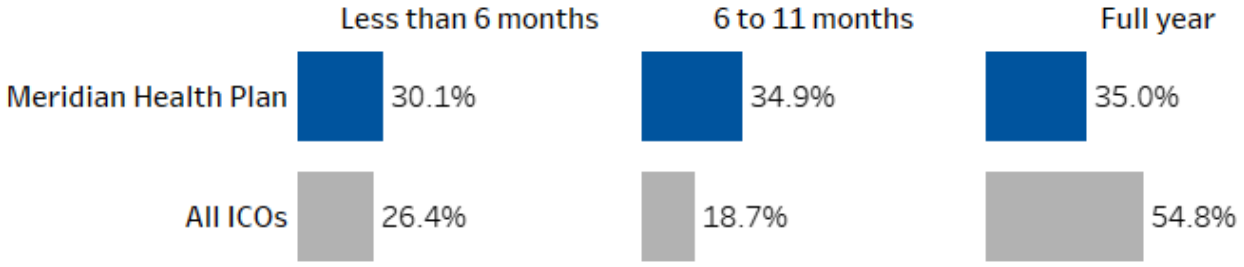


Encounter Data Logic

Member Enrollment

Figure G-18 displays the percentage of members who were continuously enrolled.

Figure G-18—Percentage of Members Who Were Continuously Enrolled—Meridian Health Plan



Conclusions

Based on the examination of the IS review and administrative profile outcomes in Section 3 and Section 4, respectively, for **Meridian Health Plan**, HSAG identified the following areas of strength and opportunities for improvement. Along with each opportunity for improvement, HSAG has also provided a recommendation to help target improvement efforts.

IS Review Conclusions

Strengths

Strength #1: Meridian Health Plan demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The ICO has also established data review and correction processes that efficiently address quality concerns identified by MDHHS.

Opportunities for Improvement

Weakness #1: Meridian Health Plan indicated that it did not store any of its subcontractor data.

Why the weakness exists: Storing subcontractor encounter data within **Meridian Health Plan**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Meridian Health Plan**'s overall capabilities, it should consider storing its subcontractor encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Meridian Health Plan did not indicate timeliness quality checks were performed for claims/encounters originating from its behavioral health and pharmacy subcontractors.

Why the weakness exists: Timeliness quality checks are crucial to ensuring that claims and encounters are submitted within the stipulated time frames.

Recommendation: Meridian Health Plan should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

Administrative Profile Conclusions

Strengths

Strength #1: Across all categories of service, all key data elements for **Meridian Health Plan** were populated at high rates, and all but one was greater than 96 percent valid.

Opportunities for Improvement

Weakness #1: Meridian Health Plan took slightly longer than other ICOs to submit its data to MDHHS. At 180 days from payment date, **Meridian Health Plan** had submitted 82.4 percent of professional encounters, 93.7 percent of institutional encounters, and 94.3 percent of pharmacy encounters.

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: Meridian Health Plan should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #2: Although not required to be populated, 64.4 percent of professional encounters contained a billing provider NPI, and 16.2 percent contained a rendering provider NPI.

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Meridian Health Plan should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Administrative Profile Results—Tabular Data

Encounter Data Summary

Member Composition

Table G-2 presents the member composition.

Table G-2—Age and Gender Distribution—Meridian Health Plan

Age Category	Number of Females	Number of Males
Age 21–34 years	401	545
Age 35–44 years	647	585
Age 45–54 years	795	648
Age 55–64 years	1,282	1,019
Age 65 and over	3,248	2,350
Total	**6,373**	**5,147**

Encounter Data Completeness

Encounter Volume by Service Month

Table G-3 through Table G-6 display the encounter volume by service month.

Table G-3—Encounter Volume: Professional Encounters—Meridian Health Plan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	17,851	5,067	3,523.0
November 2021	17,770	5,097	3,486.4
December 2021	17,946	5,121	3,504.4
January 2022	45,963	8,081	5,687.8
February 2022	39,070	8,068	4,842.6
March 2022	45,636	7,976	5,721.7
April 2022	44,359	8,344	5,316.3
May 2022	45,596	8,349	5,461.3
June 2022	44,098	8,379	5,262.9
July 2022	46,010	8,450	5,445.0
August 2022	48,235	9,065	5,321.0
September 2022	43,312	9,000	4,812.4

Table G-4—Encounter Volume: Institutional Encounters—Meridian Health Plan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	885	5,067	174.7
November 2021	959	5,097	188.1
December 2021	856	5,121	167.2
January 2022	2,003	8,081	247.9
February 2022	1,538	8,068	190.6
March 2022	1,761	7,976	220.8
April 2022	1,586	8,344	190.1
May 2022	1,565	8,349	187.4
June 2022	1,529	8,379	182.5
July 2022	1,385	8,450	163.9
August 2022	1,489	9,065	164.3
September 2022	1,502	9,000	166.9

Table G-5—Encounter Volume: Dental Encounters—Meridian Health Plan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	NA	5,067	NA
November 2021	NA	5,097	NA
December 2021	NA	5,121	NA
January 2022	NA	8,081	NA
February 2022	NA	8,068	NA
March 2022	NA	7,976	NA
April 2022	NA	8,344	NA
May 2022	NA	8,349	NA
June 2022	NA	8,379	NA
July 2022	NA	8,450	NA
August 2022	NA	9,065	NA
September 2022	NA	9,000	NA

Table G-6—Encounter Volume: Pharmacy Encounters—Meridian Health Plan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	1,619	5,067	319.5
November 2021	1,575	5,097	309.0
December 2021	1,488	5,121	290.6
January 2022	3,323	8,081	411.2
February 2022	2,882	8,068	357.2
March 2022	3,276	7,976	410.7
April 2022	2,962	8,344	355.0
May 2022	2,946	8,349	352.9
June 2022	3,124	8,379	372.8
July 2022	2,978	8,450	352.4
August 2022	3,432	9,065	378.6
September 2022	3,053	9,000	339.2

Payment Amounts Per Member Per Month

Table G-7 through Table G-10 display the monthly payment amounts PMPM by service month.

Table G-7—Paid Amount PMPM: Professional Encounters—Meridian Health Plan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	5,067	$258.75
November 2021	5,097	$274.13
December 2021	5,121	$275.93
January 2022	8,081	$436.73
February 2022	8,068	$387.35
March 2022	7,976	$439.38
April 2022	8,344	$418.87
May 2022	8,349	$433.86
June 2022	8,379	$425.13
July 2022	8,450	$440.34
August 2022	9,065	$420.43
September 2022	9,000	$382.34

Table G-8—Paid Amount PMPM: Institutional Encounters—Meridian Health Plan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	5,067	$196.99
November 2021	5,097	$193.10
December 2021	5,121	$197.27
January 2022	8,081	$235.83
February 2022	8,068	$203.26
March 2022	7,976	$221.45
April 2022	8,344	$199.85
May 2022	8,349	$195.73
June 2022	8,379	$189.64
July 2022	8,450	$182.14
August 2022	9,065	$191.88
September 2022	9,000	$185.27

Table G-9—Paid Amount PMPM: Dental Encounters—Meridian Health Plan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	5,067	NA
November 2021	5,097	NA
December 2021	5,121	NA
January 2022	8,081	NA
February 2022	8,068	NA
March 2022	7,976	NA
April 2022	8,344	NA
May 2022	8,349	NA
June 2022	8,379	NA
July 2022	8,450	NA
August 2022	9,065	NA
September 2022	9,000	NA

Table G-10—Paid Amount PMPM: Pharmacy Encounters—Meridian Health Plan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	5,067	$15.70
November 2021	5,097	$13.33
December 2021	5,121	$13.76
January 2022	8,081	$2.04
February 2022	8,068	$1.90
March 2022	7,976	$2.54
April 2022	8,344	$1.86
May 2022	8,349	$2.38
June 2022	8,379	$2.71
July 2022	8,450	$1.87
August 2022	9,065	$2.20
September 2022	9,000	$2.09

Percentage of Duplicate Encounters

Table G-11 displays the percentage of duplicate encounters by category of service.

Table G-11—Percentage of Duplicate Encounters by Category of Service—Meridian Health Plan

Category of Service	Number of Duplicate Records	Percentage of Duplicate Records
Professional	5,415	1.0%
Institutional	259	0.3%
Dental	NA	NA
Pharmacy	0	0.0%

Encounter Data Timeliness

Encounter Data Lag Triangles

Table G-12 through Table G-15 display the lag triangles between service month and submission month to MDHHS. For conciseness, lag triangles only include encounters submitted through April 2023 (a minimum of a seven-month lag); therefore, counts displayed in the total line may not equal counts displayed in encounter volume figures.

Table G-12—Encounter Data Lag Triangle: Professional Encounters—Meridian Health Plan

	Month of Service												
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	219												219
202111	2,099	245											2,344
202112	2,092	3,045	122										5,259
202201	174	1,815	1,809	0									3,798
202202	435	475	1,737	674	0								3,321
202203	1,050	355	2,070	12,657	4,382	36							20,550
202204	67	42	75	3,088	5,003	4,545	0						12,820
202205	33	48	99	13,391	13,439	4,909	882	0					32,801
202206	101	111	168	766	979	15,290	4,738	1,279	0				23,432
202207	1,260	475	119	692	911	3,110	18,072	12,996	2,729	138			40,502
202208	71	118	146	337	263	316	604	2,218	8,589	4,695	483		17,840
202209	0	0	0	0	0	0	0	0	0	0	0	0	0
202210	411	1,110	1,263	1,553	942	1,579	2,227	2,375	4,380	10,633	12,901	2,398	41,772
202211	57	49	32	163	177	178	202	1,500	2,496	12,830	14,675	6,951	39,310
202212	7,950	7,116	8,088	8,669	8,462	8,220	6,938	11,596	6,424	8,217	20,785	37,458	139,923
202301	4,196	5,426	5,336	13,213	6,452	3,596	517	834	586	487	1,640	4,213	46,496
202302	1,093	594	122	213	428	1,128	409	513	309	354	415	789	6,367
202303	28	20	41	163	192	318	323	344	301	407	432	637	3,206
202304	54	122	161	305	322	403	482	411	495	450	783	652	4,640
Total	21,390	21,166	21,388	55,884	41,952	43,628	35,394	34,066	26,309	38,211	52,114	53,098	444,600
MM	5,067	5,097	5,121	8,081	8,068	7,976	8,344	8,349	8,379	8,450	9,065	9,000	90,997
PMPM	4.22	4.15	4.18	6.92	5.20	5.47	4.24	4.08	3.14	4.52	5.75	5.90	4.89

Table G-13—Encounter Data Lag Triangle: Institutional Encounters—Meridian Health Plan

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	27												27
202111	266	15											281
202112	202	243	6										451
202201	45	152	94	0									291
202202	42	141	193	50	0								426
202203	90	121	289	1,198	362	2							2,062
202204	14	45	48	106	313	344	0						870
202205	13	12	9	73	178	238	39	0					562
202206	19	9	3	18	54	192	297	82	0				674
202207	36	34	23	59	76	208	421	613	264	5			1,739
202208	69	77	34	64	60	106	126	271	623	494	34		1,958
202209	0	0	0	0	0	0	0	0	0	0	0	0	0
202210	21	51	67	46	61	91	140	92	143	415	708	107	1,942
202211	5	6	6	19	21	53	52	36	47	77	291	617	1,230
202212	2	2	8	20	18	32	48	32	43	47	87	275	614
202301	12	3	16	36	39	43	43	45	33	33	46	87	436
202302	2	6	5	38	51	79	38	50	34	47	27	32	409
202303	38	46	37	82	72	115	92	105	104	104	105	127	1,027
202304	11	17	25	37	47	60	50	56	54	60	58	98	573
Total	914	980	863	1,846	1,352	1,563	1,346	1,382	1,345	1,282	1,356	1,343	15,572
MM	5,067	5,097	5,121	8,081	8,068	7,976	8,344	8,349	8,379	8,450	9,065	9,000	90,997
PMPM	0.18	0.19	0.17	0.23	0.17	0.20	0.16	0.17	0.16	0.15	0.15	0.15	0.17

Table G-14—Encounter Data Lag Triangle: Dental Encounters—Meridian Health Plan

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	0												0
202111	0	0											0
202112	0	0	0										0
202201	0	0	0	0									0
202202	0	0	0	0	0								0
202203	0	0	0	0	0	0							0
202204	0	0	0	0	0	0	0						0
202205	0	0	0	0	0	0	0	0					0
202206	0	0	0	0	0	0	0	0	0				0
202207	0	0	0	0	0	0	0	0	0	0			0
202208	0	0	0	0	0	0	0	0	0	0	0		0
202209	0	0	0	0	0	0	0	0	0	0	0	0	0
202210	0	0	0	0	0	0	0	0	0	0	0	0	0
202211	0	0	0	0	0	0	0	0	0	0	0	0	0
202212	0	0	0	0	0	0	0	0	0	0	0	0	0
202301	0	0	0	0	0	0	0	0	0	0	0	0	0
202302	0	0	0	0	0	0	0	0	0	0	0	0	0
202303	0	0	0	0	0	0	0	0	0	0	0	0	0
202304	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0
MM	5,067	5,097	5,121	8,081	8,068	7,976	8,344	8,349	8,379	8,450	9,065	9,000	90,997
PMPM	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table G-15—Encounter Data Lag Triangle: Pharmacy Encounters—Meridian Health Plan

	Month of Service												
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	499												499
202111	487	473											960
202112	21	525	576										1,122
202201	0	6	379	0									385
202202	0	0	9	0	0								9
202203	0	0	0	0	0	0							0
202204	0	0	0	0	0	0	0						0
202205	0	0	4	0	0	0	0	0					4
202206	0	0	0	3,062	2,607	2,964	2,630	2,555	636				14,454
202207	0	0	0	22	22	28	53	72	2,146	319			2,662
202208	0	0	0	52	82	72	72	90	104	2,490	266		3,228
202209	0	0	0	12	5	17	11	15	22	31	2,686	399	3,198
202210	0	0	0	14	18	24	41	43	51	38	160	1,830	2,219
202211	0	0	0	15	25	29	40	51	54	36	129	629	1,008
202212	0	0	0	26	30	36	19	19	16	13	27	21	207
202301	0	0	0	34	17	23	22	31	24	12	46	62	271
202302	612	571	520	9	7	11	11	13	16	8	35	31	1,844
202303	0	0	0	0	0	0	0	0	0	0	0	0	0
202304	0	0	0	13	18	19	13	11	9	9	17	16	125
Total	1,619	1,575	1,488	3,259	2,831	3,223	2,912	2,900	3,078	2,956	3,366	2,988	32,195
MM	5,067	5,097	5,121	8,081	8,068	7,976	8,344	8,349	8,379	8,450	9,065	9,000	90,997
PMPM	0.32	0.31	0.29	0.40	0.35	0.40	0.35	0.35	0.37	0.35	0.37	0.33	0.35

Field-Level Completeness and Accuracy

Table G-16 through Table G-19 provide the percentage of encounters that are present and contain valid values for key data elements for all categories of service.

Table G-16—Key Encounter Data Elements: Professional Encounters—Meridian Health Plan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	558,935	558,935	100.0%	558,935	557,577	99.8%
Header Service From Date	558,935	558,935	100.0%	558,935	558,935	100.0%
Header Service To Date	558,935	558,935	100.0%	558,935	558,935	100.0%
Detail Service From Date	558,935	558,935	100.0%	558,935	558,935	100.0%
Detail Service To Date	558,935	558,935	100.0%	558,935	558,935	100.0%
Billing Provider NPI	558,935	360,205	64.4%	360,205	360,205	100.0%
Rendering Provider NPI	558,935	90,669	16.2%	90,669	90,669	100.0%
Referring Provider NPI	558,935	29,592	5.3%	29,592	29,592	100.0%
Rendering Provider Taxonomy Code	558,935	103	<0.1%	103	103	100.0%
Primary Diagnosis Codes	558,935	558,935	100.0%	558,935	558,935	100.0%
Secondary Diagnosis Codes	558,935	61,440	11.0%	125,007	125,007	100.0%
CPT/HCPCS Codes	558,935	558,935	100.0%	558,935	558,935	100.0%
CPT/HCPCS Codes with PTP Edits	547,938	547,938	100.0%	547,938	544,460	99.4%
NDCs	558,935	968	0.2%	968	933	96.4%
Submit Date	558,935	558,935	100.0%	558,935	558,935	100.0%
ICO Paid Date	558,935	558,935	100.0%	558,935	558,935	100.0%
Header Paid Amount	558,935	558,935	100.0%	558,935	558,935	100.0%
Detail Paid Amount	558,935	558,935	100.0%	558,935	558,935	100.0%
Header TPL Paid Amount	558,935	558,935	100.0%	558,935	558,935	100.0%
Detail TPL Paid Amount	558,935	558,935	100.0%	558,935	558,935	100.0%

Table G-17—Key Encounter Data Elements: Institutional Encounters—Meridian Health Plan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	18,144	18,144	100.0%	18,144	18,043	99.4%
Header Service From Date	18,144	18,144	100.0%	17,809	17,809	100.0%
Header Service To Date	18,144	18,144	100.0%	17,809	17,809	100.0%
Detail Service From Date	80,768	80,768	100.0%	80,191	80,191	100.0%
Detail Service To Date	80,768	80,768	100.0%	80,191	80,191	100.0%
Billing Provider NPI	18,144	18,086	99.7%	18,086	18,086	100.0%
Attending Provider NPI	18,144	17,818	98.2%	17,818	17,818	100.0%
Referring Provider NPI	18,144	437	2.4%	437	437	100.0%
Attending Provider Taxonomy Code	18,144	12,507	68.9%	12,507	12,507	100.0%
Primary Diagnosis Codes	18,144	18,144	100.0%	18,144	18,144	100.0%
Secondary Diagnosis Codes	18,144	14,629	80.6%	110,634	110,634	100.0%
CPT/HCPCS Codes	80,768	61,689	76.4%	61,689	61,689	100.0%
CPT/HCPCS Codes with PTP Edits	36,037	36,037	100.0%	36,037	33,375	92.6%
Primary Surgical Procedure Codes	18,144	299	1.6%	299	299	100.0%
Secondary Surgical Procedure Codes	18,144	175	1.0%	536	536	100.0%
Revenue Codes	80,768	80,768	100.0%	80,768	80,768	100.0%
DRG Codes	18,144	518	2.9%	518	518	100.0%
Type of Bill Codes	18,144	18,144	100.0%	18,144	18,144	100.0%
NDCs	80,768	10,118	12.5%	10,118	9,990	98.7%
Submit Date	80,768	80,768	100.0%	80,768	80,768	100.0%
ICO Paid Date	80,768	80,191	99.3%	80,191	80,191	100.0%
Header Paid Amount	18,144	18,144	100.0%	18,144	17,772	97.9%
Detail Paid Amount	80,768	80,191	99.3%	80,191	80,191	100.0%
Header TPL Paid Amount	18,144	18,144	100.0%	18,144	18,134	99.9%
Detail TPL Paid Amount	80,768	80,768	100.0%	80,768	80,768	100.0%

Table G-18—Key Encounter Data Elements: Dental Encounters—Meridian Health Plan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	0	0	NA	0	0	NA
Header Service From Date	0	0	NA	0	0	NA
Header Service To Date	0	0	NA	0	0	NA
Detail Service From Date	0	0	NA	0	0	NA
Detail Service To Date	0	0	NA	0	0	NA
Billing Provider NPI	0	0	NA	0	0	NA
Rendering Provider NPI	0	0	NA	0	0	NA
Referring Provider NPI	0	0	NA	0	0	NA
Rendering Provider Taxonomy Code	0	0	NA	0	0	NA
Primary Diagnosis Codes	0	0	NA	0	0	NA
CDT Codes	0	0	NA	0	0	NA
Tooth Number	0	0	NA	0	0	NA
Tooth Surface 1-5	0	0	NA	0	0	NA
Oral Cavity Code	0	0	NA	0	0	NA
Submit Date	0	0	NA	0	0	NA
ICO Paid Date	0	0	NA	0	0	NA
Header Paid Amount	0	0	NA	0	0	NA
Detail Paid Amount	0	0	NA	0	0	NA
Header TPL Paid Amount	0	0	NA	0	0	NA
Detail TPL Paid Amount	0	0	NA	0	0	NA

Table G-19—Key Encounter Data Elements: Pharmacy Encounters—Meridian Health Plan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	32,659	32,659	100.0%	32,659	32,498	99.5%
Date of Service	32,659	32,659	100.0%	32,543	32,543	100.0%
Billing Provider NPI	32,659	32,659	100.0%	32,659	32,659	100.0%
Prescribing Provider NPI	32,659	32,659	100.0%	32,659	32,659	100.0%
NDCs	32,659	32,659	100.0%	32,659	32,542	99.6%
Submit Date	32,659	32,659	100.0%	32,659	32,659	100.0%
ICO Paid Date	32,659	32,543	99.6%	32,543	32,543	100.0%
Paid Amount	32,659	32,486	99.5%	32,486	32,486	100.0%
TPL Paid Amount	32,659	0	0.0%	0	0	NA

Appendix H. Results for Molina Healthcare of Michigan

Appendix H contains the IS review and administrative profile results, strengths, weaknesses, and recommendations, as applicable, that HSAG identified from the EDV study for **Molina Healthcare of Michigan**.

IS Review Findings

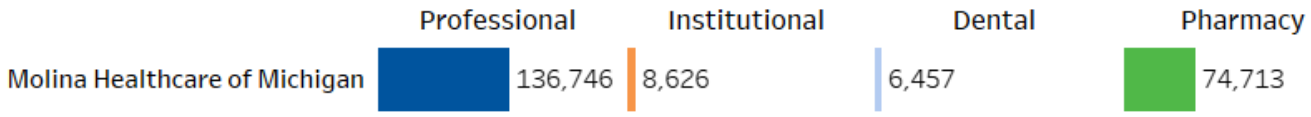
Please refer to Section 3: Information Systems Review Findings for **Molina Healthcare of Michigan**'s specific findings, if any.

Administrative Profile Results

Encounter Data Summary

Figure H-1 displays the number of encounters by category of service.

Figure H-1—Number of Encounters by Category of Service—Molina Healthcare of Michigan

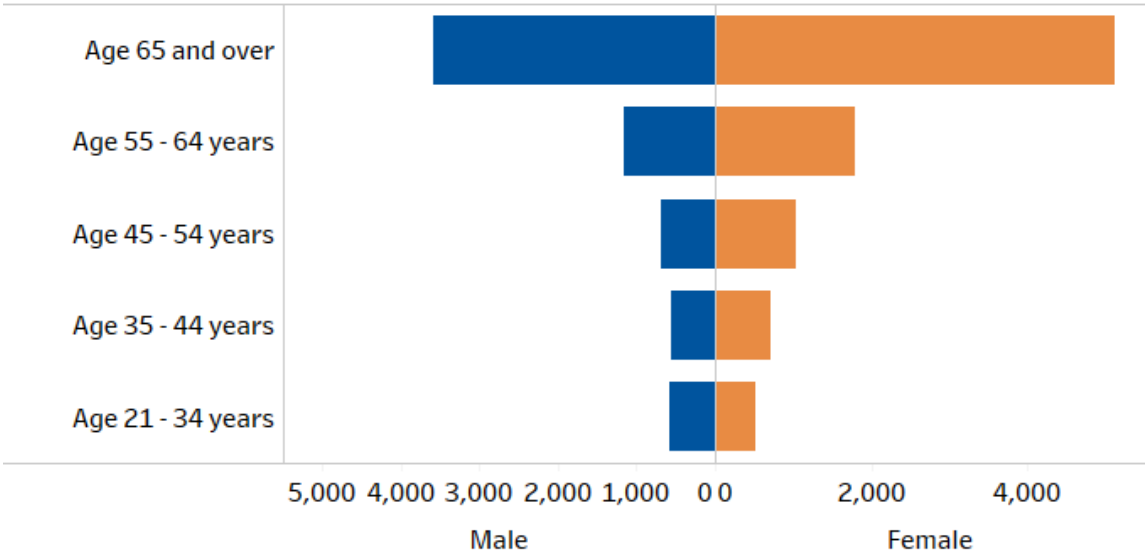


Member Composition

Figure H-2 and Figure H-3 display member demographics.

Figure H-2—Enrollment in SFY 2023—Molina Healthcare of Michigan

Figure H-3—Age and Gender Distribution—Molina Healthcare of Michigan

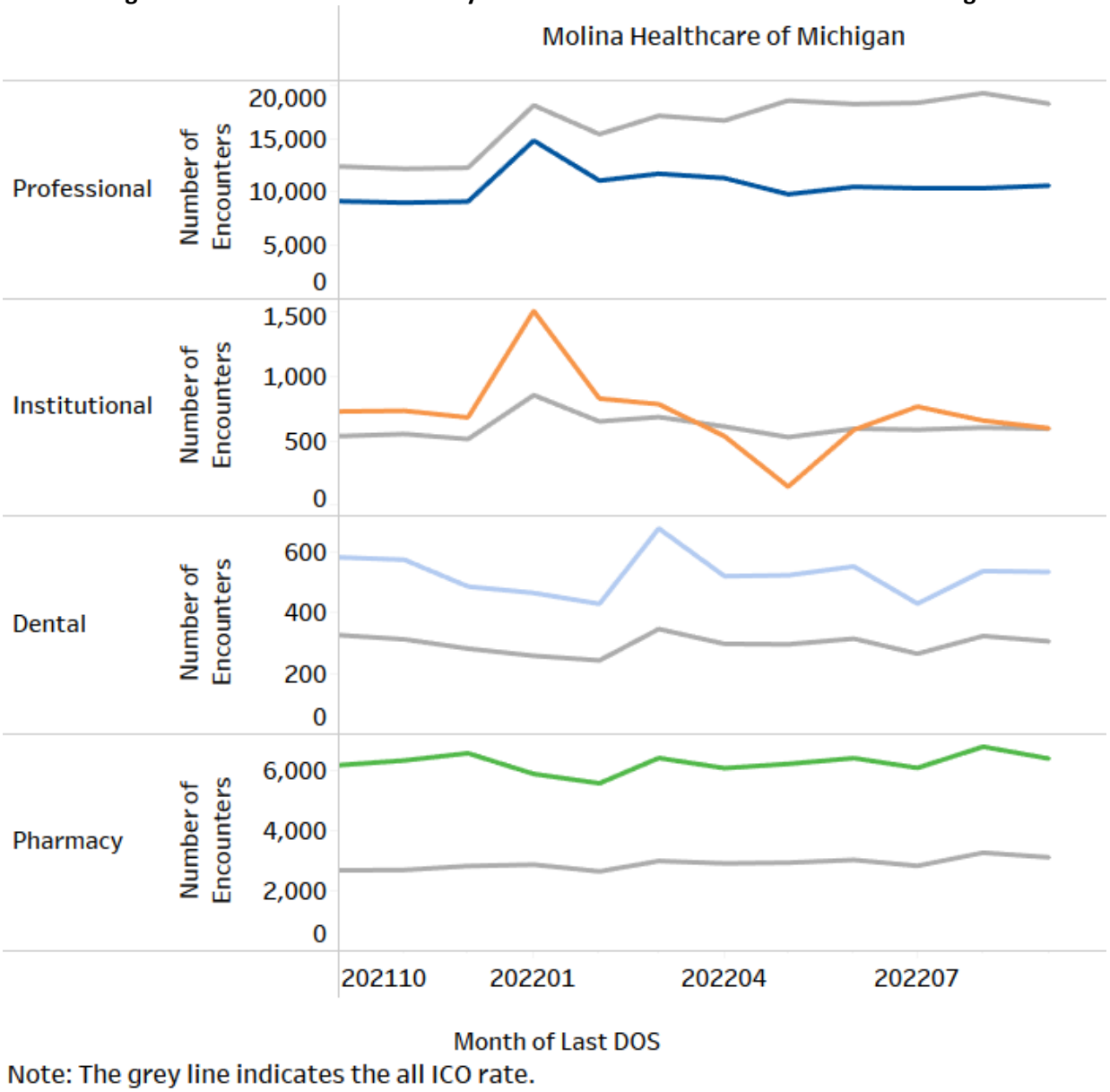


Encounter Data Completeness

Encounter Volume by Service Month

Figure H-4 displays the monthly encounter volume by service month and category of service.

Figure H-4—Encounter Volume by Service Month—Molina Healthcare of Michigan

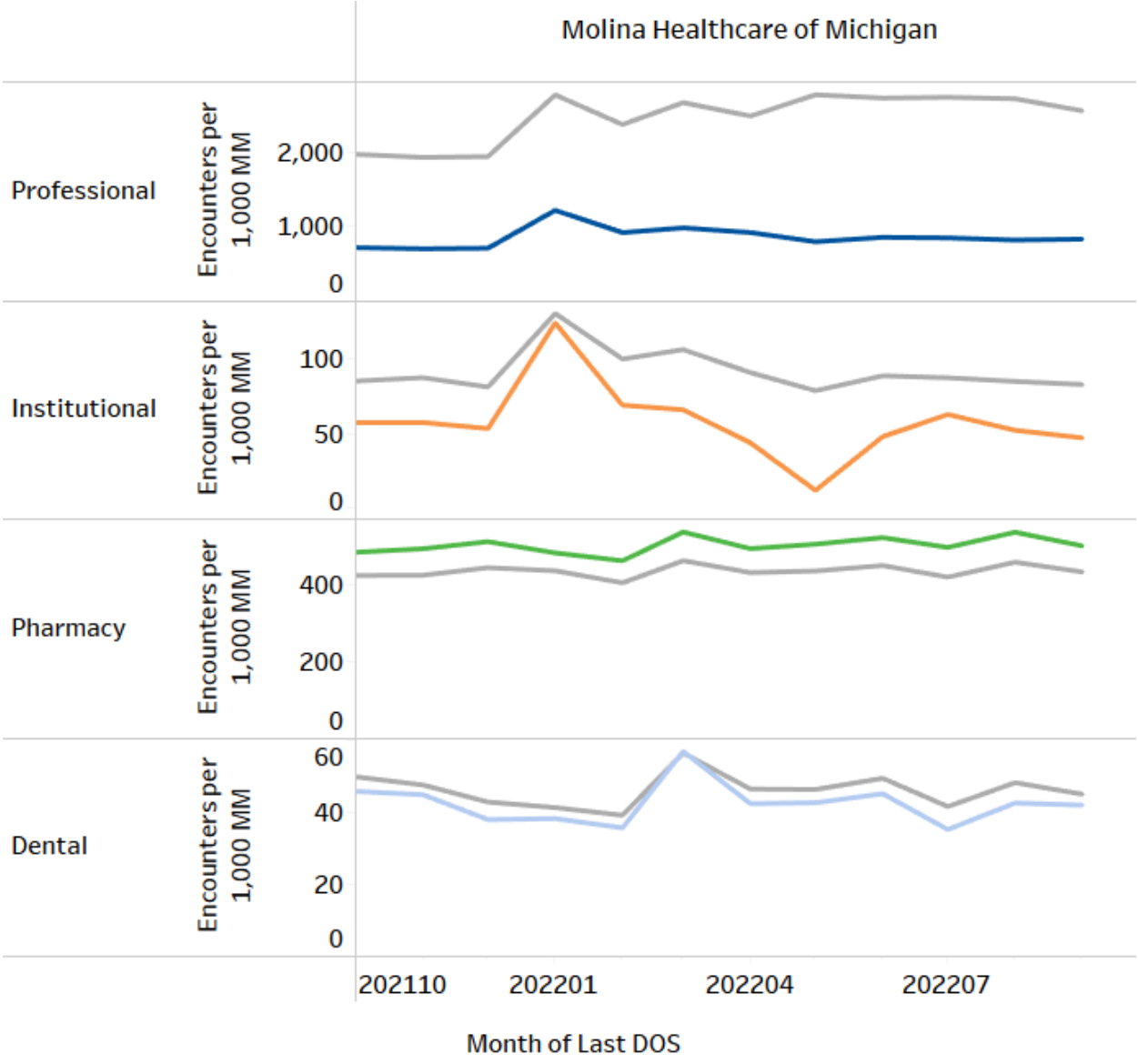


Note: The grey line indicates the all ICO rate.

Encounter Volume Per 1,000 Member Months

Figure H-5 displays the monthly encounter volume per 1,000 MM by service month and category of service.

Figure H-5—Encounter Volume per 1,000 MM—Molina Healthcare of Michigan

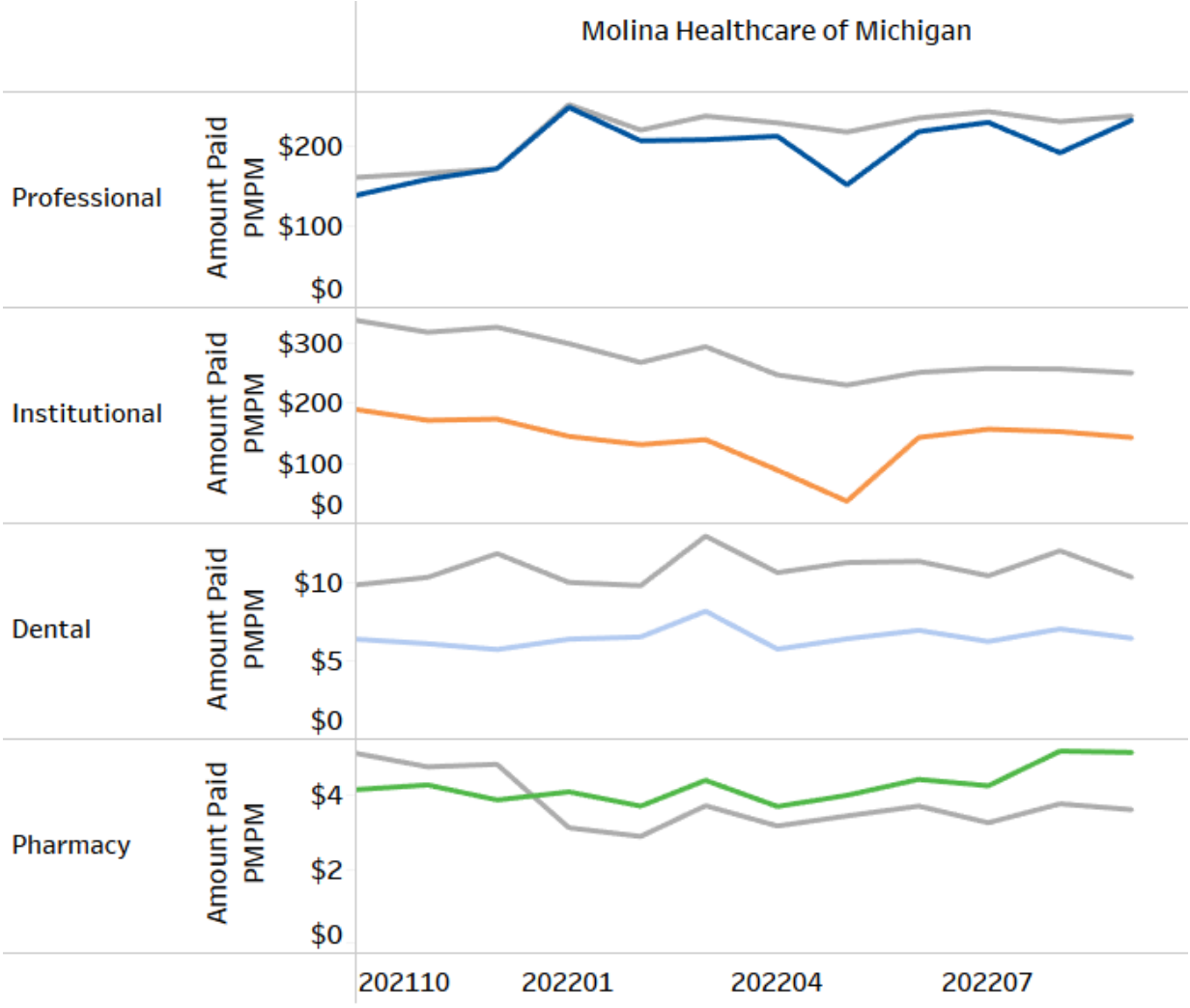


Note: The grey line indicates the all ICO rate.

Payment Amounts Per Member Per Month

Figure H-6 displays the monthly payment amounts PMPM by service month and category of service.

Figure H-6—Paid Amount PMPM—Molina Healthcare of Michigan

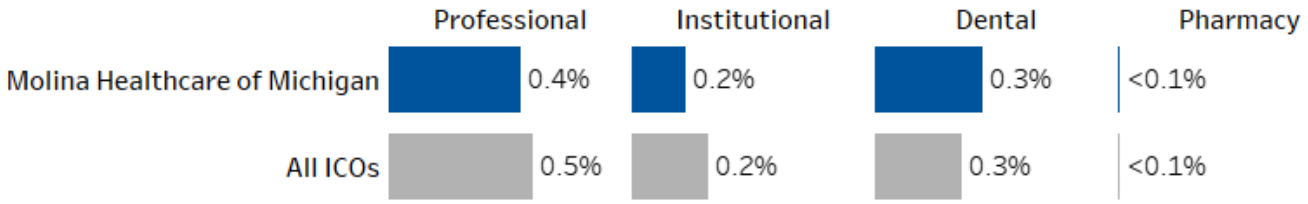


Note: The grey line indicates the all ICO rate.

Percentage of Duplicate Encounters

Figure H-7 displays the percentage of duplicate encounters.

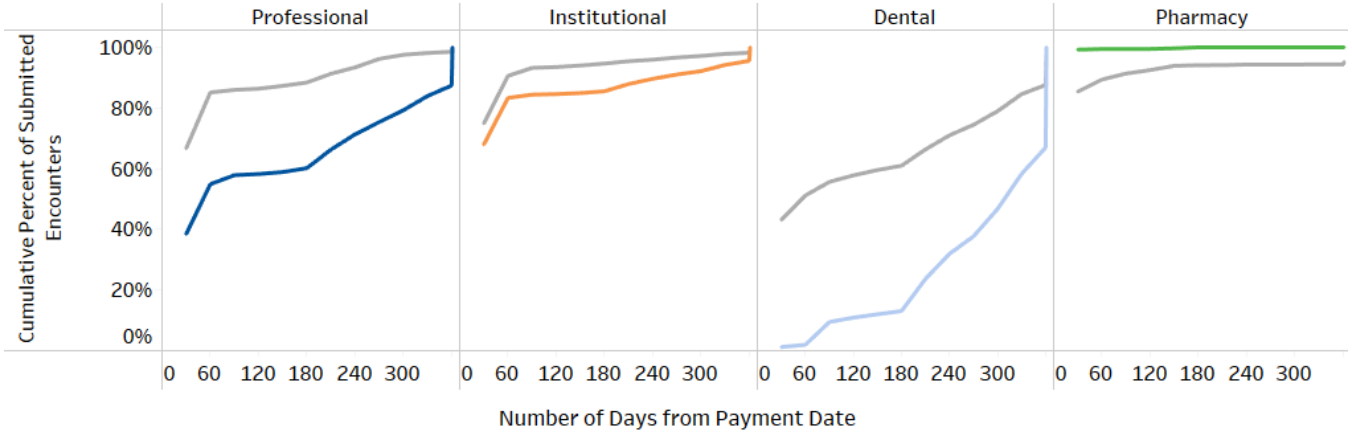
Figure H-7—Percentage of Duplicate Encounters—Molina Healthcare of Michigan



Encounter Data Timeliness

Figure H-8 and Table H-1 show the cumulative percentage of encounters submitted to MDHHS from the payment date by category of service.

Figure H-8—Cumulative Percentage of Encounters Submitted to MDHHS From ICO Payment Date by Category of Service—Molina Healthcare of Michigan



Note: The grey line indicates the all ICO rate.

Table H-1—Completeness of Encounters by Category of Service—Molina Healthcare of Michigan

Number of Days From Payment Date	Cumulative Percentage of Submitted Professional Encounters	Cumulative Percentage of Submitted Institutional Encounters	Cumulative Percentage of Submitted Dental Encounters	Cumulative Percentage of Submitted Pharmacy Encounters
Submitted Within 30 Days	38.4%	67.9%	1.2%	99.2%
Submitted Within 60 Days	54.9%	83.3%	2.0%	99.4%
Submitted Within 90 Days	57.8%	84.4%	9.5%	99.5%
Submitted Within 120 Days	58.2%	84.6%	10.9%	99.5%
Submitted Within 150 Days	58.9%	84.9%	12.0%	99.6%
Submitted Within 180 Days	60.2%	85.5%	13.1%	>99.9%
Submitted Within 210 Days	66.3%	87.9%	23.7%	>99.9%
Submitted Within 240 Days	71.3%	89.6%	31.9%	>99.9%
Submitted Within 270 Days	75.4%	91.0%	37.7%	100.0%
Submitted Within 300 Days	79.3%	92.1%	46.7%	100.0%
Submitted Within 330 Days	83.9%	94.2%	58.3%	100.0%
Submitted Within 360 Days	87.4%	95.5%	67.0%	100.0%
Submitted After 360 Days	100.0%	100.0%	100.0%	100.0%
Missing Paid or Submission Date	0.0%	0.0%	0.0%	0.0%
Submitted Prior to Paid Date	0.0%	0.0%	0.0%	0.0%

Field-Level Completeness and Accuracy

Figure H-9 through Figure H-12 provide the percentage of encounters that are present and contain valid values for key data elements.

Figure H-9—Key Professional Encounter Data Elements—Molina Healthcare of Michigan

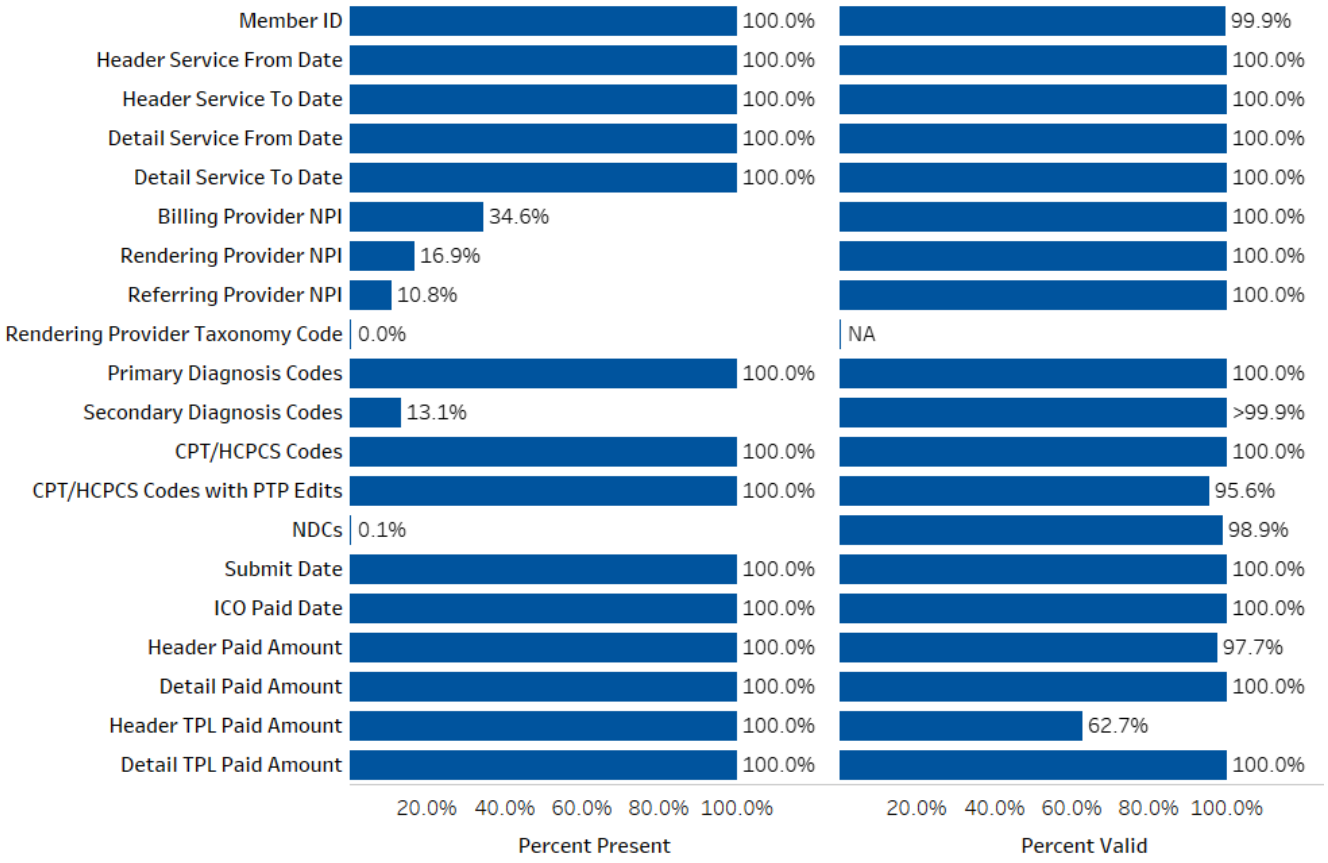


Figure H-10—Key Institutional Encounter Data Elements—Molina Healthcare of Michigan

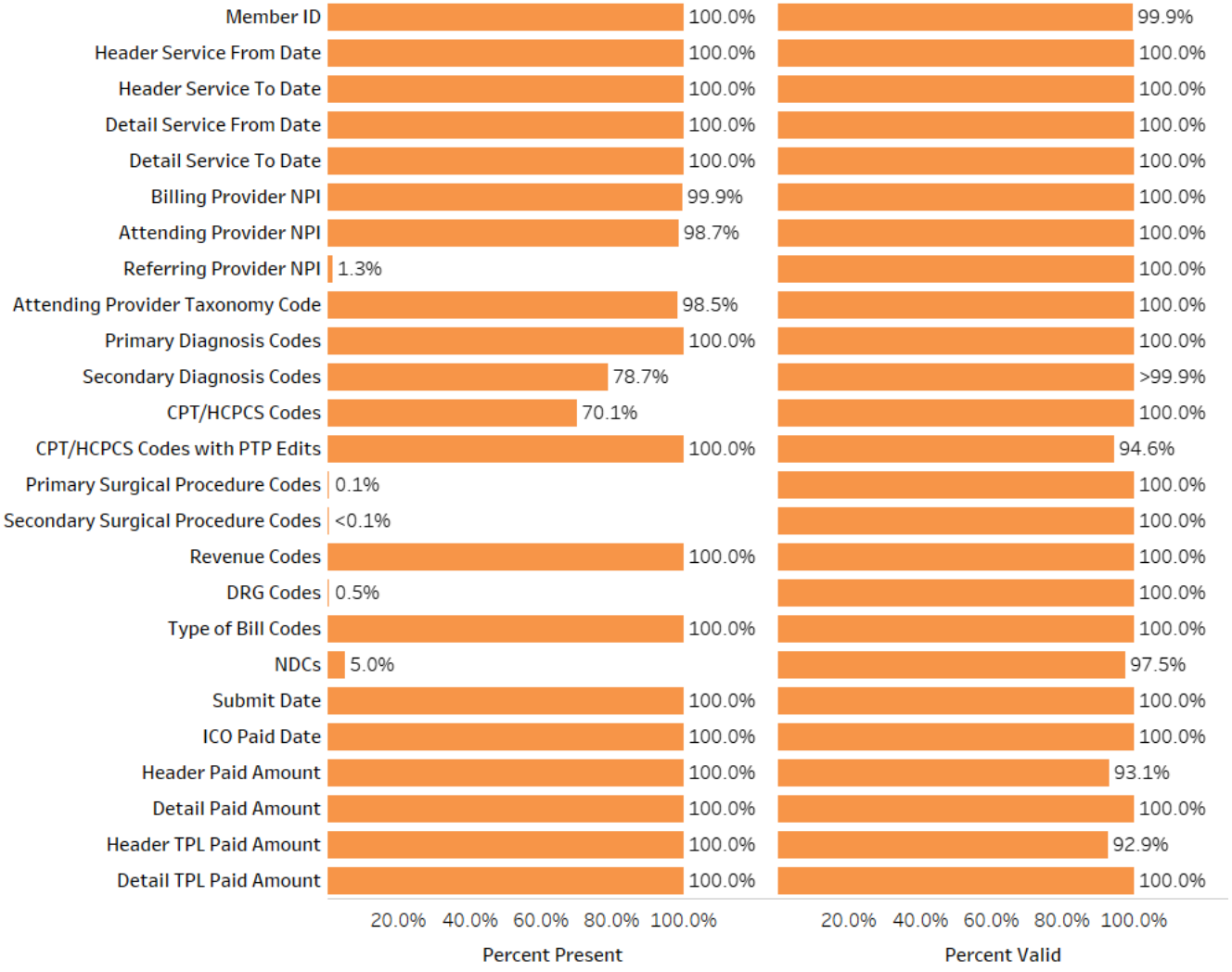


Figure H-11—Key Dental Encounter Data Elements—Molina Healthcare of Michigan

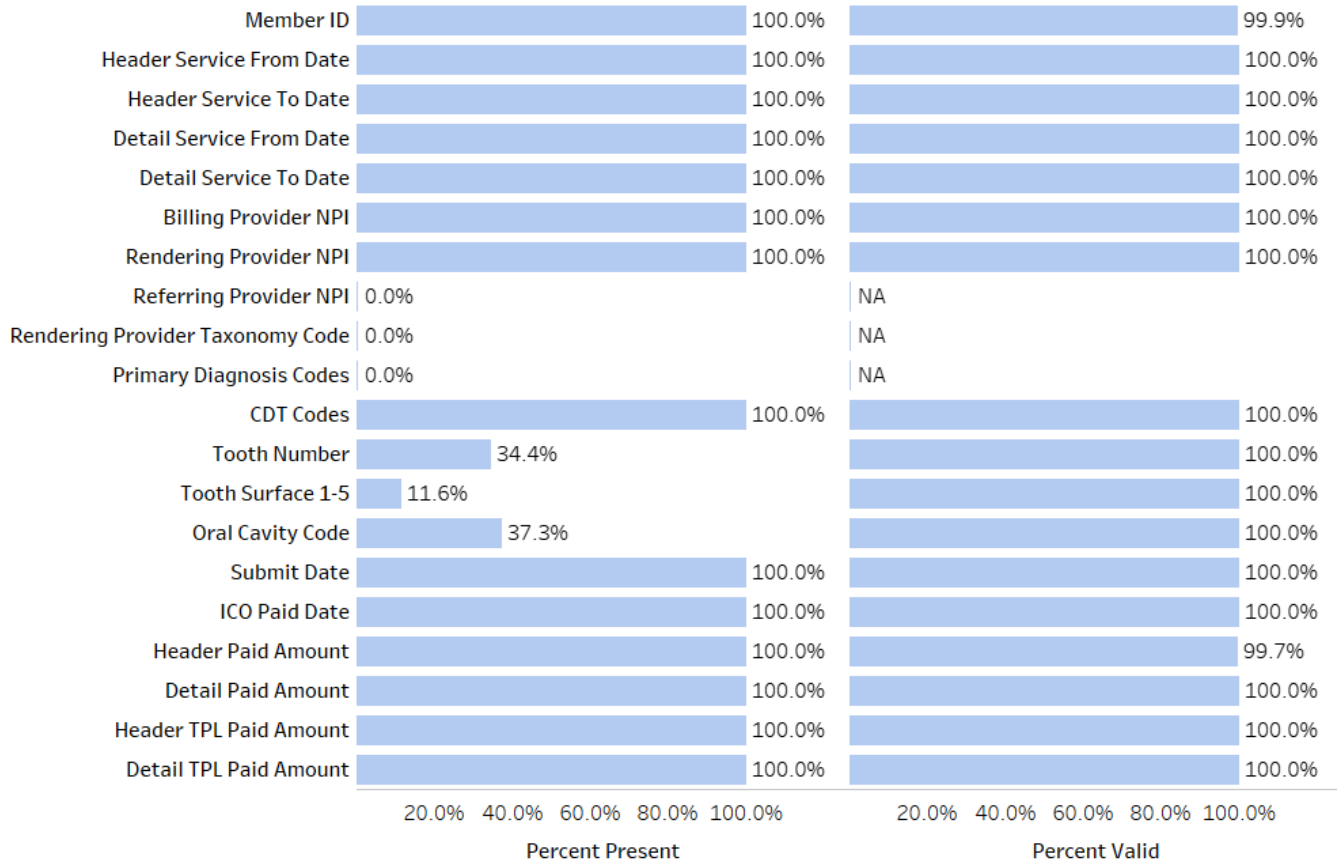
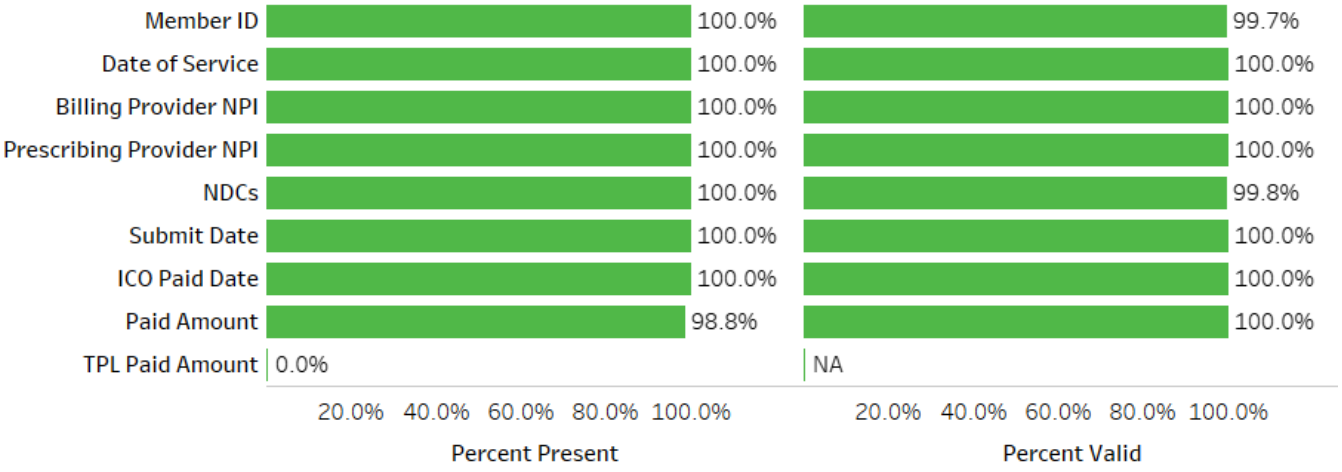


Figure H-12—Key Pharmacy Encounter Data Elements—Molina Healthcare of Michigan



Encounter Data Referential Integrity

Figure H-13 through Figure H-17 display the referential integrity results.

Figure H-13—Referential Integrity Comparison Between Enrollment and Medical/Dental Encounter Files—Molina Healthcare of Michigan

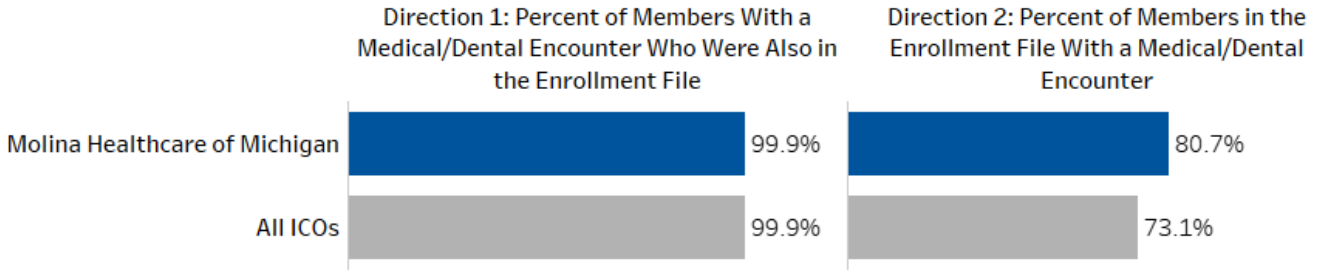


Figure H-14—Referential Integrity Comparison Between Enrollment and Pharmacy Encounter Files—Molina Healthcare of Michigan

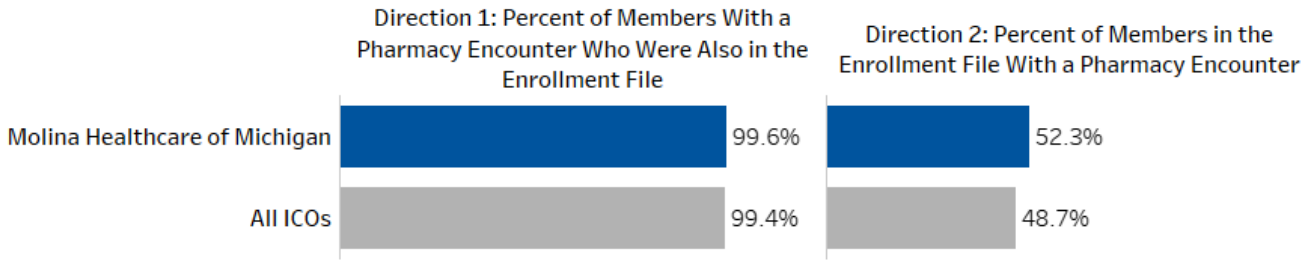


Figure H-15—Referential Integrity Comparison Between Medical/Dental Encounter and Pharmacy Encounter Files—Molina Healthcare of Michigan

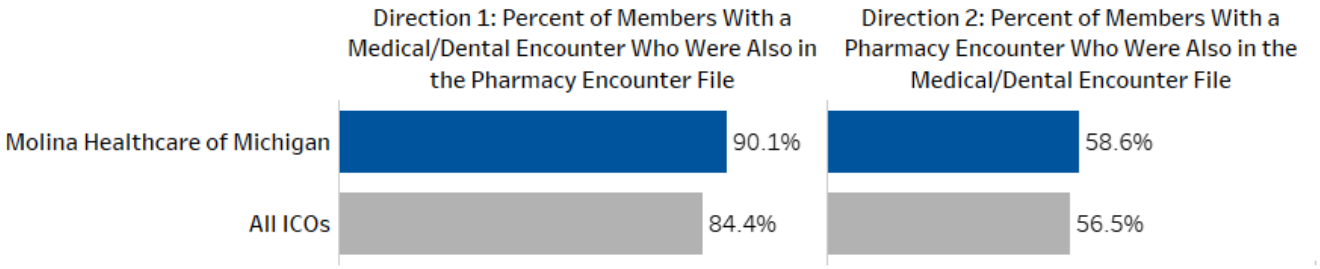


Figure H-16—Referential Integrity Comparison Between Medical/Dental Encounter and Provider Files—Molina Healthcare of Michigan

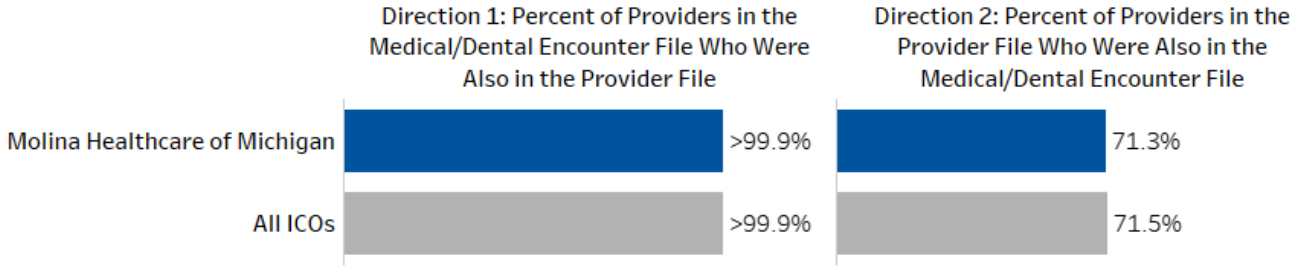
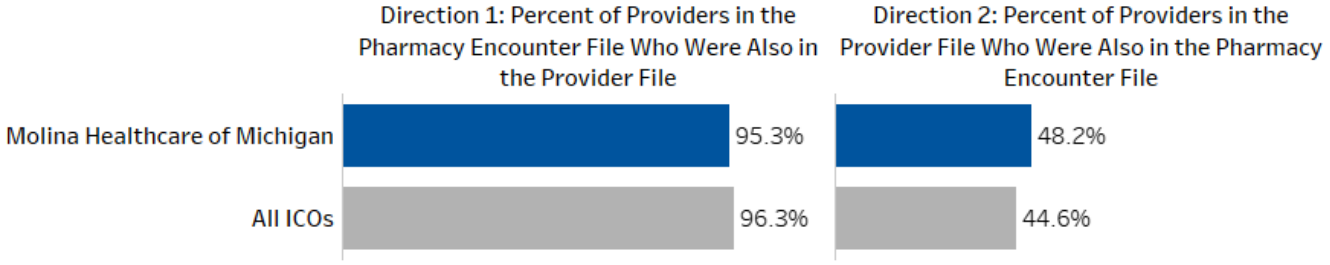


Figure H-17—Referential Integrity Comparison Between Pharmacy Encounter and Provider Files—Molina Healthcare of Michigan

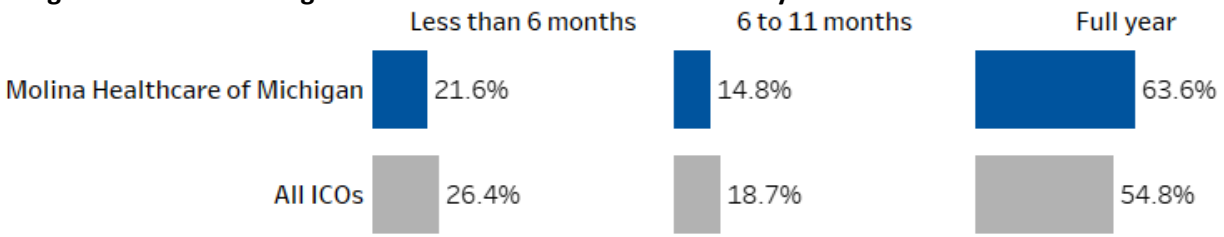


Encounter Data Logic

Member Enrollment

Figure H-18 displays the percentage of members who were continuously enrolled.

Figure H-18—Percentage of Members Who Were Continuously Enrolled—Molina Healthcare of Michigan



Conclusions

Based on the examination of the IS review and administrative profile outcomes in Section 3 and Section 4, respectively, for **Molina Healthcare of Michigan**, HSAG identified the following areas of strength and opportunities for improvement. Along with each opportunity for improvement, HSAG has also provided a recommendation to help target improvement efforts.

IS Review Conclusions

Strengths

Strength #1: Molina Healthcare of Michigan demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The ICO has also established data review and correction processes that efficiently address quality concerns identified by MDHHS.

Opportunities for Improvement

Weakness #1: Molina Healthcare of Michigan indicated that it did not store its pharmacy subcontractor data.

Why the weakness exists: Storing subcontractor encounter data within **Molina Healthcare of Michigan**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Molina Healthcare of Michigan**'s overall capabilities, it should consider storing its subcontractor encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Molina Healthcare of Michigan modified encounters from its subcontractors before submitting them to MDHHS.

Why the weakness exists: Since modifications were made to the subcontractors' encounters, it is essential to communicate these changes to each entity involved to maintain data integrity.

Recommendation: Molina Healthcare of Michigan should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

Weakness #3: Molina Healthcare of Michigan did not indicate timeliness quality checks were performed for claims/encounters originating from its pharmacy subcontractors.

Why the weakness exists: Timeliness quality checks are crucial to ensuring that claims and encounters are submitted within the stipulated time frames.

Recommendation: Molina Healthcare of Michigan should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

Administrative Profile Conclusions

Strengths

Strength #1: Molina Healthcare of Michigan submitted pharmacy encounters in a timely manner from the payment date, with 99.2 percent of all encounters submitted within 30 days of the payment date.

Strength #2: Across all categories of service, all key data elements for **Molina Healthcare of Michigan** were populated at high rates, and the majority of data elements were greater than 95 percent valid.

Opportunities for Improvement

Weakness #1: Molina Healthcare of Michigan took the longest to submit encounters to MDHHS after the payment date in three of the four categories of service out of all ICOs. At 180 days from payment date, **Molina Healthcare of Michigan** submitted 60.2 percent of professional encounters, 85.5 percent of institutional encounters, and 13.1 percent of dental encounters.

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: Molina Healthcare of Michigan should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #2: Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 95.3 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data.

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: Molina Healthcare of Michigan should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Weakness #3: Although not required to be populated, 34.6 percent of professional encounters contained a billing provider NPI, and 16.9 percent contained a rendering provider NPI.

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Molina Healthcare of Michigan should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Administrative Profile Results—Tabular Data

Encounter Data Summary

Member Composition

Table H-2 presents the member composition.

Table H-2—Age and Gender Distribution—Molina Healthcare of Michigan

Age Category	Number of Females	Number of Males
Age 21–34 years	519	578
Age 35–44 years	705	563
Age 45–54 years	1,025	689
Age 55–64 years	1,781	1,161
Age 65 and over	5,120	3,578
Total	**9,150**	**6,569**

Encounter Data Completeness

Encounter Volume by Service Month

Table H-3 through Table H-6 display the encounter volume by service month.

Table H-3—Encounter Volume: Professional Encounters—Molina Healthcare of Michigan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	9,137	12,666	721.4
November 2021	9,002	12,750	706.0
December 2021	9,105	12,754	713.9
January 2022	14,807	12,114	1,222.3
February 2022	11,061	11,977	923.5
March 2022	11,706	11,866	986.5
April 2022	11,299	12,228	924.0
May 2022	9,786	12,223	800.6
June 2022	10,478	12,190	859.6
July 2022	10,360	12,162	851.8
August 2022	10,355	12,575	823.5
September 2022	10,594	12,679	835.6

Table H-4—Encounter Volume: Institutional Encounters—Molina Healthcare of Michigan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	727	12,666	57.4
November 2021	732	12,750	57.4
December 2021	680	12,754	53.3
January 2022	1,506	12,114	124.3
February 2022	827	11,977	69.0
March 2022	783	11,866	66.0
April 2022	535	12,228	43.8
May 2022	144	12,223	11.8
June 2022	584	12,190	47.9
July 2022	764	12,162	62.8
August 2022	656	12,575	52.2
September 2022	597	12,679	47.1

Table H-5—Encounter Volume: Dental Encounters—Molina Healthcare of Michigan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	581	12,666	45.9
November 2021	573	12,750	44.9
December 2021	485	12,754	38.0
January 2022	464	12,114	38.3
February 2022	428	11,977	35.7
March 2022	676	11,866	57.0
April 2022	519	12,228	42.4
May 2022	522	12,223	42.7
June 2022	551	12,190	45.2
July 2022	429	12,162	35.3
August 2022	536	12,575	42.6
September 2022	533	12,679	42.0

Table H-6—Encounter Volume: Pharmacy Encounters—Molina Healthcare of Michigan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	6,157	12,666	486.1
November 2021	6,315	12,750	495.3
December 2021	6,554	12,754	513.9
January 2022	5,868	12,114	484.4
February 2022	5,557	11,977	464.0
March 2022	6,395	11,866	538.9
April 2022	6,060	12,228	495.6
May 2022	6,200	12,223	507.2
June 2022	6,392	12,190	524.4
July 2022	6,067	12,162	498.8
August 2022	6,770	12,575	538.4
September 2022	6,376	12,679	502.9

Payment Amounts Per Member Per Month

Table H-7 through Table H-10 display the monthly payment amounts PMPM by service month.

Table H-7—Paid Amount PMPM: Professional Encounters—Molina Healthcare of Michigan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	12,666	$138.89
November 2021	12,750	$158.83
December 2021	12,754	$172.01
January 2022	12,114	$248.05
February 2022	11,977	$206.57
March 2022	11,866	$207.87
April 2022	12,228	$212.20
May 2022	12,223	$151.95
June 2022	12,190	$217.89
July 2022	12,162	$229.39
August 2022	12,575	$191.75
September 2022	12,679	$232.24

Table H-8—Paid Amount PMPM: Institutional Encounters—Molina Healthcare of Michigan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	12,666	$189.84
November 2021	12,750	$171.70
December 2021	12,754	$173.82
January 2022	12,114	$144.92
February 2022	11,977	$131.23
March 2022	11,866	$139.47
April 2022	12,228	$88.63
May 2022	12,223	$36.78
June 2022	12,190	$143.13
July 2022	12,162	$156.85
August 2022	12,575	$152.88
September 2022	12,679	$143.00

Table H-9—Paid Amount PMPM: Dental Encounters—Molina Healthcare of Michigan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	12,666	$6.36
November 2021	12,750	$6.07
December 2021	12,754	$5.70
January 2022	12,114	$6.36
February 2022	11,977	$6.50
March 2022	11,866	$8.14
April 2022	12,228	$5.72
May 2022	12,223	$6.38
June 2022	12,190	$6.92
July 2022	12,162	$6.21
August 2022	12,575	$7.01
September 2022	12,679	$6.41

Table H-10—Paid Amount PMPM: Pharmacy Encounters—Molina Healthcare of Michigan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	12,666	$4.17
November 2021	12,750	$4.30
December 2021	12,754	$3.89
January 2022	12,114	$4.11
February 2022	11,977	$3.72
March 2022	11,866	$4.42
April 2022	12,228	$3.71
May 2022	12,223	$4.01
June 2022	12,190	$4.45
July 2022	12,162	$4.27
August 2022	12,575	$5.21
September 2022	12,679	$5.18

Percentage of Duplicate Encounters

Table H-11 displays the percentage of duplicate encounters by category of service.

Table H-11—Percentage of Duplicate Encounters by Category of Service—Molina Healthcare of Michigan

Category of Service	Number of Duplicate Records	Percentage of Duplicate Records
Professional	1,434	0.4%
Institutional	34	0.2%
Dental	53	0.3%
Pharmacy	1	<0.1%

Encounter Data Timeliness

Encounter Data Lag Triangles

Table H-12 through Table H-15 display the lag triangles between service month and submission month to MDHHS. For conciseness, lag triangles only include encounters submitted through April 2023 (a minimum of a seven-month lag); therefore, counts displayed in the total line may not equal counts displayed in encounter volume figures.

Table H-12—Encounter Data Lag Triangle: Professional Encounters—Molina Healthcare of Michigan

	Month of Service												
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	24												24
202111	1,680	190											1,870
202112	1,494	2,241	183										3,918
202201	1,550	2,449	2,798	1,286									8,083
202202	116	527	2,208	6,641	1,106								10,598
202203	10	22	25	995	1,634	622							3,308
202204	17	30	73	1,278	2,603	401	0						4,402
202205	190	70	132	974	1,947	5,317	3,337	44					12,011
202206	0	1	0	1	5	16	14	0	0				37
202207	31	34	71	118	194	653	2,461	4,257	3,414	499			11,732
202208	4	11	14	59	29	38	63	139	1,257	2,679	280		4,573
202209	165	15	10	14	101	82	271	412	624	1,611	2,979	143	6,427
202210	81	13	5	14	12	14	273	79	81	662	1,921	3,080	6,235
202211	35	33	13	20	8	18	325	69	60	501	468	2,293	3,843
202212	31	41	28	62	48	43	60	52	54	49	72	447	987
202301	1	5	14	6	4	20	7	13	15	12	18	127	242
202302	4,026	3,784	3,919	28	34	26	29	21	31	30	34	42	12,004
202303	2	4	0	4,000	3,936	5,148	5,090	4,991	5,831	5,018	5,466	58	39,544
202304	4	1	6	7	12	14	19	18	20	15	20	5,538	5,674
Total	9,461	9,471	9,499	15,503	11,673	12,412	11,949	10,095	11,387	11,076	11,258	11,728	135,512
MM	12,666	12,750	12,754	12,114	11,977	11,866	12,228	12,223	12,190	12,162	12,575	12,679	148,184
PMPM	0.75	0.74	0.74	1.28	0.97	1.05	0.98	0.83	0.93	0.91	0.90	0.92	0.91

Table H-13—Encounter Data Lag Triangle: Institutional Encounters—Molina Healthcare of Michigan

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	0												0
202111	202	4											206
202112	48	183	4										235
202201	11	50	221	3									285
202202	3	11	40	862	98								1,014
202203	2	3	3	150	328	111							597
202204	4	6	8	20	30	0	0						68
202205	50	50	37	5	33	280	213	0					668
202206	0	1	0	0	0	0	0	0	0				1
202207	1	2	3	4	2	4	2	15	99	16			148
202208	0	1	1	0	0	1	2	2	28	83	10		128
202209	2	4	8	12	11	8	9	9	13	170	313	2	561
202210	14	7	10	19	6	7	8	10	16	25	110	269	501
202211	227	238	223	235	213	206	148	47	275	291	19	122	2,244
202212	37	43	45	45	29	27	9	3	23	20	18	16	315
202301	0	0	0	0	0	2	2	1	2	4	1	3	15
202302	116	131	65	1	1	0	1	0	0	2	11	4	332
202303	1	1	1	139	68	126	134	44	121	131	146	10	922
202304	6	0	1	3	2	4	1	0	2	4	4	151	178
Total	724	735	670	1,498	821	776	529	131	579	746	632	577	8,418
MM	12,666	12,750	12,754	12,114	11,977	11,866	12,228	12,223	12,190	12,162	12,575	12,679	148,184
PMPM	0.06	0.06	0.05	0.12	0.07	0.07	0.04	0.01	0.05	0.06	0.05	0.05	0.06

Table H-14—Encounter Data Lag Triangle: Dental Encounters—Molina Healthcare of Michigan

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	0												0
202111	0	2											2
202112	0	1	0										1
202201	0	0	0	17									17
202202	0	0	0	65	0								65
202203	0	0	2	0	1	0							3
202204	0	0	0	0	0	0	0						0
202205	0	0	0	0	0	1	1	0					2
202206	0	0	0	0	0	0	0	0	0				0
202207	0	0	0	0	0	0	0	1	2	0			3
202208	0	0	0	0	0	0	0	0	0	2	0		2
202209	0	0	0	0	0	0	0	0	0	0	0	0	0
202210	0	0	0	0	0	0	0	0	0	0	0	0	0
202211	0	0	0	0	0	0	0	0	0	0	0	0	0
202212	0	0	0	0	0	0	0	0	0	0	0	0	0
202301	0	0	0	0	0	0	0	0	0	0	0	0	0
202302	596	591	495	0	0	0	0	0	0	0	0	0	1,682
202303	0	0	0	395	442	688	522	533	563	434	548	0	4,125
202304	0	0	0	0	0	0	2	0	1	0	1	548	552
Total	596	594	497	477	443	689	525	534	566	436	549	548	6,454
MM	12,666	12,750	12,754	12,114	11,977	11,866	12,228	12,223	12,190	12,162	12,575	12,679	148,184
PMPM	0.05	0.05	0.04	0.04	0.04	0.06	0.04	0.04	0.05	0.04	0.04	0.04	0.04

Table H-15—Encounter Data Lag Triangle: Pharmacy Encounters—Molina Healthcare of Michigan

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	1,106												1,106
202111	4,519	782											5,301
202112	291	5,135	1,773										7,199
202201	129	237	4,411	723									5,500
202202	7	27	116	3,998	1,567								5,715
202203	4	19	132	159	2,877	1,566							4,757
202204	9	6	7	79	181	3,629	987						4,898
202205	6	9	6	26	43	130	3,941	756					4,917
202206	17	15	12	23	25	47	156	4,287	1,514				6,096
202207	16	18	31	10	14	28	43	32	3,647	863			4,702
202208	16	25	26	31	26	25	76	235	266	4,146	628		5,500
202209	0	0	0	12	12	13	23	43	53	132	4,854	1,087	6,229
202210	1	5	8	23	29	22	40	58	65	62	247	4,195	4,755
202211	11	10	8	20	16	13	14	15	25	31	78	103	344
202212	2	0	1	9	11	12	12	10	15	12	31	59	174
202301	2	4	3	1	6	9	13	10	17	41	59	65	230
202302	5	8	5	9	10	14	10	8	9	12	18	12	120
202303	1	1	2	53	59	68	55	72	68	67	88	115	649
202304	0	0	0	436	453	505	431	395	391	393	401	377	3,782
Total	6,142	6,301	6,541	5,612	5,329	6,081	5,801	5,921	6,070	5,759	6,404	6,013	71,974
MM	12,666	12,750	12,754	12,114	11,977	11,866	12,228	12,223	12,190	12,162	12,575	12,679	148,184
PMPM	0.48	0.49	0.51	0.46	0.44	0.51	0.47	0.48	0.50	0.47	0.51	0.47	0.49

Field-Level Completeness and Accuracy

Table H-16 through Table H-19 provide the percentage of encounters that are present and contain valid values for key data elements for all categories of service.

Table H-16—Key Encounter Data Elements: Professional Encounters—Molina Healthcare of Michigan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	136,746	136,746	100.0%	136,746	136,607	99.9%
Header Service From Date	136,746	136,746	100.0%	136,746	136,746	100.0%
Header Service To Date	136,746	136,746	100.0%	136,746	136,746	100.0%
Detail Service From Date	345,379	345,379	100.0%	345,379	345,379	100.0%
Detail Service To Date	345,379	345,379	100.0%	345,379	345,379	100.0%
Billing Provider NPI	136,746	47,356	34.6%	47,356	47,356	100.0%
Rendering Provider NPI	136,746	23,106	16.9%	23,106	23,106	100.0%
Referring Provider NPI	136,746	14,757	10.8%	14,757	14,757	100.0%
Rendering Provider Taxonomy Code	136,746	0	0.0%	0	0	NA
Primary Diagnosis Codes	136,746	136,746	100.0%	136,746	136,746	100.0%
Secondary Diagnosis Codes	136,746	17,974	13.1%	37,629	37,627	>99.9%
CPT/HCPCS Codes	345,379	345,379	100.0%	345,379	345,379	100.0%
CPT/HCPCS Codes with PTP Edits	340,991	340,991	100.0%	340,991	325,997	95.6%
NDCs	345,379	375	0.1%	375	371	98.9%
Submit Date	345,379	345,379	100.0%	345,379	345,379	100.0%
ICO Paid Date	345,379	345,379	100.0%	345,379	345,379	100.0%
Header Paid Amount	136,746	136,746	100.0%	136,746	133,538	97.7%
Detail Paid Amount	345,379	345,379	100.0%	345,379	345,379	100.0%
Header TPL Paid Amount	136,746	136,746	100.0%	136,746	85,734	62.7%
Detail TPL Paid Amount	345,379	345,379	100.0%	345,379	345,379	100.0%

Table H-17—Key Encounter Data Elements: Institutional Encounters—Molina Healthcare of Michigan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	8,626	8,626	100.0%	8,626	8,617	99.9%
Header Service From Date	8,626	8,626	100.0%	8,626	8,626	100.0%
Header Service To Date	8,626	8,626	100.0%	8,626	8,626	100.0%
Detail Service From Date	19,963	19,963	100.0%	19,963	19,963	100.0%
Detail Service To Date	19,963	19,963	100.0%	19,963	19,963	100.0%
Billing Provider NPI	8,626	8,614	99.9%	8,614	8,614	100.0%
Attending Provider NPI	8,626	8,515	98.7%	8,515	8,515	100.0%
Referring Provider NPI	8,626	114	1.3%	114	114	100.0%
Attending Provider Taxonomy Code	8,626	8,500	98.5%	8,500	8,500	100.0%
Primary Diagnosis Codes	8,626	8,626	100.0%	8,626	8,626	100.0%
Secondary Diagnosis Codes	8,626	6,792	78.7%	66,817	66,816	>99.9%
CPT/HCPCS Codes	19,963	13,998	70.1%	13,998	13,998	100.0%
CPT/HCPCS Codes with PTP Edits	10,865	10,865	100.0%	10,865	10,282	94.6%
Primary Surgical Procedure Codes	8,626	11	0.1%	11	11	100.0%
Secondary Surgical Procedure Codes	8,626	4	<0.1%	19	19	100.0%
Revenue Codes	19,963	19,963	100.0%	19,963	19,963	100.0%
DRG Codes	8,626	40	0.5%	40	40	100.0%
Type of Bill Codes	8,626	8,626	100.0%	8,626	8,626	100.0%
NDCs	19,963	1,007	5.0%	1,007	982	97.5%
Submit Date	19,963	19,963	100.0%	19,963	19,963	100.0%
ICO Paid Date	19,963	19,963	100.0%	19,963	19,963	100.0%
Header Paid Amount	8,626	8,626	100.0%	8,626	8,032	93.1%
Detail Paid Amount	19,963	19,963	100.0%	19,963	19,963	100.0%
Header TPL Paid Amount	8,626	8,626	100.0%	8,626	8,016	92.9%
Detail TPL Paid Amount	19,963	19,963	100.0%	19,963	19,963	100.0%

Table H-18—Key Encounter Data Elements: Dental Encounters—Molina Healthcare of Michigan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	6,457	6,457	100.0%	6,457	6,451	99.9%
Header Service From Date	6,457	6,457	100.0%	6,457	6,457	100.0%
Header Service To Date	6,457	6,457	100.0%	6,457	6,457	100.0%
Detail Service From Date	15,787	15,787	100.0%	15,787	15,787	100.0%
Detail Service To Date	15,787	15,787	100.0%	15,787	15,787	100.0%
Billing Provider NPI	6,457	6,457	100.0%	6,457	6,457	100.0%
Rendering Provider NPI	6,457	6,457	100.0%	6,457	6,457	100.0%
Referring Provider NPI	6,457	0	0.0%	0	0	NA
Rendering Provider Taxonomy Code	6,457	0	0.0%	0	0	NA
Primary Diagnosis Codes	6,457	0	0.0%	0	0	NA
CDT Codes	15,787	15,787	100.0%	15,787	15,787	100.0%
Tooth Number	15,787	5,432	34.4%	5,432	5,432	100.0%
Tooth Surface 1-5	15,787	1,837	11.6%	4,073	4,073	100.0%
Oral Cavity Code	15,787	5,891	37.3%	5,891	5,891	100.0%
Submit Date	15,787	15,787	100.0%	15,787	15,787	100.0%
ICO Paid Date	15,787	15,787	100.0%	15,787	15,787	100.0%
Header Paid Amount	6,457	6,457	100.0%	6,457	6,437	99.7%
Detail Paid Amount	15,787	15,787	100.0%	15,787	15,787	100.0%
Header TPL Paid Amount	6,457	6,457	100.0%	6,457	6,457	100.0%
Detail TPL Paid Amount	15,787	15,787	100.0%	15,787	15,787	100.0%

Table H-19—Key Encounter Data Elements: Pharmacy Encounters—Molina Healthcare of Michigan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	74,713	74,713	100.0%	74,713	74,472	99.7%
Date of Service	74,713	74,713	100.0%	74,713	74,713	100.0%
Billing Provider NPI	74,713	74,713	100.0%	74,713	74,713	100.0%
Prescribing Provider NPI	74,713	74,713	100.0%	74,713	74,713	100.0%
NDCs	74,713	74,713	100.0%	74,713	74,573	99.8%
Submit Date	74,713	74,713	100.0%	74,713	74,713	100.0%
ICO Paid Date	74,713	74,713	100.0%	74,713	74,713	100.0%
Paid Amount	74,713	73,788	98.8%	73,788	73,788	100.0%
TPL Paid Amount	74,713	0	0.0%	0	0	NA

Appendix I. Results for Upper Peninsula Health Plan

Appendix I contains the IS review and administrative profile results, strengths, weaknesses, and recommendations, as applicable, that HSAG identified from the EDV study for **Upper Peninsula Health Plan**.

IS Review Findings

Please refer to Section 3: Information Systems Review Findings for **Upper Peninsula Health Plan**'s specific findings, if any.

Administrative Profile Results

Encounter Data Summary

Figure I-1 displays the number of encounters by category of service.

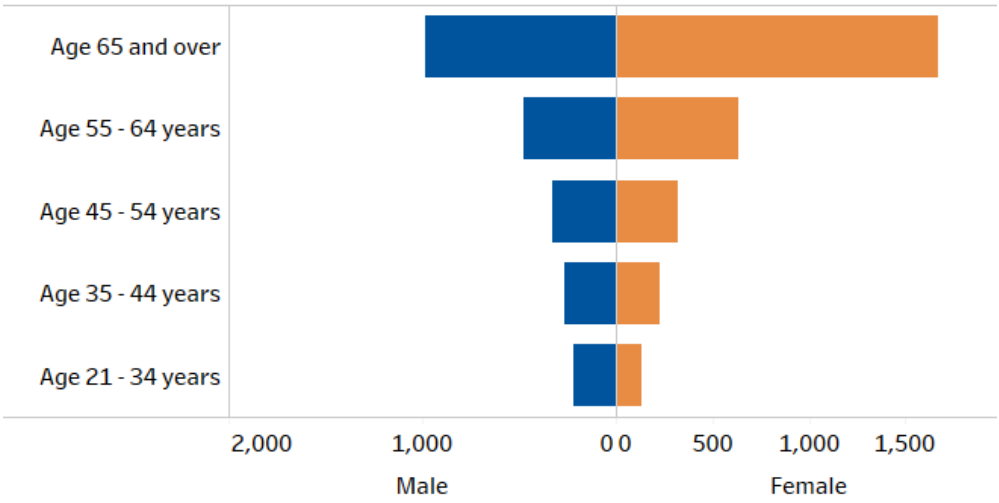
Figure I-1—Number of Encounters by Category of Service—Upper Peninsula Health Plan

Member Composition

Figure I-2 and Figure I-3 display member demographics.

Figure I-2—Enrollment in SFY 2023—Upper Peninsula Health Plan

Figure I-3—Age and Gender Distribution—Upper Peninsula Health Plan

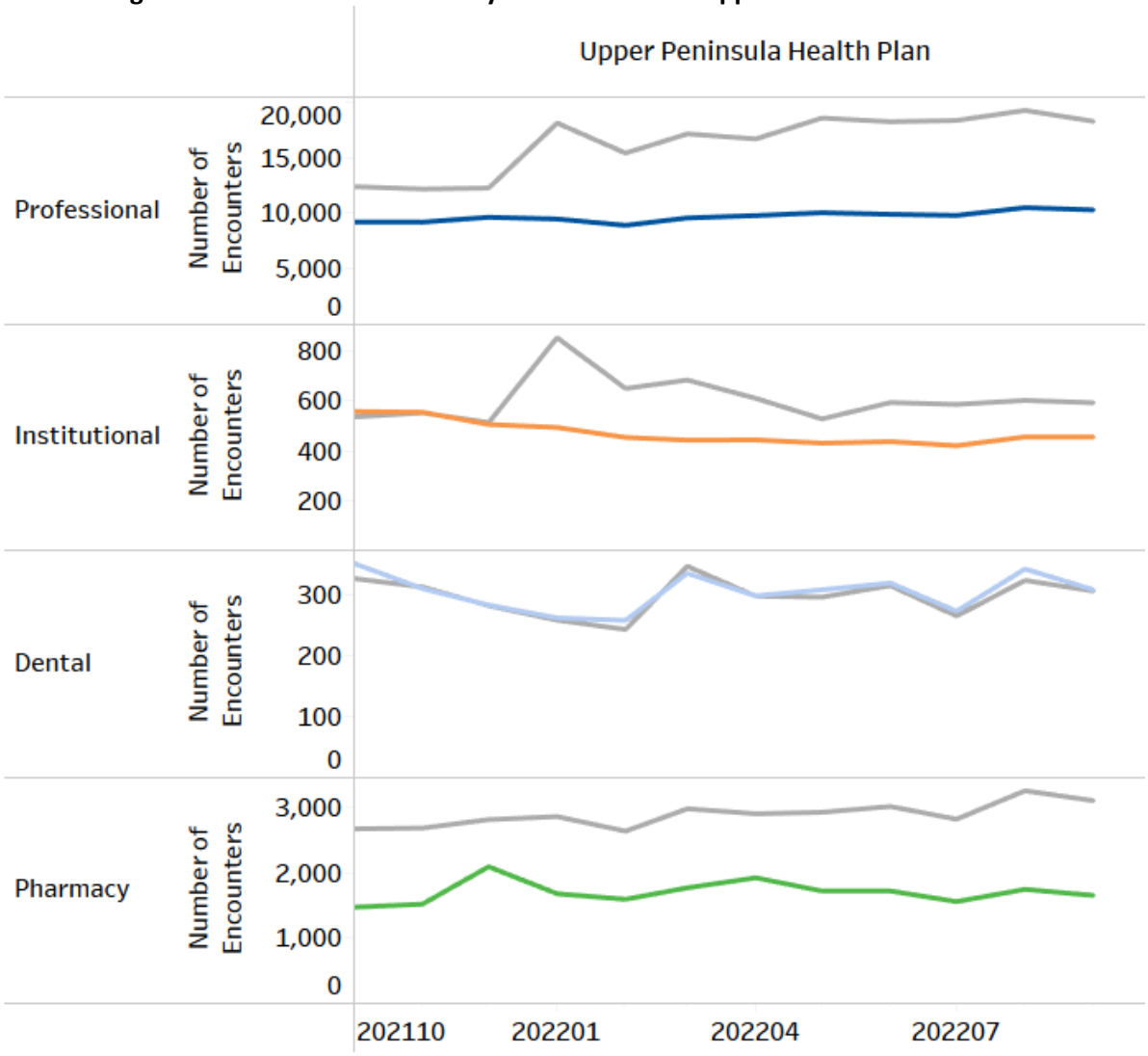


Encounter Data Completeness

Encounter Volume by Service Month

Figure I-4 displays the monthly encounter volume by service month and category of service.

Figure I-4—Encounter Volume by Service Month—Upper Peninsula Health Plan

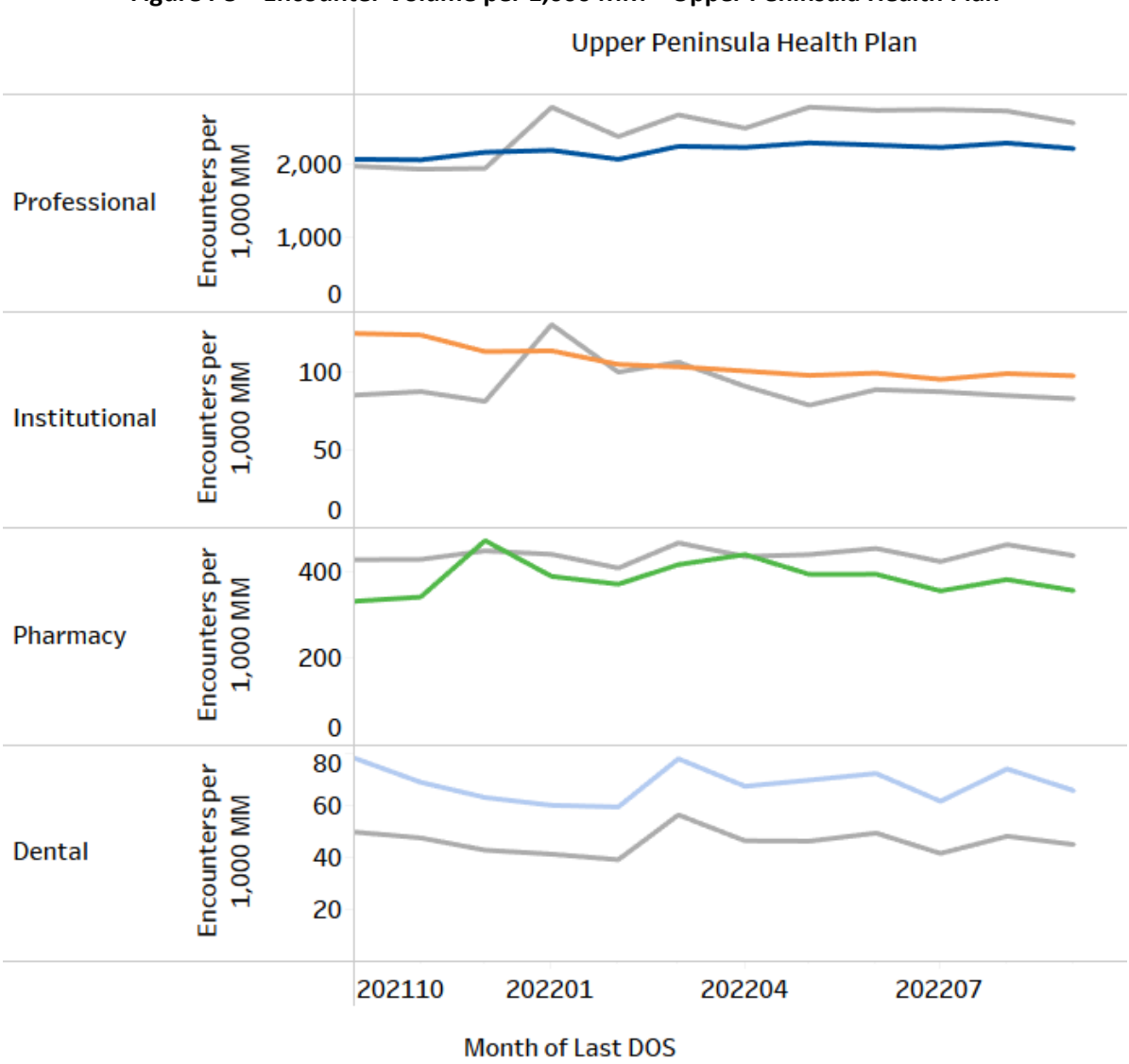


Note: The grey line indicates the all ICO rate.

Encounter Volume Per 1,000 Member Months

Figure I-5 displays the monthly encounter volume per 1,000 MM by service month and category of service.

Figure I-5—Encounter Volume per 1,000 MM—Upper Peninsula Health Plan

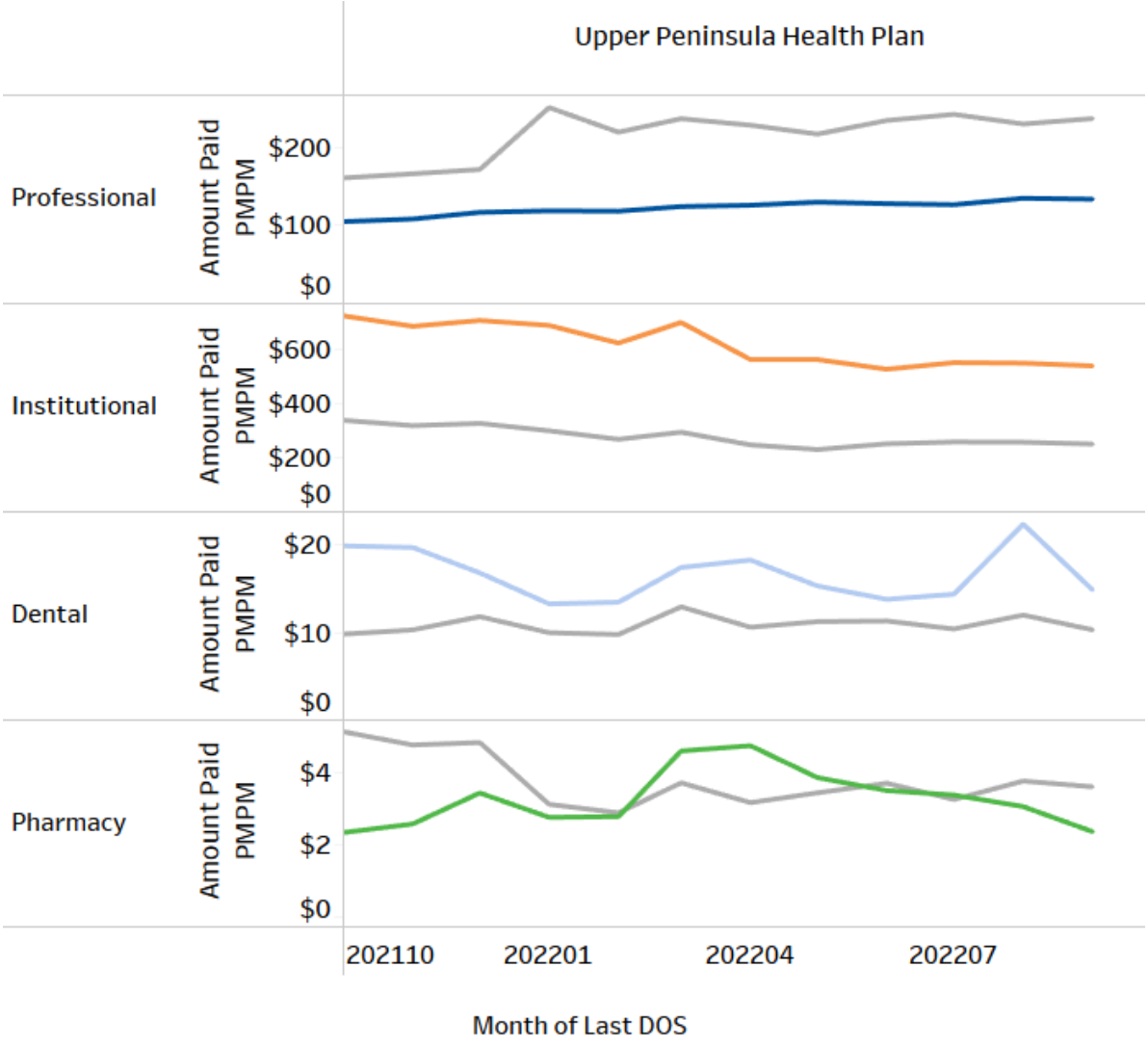


Note: The grey line indicates the all ICO rate.

Payment Amounts Per Member Per Month

Figure I-6 displays the monthly payment amounts PMPM by service month and category of service.

Figure I-6—Paid Amount PMPM—Upper Peninsula Health Plan

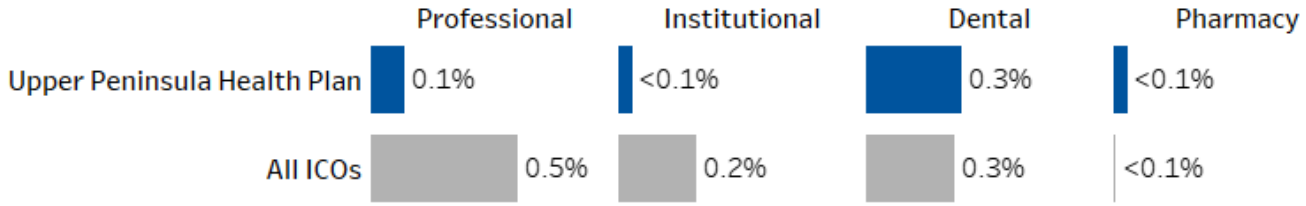


Note: The grey line indicates the all ICO rate.

Percentage of Duplicate Encounters

Figure I-7 displays the percentage of duplicate encounters.

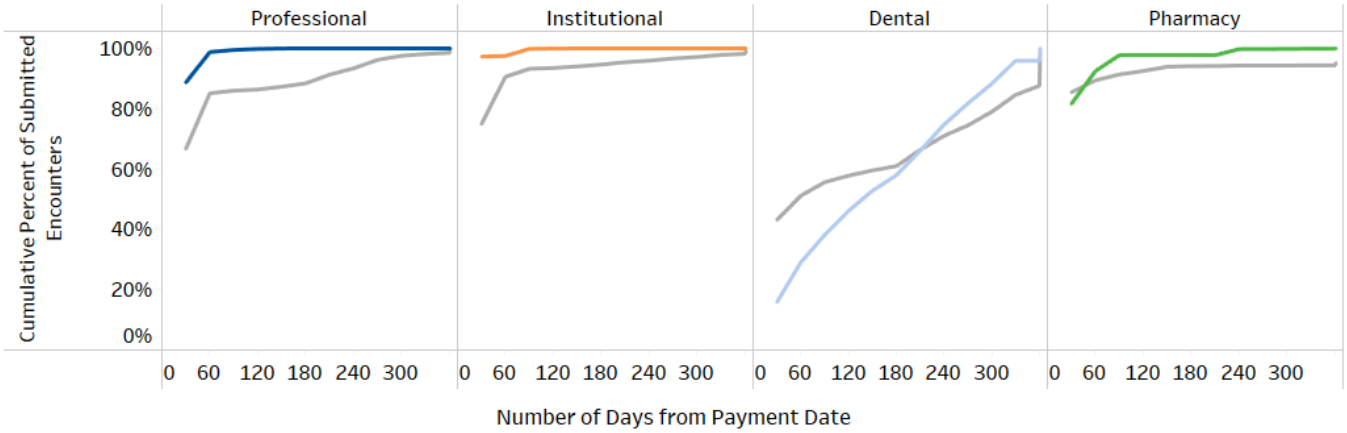
Figure I-7—Percentage of Duplicate Encounters—Upper Peninsula Health Plan



Encounter Data Timeliness

Figure I-8 and Table I-1 show the cumulative percentage of encounters submitted to MDHHS from the payment date by category of service.

Figure I-8—Cumulative Percentage of Encounters Submitted to MDHHS From ICO Payment Date by Category of Service—Upper Peninsula Health Plan



Note: The grey line indicates the all ICO rate.

Table I-1—Completeness of Encounters by Category of Service—Upper Peninsula Health Plan

Number of Days From Payment Date	Cumulative Percentage of Submitted Professional Encounters	Cumulative Percentage of Submitted Institutional Encounters	Cumulative Percentage of Submitted Dental Encounters	Cumulative Percentage of Submitted Pharmacy Encounters
Submitted Within 30 Days	88.7%	97.3%	15.9%	81.6%
Submitted Within 60 Days	98.8%	97.5%	29.1%	92.4%
Submitted Within 90 Days	99.5%	99.8%	38.2%	97.7%
Submitted Within 120 Days	99.8%	99.9%	46.1%	97.7%
Submitted Within 150 Days	99.9%	>99.9%	52.8%	97.7%
Submitted Within 180 Days	>99.9%	>99.9%	57.9%	97.7%
Submitted Within 210 Days	>99.9%	>99.9%	66.0%	97.7%
Submitted Within 240 Days	>99.9%	>99.9%	74.7%	99.7%
Submitted Within 270 Days	>99.9%	100.0%	81.7%	99.8%
Submitted Within 300 Days	>99.9%	100.0%	88.3%	99.8%
Submitted Within 330 Days	>99.9%	100.0%	95.9%	99.9%
Submitted Within 360 Days	>99.9%	100.0%	95.9%	99.9%
Submitted After 360 Days	100.0%	100.0%	100.0%	100.0%
Missing Paid or Submission Date	0.0%	0.0%	0.0%	0.0%
Submitted Prior to Paid Date	0.0%	0.0%	0.0%	0.0%

Field-Level Completeness and Accuracy

Figure I-9 through Figure I-12 provide the percentage of encounters that are present and contain valid values for key data elements.

Figure I-9—Key Professional Encounter Data Elements—Upper Peninsula Health Plan

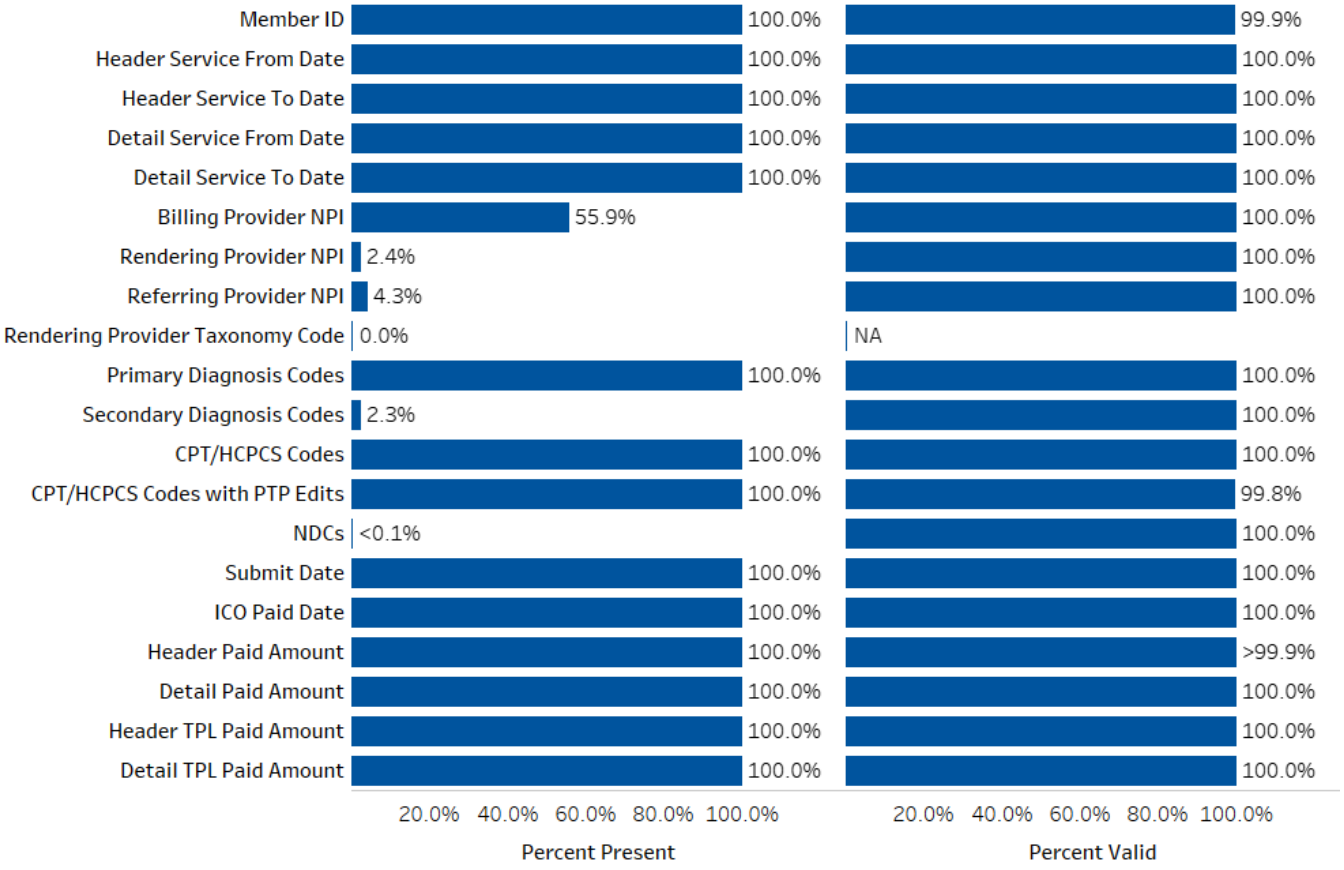


Figure I-10—Key Institutional Encounter Data Elements—Upper Peninsula Health Plan

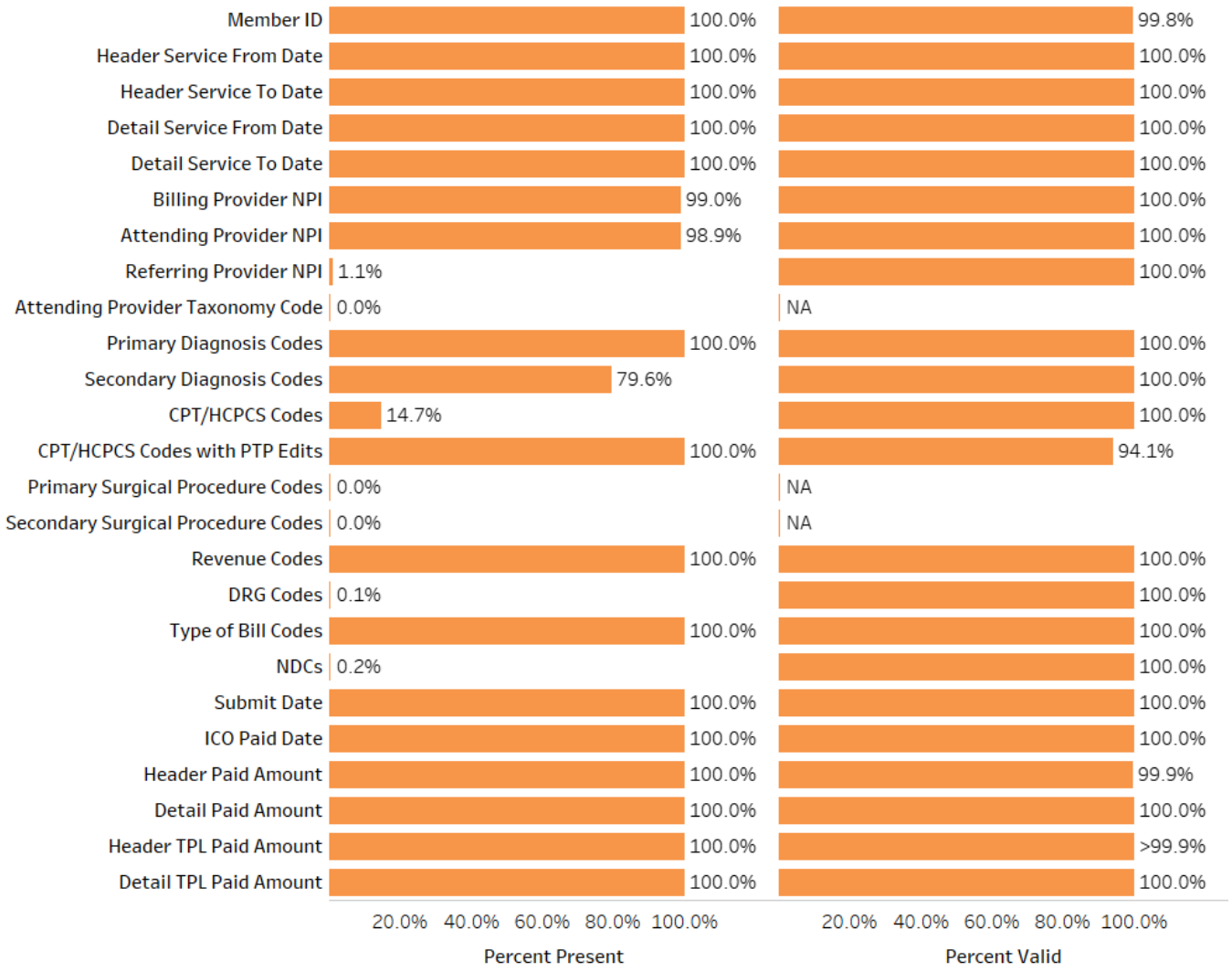


Figure I-11—Key Dental Encounter Data Elements—Upper Peninsula Health Plan

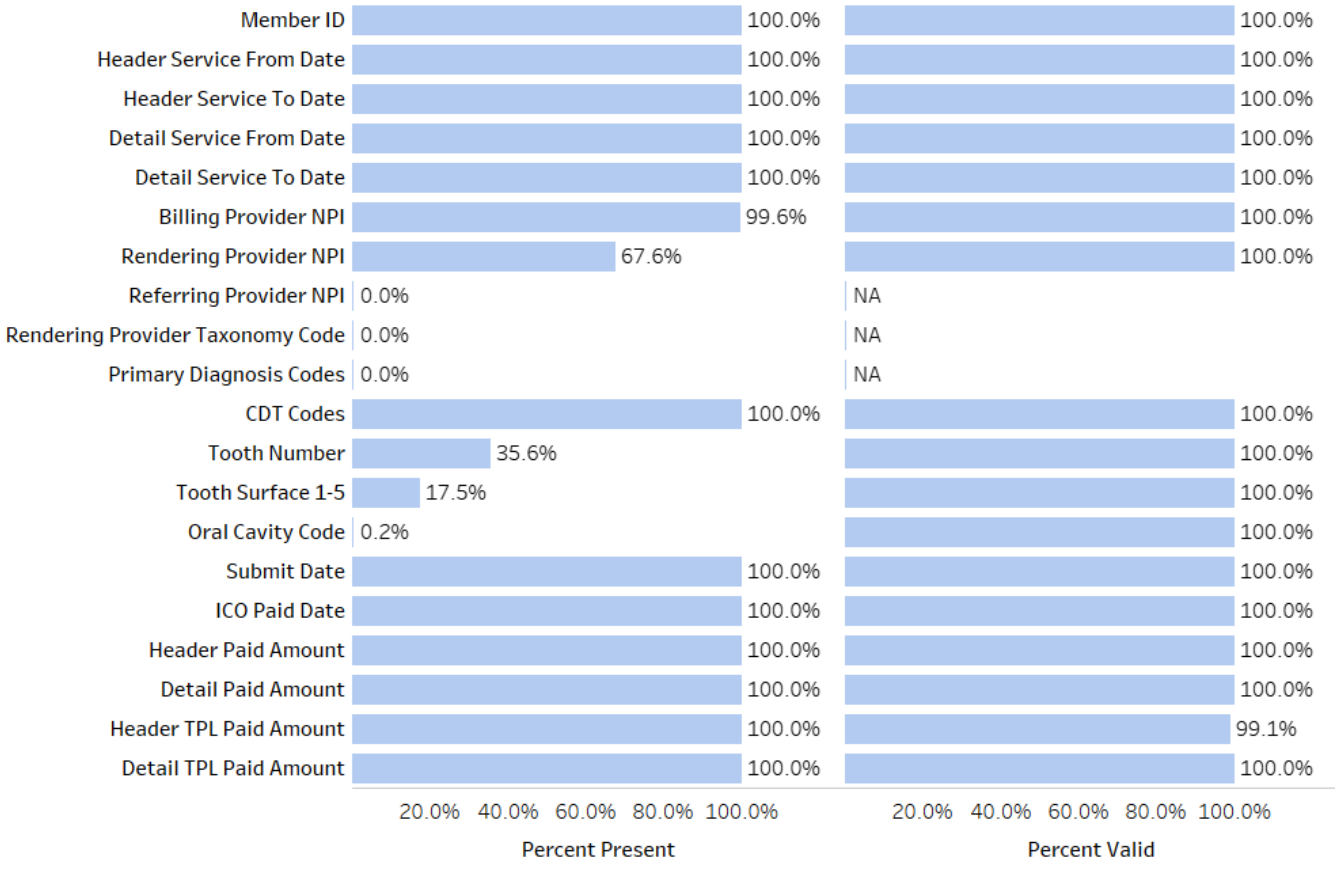
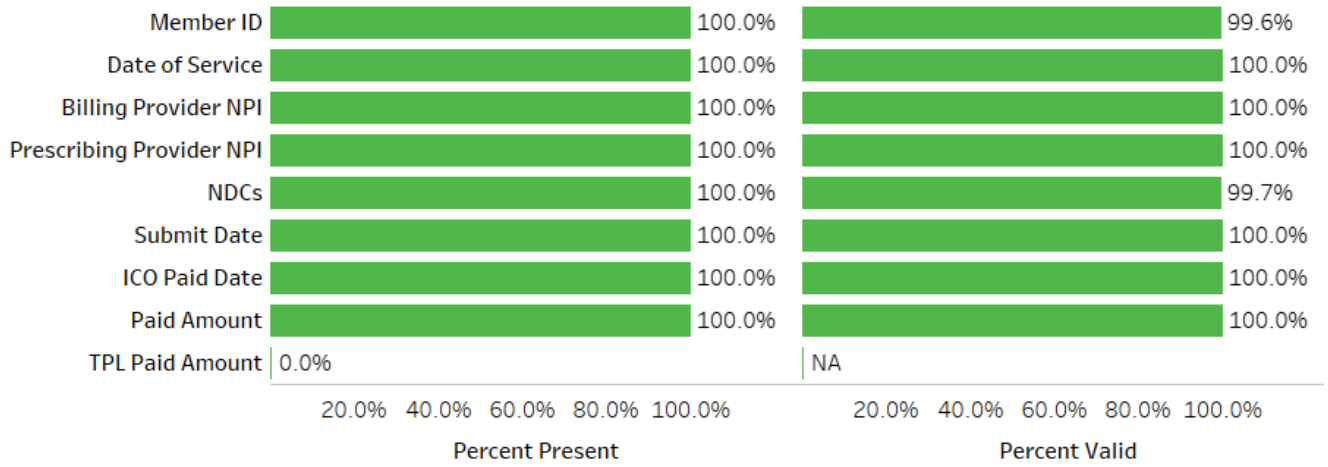


Figure I-12—Key Pharmacy Encounter Data Elements—Upper Peninsula Health Plan



Encounter Data Referential Integrity

Figure I-13 through Figure I-17 display the referential integrity results.

Figure I-13—Referential Integrity Comparison Between Enrollment and Medical/Dental Encounter Files—Upper Peninsula Health Plan

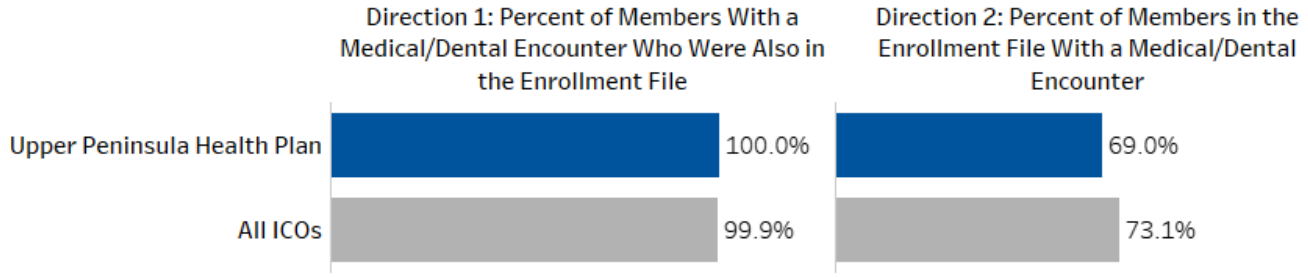


Figure I-14—Referential Integrity Comparison Between Enrollment and Pharmacy Encounter Files—Upper Peninsula Health Plan

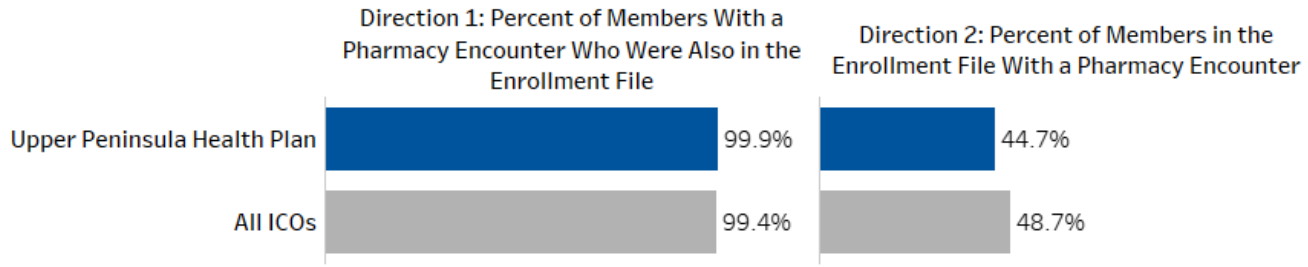


Figure I-15—Referential Integrity Comparison Between Medical/Dental Encounter and Pharmacy Encounter Files—Upper Peninsula Health Plan

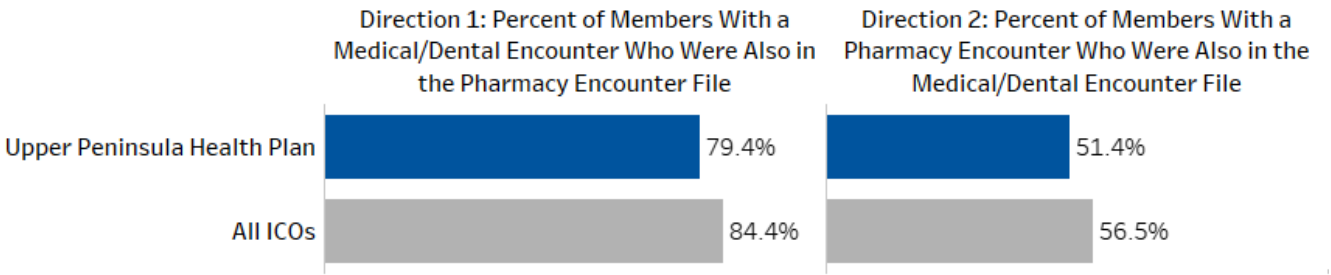


Figure I-16—Referential Integrity Comparison Between Medical/Dental Encounter and Provider Files—Upper Peninsula Health Plan

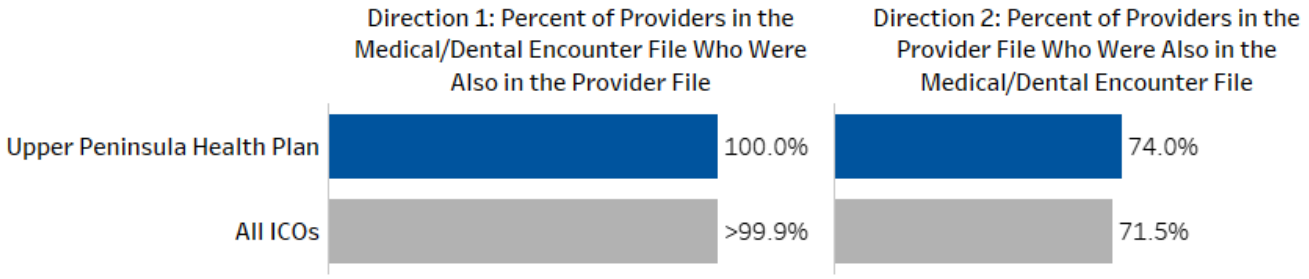
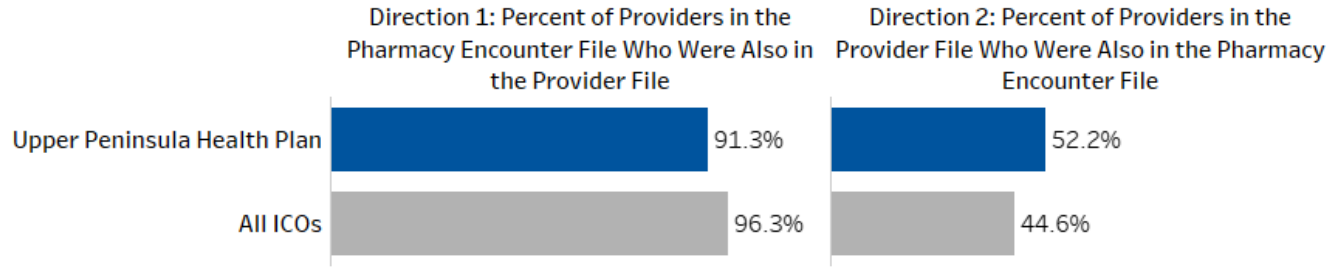


Figure I-17—Referential Integrity Comparison Between Pharmacy Encounter and Provider Files—Upper Peninsula Health Plan

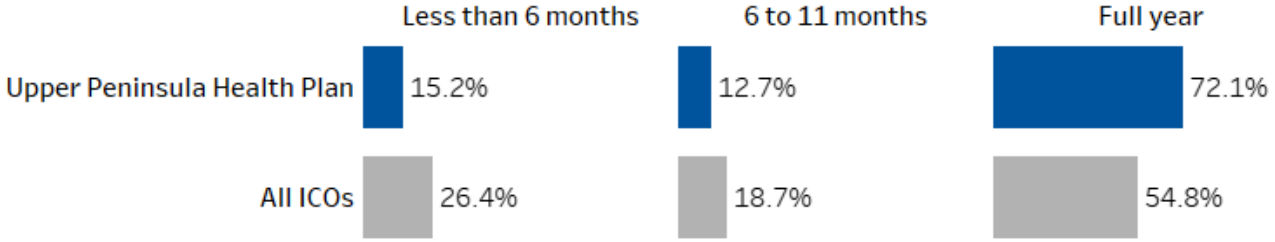


Encounter Data Logic

Member Enrollment

Figure I-18 displays the percentage of members who were continuously enrolled.

Figure I-18—Percentage of Members Who Were Continuously Enrolled—Upper Peninsula Health Plan



Conclusions

Based on the examination of the IS review and administrative profile outcomes in Section 3 and Section 4, respectively, for **Upper Peninsula Health Plan**, HSAG identified the following areas of strength and opportunities for improvement. Along with each opportunity for improvement, HSAG has also provided a recommendation to help target improvement efforts.

IS Review Conclusions

Strengths

Strength #1: Upper Peninsula Health Plan demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The ICO has also established data review and correction processes that efficiently address quality concerns identified by MDHHS.

Opportunities for Improvement

Weakness #1: Upper Peninsula Health Plan did not indicate timeliness quality checks were performed for claims/encounters originating from all of its subcontractors.

Why the weakness exists: Timeliness quality checks are crucial to ensuring that claims and encounters are submitted within the stipulated time frames.

Recommendation: Upper Peninsula Health Plan should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

Weakness #2: Upper Peninsula Health Plan reported only conducting the field-level completeness and accuracy quality check for claims/encounters stored in its data warehouses.

Why the weakness exists: No other checks, such as the monthly claim volume submission or timeliness, were mentioned.

Recommendation: Upper Peninsula Health Plan should enhance its quality checks for claims and encounters collected and stored by **Upper Peninsula Health Plan** by considering the following, among other actions:

- Implement timeliness checks to ensure that submissions comply with State or contractual deadlines.
- Create a standardized process for checking claim volume submissions to confirm that they align with expected volumes.
- Implement automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions.
- Periodically review and adjust timeliness quality checks based on performance data and any changes in regulations or contractual requirements.

Administrative Profile Conclusions

Strengths

Strength #1: **Upper Peninsula Health Plan** submitted professional, institutional, and pharmacy encounters in a timely manner from the payment date, with greater than 97 percent of these encounters submitted within 90 days of the payment date.

Strength #2: Across all categories of service, all key data elements for **Upper Peninsula Health Plan** were populated at high rates, and all but one was greater than 99 percent valid.

Opportunities for Improvement

Weakness #1: Although **Upper Peninsula Health Plan** submitted professional, institutional, and pharmacy encounters in a timely manner, **Upper Peninsula Health Plan** did not submit dental encounters timely. About 58 percent of dental encounters were submitted within 180 days of payment.

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: **Upper Peninsula Health Plan** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #2: Although 100 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 91.3 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data.

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: **Upper Peninsula Health Plan** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Weakness #3: Although not required to be populated, 55.9 percent of professional encounters contained a billing provider NPI, and 2.4 percent contained a rendering provider NPI.

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: **Upper Peninsula Health Plan** should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Administrative Profile Results—Tabular Data

Encounter Data Summary

Member Composition

Table I-2 presents the member composition.

Table I-2—Age and Gender Distribution—Upper Peninsula Health Plan

Age Category	Number of Females	Number of Males
Age 21–34 years	133	220
Age 35–44 years	230	268
Age 45–54 years	318	329
Age 55–64 years	636	476
Age 65 and over	1,671	986
Total	**2,988**	**2,279**

Encounter Data Completeness

Encounter Volume by Service Month

Table I-3 through Table I-6 display the encounter volume by service month.

Table I-3—Encounter Volume: Professional Encounters—Upper Peninsula Health Plan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	9,219	4,460	2,067.0
November 2021	9,203	4,471	2,058.4
December 2021	9,641	4,460	2,161.7
January 2022	9,482	4,335	2,187.3
February 2022	8,913	4,314	2,066.1
March 2022	9,578	4,272	2,242.0
April 2022	9,790	4,396	2,227.0
May 2022	10,046	4,390	2,288.4
June 2022	9,903	4,386	2,257.9
July 2022	9,804	4,403	2,226.7
August 2022	10,497	4,592	2,285.9
September 2022	10,300	4,659	2,210.8

Table I-4—Encounter Volume: Institutional Encounters—Upper Peninsula Health Plan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	557	4,460	124.9
November 2021	554	4,471	123.9
December 2021	505	4,460	113.2
January 2022	493	4,335	113.7
February 2022	453	4,314	105.0
March 2022	442	4,272	103.5
April 2022	443	4,396	100.8
May 2022	430	4,390	97.9
June 2022	436	4,386	99.4
July 2022	420	4,403	95.4
August 2022	455	4,592	99.1
September 2022	455	4,659	97.7

Table I-5—Encounter Volume: Dental Encounters—Upper Peninsula Health Plan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	350	4,460	78.5
November 2021	309	4,471	69.1
December 2021	282	4,460	63.2
January 2022	261	4,335	60.2
February 2022	257	4,314	59.6
March 2022	334	4,272	78.2
April 2022	297	4,396	67.6
May 2022	307	4,390	69.9
June 2022	318	4,386	72.5
July 2022	272	4,403	61.8
August 2022	341	4,592	74.3
September 2022	307	4,659	65.9

Table I-6—Encounter Volume: Pharmacy Encounters—Upper Peninsula Health Plan

Month of Service	Number of Encounters	Number of MM	Encounter Volume per 1,000 MM
October 2021	1,473	4,460	330.3
November 2021	1,520	4,471	340.0
December 2021	2,094	4,460	469.5
January 2022	1,679	4,335	387.3
February 2022	1,594	4,314	369.5
March 2022	1,770	4,272	414.3
April 2022	1,923	4,396	437.4
May 2022	1,721	4,390	392.0
June 2022	1,721	4,386	392.4
July 2022	1,559	4,403	354.1
August 2022	1,746	4,592	380.2
September 2022	1,653	4,659	354.8

Payment Amounts Per Member Per Month

Table I-7 through Table I-10 display the monthly payment amounts PMPM by service month.

Table I-7—Paid Amount PMPM: Professional Encounters—Upper Peninsula Health Plan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	4,460	$105.08
November 2021	4,471	$108.46
December 2021	4,460	$117.03
January 2022	4,335	$118.99
February 2022	4,314	$118.48
March 2022	4,272	$124.43
April 2022	4,396	$126.14
May 2022	4,390	$130.07
June 2022	4,386	$128.10
July 2022	4,403	$126.84
August 2022	4,592	$134.99
September 2022	4,659	$133.86

Table I-8—Paid Amount PMPM: Institutional Encounters—Upper Peninsula Health Plan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	4,460	$724.53
November 2021	4,471	$685.76
December 2021	4,460	$707.55
January 2022	4,335	$688.98
February 2022	4,314	$623.74
March 2022	4,272	$700.11
April 2022	4,396	$562.99
May 2022	4,390	$562.86
June 2022	4,386	$527.12
July 2022	4,403	$551.53
August 2022	4,592	$549.59
September 2022	4,659	$539.49

Table I-9—Paid Amount PMPM: Dental Encounters—Upper Peninsula Health Plan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	4,460	$19.87
November 2021	4,471	$19.69
December 2021	4,460	$16.79
January 2022	4,335	$13.26
February 2022	4,314	$13.45
March 2022	4,272	$17.41
April 2022	4,396	$18.26
May 2022	4,390	$15.30
June 2022	4,386	$13.78
July 2022	4,403	$14.36
August 2022	4,592	$22.35
September 2022	4,659	$14.85

Table I-10—Paid Amount PMPM: Pharmacy Encounters—Upper Peninsula Health Plan

Month of Service	Number of MM	Paid Amount PMPM
October 2021	4,460	$2.35
November 2021	4,471	$2.59
December 2021	4,460	$3.45
January 2022	4,335	$2.77
February 2022	4,314	$2.79
March 2022	4,272	$4.62
April 2022	4,396	$4.77
May 2022	4,390	$3.88
June 2022	4,386	$3.52
July 2022	4,403	$3.39
August 2022	4,592	$3.07
September 2022	4,659	$2.38

Percentage of Duplicate Encounters

Table I-11 displays the percentage of duplicate encounters by category of service.

Table I-11—Percentage of Duplicate Encounters by Category of Service—Upper Peninsula Health Plan

Category of Service	Number of Duplicate Records	Percentage of Duplicate Records
Professional	148	0.1%
Institutional	3	<0.1%
Dental	28	0.3%
Pharmacy	9	<0.1%

Encounter Data Timeliness

Encounter Data Lag Triangles

Table I-12 through Table I-15 display the lag triangles between service month and submission month to MDHHS. For conciseness, lag triangles only include encounters submitted through April 2023 (a minimum of a seven-month lag); therefore, counts displayed in the total line may not equal counts displayed in encounter volume figures.

Table I-12—Encounter Data Lag Triangle: Professional Encounters—Upper Peninsula Health Plan

	Month of Service												
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	103												103
202111	2,904	258											3,162
202112	6,503	3,008	160										9,671
202201	511	6,572	3,497	225									10,805
202202	58	189	6,646	2,926	201								10,020
202203	19	13	162	1,698	2,436	209							4,537
202204	1	6	3	5,202	6,566	1,140	112						13,030
202205	0	1	7	83	326	8,581	2,854	120					11,972
202206	1	0	44	126	93	254	7,144	2,649	56				10,367
202207	1	33	2	13	14	46	276	7,630	3,221	224			11,460
202208	1	12	10	9	9	41	81	292	1,800	3,399	197		5,851
202209	3	2	3	7	30	12	44	61	5,445	6,484	3,432	241	15,764
202210	0	1	0	19	21	53	71	50	150	333	7,165	4,318	12,181
202211	0	1	2	7	20	8	2	49	63	161	589	6,436	7,338
202212	0	0	0	0	0	1	1	3	5	175	298	417	900
202301	0	1	0	0	0	0	1	0	10	4	5	27	48
202302	0	0	0	0	1	0	0	1	5	0	2	19	28
202303	0	0	0	0	1	0	0	0	0	2	2	7	12
202304	0	0	0	0	0	0	1	1	0	2	1	6	11
Total	10,105	10,097	10,536	10,315	9,718	10,345	10,587	10,856	10,755	10,784	11,691	11,471	127,260
MM	4,460	4,471	4,460	4,335	4,314	4,272	4,396	4,390	4,386	4,403	4,592	4,659	53,138
PMPM	2.27	2.26	2.36	2.38	2.25	2.42	2.41	2.47	2.45	2.45	2.55	2.46	2.39

Table I-13—Encounter Data Lag Triangle: Institutional Encounters—Upper Peninsula Health Plan

	Month of Service												
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	0												0
202111	167	20											187
202112	14	148	15										177
202201	11	17	105	0									133
202202	3	11	26	340	6								386
202203	6	5	16	45	372	2							446
202204	5	5	6	10	21	293	2						342
202205	339	331	316	24	18	112	389	4					1,533
202206	4	6	7	2	3	8	18	163	0				211
202207	1	2	4	33	4	7	5	234	246	0			536
202208	2	2	3	7	3	2	5	5	49	335	6		419
202209	3	4	1	4	3	2	3	3	12	60	313	2	410
202210	4	4	5	9	5	1	4	7	112	11	113	393	668
202211	0	0	0	13	10	6	8	7	5	3	5	23	80
202212	0	0	0	5	6	4	1	4	1	2	3	16	42
202301	0	0	2	2	2	2	2	4	3	5	7	4	33
202302	0	0	0	0	0	0	2	0	2	3	2	5	14
202303	0	0	0	0	0	1	1	0	2	0	0	2	6
202304	0	0	0	0	0	0	0	0	2	0	2	2	6
Total	559	555	506	494	453	440	440	431	434	419	451	447	5,629
MM	4,460	4,471	4,460	4,335	4,314	4,272	4,396	4,390	4,386	4,403	4,592	4,659	53,138
PMPM	0.13	0.12	0.11	0.11	0.11	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.11

Table I-14—Encounter Data Lag Triangle: Dental Encounters—Upper Peninsula Health Plan

Month of Service													
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	0												0
202111	317	0											317
202112	45	276	0										321
202201	0	0	0	0									0
202202	0	0	1	0	0								1
202203	0	0	0	0	0	0							0
202204	0	0	0	0	1	0	0						1
202205	0	0	0	0	0	1	0	0					1
202206	0	0	0	0	0	0	0	0	0				0
202207	0	0	0	0	0	0	0	0	1	0			1
202208	0	0	0	0	0	0	0	0	0	0	0		0
202209	0	0	0	0	0	0	0	0	0	0	0	0	0
202210	5	49	295	263	267	349	284	177	326	274	350	272	2,911
202211	0	1	0	2	1	0	0	1	1	1	2	30	39
202212	0	0	0	0	0	0	0	0	1	0	0	2	3
202301	0	0	0	0	0	0	1	1	1	3	2	2	10
202302	0	0	0	0	1	0	0	1	0	0	1	0	3
202303	0	0	0	0	0	0	0	0	0	0	0	0	0
202304	0	0	0	0	0	0	0	0	1	0	0	0	1
Total	367	326	296	265	270	350	285	180	331	278	355	306	3,609
MM	4,460	4,471	4,460	4,335	4,314	4,272	4,396	4,390	4,386	4,403	4,592	4,659	53,138
PMPM	0.08	0.07	0.07	0.06	0.06	0.08	0.06	0.04	0.08	0.06	0.08	0.07	0.07

Table I-15—Encounter Data Lag Triangle: Pharmacy Encounters—Upper Peninsula Health Plan

	Month of Service												
Submission Month	**202110**	**202111**	**202112**	**202201**	**202202**	**202203**	**202204**	**202205**	**202206**	**202207**	**202208**	**202209**	**Total**
202110	454												454
202111	1,003	469											1,472
202112	14	1,047	411										1,472
202201	0	2	986	375									1,363
202202	0	2	3	915	436								1,356
202203	1	0	697	387	1,142	441							2,668
202204	0	0	0	0	1	1,302	412						1,715
202205	0	0	0	0	2	12	1,502	355					1,871
202206	0	0	0	0	0	0	2	1,365	488				1,855
202207	0	0	0	0	0	2	2	1	1,230	311			1,546
202208	0	0	0	0	0	0	0	0	1	1,246	423		1,670
202209	0	0	0	0	0	0	0	0	0	1	1,316	384	1,701
202210	0	0	0	0	0	0	0	0	0	0	0	855	855
202211	0	0	0	0	0	0	0	0	0	0	0	3	3
202212	0	0	1	1	12	11	0	0	0	0	1	1	27
202301	0	0	0	0	0	0	0	0	0	0	0	0	0
202302	0	0	0	0	0	0	0	0	0	0	0	0	0
202303	0	0	0	0	0	0	0	0	0	0	0	0	0
202304	0	0	0	0	0	0	0	0	0	1	6	408	415
Total	1,472	1,520	2,098	1,678	1,593	1,768	1,918	1,721	1,719	1,559	1,746	1,651	20,443
MM	4,460	4,471	4,460	4,335	4,314	4,272	4,396	4,390	4,386	4,403	4,592	4,659	53,138
PMPM	0.33	0.34	0.47	0.39	0.37	0.41	0.44	0.39	0.39	0.35	0.38	0.35	0.38

Field-Level Completeness and Accuracy

Table I-16 through Table I-19 provide the percentage of encounters that are present and contain valid values for key data elements for all categories of service.

Table I-16—Key Encounter Data Elements: Professional Encounters—Upper Peninsula Health Plan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	127,331	127,331	100.0%	127,331	127,164	99.9%
Header Service From Date	127,331	127,331	100.0%	127,331	127,331	100.0%
Header Service To Date	127,331	127,331	100.0%	127,331	127,331	100.0%
Detail Service From Date	139,744	139,744	100.0%	139,744	139,744	100.0%
Detail Service To Date	139,744	139,744	100.0%	139,744	139,744	100.0%
Billing Provider NPI	127,331	71,145	55.9%	71,145	71,145	100.0%
Rendering Provider NPI	127,331	3,075	2.4%	3,075	3,075	100.0%
Referring Provider NPI	127,331	5,442	4.3%	5,442	5,442	100.0%
Rendering Provider Taxonomy Code	127,331	0	0.0%	0	0	NA
Primary Diagnosis Codes	127,331	127,331	100.0%	127,331	127,331	100.0%
Secondary Diagnosis Codes	127,331	2,934	2.3%	4,981	4,981	100.0%
CPT/HCPCS Codes	139,744	139,744	100.0%	139,744	139,744	100.0%
CPT/HCPCS Codes with PTP Edits	139,458	139,458	100.0%	139,458	139,224	99.8%
NDCs	139,744	7	<0.1%	7	7	100.0%
Submit Date	139,744	139,744	100.0%	139,744	139,744	100.0%
ICO Paid Date	139,744	139,744	100.0%	139,744	139,744	100.0%
Header Paid Amount	127,331	127,331	100.0%	127,331	127,306	>99.9%
Detail Paid Amount	139,744	139,744	100.0%	139,744	139,744	100.0%
Header TPL Paid Amount	127,331	127,331	100.0%	127,331	127,331	100.0%
Detail TPL Paid Amount	139,744	139,744	100.0%	139,744	139,744	100.0%

Table I-17—Key Encounter Data Elements: Institutional Encounters—Upper Peninsula Health Plan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	5,659	5,659	100.0%	5,659	5,647	99.8%
Header Service From Date	5,659	5,659	100.0%	5,659	5,659	100.0%
Header Service To Date	5,659	5,659	100.0%	5,659	5,659	100.0%
Detail Service From Date	6,520	6,520	100.0%	6,520	6,520	100.0%
Detail Service To Date	6,520	6,520	100.0%	6,520	6,520	100.0%
Billing Provider NPI	5,659	5,603	99.0%	5,603	5,603	100.0%
Attending Provider NPI	5,659	5,599	98.9%	5,599	5,599	100.0%
Referring Provider NPI	5,659	61	1.1%	61	61	100.0%
Attending Provider Taxonomy Code	5,659	0	0.0%	0	0	NA
Primary Diagnosis Codes	5,659	5,659	100.0%	5,659	5,659	100.0%
Secondary Diagnosis Codes	5,659	4,507	79.6%	43,039	43,039	100.0%
CPT/HCPCS Codes	6,520	961	14.7%	961	961	100.0%
CPT/HCPCS Codes with PTP Edits	185	185	100.0%	185	174	94.1%
Primary Surgical Procedure Codes	5,659	0	0.0%	0	0	NA
Secondary Surgical Procedure Codes	5,659	0	0.0%	0	0	NA
Revenue Codes	6,520	6,520	100.0%	6,520	6,520	100.0%
DRG Codes	5,659	5	0.1%	5	5	100.0%
Type of Bill Codes	5,659	5,659	100.0%	5,659	5,659	100.0%
NDCs	6,520	16	0.2%	16	16	100.0%
Submit Date	6,520	6,520	100.0%	6,520	6,520	100.0%
ICO Paid Date	6,520	6,520	100.0%	6,520	6,520	100.0%
Header Paid Amount	5,659	5,659	100.0%	5,659	5,652	99.9%
Detail Paid Amount	6,520	6,520	100.0%	6,520	6,520	100.0%
Header TPL Paid Amount	5,659	5,659	100.0%	5,659	5,658	>99.9%
Detail TPL Paid Amount	6,520	6,520	100.0%	6,520	6,520	100.0%

Table I-18—Key Encounter Data Elements: Dental Encounters—Upper Peninsula Health Plan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	3,774	3,774	100.0%	3,774	3,774	100.0%
Header Service From Date	3,774	3,774	100.0%	3,774	3,774	100.0%
Header Service To Date	3,774	3,774	100.0%	3,774	3,774	100.0%
Detail Service From Date	9,567	9,567	100.0%	9,567	9,567	100.0%
Detail Service To Date	9,567	9,567	100.0%	9,567	9,567	100.0%
Billing Provider NPI	3,774	3,760	99.6%	3,760	3,760	100.0%
Rendering Provider NPI	3,774	2,552	67.6%	2,552	2,552	100.0%
Referring Provider NPI	3,774	0	0.0%	0	0	NA
Rendering Provider Taxonomy Code	3,774	0	0.0%	0	0	NA
Primary Diagnosis Codes	3,774	0	0.0%	0	0	NA
CDT Codes	9,567	9,567	100.0%	9,567	9,567	100.0%
Tooth Number	9,567	3,405	35.6%	3,405	3,405	100.0%
Tooth Surface 1-5	9,567	1,670	17.5%	3,891	3,891	100.0%
Oral Cavity Code	9,567	21	0.2%	21	21	100.0%
Submit Date	9,567	9,567	100.0%	9,567	9,567	100.0%
ICO Paid Date	9,567	9,567	100.0%	9,567	9,567	100.0%
Header Paid Amount	3,774	3,774	100.0%	3,774	3,774	100.0%
Detail Paid Amount	9,567	9,567	100.0%	9,567	9,567	100.0%
Header TPL Paid Amount	3,774	3,774	100.0%	3,774	3,740	99.1%
Detail TPL Paid Amount	9,567	9,567	100.0%	9,567	9,567	100.0%

Table I-19—Key Encounter Data Elements: Pharmacy Encounters—Upper Peninsula Health Plan

	Percent Present			Percent Valid		
Data Element	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Member ID	20,469	20,469	100.0%	20,469	20,391	99.6%
Date of Service	20,469	20,469	100.0%	20,469	20,469	100.0%
Billing Provider NPI	20,469	20,469	100.0%	20,469	20,469	100.0%
Prescribing Provider NPI	20,469	20,469	100.0%	20,469	20,469	100.0%
NDCs	20,469	20,469	100.0%	20,469	20,411	99.7%
Submit Date	20,469	20,469	100.0%	20,469	20,469	100.0%
ICO Paid Date	20,469	20,469	100.0%	20,469	20,469	100.0%
Paid Amount	20,469	20,469	100.0%	20,469	20,469	100.0%
TPL Paid Amount	20,469	0	0.0%	0	0	NA