Florida Agency for Health Care Administration

SFY 2021–2022 Encounter Data Validation Study: Aggregate Report

September 2022

HSAG HEALTH SERVICES ADVISORY GROUP

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Glossary of Acronyms

Agency	Florida Agency for Health Care Administration
ALF	Assisted Living Facility
ARNP	Advance Registered Nurse Practitioner
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CY	Calendar Year
DRG	Diagnosis Related Group
E&M	Evaluation and Management
EDV	Encounter Data Validation
EQR	External Quality Review
HCBS	Home- and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HSAG	Health Services Advisory Group, Inc.
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICF/DD	Private Intermediate Care Facilities/Developmentally Disabled
ICN	Internal Control Number
ID	Identification
IRR	Interrater Reliability
LTC	Long-Term Care
MM	Member Months
MMA	Managed Medical Assistance
MMIS	Medicaid Management Information System
NDC	National Drug Code
NPI	National Provider Identifier
SAFE	Secure Access File Exchange
SFY	State Fiscal Year
SNF	Skilled Nursing Facility
TCN	Transaction Control Number
TPID	Trading Partner ID

Plan Names

HSAG assessed the encounters submitted by the Florida Agency for Health Care Administration's (Agency's) contracted Managed Medical Assistance (MMA) comprehensive and long-term care (LTC) plans (collectively referred to as "plans"). The table below lists the contracted plans included in this study.

List of Contracted Plans

Plan Name	Plan Abbreviation	Shortened Name
MMA Comprehensive Plans		
Aetna Better Health of Florida, Inc.	AET-C	Aetna-C
Humana Medical Plan, Inc.	HUM-C	Humana-C
Molina Healthcare of Florida, Inc.	MOL-C	Molina-C
Simply Healthcare Plans, Inc.	SIM-C	Simply-C
Sunshine State Health Plan, Inc.	SUN-C	Sunshine-C
UnitedHealthcare of Florida, Inc.	UNI-C	United-C
Wellcare of Florida DBA Staywell Health Plan of Florida, Inc.[1]	STW-C	Staywell-C
LTC Plan		
Florida Community Care, LLC	FCC-L	Florida Community Care-L

[1] Acquired by Sunshine State Health Plan, Inc. as of October 1, 2021.

1. Executive Summary

Introduction

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of the encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitation rates, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of the state's overall management and oversight of its Medicaid managed care program and in demonstrating its care and service responsibility and fiscal stewardship.

During state fiscal year (SFY) 2021–2022, the Agency contracted with Health Services Advisory Group, Inc. (HSAG) to conduct an Encounter Data Validation (EDV) study. The goal of the SFY 2021–2022 EDV study is to examine the extent to which the LTC encounters submitted to the Agency by its plans are complete and accurate.

Overview of 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*, October 2019,[1-1,] HSAG conducted the following core evaluation activities for the EDV activity:

- Comparative analysis—Analysis of the Agency's electronic encounter data completeness and accuracy through a comparison between the Agency's electronic encounter data and the data extracted from the plans' data systems. The comparative analysis of the encounter data involved a series of analyses divided into two analytic sections:
  1. HSAG assessed **record-level data completeness** using the following metrics for each LTC encounter type:
  - *Record omission*—The percentage of records present in the plan-submitted files that were not found in the Agency-submitted files.
  - *Record surplus*—The percentage of records present in the Agency-submitted files that were not found in the plan-submitted files.

[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*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: June 21, 2022.

2. Based on the number of records present in both data sources, HSAG examined **data element-level completeness and accuracy** for key data elements based on the following metrics:
   - *Element omission*—The percentage of records with values present in the plan-submitted files but not present in the Agency-submitted files.
   - *Element surplus*—The percentage of records with values present in the Agency-submitted files but not present in the plan-submitted files.
   - *Element accuracy*—The percentage of records with the same values in both the Agency- and plan-submitted files.

- Clinical record and plan of care review—Analysis of the Agency's electronic encounter data completeness and accuracy by comparing the Agency's electronic encounter data to the information documented in the corresponding enrollees' clinical records and plans of care.

Snapshot of Findings and Recommendations

Comparative Analysis

Record Completeness

Table 1-1 displays the statewide and plan range of record omission and record surplus rates by LTC encounter type. **Lower rates indicate better performance for both record omission and record surplus**, and rates at or lower than 5.0 percent are generally considered low.

Table 1-1—Encounter Data Completeness Summary

	Record Omission[1]		Record Surplus[2]	
Encounter Type	All Plans' Rate	Plan Range	All Plans' Rate	Plan Range
LTC Professional	2.9%	0.4%–6.5%	3.1%	1.1%–6.3%
LTC Institutional	7.2%	1.1%–26.5%	5.7%	0.4%–25.7%

[1] Records present in the plan-submitted files but not found in the Agency-submitted files.
[2] Records present in the Agency-submitted files but not found in the plan-submitted files.

Findings: The overall record omission and surplus rates were low (i.e., at or lower than 5.0 percent) for the LTC professional encounters, suggesting low discrepancies at the record level when comparing the Agency-submitted files to the plan-submitted files. One plan with a high LTC professional record surplus rate indicated that most records identified as surplus were not LTC encounter records. The overall record omission and surplus rates for LTC institutional encounters were high (i.e., more than 5.0 percent). Since both the Agency- and plan-submitted files represent the same administrative data, the most likely reasons for noted discrepancies, whether in the form of record omission or surplus, are system-related processes issues. For plans with high LTC institutional record omission rates, some plans noted errors in their data extract for the study, while others noted that the records identified as an omission were valid records submitted to the Agency. Similarly, plans with high LTC institutional record surplus rates also noted errors in extracting data for the study contributed to the number of records identified as surplus.

Of note, HSAG received direction from the Agency that plans were to submit LTC encounters to the Agency using the plan-specific *Trading Partner ID* (*TPID*) as provided by the Agency. However, while collecting and processing the requested encounter data from the Agency and the plans for the study, one plan noted that it had submitted the LTC encounters to the Agency using two *TPID*s, of which one was in error (i.e., not using the appropriate *TPID*). Of note, for the plan-submitted data associated with the incorrect *TPID*, there were nearly 420,000 records for the LTC professional encounters and nearly 21,000 records for the LTC institutional encounters as compared to 3.8 million and more than 850,000 records in the Agency-submitted data. The Agency determined that the plan was not required to resubmit the incorrect *TPID* submission for the study. As such, this plan's encounters for the specific *TPID* were not considered for the comparative analysis.

Data Element Completeness and Accuracy

Table 1-2 displays the statewide data element omission, surplus, and accuracy results for key data elements evaluated from the LTC professional and LTC institutional encounters. For data element omission and surplus, lower rates indicate better performance, whereas for element accuracy, higher rates indicate better performance. Generally, for element omission and element surplus, rates at or lower than 5.0 percent are considered low, whereas for element accuracy, rates at or greater than 95.0 percent are considered high.

Table 1-2—Element Omission, Surplus, and Accuracy Rates: LTC Professional and LTC Institutional Encounters

	LTC Professional			LTC Institutional		
Key Data Element	Omission	Surplus	Accuracy Rate	Omission	Surplus	Accuracy Rate
Enrollee ID	0.0%	0.0%	>99.9%	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	87.6%	0.0%	0.0%	99.1%
Header Service To Date	0.0%	0.0%	87.7%	0.0%	0.0%	99.3%
Detail Service From Date	0.0%	0.0%	99.9%	0.0%	<0.1%	99.2%
Detail Service To Date	0.0%	0.0%	99.9%	0.0%	<0.1%	99.1%
Admission Date				0.1%	0.1%	99.1%
Billing Provider National Provider Identifier (NPI)	<0.1%	0.3%	93.2%	0.0%	0.6%	88.2%
Rendering Provider NPI	<0.1%	86.8%	65.5%			
Attending Provider NPI				4.2%	0.1%	95.2%
Referring Provider NPI	1.7%	<0.1%	94.9%	1.1%	0.0%	100%
Primary Diagnosis Code	<0.1%	0.5%	98.8%	<0.1%	0.0%	97.2%
Secondary Diagnosis Code[1]	3.5%	<0.1%	84.0%	2.5%	<0.1%	55.5%
Procedure Code	<0.1%	0.5%	99.9%	0.1%	<0.1%	99.9%
Procedure Code Modifier	<0.1%	0.5%	99.8%	<0.1%	<0.1%	>99.9%
Units of Service	0.0%	0.2%	98.0%	0.0%	0.0%	56.5%

Key Data Element	LTC Professional			LTC Institutional		
	Omission	Surplus	Accuracy Rate	Omission	Surplus	Accuracy Rate
Primary Surgical Procedure Code				0.0%	<0.1%	97.4%
National Drug Code (NDC)	<0.1%	0.0%	NA[2]	0.1%	0.0%	NA[2]
Revenue Code				0.0%	0.0%	99.6%
Diagnosis Related Group (DRG)				34.6%	0.1%	15.3%
Header Paid Amount	0.2%	0.0%	99.1%	0.0%	0.0%	74.6%
Detail Paid Amount	0.2%	<0.1%	96.0%	<0.1%	<0.1%	92.7%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.
Note: Gray cells indicate that data elements were not evaluated for certain encounter types.

Findings: Overall, among encounters that could be matched between the Agency- and plan-submitted data, the encounter data elements exhibited a high level of completeness (i.e., low omission and low surplus rates) across both LTC encounter types (i.e., LTC professional and LTC institutional encounters). The element omission and surplus rates were at or below 5.0 percent for the key data elements evaluated, with few exceptions. Data elements with relatively incomplete data included *Rendering Provider NPI* in the LTC professional encounters and *DRG* in the LTC institutional encounters. The high surplus rate for the *Rendering Provider NPI* data element was mostly due to this data element being populated with the same values as *Billing Provider NPI* in the Agency-submitted data, while the plan-submitted data had no values populated in the *Rendering Provider NPI* data element. The high omission rate for the *DRG* data element was attributed to one plan, where the plan understood that per the Agency, the data element was not required to be sent; however, this data element was included in the plan's data extract for the study.

Overall, data element accuracy rates associated with the LTC professional encounter type were mostly high, with nine out of 15 key data elements evaluated showing at least 95.0 percent accuracy. Similarly, data element accuracy rates associated with the LTC institutional encounter type were also mostly high, with 13 out of 19 key data elements evaluated showing at least 95.0 percent accuracy. For plans with low data element accuracy rates, some of the reasons for the low accuracy are as follows:

- Dates of service: The low overall accuracy rates for the *Header Service From Date* and *Header Service To Date* data elements associated with the LTC professional encounters were mostly attributed to one plan, where the date submitted by the plan represents the entire claim while the Agency-submitted dates apply only to the specific encounter line.
- Provider: For the *Billing Provider NPI* data element within the LTC professional and institutional encounters, the low overall accuracy rates for this data element were mostly attributed to one plan, which indicated that the discrepancies were due to data extraction errors. For the *Rendering Provider NPI* data element within the LTC professional encounters, the low overall accuracy rate was also mostly attributed to one plan, which indicated that the discrepancies were due to data extraction errors, while other plans noted either the Agency populated this field with the *Billing Provider NPI* when this field was missing, or some represented different NPIs for the same provider.

- Secondary diagnosis code: Five of the eight plans had low accuracy rates for the *Secondary Diagnosis Code* data element within the LTC professional and institutional encounters. Based on responses received from most plans regarding the data element discrepancies, the discrepant values were due to how the secondary diagnosis codes were ordered when compared to the Agency's ordering of the data element; sequentially versus alphabetically. However, one plan noted that it had included the admitting diagnosis codes in its submission.
- Units of service: All except one plan had low accuracy rates for the *Units of Service* data element within the LTC institutional encounters. Based on responses received from the plans regarding the data element discrepancies, the reasons for the discrepancies were either due to data extraction errors, the Agency submitted values were for length of stay, or encounter rejections.
- DRG: The low overall accuracy rate for the *DRG* data element was mostly attributed to the low accuracy rates for three plans. Based on responses received from two of the plans, both noted that they have been submitting four-digit DRGs to the Agency, while the Agency is reporting only the first three digits.
- Payment amount: The low overall accuracy rates for the *Header Paid Amount* and *Detail Paid Amount* data elements associated with the LTC institutional encounters were attributed to the low accuracy rates for two plans. One plan attributed the issue with both data elements to the Agency-submitted values, where the paid amount the plan submitted reflected the Medicaid paid dollars while the Agency submitted values were for Medicare dollars. The other plan with a low accuracy rate for the *Header Paid Amount* data element noted that it had resolved the issue with a recent system enhancement.

Recommendations: Based on the comparative analysis results, HSAG recommends the following to the Agency to improve LTC encounter data completeness and accuracy:

- As described previously, HSAG received direction from the Agency that the LTC encounters were submitted based on plan-specific *TPID*s. However, during the study it was identified that the *TPID* would not be appropriate for identifying an encounter as an LTC encounter. As such, HSAG recommends that the Agency work with its Medicaid Management Information System (MMIS) data vendor and the Agency's analytic team to develop a mechanism or method to determine encounters that would constitute as LTC encounters. Once the mechanism has been developed, the information should be communicated to the plans to ensure that LTC encounters are submitted accordingly and can be identified explicitly.
- The comparative analysis results for the LTC professional encounters indicate a higher degree of record completeness compared to the LTC institutional encounters. As such, HSAG recommends that the Agency continue its current efforts in monitoring encounter data submissions and addressing any identified data issues with the plans' encounter file submissions.
- While the comparative analysis results indicated a high degree of element completeness and accuracy for most key data elements evaluated across both the LTC professional and LTC institutional encounters, the results also indicated that there were key data elements with low accuracy rates. As such, for those key data elements with low accuracy rates, HSAG recommends that the Agency works with the specific plan(s) in resolving how the associated data element(s) should be submitted, collected, and reported. Examples include the payment amount, where one plan noted that the payment amounts in the Agency data were for Medicare dollars instead of Medicaid dollars; units of service, where one plan noted that the units of service within the Agency data were for length of stay; and DRG, where two plans noted they had submitted four-digit codes while the

Agency data reported three-digit codes. HSAG also recommends that the Agency encourage plans with discrepant items noted in the data discrepancy reports to communicate and investigate the root cause of the discrepancies with the Agency.

- For future EDV studies, to help improve the study data requests and submissions for the study, HSAG recommends that the Agency and HSAG work more collaboratively with the Agency's staff members who work on the encounter data as well as have historical and current information on any Florida-specific instructions or guidance to the plans regarding encounter data submissions to the Agency. For example, it would be beneficial for HSAG to understand the Agency's internal processing and extraction of the diagnosis codes within the MMIS so that the information can be shared with the plans when requesting data for the study. This will ensure the Agency, HSAG, and the plans have a shared understanding of how data elements within each encounter type should be reported.

LTC Record and Plan of Care Review Findings

Data Completeness and Accuracy

Table 1-3 displays the LTC record omission, encounter data omission, element accuracy, and all-element accuracy rates for each key data element.

Table 1-3—Encounter Data Completeness and Accuracy Summary

Key Data Element	LTC Record Omission[1]		Encounter Data Omission[2]		Element Accuracy	
	All Plans' Rate	Plan Range	All Plans' Rate	Plan Range	All Plans' Rate	Plan Range
Date of Service	22.1%	1.3%–44.9%			—	—
Diagnosis Code	44.3%	9.2%–72.7%	0.0%	0.0%–0.0%	99.4%	98.8%–100%
Procedure Code	16.7%	1.5%–37.6%	0.1%	0.0%–1.0%	99.2%	98.5%–100%
Procedure Code Modifier	25.7%	3.2%–100%	0.0%	0.0%–0.0%	99.3%	96.8%–100%
All-Element Accuracy[3]					82.8%	62.8%–92.2%

"—" Indicates that the accuracy rate analysis was not applicable to a given data element.

[1] Services documented in the encounter data but not supported by the enrollees' LTC records.

[2] Services documented in the enrollees' LTC records but not in the encounter data.

[3] The all-element accuracy rate describes the percentage of dates of service present in both the Agency's encounter data and in the LTC records with **all** data elements coded correctly (i.e., not omitted from the LTC record, not omitted from the encounter data, and when populated have the same values).

Note: Gray cells indicate that study indicators were not applicable; therefore, the study indicators were not evaluated.

Findings: Overall, the *Date of Service* data element within the Agency's encounter data was not well supported by the enrollees' LTC records, as evidenced by the high overall LTC record omission rate (22.1 percent). Similarly, the other three data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were also not well supported by the LTC records, with LTC record omission rates of 44.3 percent, 16.7 percent, and 25.7 percent, respectively. As determined during the review, the

LTC record omissions were primarily influenced by LTC record non-submission and, consequently, LTC record omissions for *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*. In the analysis, when no LTC records were submitted for a sampled date of service, all other key data elements associated with that date of service were treated as LTC record omissions. In contrast, the overall encounter data omission rates were very low for each of the key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*), indicating that all key data elements found in the submitted LTC records were well supported by the information found in the Agency's encounter data, with overall rates of 0.1 percent or less. Overall, when key data elements were present in both the Agency's encounter data and the enrollees' LTC records and were evaluated independently, the data elements were found to be accurate, where each had an accuracy rate of greater than 99.0 percent. Nearly 83.0 percent of the dates of service present in both sources (i.e., the Agency's encounter data and the LTC records) contained matching values for all three key data elements when compared to the enrollees' LTC records.

Review of Plan of Care Documentation

Table 1-4 presents a summary of results from the review of the plan of care documentation.

Table 1-4—Plan of Care Document Review Summary

Plan of Care Document Reviewed Items	N	%
Date of service identified in encounter data	1,313	—
Valid plan of care submission[1]	1,020	77.7%
– Plan of care document was from provider[2]	168	16.5%
– Plan of care document was from the plan[2]	852	83.5%
Plan of care documentation was signed[2]	826	81.0%
Selected dates of service were within the effective dates of the plan of care documents[3]	813	98.4%
Servicing providers were documented[4]	780	95.9%
Documented servicing providers support provider information in the LTC records[5]	557	71.4%
Documented procedures support procedures identified in the LTC records[4]	558	68.6%
Documented number of units support the units identified in the LTC records[4]	583	71.7%

"—" Indicates percentage is not applicable.
[1] Denominator was based on number of dates of service identified in the encounter data.
[2] Denominator was based on the number of valid plans of care.
[3] Denominator was based on the number of plans of care with an appropriate signature.
[4] Denominator was based on the number of plans of care where the selected date of service was within the effective dates of the plan of care.
[5] Denominator was based on whether the servicing provider was documented.

Findings: Of the 1,313 dates of service identified in the encounter data for which HSAG requested plans to submit plan of care documentation, 77.7 percent (1,020 out of 1,313) were submitted with valid documentation. Among the plan of care documentation available for review and assessed as valid plan of care documentation, 83.5 percent (852 out of 1,020) were plan of care documents from the plan, while the remaining documents (168 out of 1,020) were from the providers (e.g., skilled nursing facility [SNF] or home- and community-based services [HCBS] providers). In general, most plan of care documentation

available for review contained the appropriate signatures, included plan of care effective dates that covered selected dates of service, and identified valid servicing providers. However, when the servicing providers, plan of care procedures, and associated number of units were compared to the enrollees' LTC records, fewer plan of care documentation supported information documented in the LTC records. Only 68.5 percent (557 out of 813) of the servicing provider information within the plan of care documents supported the provider information contained in the LTC records. Similarly, 68.6 percent (558 out of 813) had procedure codes documented that supported procedure codes included in the LTC records. Finally, 71.7 percent (583 out of 813) of units of service in the plan of care documentation supported information documented in the LTC records. Of note, most servicing provider, procedure code, and units of service discrepancies, when compared to the LTC records information for the associated dates of service, were due to LTC records not submitted for the study.

Recommendations: Based on the LTC records and plan of care review results, HSAG recommends the following to the Agency to improve LTC encounter data completeness and accuracy as well as opportunities for improvement in the care plan development:

- The plans' LTC record submissions were low which affected the LTC record omission study indicators for all key data elements evaluated. As such, to ensure the plans' accountability for record procurement requirements, the Agency may consider strengthening and/or enforcing its contract requirements with the plans regarding provision of oversight activities in this area. Additionally, plans cited non-responsive provider or provider did not respond in a timely manner as the major reasons for LTC record non-submissions. As such, HSAG recommends the Agency communicate to the plans that this may be an issue with the contract language between the plans and their contracted providers. Plans should have language within their contract with their provider network/subcontractors addressing submission of records for the purpose of audits, inspection, and/or examination of enrollees' clinical records and/or documentation.
- As recommended in the prior year's EDV activity, since the results of record and plan of care document reviews are dependent on the plans' submission of complete and accurate supporting documentation, HSAG recommends the Agency consider setting record submission standards to ensure the plans are more responsive in procuring requested records. By having the plans submit complete and accurate documentation and/or records, results will be more representative of the actual documentation available.
- In reviewing the plan of care documentation (i.e., developed by the facility or the plan), there were components of the documents that were not complete and/or did not support information documented in the LTC records. As such, HSAG recommends the Agency work with the plans to ensure plan or case management involvement in the care plan development, implementation, and oversight. For example, for HCBS services, the plan should be more involved in developing a care plan and coordinating services along with the HCBS caregiver. Additionally, in order to allow for proper oversight of clinical services and care management activities, it is important to build expectations directly in contracts regarding the development and submission of supporting documentation. Furthermore, in order to ensure clinical documentation is complete and valid, modifications to the contract should include language that outlines minimum documentation requirements and expected templates for plans of care. The inclusion of this information ensures the availability to information critical to oversight activities.

2. Encounter Data File Review

Background

Based on the approved scope of work, HSAG worked with the Agency's analytic team to develop the data submission requirements for conducting the EDV study. Once finalized, the data submission requirements were submitted to both the Agency and the plans to guide the extraction and collection of study data. Data were requested for LTC professional and institutional encounters with dates of service between January 1, 2020, and December 31, 2020, that were in their final status and submitted to the Agency on or before July 31, 2021. In addition to the file specifications, the data submission requirements also included the required data types (i.e., LTC professional and LTC institutional) and the associated required data elements. HSAG also requested the Agency to provide supporting data files related to enrollment, demographics, and providers associated with the encounter files.

The set of encounter files received from the Agency and the plans was used to examine the extent to which the data extracted and submitted were reasonable and complete. HSAG's review involved multiple methods and evaluated that:

- The volume of submitted encounters was reasonable.
- Key encounter data fields contained complete and/or valid values.
- Other anomalies associated with the data extraction and submission were documented.

Encounter Volume Completeness and Reasonableness

Capturing, sending, and receiving encounter data has historically been difficult and costly for the plans and state alike. The encounter data collection process is lengthy and has many steps wherein data can be lost or errors can be introduced into submitted data elements. Assessment of the completeness and accuracy of encounter data provides insight into areas that need improvement for these processes and quantifies the general reliability of encounter data. These analyses were performed with the key data elements as individual units of assessment at the aggregate level for the encounter data sources (the plans' encounter systems and the Agency's encounter system) and stratified by individual plan.

Encounter Data Submission by the Agency and the Plans

HSAG received the initial set of data files from the plans in October 2021. All encounters submitted by the plans to HSAG underwent a preliminary file review to ensure that the submitted data files were generally comparable to the encounters extracted and submitted by the Agency. HSAG provided a preliminary file review results document to each plan identifying issues noted during the review. Additionally, HSAG provided example records in which discrepancies were identified when compared to the Agency-submitted files during the review of the plans' initial data submission.

For the current year's study, HSAG received direction from the Agency that plans should submit LTC encounters according to the plan-specific *TPID* provided by the Agency. Based on the review results, the plans had one opportunity to resubmit their files. If the plan chose not to address the identified discrepancies, HSAG used the original data submission files in the comparative analysis component of the study. Of note, during the preliminary review of data received from Molina-C, HSAG identified an additional *TPID* submitted by Molina-C that was not included in the Agency-submitted data. Molina-C notified HSAG that it had submitted LTC encounters to the Agency in error for *TPID* 301836, which is not the appropriate *TPID* for LTC submissions to the Agency. While HSAG worked with the Agency to determine the resolution, the Agency determined that Molina-C was not required to resubmit the incorrect TPID submission for the study. As such, Molina-C's encounters with *TPID* 301836 were not considered for the administrative analysis.

Table 2-1 displays the encounter data volume submitted by the Agency and the initial/resubmitted data files submitted by the plans. The table highlights the number of records submitted by each source as well as the percentage difference in counts relative to Agency's data between the two sources. As noted in the "Encounter Data Validation Methodology" section, both the Agency and the plans were required to supply the same data (i.e., final status claims/encounters that were submitted to the Agency as of July 31, 2021, for dates of service from January 1, 2020, through December 31, 2020).

Table 2-1—Encounter Data Submission by the Agency and the Plans (January 1, 2020—December 31, 2020)

Plan	LTC Professional			LTC Institutional		
	Records Submitted		Percent Difference (Relative to Agency Data)	Records Submitted		Percent Difference (Relative to Agency Data)
	Agency	Plan		Agency	Plan	
AET-C	966,742	980,718	(1.4%)	204,381	218,493	(6.9%)
FCC-L	1,196,368	1,201,748	(0.4%)	413,887	416,815	(0.7%)
HUM-C	7,469,793	7,378,118	1.2%	1,103,437	1,081,425	2.0%
MOL-C	433,825	431,060	0.6%	4,409	5,025	(4.0%)
SIM-C	2,959,662	3,099,776	(4.7%)	208,087	210,322	(1.1%)
STW-C	2,152,234	2,196,658	(2.1%)	390,448	415,348	(6.4%)
SUN-C	6,672,699	6,658,945	0.2%	1,678,730	1,722,985	(2.6%)
UNI-C	2,401,495	2,258,088	6.0%	94,913	93,993	1.0%
All Plans	**24,252,818**	**24,205,111**	**0.2%**	**4,098,292**	**4,164,406**	**(1.6%)**

Key Findings: Table 2-1

- Overall, for LTC professional encounters, the total encounter records submitted by the Agency had 0.2 percent more records compared to the plan-submitted records. While most plans had relatively comparable numbers of LTC professional encounter records submitted for the study, Simply-C had a relatively higher percentage of records and United-C had a lower percentage of records compared to the encounter records submitted by the Agency for the study.

- Overall, for LTC institutional encounters, the total encounter records submitted by the plans had 1.6 percent more records compared to the Agency-submitted records. While most plans had relatively comparable numbers of LTC institutional encounter records submitted for the study, Aetna-C, Molina-C, and Staywell-C had a relatively higher percentage of records compared to the encounter records submitted by the Agency for the study.

Utilization Statistics

The volume of encounters submitted by a plan provides useful information on the completeness of the Agency's encounter data. Lags in encounter submissions were accounted for in the data collection period by requesting only finalized records submitted to the Agency within the study period from participating plans. The evaluation of "encounters" in this section refers to the unique combination of plan, enrollee identification (ID), provider number/NPI, and date of service. Since only unique combinations of these data elements were considered, duplicate records were removed.

Overall, the encounter counts reflect the number of encounters that a plan's enrollees experienced. Additionally, to normalize the encounter counts by the enrollee counts, the encounter counts per 1,000 member months (MM) were also calculated. The MM presented were calculated based on all enrollees enrolled with the participating plans.

Table 2-2 provides a general overview of the average utilization per enrollee by plan from the beginning of calendar year (CY) 2020 through December 31, 2020 (January 1, 2020, through December 31, 2020) for LTC professional and LTC institutional encounters.

Table 2-2—Encounter Data Overview

		LTC Professional		LTC Institutional	
Plan	Average Number of Enrollees per Month[1]	Total Number of Encounters[2]	Total Encounters per 1,000 MM[3]	Total Number of Encounters[2]	Total Encounters per 1,000 MM[3]
AET-C	4,147	220,838	4,438	35,727	718
FCC-L	11,219	379,858	2,822	70,323	522
HUM-C	28,050	2,284,008	6,786	202,116	600
MOL-C	3,021	174,045	4,802	1,058	29
SIM-C	10,225	1,045,480	8,520	48,832	398
STW-C	10,508	832,506	6,602	72,669	576
SUN-C	38,850	4,639,522	9,952	435,798	935
UNI-C	11,307	830,018	6,118	61,339	452
All Plans	**117,326**	**10,406,275**	**7,391**	**927,862**	**659**

[1] The average number of enrollees was calculated by dividing the total number of MM by 12 to align with the number of months in the encounter data for the review period of January 1, 2020, through December 31, 2020.

[2] An encounter was defined by a unique combination of plan, enrollee ID, provider ID number, and date of service in the encounter data for the review period of January 1, 2020, through December 31, 2020.

[3] The total encounters per 1,000 MM rate was calculated by dividing the total number of encounters by the total MM for the same review period and multiplying the results by 1,000.

Key Findings: Table 2-2

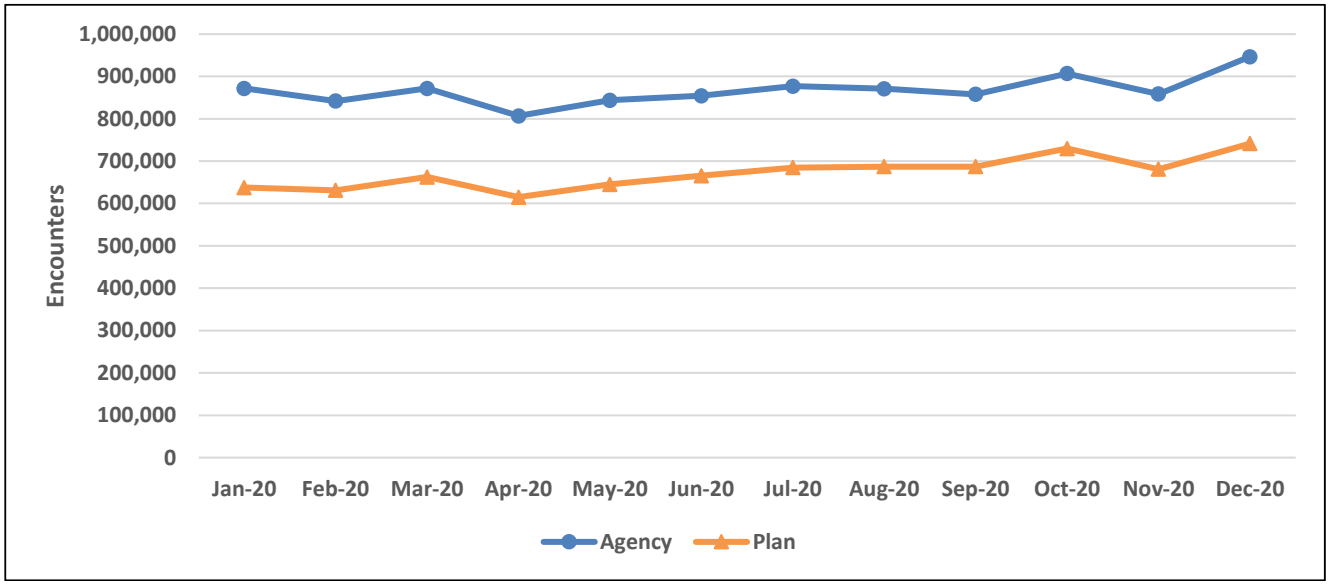
- For LTC professional encounters, more than 10 million encounters occurred during the study period, averaging 7,391 LTC professional encounters per 1,000 MM. The encounters per 1,000 MM ranged from 2,822 (Florida Community Care-L) to 9,952 (Sunshine-C).
- For LTC institutional encounters, nearly one million encounters occurred during the study period, averaging 659 LTC institutional encounters per 1,000 MM. The encounters per 1,000 MM ranged from 29 (Molina-C) to 935 (Sunshine-C).

Monthly Variations of Encounters for Dates of Service

This section highlights the overall encounter data volume trends over time for the Agency and the plans for LTC professional and LTC institutional encounters.

Examination of the volume of encounters submitted each month provided additional insight into potential problems with data completeness observed in greater context in the comparative analysis and LTC record review portions of this assessment. The monthly assessment of encounter volume included only those encounters documented within the plans' systems and submitted to the Agency with a date of service during the study period. Figure 2-1 and Figure 2-2 illustrate the overall encounter data volume trends over time by the Agency and the plans. A unique combination of key data fields consisting of plan, enrollee ID, provider ID number, and date of service was used to uniquely define an encounter.

Figure 2-1—Monthly Variations in LTC Professional Encounters for the Agency and the Plans

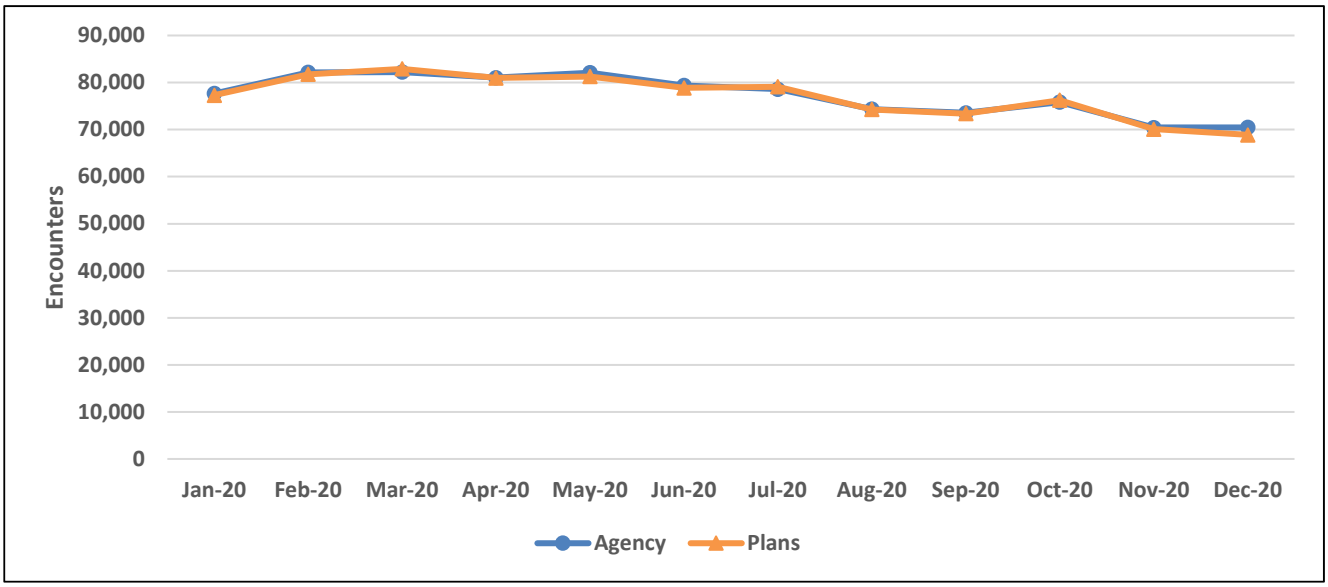


Key Findings: Figure 2-1

- While the overall encounter data volume by month for LTC professional encounters was greater for the Agency, the volume trend for the Agency and the plans was similar, with both data sources showing similar patterns of monthly fluctuations.

- The average difference in the LTC professional encounter volume between the Agency and the plans was 194,922 encounters during the 12 months. The difference in the monthly encounter volume between the two sources (i.e., the Agency and plan) was attributed to Sunshine-C's encounter submissions, in which the header service date fields reflected an entire claim, while the Agency's encounter for Sunshine-C the header service date fields was for a specific encounter line.

Figure 2-2—Monthly Variations in LTC Institutional Encounters for the Agency and the Plans



Key Findings: Figure 2-2

- Similar to the LTC professional encounters, the encounter data volume trend by month for LTC institutional encounters was similar for both the Agency-submitted encounters compared to the plan-submitted encounters, with both data sources showing similar patterns of monthly fluctuations.
- The average difference in the LTC institutional encounter volume between the Agency and the plans was approximately 230 encounters during the 12 months.

Encounter Field Completeness and Reasonableness

To determine the completeness and reasonableness of the Agency's and the plans' electronic claims/encounter data, HSAG examined the percentage of key data elements (e.g., *Provider NPI* and *Procedure Code*) that contained data and were populated with expected values. As discussed in the "Encounter Data Validation Methodology" section, the study was restricted to specific criteria with the assumption that encounters received from both sources were in their final status as requested in the data submission requirements document. Key data elements with values not populated were evaluated for completeness but did not contribute to the calculations for accuracy (i.e., percent not populated and percent valid). Accuracy rates were assessed based on whether submitted values were in the correct format and the data elements contained expected values (percent valid). For example, a record wherein the *Billing*

Provider NPI was populated with a value of "000000000" would be considered to have a value present but not as having a valid value.

To determine the completeness and reasonableness of the Agency- and plan-submitted encounter data, HSAG evaluated each key data element based on the following metrics.

- Percent Not Populated: The required data elements were not present on the submitted file or, if data elements were present on the file, values were not populated in those data elements.
- Percent With Valid Values: The data elements have values present, which are the expected values.

Table 2-3 shows the key data elements and the associated criteria for validity for each encounter type included in this study.

Table 2-3—Key Encounter Data Elements

Key Data Element	LTC Professional	LTC Institutional	Criteria for Validity
Enrollee ID	√	√	In enrollment file supplied by the Agency
Diagnosis Code (1 through 4)	√	√	In International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis code set
Surgical Procedure Code (1 through 4)		√	In ICD-10-CM surgical procedure code set
Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Procedure Code	√	√	In national CPT and HCPCS procedure code sets
NDC	√	√	In national NDC code sets
Revenue Code		√	In national revenue code sets
Billing Provider NPI	√	√	In provider file supplied by the Agency
Rendering Provider NPI	√		In provider file supplied by the Agency
Attending Provider NPI		√	In provider file supplied by the Agency
Referring Provider NPI	√	√	In provider file supplied by the Agency

Table 2-4 shows the percent not populated and valid rates for key data fields associated with the LTC professional encounters for data extracted from the Agency's and the plans' claims/encounter systems.

Table 2-4—Element Completeness (Percent Not Populated) and Accuracy (Percent Valid): LTC Professional Encounters

Data Element	Agency-Submitted Data		Plan-Submitted Data	
	Percent Not Populated	Percent Valid	Percent Not Populated	Percent Valid
Enrollee ID	0.0%	>99.9%	0.0%	>99.9%
Billing Provider NPI	1.5%	99.2%	0.4%	99.6%
Rendering Provider NPI[1]	<0.1%	99.2%	91.0%	99.1%
Referring Provider NPI[1]	96.4%	99.1%	94.2%	97.9%
CPT/HCPCS Procedure Code	1.0%	>99.9%	0.5%	>99.9%
NDC[1]	99.6%	96.5%	>99.9%	68.3%
Diagnosis Code 1	1.8%	>99.9%	0.8%	>99.9%
Diagnosis Code 2[1]	97.9%	100%	94.6%	>99.9%
Diagnosis Code 3[1]	98.8%	100%	98.2%	>99.9%
Diagnosis Code 4[1]	99.2%	>99.9%	98.7%	>99.9%

[1] *Rendering Provider NPI*, *Referring Provider NPI*, *NDC*, *Diagnosis Code 2*, *Diagnosis Code 3*, and *Diagnosis Code 4* fields are situational (i.e., not required for every LTC professional transaction).

Key Findings: Table 2-4

- Data elements with values not populated within the Agency-submitted LTC professional encounters were relatively comparable to the plan-submitted LTC professional encounters for most data elements evaluated, with a few exceptions.
- Of the provider-related data elements, relatively equivalent percentages of values not populated were observed for *Billing Provider NPI* and *Referring Provider NPI* for both the Agency- and plan-submitted encounters. However, the percentage of values not populated was higher for the plan-submitted encounters than for the Agency-submitted encounters for *Rendering Provider NPI*.
- While most diagnoses-related data elements had equivalent percentages of values not populated, the Agency-submitted encounters had a higher percentage of values not populated for *Diagnosis Code 2* compared to the plan-submitted encounters.
- Percent valid values for all evaluated data elements were high for both the Agency- and plan-submitted encounters, except for the *NDC* percent valid value for the plan-submitted encounters. The low validity was mostly attributed to Sunshine-C's submission of the *NDC* values with a length of 10 instead of 11.

Table 2-5 shows the percent not populated and valid rates for key data fields associated with the LTC institutional encounters for data extracted from the Agency's and the plans' claims/encounter systems.

Table 2-5—Element Completeness (Percent Not Populated) and Accuracy (Percent Valid): LTC Institutional Encounters

Data Element	Agency-Submitted Data		Plan-Submitted Data	
	Percent Not Populated	Percent Valid	Percent Not Populated	Percent Valid
Enrollee ID	0.0%	99.9%	0.0%	99.9%
Billing Provider NPI	0.0%	99.5%	0.5%	99.7%
Attending Provider NPI[A]	7.2%	99.4%	1.9%	98.4%
Referring Provider NPI[A]	>99.9%	100%	99.6%	90.1%
CPT/HCPCS Procedure Code[A]	30.1%	>99.9%	32.2%	99.8%
Revenue Code	0.0%	99.6%	<0.1%	99.9%
NDC [A]	100%	NA	99.9%	36.7%
Diagnosis Code 1	<0.1%	>99.9%	<0.1%	>99.9%
Diagnosis Code 2[A]	15.4%	>99.9%	10.6%	>99.9%
Diagnosis Code 3[A]	19.1%	>99.9%	18.8%	>99.9%
Diagnosis Code 4[A]	22.2%	>99.9%	21.8%	>99.9%
Surgical Procedure Code 1[A]	>99.9%	100%	>99.9%	100%
Surgical Procedure Code 2[A]	>99.9%	100%	>99.9%	100%
Surgical Procedure Code 3[A]	>99.9%	100%	>99.9%	100%
Surgical Procedure Code 4[A]	>99.9%	100%	>99.9%	100%

[A] *Attending Provider NPI*, *Referring Provider NPI*, *CPT/HCPCS Procedure Code*, *NDC*, *Diagnosis Code 2*, *Diagnosis Code 3*, *Diagnosis Code 4*, *Surgical Procedure Code 1*, *Surgical Procedure Code 2*, *Surgical Procedure Code 3*, and *Surgical Procedure Code 4* are situational (i.e., not required for every institutional transaction).

"NA" denotes all records had values not populated for this data element; therefore, validity could not be assessed.

Key Findings: Table 2-5

- Data elements with values not populated within the Agency-submitted LTC institutional encounters were relatively comparable to the plan-submitted LTC institutional encounters for most data elements evaluated, with a few exceptions.
- Of the provider-related data elements, relatively equivalent percentages of values not populated were observed for *Billing Provider NPI* and *Referring Provider NPI* for both the Agency- and plan-submitted encounters. However, the percentage of values not populated was higher for the Agency-submitted encounters than for the plan-submitted encounters for *Attending Provider NPI*.
- While most diagnoses-related data elements had equivalent percentages of values not populated, the Agency-submitted encounters had a higher percentage of values not populated for *Diagnosis Code 2* compared to the plan-submitted encounters.

- Percent valid values for all evaluated data elements were high for both the Agency- and plan-submitted encounters, except for the *Referring Provider NPI* and *NDC* percent valid values for the plan-submitted encounters. The low validity for *NDC* was mostly attributed to Sunshine-C's submission of the *NDC* values with a length of 10 instead of 11. The low validity for *Referring Provider NPI* was mostly attributed to plans sending NPI values of "1346339561" that were not included in the Agency-submitted provider data.

3. Comparative Analysis

Background

This section presents findings from the results of the comparative analysis of LTC encounter data maintained by the Agency and the plans. The analysis examined the extent to which LTC encounters submitted by the plans and maintained in Florida's MMIS (and data subsequently extracted and submitted by the Agency to HSAG for the study) were accurate and complete when compared to data stored in the plans' data systems (which were extracted and submitted by the plans to HSAG for the study). Clarifications regarding defining "accurate" and "complete" are included in Appendix A.

HSAG requested both the Agency and the plans to submit the final status of the LTC encounter in their data submissions for the study. The LTC encounters included encounters that were transmitted via 837 Professional (837P) or 837 Institutional (837I) transactions. For purposes of this report, the LTC encounters from the 837P and 837I transactions will be referred to as "LTC professional" and "LTC institutional" encounters, respectively.

As described in the previous section, "Encounter Data File Review", based on direction from the Agency, HSAG requested the LTC encounters according to the plan-specific *TPID* provided by the Agency. According to the lists of *TPID*s, Molina-C was to submit LTC encounters for *TPID* 301827. However, during the preliminary review of data received from Molina-C, HSAG identified an additional *TPID* submitted by Molina-C that was not included in the Agency-submitted data. Molina-C notified HSAG that it had submitted LTC encounters to the Agency in error for *TPID* 301836, which is not the appropriate *TPID* for LTC submissions to the Agency. Of note, for the Molina-submitted data associated with the incorrect *TPID*, there were nearly 420,000 records for the LTC professional encounters and nearly 21,000 records for the LTC institutional encounters as compared to 3.8 million and more than 850,000 records in the Agency-submitted data. As such, Molina-C's encounters with *TPID* 301836 were not considered for the comparative analysis.

To compare the Agency's and the plans' submitted data, HSAG developed a comparable match key between the two data sources. Data fields used in developing the match key may vary by plan and encounter type but generally included the *Internal Control Number* (*ICN*) field and the associated detail line sequence number. These data elements were concatenated to create a unique match key, which became the unique identifier for each encounter detail line in the Agency's and each plan's data. For the plans' data without reasonable match rates when using the *ICN* to create the match key, HSAG used the *Transaction Control Number* (*TCN*) to develop the match key. Additionally, if using only the *ICN* or *TCN* and the detail line sequence number generated a low match rate, HSAG selected other data elements (e.g., *Procedure Code*) to develop the match key.

Record Completeness

As described in the "Encounter Data Validation Methodology" section, two aspects of record completeness are used for each encounter data type—record omission and record surplus.

Encounter record omission and surplus rates are summary metrics designed to evaluate discrepancies between two data sources—i.e., primary and secondary. The primary data source refers to data maintained by an organization (e.g., the plan) responsible for sending data to another organization (e.g., the Agency). The data acquired by the receiving organization is referred to as the secondary data source. By comparing these two data sources (i.e., primary and secondary), the analysis yields the percentage of records contained in one source and not the other, and vice versa. As such, encounter record omission refers to the percentage of encounters reported in the primary data source but missing from the secondary data source. For this analysis, the omission rate identifies the percentage of encounters reported by a plan but missing from the Agency's data. Similarly, the encounter record surplus refers to the percentage of encounters reported in the secondary data source (the Agency) but missing from the primary data source (the plan).

Encounter Data Record Omission and Surplus

Table 3-1 displays the number of plans with record omission rates (i.e., the percentage of records present in the files submitted by the plans that were not found in the Agency's files) based on rates at or lower than 5.0 percent (i.e., low) and higher than 5.0 percent (i.e., high).

Table 3-1 also displays the number of plans with record surplus rates (i.e., the percentage of records present in the Agency's files but not present in the files submitted by the plans) based on rates at or lower than 5.0 percent (i.e., low) and higher than 5.0 percent (i.e., high).

Lower rates indicate better performance for both record omission and record surplus. Fully detailed tables for each plan are provided in the plan-specific appendices.

Table 3-1—Record Omission and Record Surplus Rates by LTC Encounter Type

	Record Omission		Record Surplus	
Encounter Type	Number of Plans with Rate ≤ 5%	Number of Plans with Rate > 5%	Number of Plans with Rate ≤ 5%	Number of Plans with Rate > 5%
LTC Professional	7	1	7	1
LTC Institutional	2	6	6	2

Key Findings: Table 3-1

- The LTC professional encounters exhibited more complete data compared to the LTC institutional encounters, with low record omission and surplus rates (i.e., at or lower than 5.0 percent) for seven of the eight plans.

  - One plan (i.e., Simply-C) had a record omission rate of 6.5 percent, while one plan (i.e., United-C) had a record surplus rate of 6.3 percent.
  - Based on responses received from Simply-C on records identified as an omission, Simply-C noted that, after reviewing the example discrepant records, the records should have been included in the Agency-submitted data.
  - In response to records identified as surplus, United-C indicated, based on the example discrepant records provided by HSAG to United-C, the discrepant encounter records were not LTC encounters and, therefore, were excluded from the data extract for the study.
- For LTC institutional encounters, six of the eight plans had high record omission rates (i.e., more than 5.0 percent), while only two of the eight plans had high record surplus rates (i.e., more than 5.0 percent).
  - Six plans (i.e., Aetna-C, Humana-C, Molina-C, Simply-C, Staywell-C, and Sunshine-C) had record omission rates of more than 5.0 percent (i.e., 8.5 percent, 7.0 percent, 15.9 percent, 26.5 percent, 10.3 percent, and 5.9 percent, respectively). While Humana-C and Molina-C indicated errors in their data extract processes, the other plans noted that the example discrepant omission records generally were valid records that were submitted to the Agency.
  - Two plans (i.e., Humana-C and Simply-C) had record surplus rates of more than 5.0 percent (i.e., 8.9 percent and 25.7 percent, respectively). In its response to example records identified as surplus, Humana-C noted that a data extract error contributed to the number of records identified as surplus. Simply-C noted in its response that, after reviewing the example discrepant records, most records had been recouped and voided; however, the void was processed after the July 2021 report date. As such, in instances where Simply-C excluded the records, the Agency-submitted included them (i.e., identified as surplus), while where Simply-C included these records, the Agency-submitted data excluded them (i.e., identified as omission).

Data Element Completeness

Data element completeness measures were based on the number of records that matched in both the Agency's and plan's data files. Element-level completeness is evaluated based on element omission and element surplus rates. The element omission rate represents the percentage of records with values present in the plan's submitted data files but not in the Agency's data files. Similarly, the element surplus rate reports the percentage of records with values present in the Agency's data files but not in the plan's submitted data files. The data elements are considered relatively complete when they have low element omission and surplus rates. Generally, based on HSAG's experience with other states, rates at or lower than 5.0 percent would be considered low at the element level.

This section also presents the data accuracy results by key data element and evaluates accuracy based on the percentage of records with values present in both data sources that contain the same values. Records with values missing in both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element. Higher data element accuracy rates indicate that the values populated for a data element in the Agency's submitted encounter data are more accurate.

Data Element Omission and Surplus

Table 3-2 displays the number of plans with data element omission and surplus rates for LTC professional encounters, based on rates at or lower than 5.0 percent (i.e., low) and higher than 5.0 percent (i.e., high). **For the element omission and element surplus indicators, lower rates indicate better performance**. Fully detailed tables for each plan are provided in the plan-specific appendices.

Table 3-2—Data Element Omission and Surplus: LTC Professional Encounters

	Omission		Surplus	
Key Data Element	Number of Plans with Rate ≤ 5%	Number of Plans with Rate >5%	Number of Plans with Rate ≤ 5%	Number of Plans with Rate >5%
Enrollee ID	8	0	8	0
Header Service From Date	8	0	8	0
Header Service To Date	8	0	8	0
Detail Service From Date	8	0	8	0
Detail Service To Date	8	0	8	0
Billing Provider NPI	8	0	8	0
Rendering Provider NPI	8	0	2	6
Referring Provider NPI	8	0	8	0
Primary Diagnosis Code	8	0	7	1
Secondary Diagnosis Code[1]	5	3	8	0
Procedure Code	8	0	7	1
Procedure Code Modifier	8	0	7	1
Units of Service	8	0	8	0
NDC	8	0	8	0
Header Paid Amount	8	0	8	0
Detail Paid Amount	8	0	8	0

[1] Calculated for *Diagnosis Code 2* only.

Key Findings: Table 3-2

- Overall, all plans had low omission rates (i.e., at or lower than 5.0 percent) for all data elements evaluated for LTC professional encounters, except for element omission rates associated with *Secondary Diagnosis Code*.
  - Three plans (i.e., Florida Community Care-L, Sunshine-C, and United-C) had relatively high omission rates for *Secondary Diagnosis Code* (i.e., 5.6 percent, 5.1 percent, and 6.3 percent, respectively). After reviewing the example records provided by HSAG, Florida Community Care-L noted that the discrepancies in its omission rates were due to encounter rejections. All

three plans indicated that they understood the nature of the discrepancy and noted that their reporting logic will be corrected accordingly.

- Overall, nearly all plans had low surplus rates (i.e., at or lower than 5.0 percent) for all data elements evaluated for LTC professional encounters, except for element surplus rates associated with *Rendering Provider NPI*, *Primary Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*.
  - The *Rendering Provider NPI* data element surplus rates were high (i.e., more than 5.0 percent) for six plans (i.e., Aetna-C, Humana-C, Staywell-C, Sunshine-C, Simply-C, and United-C). Based on the investigation efforts on the examples provided by HSAG, the plans indicated that they had submitted values for *Billing Provider NPI* but did not submit *Rendering Provider NPI* for values that were the same as the *Billing Provider NPI*. However, it appears that the Agency populated the *Rendering Provider NPI* field with the same values as the *Billing Provider NPI* field.
  - Aetna-C's surplus rate for the *Primary Diagnosis Code* data element was high at 11.4 percent. In its response, Aetna-C noted that it had not received diagnosis code data from its sub-capitated vendor; therefore, this data element was missing in its submission for the study. However, the Agency had acquired these data and populated the field accordingly.
  - Aetna-C's surplus rates for the *Procedure Code* and *Procedure Code Modifier* data elements were also high at 11.4 percent each. Aetna-C attributed these high rates to receiving incomplete data from its sub-capitated vendors.

Table 3-3 displays the number of plans with data element omission and surplus rates for LTC institutional encounters, based on rates at or lower than 5.0 percent (i.e., low) and higher than 5.0 percent (i.e., high). **For the element omission and element surplus indicators, lower rates indicate better performance**. Fully detailed tables for each plan are provided in the plan-specific appendices.

Table 3-3—Data Element Omission and Surplus: LTC Institutional Encounters

	Omission		Surplus	
Key Data Element	Number of Plans with Rate ≤ 5%	Number of Plans with Rate >5%	Number of Plans with Rate ≤ 5%	Number of Plans with Rate >5%
Enrollee ID	8	0	8	0
Header Service From Date	8	0	8	0
Header Service To Date	8	0	8	0
Detail Service From Date	8	0	8	0
Detail Service To Date	8	0	8	0
Admission Date	8	0	8	0
Billing Provider NPI	8	0	8	0
Attending Provider NPI	6	2	8	0
Referring Provider NPI	8	0	8	0
Primary Diagnosis Code	8	0	8	0

Key Data Element	Omission		Surplus	
	Number of Plans with Rate ≤ 5%	Number of Plans with Rate >5%	Number of Plans with Rate ≤ 5%	Number of Plans with Rate >5%
Secondary Diagnosis Code[1]	6	2	8	0
Procedure Code	8	0	8	0
Procedure Code Modifier	8	0	8	0
Units of Service	8	0	8	0
Primary Surgical Procedure Code	8	0	8	0
NDC	8	0	8	0
Revenue Code	8	0	8	0
DRG	7	1	8	0
Header Paid Amount	8	0	8	0
Detail Paid Amount	8	0	8	0

[1] Calculated for *Diagnosis Code 2* only.

Key Findings: Table 3-3

- Overall, all plans had low omission rates (i.e., at or lower than 5.0 percent) for all data elements evaluated for LTC institutional encounters, except for element omission rates associated with *Attending Provider NPI*, *Secondary Diagnosis Code*, and *DRG*.
  - Two plans (i.e., Florida Community Care-L and Molina-C) had relatively high omission rates for the *Attending Provider NPI* data element (i.e., 17.0 percent and 21.7 percent, respectively). Florida Community Care-L noted in its response that it did not begin submitting *Attending Provider NPI* data until April 2022. As such, the Agency would not have the *Attending Provider NPI* values in its data extract for the study. Molina-C reviewed the example discrepant records provided by HSAG and was able to determine the reason why the values were not included in the Agency-submitted data for the study.
  - The *Secondary Diagnosis Code* data element omission rates were high for two plans (i.e., Aetna-C and Staywell-C) at 5.3 percent and 7.7 percent, respectively. Both plans explained that the records with values identified as an omission were a result of reporting the diagnosis code as a *Secondary Diagnosis Code* on admission, while the Agency did not report it as a *Secondary Diagnosis Code*.
  - Sunshine-C's omission rate for the *DRG* data element was high at 82.4 percent. In its response, Sunshine-C indicated that although the Agency had instructed that the *DRG* data element reporting is optional, it has reported what was billed on the claim.
- Overall, all plans had low surplus rates (i.e., at or lower than 5.0 percent) for all data elements evaluated for LTC institutional encounters.

Data Element Accuracy

For data element accuracy, HSAG classified the accuracy rates based on the following:

- High performance: Rates at or higher than 95.0 percent
- Low performance: Rates at or higher than 85.0 percent and lower than 95.0 percent
- Very low performance: Rates lower than 85.0 percent

Table 3-4 displays the number of plans with data element accuracy rates for LTC professional encounters, based on rates at or higher than 95.0 percent (i.e., high) and lower than 95.0 percent (i.e., low or very low). **For this indicator, higher rates indicate better performance**. Fully detailed tables for each plan are provided in the plan-specific appendices.

Table 3-4—Data Element Accuracy: LTC Professional Encounters

Key Data Element	Number of Plans with Accuracy Rate < 95% (Low/Very Low)	Number of Plans with Accuracy Rate ≥ 95% (High)
Enrollee ID	0	8
Header Service From Date	1	7
Header Service To Date	1	7
Detail Service From Date	0	8
Detail Service To Date	0	8
Billing Provider NPI	1	7
Rendering Provider NPI	3	5
Referring Provider NPI[1]	2	3
Primary Diagnosis Code	0	8
Secondary Diagnosis Code[2]	5	3
Procedure Code	0	8
Procedure Code Modifier	1	7
Units of Service	1	7
NDC[3]	0	0
Header Paid Amount	2	6
Detail Paid Amount	2	6

[1] Some plans had no records with values present in both data sources (i.e., the Agency and plans). As such, the data element accuracy could not be evaluated for some of these plans.

[2] Calculated for *Diagnosis Code 2* only.

[3] No plans had records with values present in both data sources (i.e., the Agency and plans). As such, the data element accuracy could not be evaluated for all plans.

Key Findings: Table 3-4

- The accuracy rates for data elements that were evaluated for the LTC professional encounters were generally high for most plans. Data elements associated with header dates of service, provider information, secondary diagnosis code, procedure code modifier, and payment amount showed very low accuracy rates for at least one plan (below 85%).
  - Sunshine-C had very low accuracy rates for the *Header Service From Date* and *Header Service To Date* data elements at 56.5 percent each. In its response to the example records with discrepant values, Sunshine-C noted that the date it submitted for the study represents the entire claim, while the Agency-submitted dates apply only to the specific encounter line.
  - The accuracy rate for the *Billing Provider NPI* data element was very low for one plan (i.e., Florida Community Care-L) with a rate of 12.6 percent. Florida Community Care-L noted in its response that the discrepancies were due to data extraction errors.
  - For *Rendering Provider NPI*, the accuracy rates were very low for Florida Community Care-L at 13.0 percent. Florida Community Care-L noted in its response that the discrepancies were due to data extraction errors, while other plans noted that either the Agency populated this field with the *Billing Provider NPI* when this field was missing, or some represented different NPIs for the same provider. The rates for two plans (i.e., Humana-C, and Staywell-C) were at 93.0 percent, and 93.6 percent, respectively.
  - The *Secondary Diagnosis Code* data element accuracy rates were low for five plans (i.e., Aetna-C, Florida Community Care-L, Humana-C, Simply-C, and United-C). Based on responses received from these plans, the discrepant values were due to how the secondary diagnosis codes were ordered when compared to the Agency's ordering of the data element; sequentially versus alphabetically.
  - Aetna-C had accuracy rate for the *Procedure Code Modifier* data element at 88.5 percent. Based on its review of the example record with discrepant values, Aetna-C attributed the low accuracy result to receiving incomplete data from its capitated vendors.
  - Two plans (i.e., Aetna-C and Molina-C) had accuracy rates for the *Header Paid Amount* (i.e., 90.4 percent and 93.7 percent, respectively) and *Detail Paid Amount* (i.e., 9.5 percent and 93.9 percent, respectively) data elements. Aetna-C attributed part of its discrepancies to $0 amounts reported by its sub-capitated vendors. Both Aetna-C and Molina-C, however, also attributed the discrepancies to the Agency-submitted data. For *Header Paid Amount*, Aetna-C noted that the Agency data had "*Total Billed Amount*" values populated as *Header Paid Amount*, while both plans submitted the *Header Paid Amount* values in their data extracts for the study. Similarly, Molina-C indicated that the Agency-submitted data had the respective "*Charge Amount*" values and not the paid amount for discrepancies that were identified in both data elements. For the *Detail Paid Amount* data element, Aetna-C indicated that the discrepancies stemmed from the Agency-submitted data, where this data element was populated with the *Header Paid Amount* values instead of the *Detail Paid Amount* values.

Table 3-5 displays the number of plans with data element accuracy rates for LTC institutional encounters, based on rates at or higher than 95.0 percent (i.e., high) and lower than 95.0 percent (i.e., low or very low).

For this indicator, higher rates indicate better performance. Detailed tables for each plan are provided in the plan-specific appendices.

Table 3-5—Data Element Accuracy: LTC Institutional Encounters

Key Data Element	Number of Plans with Accuracy Rate < 95% (Low/Very Low)	Number of Plans with Accuracy Rate ≥ 95% (High)
Enrollee ID	0	8
Header Service From Date	1	7
Header Service To Date	1	7
Detail Service From Date	1	7
Detail Service To Date	1	7
Admission Date	1	7
Billing Provider NPI	1	7
Attending Provider NPI	3	5
Referring Provider NPI[1]	0	3
Primary Diagnosis Code	1	7
Secondary Diagnosis Code[2]	5	3
Procedure Code	0	8
Procedure Code Modifier	0	8
Units of Service	7	1
Primary Surgical Procedure Code[1]	1	5
NDC[3]	0	0
Revenue Code	0	8
DRG[1]	3	2
Header Paid Amount	2	6
Detail Paid Amount	1	7

[1] Some plans had no records with values present in both data sources (i.e., the Agency and plans). As such, the data element accuracy could not be evaluated for some of these plans.
[2] Calculated for *Diagnosis Code 2* only.
[3] No plans had records with values present in both data sources (i.e., the Agency and plans). As such, the data element accuracy could not be evaluated for all plans.

Key Findings: Table 3-5

- The accuracy rates for data elements that were evaluated for the LTC institutional encounters were generally high for most plans, with some exceptions. Data elements associated with dates of service, provider information, diagnosis code, units of service, primary surgical procedure code, DRG, and payment amount showed low accuracy rates for at least one plan.
  - Staywell-C had accuracy rates for the *Header Service From Date* and *Admission Date* data elements at 93.6 percent and 91.2 percent, respectively. For the *Header Service From Date* data element, Staywell-C noted in its response to the discrepancies that the Agency-submitted data

populated this field with the line level first date of service compared to the header level first date of service as reported in the Staywell-C-submitted data. Staywell-C also indicated that it populated the header level first date of service as the admission date.

- United-C had accuracy rates for the *Header Service To Date*, *Detail Service From Date*, and *Detail Service To Date* data elements at 94.6 percent, 73.2 percent, and 68.5 percent, respectively. Based on United-C investigation efforts to identify the root cause of the discrepancies, United-C noted a difference between the logic used by United-C and the Agency in extracting the data for the study.
- Three plans (i.e., Humana-C, Molina-C, and Simply-C) had accuracy rates for the *Attending Provider NPI* data element at 94.6 percent, 90.6 percent, and 94.7 percent, respectively. Based on the review of the example records with discrepant values, the plans affirmed the accuracy of the values they had submitted for the study. Humana-C noted that the Agency data appeared to have values being substituted with other NPIs, where in one instance the Agency-submitted NPI was an organizational NPI, which would be inappropriate for this data element. Molina-C also noted a similar finding based on its investigation efforts on the example records that were provided, indicating that the NPI submitted by the Agency generally represented the same provider and was sometimes but not always linked to the same Medicaid ID.
- Florida Community Care-L had a very low accuracy rate for the *Billing Provider NPI* data element at 4.4 percent. Based on responses received from Florida Community Care-L, it attributed the low accuracy rate for this data element to report generation errors.
- Simply-C had a very low accuracy rate for the *Primary Diagnosis Code* data element at 31.4 percent. Simply-C noted that the low rate resulted from a report generation defect and acknowledged that the Agency-submitted data had the accurate values. Five plans (i.e., Aetna-C, Florida Community Care-L, Humana-C, Staywell-C, and Simply-C) had very low accuracy rates (i.e., 34.0 percent, 4.7 percent, 32.6 percent, 0.5 percent, and 31.4 percent, respectively) for the *Secondary Diagnosis Code* data element. Based on responses received from these plans, the discrepant values were due to how the secondary diagnosis codes were ordered when compared to the Agency's ordering of the data element; sequentially versus alphabetically. However, Staywell-C noted that it had included the admitting diagnosis codes as secondary diagnosis codes in its submission.
- All plans except Aetna-C had low or very low accuracy rates for the *Units of Service* data element: Florida Community Care-L (31.2 percent), Humana-C (39.9 percent), Molina-C (82.8 percent), Staywell-C (29.4 percent), Sunshine-C (70.5 percent), Simply-C (77.0 percent), and United-C (91.6 percent). Florida Community Care-L indicated the discrepancy was due to "encounter rejections." Humana-C, Molina-C, Simply-C, and Staywell-C attributed the discrepancies to the Agency-submitted values; for example, Simply-C noted that it had submitted the values accordingly, which aligned with data submitted on the 837I to the Agency. Molina-C noted that among the discrepant values, the Agency-submitted values were for "Length of Stay" or duration of the associated claims in totality of claim and not at the encounter line level. United-C identified reporting errors as the root cause for most discrepancies included in the example records provided by HSAG.

- Simply-C had a very low accuracy rate for the *Primary Surgical Procedure Code* data element at 1.1 percent. Simply-C attributed the low accuracy rate to a report generation error related to the sequencing of surgical procedure codes.
- Three plans (i.e., Simply-C, Sunshine-C, and United-C) had very low accuracy rates for the *DRG* data element at 7.2 percent, 0.0 percent, and 0.0 percent, respectively. Simply-C did not provide an explanation for the discrepancies but indicated that the values submitted for the study accurately reflected data submitted to the Agency. Sunshine-C and United-C both noted that they have been submitting four-digit codes to the Agency; however, the Agency is reporting only the first three digits. United-C indicated that it would adjust its future reporting accordingly.
- Two plans (i.e., Florida Community Care-L and Humana-C) had very low accuracy rates for the *Header Paid Amount* data element at 31.4 percent and 32.4 percent, respectively. Florida Community Care-L also had a very low accuracy rate for the *Detail Paid Amount* data element at 32.3 percent. Based on responses received from Florida Community Care-L, it attributed discrepancies associated with both data elements to the Agency-submitted values. Florida Community Care-L noted that the encounters with the discrepant values were all crossover encounters. The paid amounts that Florida Community Care-L had submitted for the study reflected the Medicaid paid dollars, while the Agency-submitted values were for Medicare dollars. Humana-C, however, indicated that it had resolved the issue with a recent "system enhancement."

4. Long-Term Care Record and Plan of Care Review

Background

LTC records and documentation (including the LTC records and treatment-related documentation) are considered the "gold standard" for documenting Medicaid enrollees' access to and quality of services. The file review and comparative analysis components of the study seek to determine the completeness and accuracy of the Agency's encounter data and how comparable these data are to the plans' data from which it is based, respectively. The LTC record review further assesses data quality through investigating the completeness and accuracy of the Agency's encounters compared to the information documented in the corresponding clinical records of Medicaid enrollees. In this study, HSAG also reviewed the plan of care documentation for individuals with LTC types of services.

HSAG reviewed and compared enrollees' LTC information between data sources (the Agency's encounters and provider-submitted LTC records) using a unique combination of the enrollees' Medicaid IDs and the NPIs of the rendering provider for specific dates of service.

This section presents the results and findings of the LTC record and plan of care reviews to examine the extent to which services documented in the LTC records were not present in the encounter data (encounter data omission), as well as the extent to which services documented in the encounter data were not present in the enrollees' corresponding LTC records (LTC record omission). This section also presents findings from the evaluation of the accuracy of the diagnosis codes, procedure codes, and procedure code modifiers submitted to the Agency based on documentation contained in the enrollees' LTC records.

Additionally, this section also presents results and findings on whether the LTC services reported in the encounters are supported by the enrollees' plans of care. HSAG reviewed the plan of care documentation for alignment with effective dates, service providers, and units of service.

LTC Record and Plan of Care Documentation Submission

As noted in Appendix A of this report related to the "Encounter Data Validation Methodology," HSAG maintained a minimum of 146 cases randomly selected per plan (i.e., a total of 1,168 records from the eight participating plans). These 146 cases per plan were to be comprised of LTC records with the associated sampled dates of service and plan of care documentation associated with the selected enrollee and date of service. Based on this approach, to ensure sufficient cases were available to be reviewed, an additional 25 percent oversample (or 37 cases per plan) were sampled to replace records not procured. As such, plans with an adequate number of cases eligible for the study were responsible for procuring a minimum of 183 total sampled enrollees' LTC records and plan of care documentation per plan (i.e., 146 sample and 37 oversample) from their contracted providers for services rendered during the study period.

Table 4-1 shows the LTC record procurement status for each of the participating plans, detailing the number of LTC records requested as well as the number and percentage of LTC records submitted by each plan as indicated in the submitted tracking sheets.

Table 4-1—LTC Record Submission

Plan	Number of LTC Records Requested	Number of LTC Records Submitted[1]	Percentage of LTC Records Submitted
AET-C[2]	172	95	55.2%
FCC-L	183	175	95.6%
HUM-C	183	172	94.0%
MOL-C	183	150	82.0%
SIM-C	183	178	97.3%
STW-C	183	87	47.5%
SUN-C	183	90	49.2%
UNI-C	183	128	69.9%
All Plans	**1,453**	**1,075**	**74.0%**

[1] The number of LTC records submitted was based on the plans' responses within the submitted tracking sheets.
[2] Aetna-C only had 172 cases meeting the eligibility criteria for the study.

Table 4-2 highlights the key reasons LTC records were not submitted by each plan. Detailed tables for each plan are provided in the plan-specific appendices.

Table 4-2—Reasons for Missing LTC Records

Non-Submission Reason	All Plans	
	Number	Percent
LTC record not located at this facility; location unknown.	31	8.2%
Enrollee is a patient of the practice; however, no documentation was available for requested dates of service.	63	16.7%
Enrollee was not a patient of the practice.	14	3.7%
Non-responsive provider or provider did not respond in a timely manner.	225	59.5%
Provider refused to release LTC record.	0	0.0%
Facility is permanently closed; unable to procure LTC record documentation.	9	2.4%
Other	36	9.5%
Totals	**378**	**100%**

Key Findings: Table 4-1 and Table 4-2

- LTC records were requested to be procured by the eight participating plans for a total of 1,453 cases (i.e., sample and oversample). While all plans completed and submitted all tracking sheets associated with the requested cases, more than 25 percent included no LTC record documentation associated with the requested cases. Overall, plans indicated in their tracking sheets that 74.0 percent (1,075 cases out of 1,453) of the requested LTC record documentations were submitted. The rate of LTC records received from plans varied considerably among plans, with rates ranging from 47.5 percent (Staywell-C) to 97.3 percent (Simply-C).
- Of the requested 1,453 cases, 378 LTC records were not submitted for various reasons. Some of the commonly cited reasons for non-submission were "*Non-responsive provider or provider did not respond in a timely manner*" (59.5 percent), "*Enrollee is a patient of the practice; however, no documentation was available for requested dates of service*" (16.7 percent), "*LTC record not located at this facility; location unknown*" (8.2 percent), and "*Other*" (9.5 percent).
- "*Non-responsive provider or provider did not respond in a timely manner*" was the top non-submission reason reported by four (Aetna-C, Staywell-C, Sunshine-C, and United-C) of the eight plans.
- "*Enrollee is a patient of the practice; however, no documentation was available for requested dates of service*" was reported by all plans except Florida Community Care-L and Simply-C.

Table 4-3 shows the plan of care documentation submission status for each participating plan, detailing the number of plan of care documents requested as well as the number and percentage of plan of care documents submitted by each plan as indicated in the submitted tracking sheets.

Table 4-3—Plan of Care Documentation Submission[1]

Plan	Number of Plan of Care Documents Requested	Number of Plan of Care Documents Submitted[2]	Percentage of Plan of Care Documents Submitted
AET-C	172	172	100%
FCC-L	183	183	100%
HUM-C	183	178	97.3%
MOL-C	183	132	72.1%
SIM-C	183	183	100%
STW-C	183	150	82.0%
SUN-C	183	167	91.3%
UNI-C	183	166	90.7%
All Plans	**1,453**	**1,331**	**91.6%**

[1] The plan of care documentation submission includes documents submitted from either the provider's plan of care or from the plan's plan of care.

[2] The number of plan of care documents submitted is based on the plans' responses within the submitted tracking sheets.

Table 4-4 highlights the key reasons plan of care documents were not submitted by each plan. Detailed tables for each plan are provided in the plan-specific appendices.

Table 4-4—Reasons for Missing Plan of Care Documentation

Non-Submission Reason	All Plans	
	Number	Percent
Plan of care document not located at this facility; location unknown.	25	20.5%
Enrollee is a patient of the practice; however, no documentation is available.	24	19.7%
Enrollee was not a patient of the practice.	8	6.6%
Non-responsive provider or provider did not respond in a timely manner.	33	27.0%
Provider/plan refused to release plan of care documentation.	0	0.0%
Facility is permanently closed; unable to procure plan of care documentation.	0	0.0%
Other	32	26.2%
Totals	**122**	**100%**

Key Findings Table 4-3 and Table 4-4

- Plan of care documentation was requested to be submitted by the eight participating plans for a total of 1,453 plan of care documents (i.e., for sample and oversample cases). While all plans completed and submitted tracking sheets associated with the requested cases, plans noted in their tracking sheets that 91.6 percent of the requested documents were submitted. The rate of plan of care documents submitted by plans varied among plans, with rates ranging from 72.1 percent (Molina-C) to 100 percent (Aetna-C, Florida Community Care-L, and Simply-C).
- Of the requested documentation, 122 plan of care documents were not submitted for various reasons. "*Non-responsive provider or provider did not respond in a timely manner*" was the most common cited reason. Other cited reasons include: "*Plan of care document not located at this facility; location unknown*," "*Enrollee is a patient of the practice; however, no documentation is available*," and "*Other*."
- Four plans (Molina-C, Staywell-C, Sunshine-C, and United-C) selected "*Other*" as their reason for not submitting plan of care documentation, where Molina-C and United-C made up most of the cases (i.e., 17 and 11 cases, respectively). Molina-C noted in its response within the tracking sheets that the documentation was not submitted since the requested dates of service were for medical visits. United-C noted in its response for selecting "*Other*" that the plan of care documentation was not located by the health plan and, therefore, its location was unknown.

Encounter Data Completeness

HSAG evaluated encounter data completeness by identifying differences between key data elements from the Agency-based LTC encounters and the corresponding LTC records submitted for the analysis. These data elements included *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*. LTC record omission and encounter data omission represent two aspects of encounter data completeness through their identification of vulnerabilities in the process of claims documentation and communication among the providers, plans, and the Agency.

LTC record omission occurred when an encounter data element (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) was not documented in the LTC record associated with that specific Agency encounter. LTC record omissions suggest opportunities for improvement within the provider's internal processes, such as billing processes and record documentation.

Encounter data omissions occurred when an encounter data element (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) was documented in the LTC record but not found in the associated Agency encounter. Encounter data omissions also suggest opportunities for improvement in the areas of claims submissions and/or processing routes among the providers, plans, and the Agency.

HSAG evaluated the LTC record omission and the encounter data omission rates for each plan using dates of service selected for the assessment sample. **For both rates, lower values indicate better performance**.

Date of Service Completeness

Table 4-5 presents the percentage of dates of service identified in the encounter data that were not found in the enrollees' LTC records (i.e., LTC record omission) by each of the participating plans. Analysis was conducted at the date of service level. Detailed tables for each plan are provided in the plan-specific appendices.

Table 4-5—LTC Record Omission for Date of Service

Plan	Date of Service Identified in Encounter Data	Date of Service Not Supported by Documentation in LTC Record	
		Number	Percent
AET-C	167	75	44.9%
FCC-L	178	11	6.2%
HUM-C	155	20	12.9%
MOL-C	150	2	1.3%
SIM-C	163	3	1.8%
STW-C	157	63	40.1%
SUN-C	169	66	39.1%
UNI-C	174	50	28.7%
All Plans	**1,313**	**290**	**22.1%**

Key Findings: Table 4-5

- Overall, dates of service within the Agency's encounter data showed that 22.1 percent were not supported by the enrollees' LTC records (i.e., LTC record omission).
- As displayed in Table 4-1, the overall LTC record submission rate was low at 74.0 percent. The high LTC record omission rate is consistent relative to the LTC record submission rate, where a lower LTC record submission rate would generally show a higher LTC record omission rate (i.e., poor performance) for each key data element.
- The LTC record omission rates for dates of service ranged from 1.3 percent (Molina-C) to 44.9 percent (Aetna-C).

Diagnosis Code Completeness

Table 4-6 presents the percentage of diagnosis codes identified in the encounter data that had no supporting documentation in the enrollees' LTC records (i.e., LTC record omission) and the percentage of diagnosis codes from the enrollees' LTC records that were not found in the encounter data (i.e., encounter data omission). HSAG conducted the analyses at the diagnosis code level. Detailed tables for each plan are provided in the plan-specific appendices.

Table 4-6—LTC Record Omission and Encounter Data Omission for Diagnosis Code

Plan	LTC Record Diagnosis Code Omission		Encounter Data Diagnosis Code Omission	
	Number of Diagnosis Codes Identified in Encounter Data	Percent Not Supported by Enrollee's LTC Records*	Number of Diagnosis Codes Identified in Enrollee's LTC Records	Percent Not Found in the Encounter Data*
AET-C	814	72.7%	222	0.0%
FCC-L	721	25.5%	537	0.0%
HUM-C	719	32.1%	488	0.0%
MOL-C	355	9.3%	322	0.0%
SIM-C	360	9.2%	327	0.0%
STW-C	489	59.3%	199	0.0%
SUN-C	797	59.6%	322	0.0%
UNI-C	603	52.2%	288	0.0%
All Plans	**4,858**	**44.3%**	**2,705**	**0.0%**

* Lower rates indicate better performance.

Key Findings: Table 4-6

- LTC record omission (diagnosis code):

  - Overall, 44.3 percent of the diagnosis codes in the electronic encounter data had no supporting documents in the enrollees' LTC records (i.e., LTC record omission).
  - The LTC record omission rates varied across plans, ranging from 9.2 percent (Simply-C) to 72.7 percent (Aetna-C).
  - The LTC record omission for diagnosis codes was mostly influenced by LTC record non-submission and LTC record omission for the *Date of Service* data element. In the analysis, when LTC records were not submitted for a requested date of service, all diagnosis codes associated with that date of service were treated as LTC record omissions. As such, in general, plans with higher LTC record omission rates for dates of service also tended to have higher omission rates for diagnosis codes.
  - For cases with LTC records to validate the encounter date of service, diagnosis codes that were frequently omitted from the enrollees' LTC records included:
    - I10: Essential (primary) hypertension; Frequency = 92.
    - K219: Gastro-esophageal reflux disease without esophagitis; Frequency = 54.
    - E875: Hyperkalemia; Frequency = 53.
    - M6281: Muscle weakness (generalized); Frequency = 50.
    - E119: Type 2 diabetes mellitus without complications; Frequency = 46.
  - Of note, most diagnosis codes that were considered omitted from the enrollees' LTC records were generally due to LTC records that were not submitted for the study.
- Encounter data omission (diagnosis code):
  - Overall, there were no diagnosis codes identified in the LTC records that were not found in the electronic encounter data (i.e., all diagnosis codes documented in the LTC records were also found in the electronic encounter data).
  - The overall encounter data omission for the *Diagnosis Code* data element showed better performance than the LTC record omission for the same data element.

Procedure Code Completeness

Table 4-7 presents the percentage of procedure codes identified in the LTC encounter data that had no supporting documentation in the enrollees' LTC records (i.e., LTC record omission) and the percentage of procedure codes from the enrollees' LTC records that were not found in the encounter data (i.e., encounter data omission). Detailed tables for each plan are provided in the plan-specific appendices.

Table 4-7—LTC Record Omission and Encounter Data Omission for Procedure Code

Plan	LTC Record Procedure Code Omission		Encounter Data Procedure Code Omission	
	Number of Procedure Codes Identified in Encounter Data	Percent Not Supported by Enrollee's LTC Records*	Number of Procedure Codes Identified in Enrollee's LTC Records	Percent Not Found in the Encounter Data*
AET-C	132	28.0%	95	0.0%
FCC-L	134	1.5%	132	0.0%
HUM-C	144	9.0%	131	0.0%
MOL-C	215	5.6%	203	0.0%
SIM-C	217	3.7%	209	0.0%
STW-C	210	37.6%	131	0.0%
SUN-C	145	28.3%	105	1.0%
UNI-C	187	20.9%	148	0.0%
All Plans	**1,384**	**16.7%**	**1,154**	**0.1%**

* Lower rates indicate better performance.

Key Findings: Table 4-7

- LTC record omission (procedure code):
  - Overall, procedure codes within the encounter data showed 16.7 percent had no supporting documentation in the enrollees' LTC records (i.e., LTC record omission).
  - In the analysis, when no LTC records were submitted for the sampled date of service, all procedure codes associated with that date of service were treated as LTC record omissions. Similarly, for cases identified as LTC record omissions for dates of service, all procedure codes associated with those cases were counted as LTC record omissions due to non-submission of LTC records or documents submitted that did not support the sampled date of service.
  - For cases with LTC records to validate the encounter date of service, procedure codes that were frequently omitted from the enrollees' LTC records included:
    - S5130: Homemaker service, not otherwise specified; per 15 minutes; Frequency = 33.
    - T2030: Assisted living, waiver; per month; Frequency = 30.
    - T1019: Personal care services, per 15 minutes; Frequency = 29.
  - Of note, most procedure codes that were considered omitted from the enrollees' LTC records were generally due to LTC records that were not submitted for the study.
- Encounter data omission (procedure code):
  - Overall, 0.1 percent of the procedure codes identified in the LTC records were not found in the encounter data (i.e., encounter data omission).

Procedure Code Modifier Completeness

Table 4-8 presents the percentage of procedure code modifiers identified in the LTC encounter data that had no supporting documentation in the enrollees' LTC records (i.e., LTC record omission) and the percentage of procedure code modifiers from the enrollees' LTC records that were not found in the encounter data (i.e., encounter data omission). Detailed tables for each plan are provided in the plan-specific appendices.

Table 4-8—LTC Record Omission and Encounter Data Omission for Procedure Code Modifier

Plan	LTC Record Procedure Code Modifier Omission		Encounter Data Procedure Code Modifier Omission	
	Number of Procedure Code Modifiers Identified in Encounter Data	Percent Not Supported by Enrollee's LTC Records*	Number of Procedure Code Modifiers Identified in Enrollee's LTC Records	Percent Not Found in the Encounter Data*
AET-C	31	3.2%	30	0.0%
FCC-L	17	5.9%	16	0.0%
HUM-C	39	20.5%	31	0.0%
MOL-C	47	44.7%	26	0.0%
SIM-C	50	24.0%	38	0.0%
STW-C	70	40.0%	42	0.0%
SUN-C	1	100%	0	NA
UNI-C	130	20.8%	103	0.0%
All Plans	**385**	**25.7%**	**286**	**0.0%**

* Lower rates indicate better performance.
Note: NA indicates there were no procedure code modifiers identified in the LTC records; therefore, there were no rates to report.

Key Findings: Table 4-8

- LTC record omission (procedure code modifier):
  - Overall, 25.7 percent of the procedure code modifiers identified in the Agency's encounter data were not supported by the enrollees' LTC records.
  - The overall LTC record omission rate for procedure code modifiers could have been attributed to several factors, including LTC record non-submission for which subsequent procedure codes and procedure code modifiers were treated as LTC record omissions; omitted procedure codes for which associated procedure code modifiers were also omitted; and providers not documenting the evidence related to the modifiers in the LTC records despite submitting modifiers to the plans.
  - The procedure code modifiers most frequently found in the encounter data but not documented in the LTC records was "U2" (Medicaid level of care 2, as defined).
- Encounter data omission (procedure code modifier):
  - Overall, there were no procedure code modifiers identified in the LTC records that were not found in the electronic encounter data (i.e., all procedure code modifiers documented in the LTC records were also found in the electronic encounter data).

Encounter Data Accuracy

Encounter data accuracy was evaluated for dates of service that existed in both the Agency's encounter data and the submitted LTC records, with values present in both data sources for the evaluated data element. HSAG considered the encounter data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) accurate if documentation in the LTC records supported the values contained in the electronic encounter data. Higher accuracy rates for each data element indicate better performance.

Diagnosis Code Accuracy

Table 4-9 presents the percentage of diagnosis codes associated with validated dates of service from the encounter data that were correctly coded based on the enrollees' LTC records. In addition, errors found in the diagnosis coding were separated into two categories: inaccurate coding and specificity error. Inaccurate coding occurred when the diagnosis code submitted by the provider should have been selected from a different family of codes based on the documentation in the LTC record (e.g., R51 [headache] versus the documentation supporting G43 [migraine]). A specificity error occurred when the documentation supported a more specific code than was listed in the Agency's encounter data (e.g., unspecified abdominal pain [R10.9] when the provider noted during the exam that the abdominal pain was in the right lower quadrant [R10.31]). Specificity errors also include diagnosis codes that do not have the required fourth or fifth digit. Inaccurate diagnosis coding and specificity error in the LTC records were collectively considered as the denominator for the error type rates in Table 4-9. Detailed tables for each plan are provided in the plan-specific appendices.

Table 4-9—Accuracy Results and Error Types for Diagnosis Code

Plan	Accuracy Results		Error Type Rate	
	Number of Diagnoses Present in Both Sources	Accuracy Rate	Percent From Inaccurate Coding	Percent From Specificity Error
AET-C	222	99.5%	100%	0.0%
FCC-L	537	100%	NA	NA
HUM-C	488	98.8%	100%	0.0%
MOL-C	322	99.1%	100%	0.0%
SIM-C	327	99.7%	100%	0.0%
STW-C	199	99.5%	100%	0.0%
SUN-C	322	99.7%	100%	0.0%
UNI-C	288	99.0%	66.7%	33.3%
All Plans	**2,705**	**99.4%**	**93.8%**	**6.3%**

Note: NA indicates all diagnosis codes were coded accurately; therefore, there were no error types to report.

Key Findings: Table 4-9

- Overall, 99.4 percent of the diagnosis codes were accurate when the diagnosis codes were present in the Agency's encounter data and the LTC records.
- All plans, generally, had similarly high rates of accuracy for diagnosis codes (i.e., nearly or higher than 99.0 percent).
- For diagnosis coding inaccuracy, the errors were mostly due to discrepancies between submitted codes and the National Correct Coding Initiative coding standards, rather than specificity errors.

Procedure Code Accuracy

Table 4-10 presents the percentage of procedure codes associated with validated dates of service from the encounter data that were correctly coded based on the enrollees' LTC records. In addition, errors found in the procedure coding were separated into three categories:

- Higher level of service in the medical record: Evaluation and Management (E&M) codes documented in the medical record reflected a higher level of service performed by the provider than the E&M codes submitted in the encounter. For example, a patient was seen by a physician for a follow-up appointment for a worsening earache. The physician noted all key elements in the patient's medical record. The physician also changed the patient's medication during this visit. The encounter submitted showed a procedure code of 99212 (established patient self-limited or minor problem). With all key elements documented and a worsening condition, this visit should have been coded with a higher level of service such as 99213 (established patient low-to-moderate severity).
- Lower level of service in the medical record: E&M codes documented in the medical record reflected a lower level of service than the E&M codes submitted in the encounter data. For example, a provider's notes omitted critical documentation elements of the E&M service, or the problem treated did not warrant a high-level visit. This would apply to a patient follow-up visit for an earache that was improving, required no further treatment, and for which no further problems were noted. The encounter submitted showed a procedure code of 99213 (established patient low-to-moderate severity). However, with an improving condition, the medical record describes a lower level of service, or 99212 (established patient self-limited or minor problem).
- Inaccurate coding: The documentation in the medical records did not support the procedure codes billed, or an incorrect procedure code was used in the encounter for scenarios other than the two mentioned above.

Inaccurate coding, codes with higher levels of service, and codes with lower levels of service in medical records were collectively considered as the denominator for the error type rates in Table 4-10. Detailed tables for each plan are provided in the plan-specific appendices.

Table 4-10—Accuracy Results and Error Types for Procedure Code

Plan	Accuracy Results		Error Type Rate		
	Number of Procedure Codes Present in Both Sources	Accuracy Rate	Percent From Inaccurate Coding	Percent From Higher Levels of Service in LTC Records	Percent From Lower Levels of Service in LTC Records
AET-C	95	100%	NA	NA	NA
FCC-L	132	99.2%	100%	0.0%	0.0%
HUM-C	131	98.5%	100%	0.0%	0.0%
MOL-C	203	99.0%	0.0%	0.0%	100%
SIM-C	209	98.6%	100%	0.0%	0.0%
STW-C	131	100%	NA	NA	NA
SUN-C	104	99.0%	100%	0.0%	0.0%
UNI-C	148	100%	NA	NA	NA
All Plans	**1,153**	**99.2%**	**77.8%**	**0.0%**	**22.2%**

Note: NA indicates all procedure codes were coded accurately; therefore, there were no error types to report.

Key Findings: Table 4-10

- Overall, 99.2 percent of the procedure codes were accurate when present in both the Agency's encounter data and LTC records.
- All plans, generally, had similarly high rates of accuracy for procedure codes (i.e., nearly or higher than 99.0 percent).
- For procedure coding inaccuracy, 77.8 percent of the identified errors were associated with the use of inaccurate codes, while 22.2 percent of the identified errors resulted from providers submitting codes for higher levels of service than were supported and documented in the LTC records (i.e., the procedure code was considered an error due to a lower level of service having been documented in the LTC record).

Procedure Code Modifier Accuracy

Table 4-11 presents the percentage of procedure code modifiers associated with validated dates of service from the encounter data that were correctly coded based on the enrollees' LTC records. The errors for this data element could not be separated into subcategories; therefore, subcategories are not presented in Table 4-11. Detailed tables for each plan are provided in the plan-specific appendices.

Table 4-11—Accuracy Results and Error Types for Procedure Code Modifier

Plan	Number of Procedure Code Modifiers Present in Both Sources	Accuracy Rate
AET-C	30	100%
FCC-L	16	100%
HUM-C	31	96.8%
MOL-C	26	100%
SIM-C	38	100%
STW-C	42	97.6%
SUN-C	0	NA
UNI-C	103	100%
All Plans	**286**	**99.3%**

Note: NA indicates there were no procedure code modifiers present in both sources; therefore, there were no accuracy rates to report.

Key Findings: Table 4-11

- Overall, 99.3 percent of the procedure code modifiers were accurate when the procedure code modifiers were present in both the Agency's encounter data and the enrollees' LTC records.
- All plans with procedure code modifiers in both sources had 100 percent accuracy for the procedure code modifier data element except for Humana-C and Staywell-C, while Sunshine-C did not have any procedure code modifiers present in both sources.

All-Element Accuracy

Table 4-12 presents the percentage of dates of service present in the Agency's encounter data and in the LTC records with the same values for all key data elements listed in Table A-2. The denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service with the same values for all key data elements. Higher all-element accuracy rates indicated that the values populated in the Agency's encounter data were more complete and accurate for all key data elements when compared to the LTC records.

Table 4-12—All-Element Accuracy

Plan	Number of Dates of Service Present in Both Sources	Accuracy Rate
AET-C	92	84.8%
FCC-L	167	92.2%
HUM-C	135	75.6%
MOL-C	148	85.1%
SIM-C	160	86.9%
STW-C	94	62.8%
SUN-C	103	81.6%
UNI-C	124	84.7%
All Plans	**1,023**	**82.8%**

Key Findings: Table 4-12

- Overall, 82.8 percent of the dates of service present in both data sources contained accurate values for all three key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*). The inaccuracies were due to either a LTC record omission, encounter data omission, or element inaccuracy associated with one or more of the key data elements.
- The rates among the eight plans ranged from 62.8 percent (Staywell-C) to 92.2 percent (Florida Community Care-L).
- The inaccuracy of the *Diagnosis Code* data element contributed the most to the low all-element accuracy rate for Humana-C, while for Staywell-C, the *Diagnosis Code* and *Procedure Code* data elements contributed the most to the all-element inaccuracy.

Plan of Care Document Review

As described in Appendix A of this report related to the "Encounter Data Validation Methodology," for individuals receiving HCBS or care in LTC facilities (e.g., nursing homes or assisted living facilities [ALFs]), HSAG reviewed the associated plan of care documentation. The review evaluated whether the LTC services reported in the encounters were supported by enrollees' plans of care. HSAG reviewed plan of care documentation for alignment with authorization dates, scheduled services, units of service, and service providers. As such, the plan of care review component of the study answered the following questions:

- *Was there a valid plan of care? If so, was the plan of care document signed?*
- *Was the selected date of service within the effective dates of the plan of care?*
- *Was there a servicing provider documented in the plan of care? If so, was the servicing provider identified in the LTC record supported by the plan of care?*
- *Were the procedure codes documented in the LTC record supported by the plan of care?*
- *Were the number of units documented in the LTC record supported by the plan of care?*

Table 4-13 and Table 4-14 present findings from the review of plan of care documentation.

Table 4-13—Review of Plan of Care Documentation

Plan	Date of Service Identified in Encounter Data	Was There a Valid Plan of Care?				Plan of Care Document Was Signed[2]		Selected Date of Service Was Within the Effective Dates of the Plan of Care Document[3]	
		Valid Plan of Care[1]		Plan of Care Was From Provider[2]	Plan of Care Was From Plan[2]				
		N	%	%	%	N	%	N	%
AET-C	167	122	73.1%	15.6%	84.4%	103	84.4%	102	99.0%
FCC-L	178	171	96.1%	1.8%	98.2%	157	91.8%	156	99.4%
HUM-C	155	152	98.1%	1.3%	98.7%	71	46.7%	70	98.6%
MOL-C	150	59	39.3%	57.6%	42.4%	45	76.3%	45	100%
SIM-C	163	163	100%	0.0%	100%	162	99.4%	162	100%
STW-C	157	67	42.7%	55.2%	44.8%	48	71.6%	42	87.5%
SUN-C	169	121	71.6%	28.9%	71.1%	106	87.6%	104	98.1%
UNI-C	174	165	94.8%	23.0%	77.0%	134	81.2%	132	98.5%
All Plans	**1,313**	**1,020**	**77.7%**	**16.5%**	**83.5%**	**826**	**81.0%**	**813**	**98.4%**

[1] Denominator was based on number of dates of service identified in the encounter data.
[2] Denominator was based on the number of valid plans of care.
[3] Denominator was based on the number of plans of care with an appropriate signature.

Table 4-14—Plan of Care Documentation Compared to LTC Record Information

Plan	Selected Date of Service Was Within the Effective Dates of the Plan of Care Document	Servicing Provider Was Documented[1]		Documented Servicing Provider Supports Provider Information in the LTC Record[2]		Documented Procedures Support Procedures Identified in the LTC Record[1]		Documented Number of Units Support the Units Identified in the LTC Record[1]	
		N	%	N	%	N	%	N	%
AET-C	102	102	100%	27	26.5%	27	26.5%	27	26.5%
FCC-L	156	133	85.3%	122	91.7%	121	77.6%	143	91.7%
HUM-C	70	70	100%	62	88.6%	62	88.6%	63	90.0%
MOL-C	45	43	95.6%	30	69.8%	30	66.7%	33	73.3%
SIM-C	162	157	96.9%	148	94.3%	152	93.8%	152	93.8%
STW-C	42	40	95.2%	32	80.0%	31	73.8%	31	73.8%
SUN-C	104	103	99.0%	47	45.6%	46	44.2%	46	44.2%
UNI-C	132	132	100%	89	67.4%	89	67.4%	88	66.7%
All Plans	**813**	**780**	**95.9%**	**557**	**71.4%**	**558**	**68.6%**	**583**	**71.7%**

[1] Denominator was based on number of plans of care where the selected date of service was within the effective dates of the plan of care.
[2] Denominator was based on whether the servicing provider was documented.

Key Findings: Table 4-13 and Table 4-14

- A total of 1,313 LTC encounter dates of service were reviewed, of which a total of 1,020 (i.e., 77.7 percent) plan of care documents submitted were assessed as valid plan of care documents. Overall, among the plan of care documents reviewed as valid, 852 (i.e., 83.5 percent) were plan of care documents from the plan, while the remaining 168 (i.e., 16.5 percent) were plan of care documents from the providers.
  - Among plan of care documents that were from the providers, 40.5 percent and 58.3 percent were from SNF and HCBS providers, respectively.
  - For three plans (i.e., Florida Community Care-C, Humana-C, and Simply-C), 98.2 percent, 98.7 percent, and 100 percent, respectively, of the plan of care documents were from the plan.
  - For three plans (i.e., Aetna-C, Sunshine-C, and United-C), 84.4 percent, 71.1 percent, and 77.0 percent, respectively, of the plan of care documents were from the plan.
  - For two plans (i.e., Molina-C and Staywell-C), only 42.4 percent and 44.8 percent, respectively, of the plan of care documents were from the plan.
  - Among plan of care documents that were assessed as invalid, two plans (Staywell-C and Sunshine-C) submitted 74 out of 157 and 32 out of 169 documents, respectively, that were not plan of care documents but prior authorization forms instead.
- Approximately 81.0 percent (826 out of 1,020) of the plan of care documents available for review contained appropriate signatures. Nearly all (162 out of 163) of Simply-C's documents had

appropriate signatures, while only 46.7 percent (71 out of 152) of Humana-C's documents had appropriate signatures.

- Among the 826 plan of care documents that had appropriate signatures, a total of 813 had effective dates that included the selected dates of service. The effective dates from only 13 of the documents received were not in alignment with the selected dates of service.
- Among the 813 plan of care documents that included effective dates that were in alignment with the selected dates of service, documentation related to servicing providers, procedures, and the units of service were reviewed.
  - Nearly 96.0 percent (780 out of 813) of the documents contained the servicing provider information, of which three plans (i.e., Aetna-C, Humana-C, and United-C) had servicing provider information documented in all documents.
  - Only 71.4 percent (557 out of 780) of the servicing provider information within the plan of care documents supported the provider information contained in the LTC records.
  - More than 68.0 percent (558 out of 813) documents that had effective dates in alignment with the selected dates of service had procedure codes documented that supported procedures included in the LTC records. The discrepancy was noted mostly in documents received from two plans (i.e., Aetna-C and Sunshine-C), with only 26.5 percent (27 out of 102) and 44.2 percent (46 out of 104), respectively, in which procedures documented supported procedures included in the LTC records.
  - The units of service discrepancies when compared to the documented units within the LTC records were relatively similar to discrepancies associated with the procedure codes. This discrepancy was noted mostly in two plans (i.e., Aetna-C and Sunshine-C), with only 26.5 percent (27 out of 102) and 44.2 percent (46 out of 104), respectively, where units documented supported units included in the LTC records.
  - Of note, most servicing provider, procedure code, and units of service discrepancies, when compared to the LTC records information for the associated dates of service, were due to LTC records not submitted for the study.
- Two plans (Florida Community Care-L and Simply-C) were among the top performers with high rates of valid plan of care documentation available for review (i.e., 96.1 percent and 100 percent, respectively), and relatively few documented discrepancies noted within the submitted documents.

Appendix A: Encounter Data Validation Methodology

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of the 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. The completeness and accuracy of these data are essential to the success of the state's overall management and oversight of its Medicaid managed care program and in demonstrating its responsibility and stewardship.

Methodology

The goal of the SFY 2021–2022 EDV study is to examine the extent to which the LTC encounters submitted to the Agency by its MMA and LTC plans (collectively referred to as "plans") are complete and accurate.

In alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019,[A-1] HSAG conducted the following core evaluation activities for the EDV activity:

- Comparative analysis—Analysis of the Agency's electronic encounter data completeness and accuracy through a comparison between the Agency's electronic encounter data and the data extracted from the plans' data systems.
- Clinical record and plan of care review—Analysis of the Agency's electronic encounter data completeness and accuracy by comparing the Agency's electronic encounter data to the information documented in the corresponding enrollees' clinical records and plans of care.

Comparative Analyses

The goal of the comparative analysis is to evaluate the extent to which encounters submitted to the Agency by the plans are complete and accurate based on corresponding information stored in the plans' data systems. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in CMS Protocol 5. The encounter data are considered complete if the data provide a record of all services rendered to the enrollees, and all data in the plan's data set have been successfully transferred into the state's data system. For encounter data to be considered accurate, the data that the plans maintain represent the actual services rendered; when they were rendered (the service date); to whom they were rendered (the enrollee); by whom they were rendered (the provider); and if a payment was rendered in connection to the service, how much

[A-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*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: June 21, 2022.

was paid. Plans should also successfully map this information between themselves and the state to ensure that the data stored in the state's system match the data stored in the plan's system. The comparative analysis was performed on the LTC encounters submitted by the plans with dates of service between January 1, 2020, and December 31, 2020. The LTC encounter data from the MMA comprehensive plans and the LTC plan were included in the study. The comparative analysis component involved three key steps:

- Development of data submission requirements documents outlining encounter data submission requirements for the Agency and the plans, including technical assistance sessions.
- Conducting a file review of submitted encounter data from the Agency and the plans.
- Conducting a comparative analysis of the encounter data.

Development of Data Submission Requirements and Technical Assistance

Following the Agency's approval of the scope of work, HSAG prepared and submitted data submission requirements documents to the Agency and the plans. These documents included a brief description of the SFY 2021–2022 EDV study, a description of the review period, requested encounter data types, required data fields, and the procedures for submitting the requested data files to HSAG. The requested encounter data fields included key data elements to be evaluated in the EDV study. The Agency and the plans were requested to submit all LTC encounter data records with dates of service between January 1, 2020, and December 31, 2020, and submitted to the Agency on or before July 31, 2021. This anchor date allowed enough time for CY 2020 encounters to be submitted, processed, and available for evaluation in the Agency's data warehouse.

HSAG conducted a technical assistance session with the plans to facilitate the accurate and timely submission of data. The technical assistance session was conducted approximately one week after distributing the data submission requirements document, thereby allowing the plans time to review and prepare their questions for the session. During this technical assistance session, HSAG's EDV team introduced the SFY 2021–2022 EDV study, reviewed the data submission requirements document, and addressed all questions related to data preparation and extraction. Both the Agency and the plans were given approximately one month to extract and prepare the requested files for submission to HSAG.

Preliminary File Review

Following receipt of the Agency's and the plans' encounter data submissions, HSAG conducted a preliminary file review to determine if any data issues existed in the data files that would warrant a resubmission. The preliminary file review included the following checks:

- Data extraction—Extracted based on the data requirements document.
- Percent present—Required data fields are present on the file and have values in those fields.
- Percent with valid values—The values are the expected values; e.g., valid ICD-10-CM codes in the diagnosis field.
- Evaluation of matching claim numbers—The percentage of claim numbers matching between the data extracted from the Agency's data warehouse and the plans' data submitted to HSAG.

Based on the results of the preliminary file review, HSAG generated plan-specific reports that highlighted any major discrepancies, anomalies, or issues identified in the encounter data submissions. Either the plans or the Agency were subsequently required to resubmit data, when necessary.

Conduct the Comparative Analyses

Once HSAG received and processed the final set of data from the Agency and the plans, HSAG conducted a series of analyses, which were divided into two analytic sections.

First, HSAG assessed record-level data completeness using the following metrics for each encounter type:

- The number and percentage of records present in the files submitted by the plans that were not found in the files submitted by the Agency (***record omission***).
- The number and percentage of records present in the files submitted by the Agency but not found in the files submitted by the plans (***record surplus***).

Second, based on the number of records present in both data sources, HSAG further examined completeness and accuracy for key data elements listed in Table A-1. The analyses focused on an element-level comparison for each data element.

Table A-1—Key Data Elements for Comparative Analysis

Key Data Element	LTC Encounters From 837I	LTC Encounters From 837P
Enrollee ID	√	√
Header Service From Date	√	√
Header Service To Date	√	√
Detail Service From Date	√	√
Detail Service To Date	√	√
Admission Date	√	
Billing Provider NPI	√	√
Attending Provider NPI	√	
Rendering Provider NPI		√
Referring Provider NPI	√	√
Primary Diagnosis Code	√	√
Secondary Diagnosis Code	√	√
Procedure Code (CPT/HCPCS)	√	√
Procedure Code Modifier	√	√
Units of Service	√	√
Primary Surgical Procedure Code	√	
NDC	√	√

Key Data Element	LTC Encounters From 837I	LTC Encounters From 837P
Revenue Code	√	
DRG	√	
Header Paid Amount	√	√
Detail Paid Amount	√	√

Element-level completeness focused on an element-level comparison between both sources of data and addressed the following metrics:

- The number and percentage of records with values present in the files submitted by the plans but not present in the files submitted by the Agency (***element omission***).
- The number and percentage of records with values present in the files submitted by the Agency but not present in the files submitted by the plans (***element surplus***).

Element-level accuracy was limited to those records with values present in both the Agency's and the plans' submitted files. For a particular data element, HSAG determined:

- The number and percentage of records with exactly the same values in both the Agency's and the plans' submitted files (***element accuracy***).
- The number and percentage of records present in both data sources with exactly the same values for select data elements relevant to each encounter data type (***all-element accuracy***).

Technical Assistance

As a follow-up to the comparative analysis activity, HSAG provided technical assistance to the plans regarding the issues identified from the comparative analysis. First, HSAG drafted plan-specific encounter data discrepancy reports highlighting key areas for investigation. Second, upon the Agency's review and approval, HSAG distributed the data discrepancy reports to the plans, along with data samples to assist the plans with their internal investigations. Based on their internal investigations, plans were required to identify potential root causes of the key issues and provide written responses to the data discrepancy reports. Lastly, once HSAG reviewed the written responses, it followed up with the plans for any further clarification, when appropriate.

Clinical Record and Plan of Care Review

As outlined in the CMS protocol, record review is a complex and resource-intensive process. Clinical records (including medical and treatment-related records) are considered the "gold standard" for documenting Medicaid enrollees' access to and quality of services. The second component of the EDV study assessed the completeness and accuracy of the Agency's encounters via a review of information documented in the corresponding clinical records and plans of care of Medicaid enrollees.

The review of clinical records included services rendered between January 1, 2020, and December 31, 2020. This component of the study answered the following question:

- *Are the data elements in Table A-2 found on the LTC encounters complete and accurate when compared to information contained within the clinical records?*

Table A-2—Key Data Elements for Clinical Record Review

Key Data Elements	
Date of Service	Diagnosis Code
Procedure Code	Procedure Code Modifier

Additionally, for individuals receiving HCBS or care in LTC facilities (e.g., nursing homes), HSAG reviewed the associated *Plan of Care* documentation. The review evaluated whether the LTC services reported in the encounters were supported by enrollees' plans of care. HSAG reviewed *Plan of Care* documentation for alignment with authorization dates, scheduled services, units of service, and service providers. As such, the *Plan of Care* documentation review component of the study answered the following questions:

- *Is there a valid plan of care? If so, is the plan of care document signed*?
- *Is the selected date of service within the effective dates of the plan of care*?
- *Is there a servicing provider documented in the plan of care*? *If so, is the servicing provider identified in the clinical record supported by the plan of care*?
- *Are the procedures documented in the clinical record supported by the plan of care*?
- *Are the number of units documented in the clinical record supported by the plan of care*?

To answer the study questions, the clinical record and plan of care review involved the following key steps:

- Identified the eligible population and generated samples from data submitted by the Agency for the study.
- Assisted plans to procure clinical records and plan of care documents from LTC providers, as appropriate.
- Reviewed clinical records and plan of care documents against the Agency's encounter data.
- Calculated study indicators based on the reviewed/abstracted data.
- Drafted report based on study results.

Study Population

To be eligible for the clinical record and plan of care review, an enrollee had to be continuously enrolled in the same plan during the study period (i.e., between January 1, 2020, and December 31, 2020), and had to have had at least one LTC service during the study period. For plans that did not have members enrolled

with the same plan continuously during the study period, HSAG adjusted the continuous enrollment accordingly. In addition, enrollees with Medicare or other insurance coverage were excluded from the eligible population since the Agency does not have complete encounter data for all services they received. In this study, HSAG refers to LTC services as the services that met all criteria in Table A-3. In addition, after reviewing the encounter data from the Agency's data warehouse, HSAG discussed additional changes to these criteria with the Agency, as needed.

Table A-3—Criteria for LTC Services Included in the Study

Data Element	Criteria
LTC Services	
Claim Type	Claim Type Code = LTC
Provider Type	LTC provider types shall include but are not limited to: 01—General Hospital 05—Community Behavioral Health Services 07—Specialized Mental Health Practitioner 10—Skilled Nursing Facility 12—Private Intermediate Care Facilities/Developmentally Disabled (ICF/DD) Facility 13—Swing Bed Facility 14—Assistive Care Services 15—Hospice 23—Medical Foster Care/Personal Care Provider 25—Physician (MD) 26—Physician (DO) 27—Podiatrist 29—Physician Assistant 30—Nurse Practitioner–Advance Registered Nurse Practitioner (ARNP) 31—Registered Nurse/Registered Nurse First Assistant 32—Social Worker/Case Manager 65—Home Health Agency 66—Rural Health Clinic 67—HCBS Waiver 68—Federally Qualified Health Center 81—Professional Early Intervention Services 83—Therapist (Physical Therapist, Occupational Therapist, Speech Therapist, Respiratory Therapist) 91—Case Management Agency
TPID	TPIDs as provided by the Agency

Sampling Strategy

HSAG used a two-stage sampling technique to select samples based on the data received from the Agency. HSAG first identified all enrollees who met the study population eligibility criteria. HSAG then randomly selected the enrollees by plan based on the required sample size. Then, for each selected sample enrollee, HSAG used the SURVEYSELECT procedure in SAS®,[A-2] to randomly select one LTC visit[A-3] that occurred in the study period (i.e., January 1, 2020, through December 31, 2020).

The final sample used in the evaluation consisted of a minimum of 146 cases randomly selected per plan. If a plan had less than 146 cases that were eligible for the study, all eligible cases were included for review. An additional 25 percent oversample (or 37 cases per plan) were sampled to replace records not procured. As such, plans with an adequate number of cases eligible for the study were responsible for procuring a minimum of 183 total sampled enrollees' clinical records and plan of care documents per plan (i.e., 146 sample and 37 oversample) from their contracted LTC providers for services that occurred during the study period.

Clinical Record and Plan of Care Record Procurement

Upon receiving the final sample list from HSAG, plans were responsible for procuring the sampled enrollees' clinical records and plans of care from their contracted providers for services that occurred during the study period. In addition, plans were responsible for submitting the documentation to HSAG. To improve the procurement rate, HSAG conducted a one-hour technical assistance session with the plans to review the EDV project and the procurement protocols after distributing the sample list. Plans were instructed to submit the clinical records and plan of care documents electronically via the Secure Access File Exchange (SAFE) site to ensure the protection of protected health information. During the procurement process, HSAG worked with the plans to answer questions and monitor the number of clinical records and plan of care documents submitted. For example, HSAG provided an initial submission update when 40 percent of the documentation was expected to be submitted and a final submission status update following completion of the procurement period.

All electronic clinical records and plan of care documents that HSAG received were maintained on a secure site, which allowed HSAG's trained reviewers to validate the cases from a centralized location under supervision and oversight. As with all record reviews and research activities, HSAG had implemented a thorough Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance and protection program in accordance with federal regulations that included recurring training as well as policies and procedures that addressed physical security, electronic security, and day-to-day operations.

[A-2] SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

[A-3] To ensure that the clinical record review included all services provided on the same date of service, encounters with the same date of service and same rendering provider were consolidated into one visit for sampling purposes.

Review of Clinical Records and Plan of Care Documents

Concurrent with record procurement activities, HSAG developed detailed training documents for the record review activity and trained its review staff members on specific study protocols and conducted interrater reliability (IRR) and rate-to-standard testing. All reviewers had to achieve a 95 percent accuracy rate prior to reviewing clinical records and plan of care documents and collecting data for the study.

During the clinical record and plan of care document review activity, HSAG's trained reviewers collected and documented findings in an HSAG-designed electronic data collection tool. IRR among reviewers and reviewer accuracy were evaluated regularly throughout the study. Questions raised, and decisions made during this evaluation process were documented and communicated to all reviewers in a timely manner. In addition, HSAG analysts periodically reviewed the export files from the abstraction tool to ensure the abstraction results were complete, accurate, and consistent.

Clinical Record Review Indicators and Plan of Care Document Review Findings

Once the record review was completed, HSAG analysts exported information collected from the electronic tool, reviewed the data, and conducted the analysis. HSAG used four study indicators of data completeness and accuracy to report the record review results:

- ***Record/documentation omission rate***: the percentage of sampled dates of service identified in the electronic encounter data that were not found in the enrollees' clinical records. HSAG also calculated this rate for the other key data elements in Table A-2.
- ***Encounter data omission rate***: the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the enrollees' clinical records that were not found in the electronic encounter data.
- ***Accuracy rate of coding***: the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the electronic encounter data that were correctly coded based on the enrollees' clinical records.
- ***Overall accuracy rate:*** the percentage of dates of service with all data elements coded correctly among all validated dates of service from the electronic encounter data.

In addition to the clinical-related indicators, based on reviews of the plan of care documents, findings that included an evaluation of whether the LTC services documented for the selected dates of service were supported by the plans of care were also presented.

Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with the study:

- The comparative analysis results presented in this study are dependent on the quality of the encounter data submitted by the Agency and the plans. Any substantial and systematic errors in the

extraction and transmission of the encounter data may bias the results and compromise the validity and reliability of the study findings.

- The primary focus of the comparative analysis component of the EDV study is to assess the extent and magnitude of record and data element discrepancies between the Agency- and plan-submitted encounter data. When possible, HSAG conducted supplemental analyses into the characteristics of the omitted/surplus records when discrepancies were identified. However, these secondary investigations were limited and should be used for information only.
- The findings from the comparative analysis and record review were associated with encounters from January 1, 2020, through December 31, 2020. As such, the results may not reflect the current quality of the Agency's encounter data and changes implemented after the study began.
- Successful evaluation of enrollees' LTC records and plan of care documentation depends on the ability to locate and collect complete and accurate records and documentation. Therefore, validation results could have been affected by LTC records and/or plan of care documents that were not located and submitted, and LTC records and/or plan of care documents that were incomplete (e.g., submission of a visit summary instead of the complete LTC record).
- The findings from the LTC record review component of this study are associated with LTC visits and may not be applicable to other claim types.
- Due to the relatively small size of sample cases for each plan, plan-specific rates for select indicators should be interpreted with caution.

Appendix B: Results for Aetna Better Health of Florida, Inc.

This appendix contains the comparative analysis and LTC record and plan of care review results and findings for Aetna Better Health of Florida, Inc. (Aetna-C/AET-C).

Comparative Analysis

This section presents Aetna-C's results for comparative analysis. Based on study findings from the comparative analysis component, HSAG initiated follow-up activities designed to assist the plans in addressing major encounter data issues identified from this study. First, HSAG distributed the data discrepancy reports to each plan, which included a description of key issues for the plans to review. Additionally, samples of encounters highlighting identified issues were also distributed to further assist the plans in reviewing the results.

Second, the plans were required to submit written responses on any required resolutions or follow-up items identified and noted in the discrepancy reports. These next sections present the comparative analysis results as reported in the data discrepancy report for Aetna-C. Additionally, the images of Aetna-C's responses based on its investigation efforts on the example discrepant records are provided at the end of this appendix.

Record Completeness

There are two aspects of record completeness—record omission and record surplus. A record omission occurs when a record is present in the plan's submitted data files for the study but not in the Agency's data files. Similarly, a record surplus occurs when a record is present in the Agency's data files but not in the plan's submitted data files. The Agency encounter data are considered relatively complete when the record omission and record surplus rates are low.

Table B-1 displays the percentage of records present in the Aetna-C-submitted files that were not found in the Agency-submitted files (record omission) and the percentage of records present in the Agency-submitted files but not present in the Aetna-C-submitted files (record surplus) for the LTC encounters. **Lower rates indicate better performance for both record omission and record surplus**.

Table B-1—Record Omission and Surplus

Encounter Type	Omission (Missing in the Agency's Files)	Surplus (Missing in Plan Files)
LTC Professional	2.5%	1.1%
LTC Institutional	8.5%	2.2%

Key Findings: Table B-1

- There were no issues noted regarding the record omission and surplus rates of 2.5 percent and 1.1 percent, respectively, for the LTC professional encounters.
- While there were no issues noted regarding the record surplus rate of 2.2 percent for the LTC institutional encounters, the omission rate was high at 8.5 percent. Further analysis revealed that 95.0 percent of omitted encounters had a claim type of "A" (i.e., inpatient crossover), and all encounters had a claim frequency type code of "1" (i.e., original claim).

Data Element Completeness and Accuracy

Data element completeness measures were based on the number of records that matched in both the Agency's data files and the plan's data files. Element-level completeness is evaluated based on element omission and element surplus rates. The element omission rate represents the percentage of records with values present in the plan's submitted data files but not in the Agency's data files. Similarly, the element surplus rate reports the percentage of records with values present in the Agency's data files but not in the plan's submitted data files. The data elements are considered relatively complete when they have low element omission and surplus rates.

Data element accuracy is limited to those records present in both data sources with values present in both data sources. Records with values missing in both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element.

For records that matched in both the Agency-submitted files and the plan-submitted files, the percentage of records with values absent in both data sources was also calculated as supplemental information. It is important to note that for element absent, in general, lower rates would be preferred, indicating fewer records had values not populated in both data sources. However, higher rates do not necessarily indicate poor performance since some data elements are not required for every encounter transaction. Some examples include data elements that are characterized by situational reporting requirements—e.g., secondary diagnosis code, procedure code modifier.

LTC Institutional Encounters

Table B-2 displays Aetna-C's data element omission, surplus, absent, and accuracy rates for the LTC institutional encounters.

Table B-2—Data Element Completeness and Accuracy for LTC Institutional Encounters

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	100%
Header Service From Date	0.0%	0.0%	0.0%	99.7%
Header Service To Date	0.0%	0.0%	0.0%	98.6%
Detail Service From Date	0.0%	0.0%	0.0%	98.8%

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Detail Service To Date	0.0%	0.0%	0.0%	98.7%
Admission Date	<0.1%	0.0%	0.4%	100%
Billing Provider NPI	0.0%	<0.1%	0.0%	99.9%
Attending Provider NPI	1.7%	0.0%	<0.1%	95.6%
Referring Provider NPI	0.0%	0.0%	100%	NA[2]
Primary Diagnosis Code	0.0%	0.0%	0.0%	>99.9%
Secondary Diagnosis Code[1]	5.3%	0.0%	3.0%	34.0%
Procedure Code	1.6%	<0.1%	15.1%	99.3%
Procedure Code Modifier	<0.1%	<0.1%	33.5%	99.8%
Units of Service	0.0%	0.0%	0.0%	96.6%
Primary Surgical Procedure Code	0.0%	0.0%	>99.9%	100%
NDC	<0.1%	0.0%	>99.9%	NA[2]
Revenue Code	0.0%	0.0%	0.0%	97.6%
DRG	0.0%	<0.1%	99.9%	100%
Header Paid Amount	0.0%	0.0%	0.0%	>99.9%
Detail Paid Amount	0.0%	0.0%	0.0%	99.9%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table B-2

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC institutional encounter data elements evaluated except the omission rate for the *Secondary Diagnosis Code* data element.
  - The omission rate for the *Secondary Diagnosis Code* data element was high at 5.3 percent. Of note, Aetna-C populated more secondary diagnosis codes than the Agency in 87.1 percent of records.
- The LTC institutional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Aetna-C-submitted data), except for the accuracy rate associated with the *Secondary Diagnosis Code* data element.
  - The accuracy rate for the *Secondary Diagnosis Code* data element was very low at 34.0 percent. It appears that the order of the secondary diagnosis codes differed between the Aetna-C-submitted data and the Agency-submitted data. When the *Secondary Diagnosis Code* values were compared to the values of other submitted diagnosis codes, the Agency-submitted *Secondary Diagnosis Code* values appeared 99.8 percent of the time in the Aetna-C-submitted data. Similarly, the Aetna-C-submitted *Secondary Diagnosis Code* values appeared 93.3 percent of the time in the Agency-submitted data for these mismatches.

LTC Professional Encounters

Table B-3 displays Aetna-C's data element omission, surplus, absent, and accuracy rates for the LTC professional encounters.

Table B-3—Data Element Completeness and Accuracy for LTC Professional Encounters

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	99.8%
Header Service From Date	0.0%	0.0%	0.0%	98.6%
Header Service To Date	0.0%	0.0%	0.0%	98.7%
Detail Service From Date	0.0%	0.0%	0.0%	98.3%
Detail Service To Date	0.0%	0.0%	0.0%	98.3%
Billing Provider NPI	0.0%	<0.1%	0.0%	96.3%
Rendering Provider NPI	0.0%	12.6%	0.0%	95.8%
Referring Provider NPI	0.0%	1.1%	98.9%	NA[2]
Primary Diagnosis Code	0.0%	11.4%	0.0%	98.5%
Secondary Diagnosis Code[1]	3.8%	<0.1%	93.9%	91.7%
Procedure Code	0.0%	11.4%	0.0%	98.6%
Procedure Code Modifier	<0.1%	11.4%	78.9%	88.5%
Units of Service	0.0%	0.0%	0.0%	86.1%
NDC	<0.1%	0.0%	>99.9%	NA[2]
Header Paid Amount	0.0%	0.0%	0.0%	90.4%
Detail Paid Amount	0.0%	0.0%	0.0%	9.5%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table B-3

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC professional encounter data elements evaluated except the surplus rates for the *Rendering Provider NPI*, *Primary Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data elements.
  - The surplus rate for the *Rendering Provider NPI* data element was high at 12.6 percent. Among NPIs identified as surplus for this data element, 99.9 percent of the NPIs were the same as the *Billing Provider NPI* values within the Agency-submitted data. Therefore, it is likely that the *Rendering Provider NPI* values in the Agency's data were created based on the *Billing Provider NPI* values during the Agency's internal processing.
  - For the *Primary Diagnosis Code* data element, Aetna-C had a high surplus rate of 11.4 percent. Among the primary diagnosis codes identified as surplus, 99.9 percent had a diagnosis code value of "R5381."

  - The surplus rates for the *Procedure Code* and *Procedure Code Modifier* data elements were high at 11.4 percent each. Further investigation showed that 56.0 percent and 37.0 percent of surplus records for the *Procedure Code* data element had values of "T1019" and "S5130," respectively. Procedure code modifier values identified as surplus were mostly associated with surplus records for the *Procedure Code* data element.

- The LTC professional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Aetna-C-submitted data), except for the accuracy rates associated with the *Secondary Diagnosis Code*, *Procedure Code Modifier*, *Units of Service*, *Header Paid Amount*, and *Detail Paid Amount* data elements.
  - The accuracy rate for the *Secondary Diagnosis Code* data element was at 91.7 percent. It appears that the order of the secondary diagnosis codes differed between the Aetna-C-submitted data and the Agency-submitted data. When the *Secondary Diagnosis Code* values were compared to the values of other submitted diagnosis codes, the Agency-submitted *Secondary Diagnosis Code* values appeared 100 percent of the time in the Aetna-C-submitted data. Similarly, the Aetna-C-submitted *Secondary Diagnosis Code* values appeared 97.8 percent of the time in the Agency-submitted data for these mismatches.
  - For the *Procedure Code Modifier* data element, the accuracy rate was at 88.5 percent. For 87.5 percent of the records that did not have the same *Procedure Code Modifier* values, the Agency-submitted data had a value of "RE" while the Aetna-C-submitted data had a value of "DR."
  - The accuracy rate for the *Units of Service* data element was at 86.1 percent. Among records that did not match for this data element, for 82.5 percent of these mismatches, Aetna-C submitted a value of "0," while the Agency provided a non-zero value.
  - The *Header Paid Amount* data element had accuracy rate at 90.4 percent. For records in which the Aetna-C-submitted *Header Paid Amount* value did not match the Agency-submitted *Header Paid Amount* value, the Aetna-C-submission had a value of "0" for 88.2 percent of records.
  - For the *Detail Paid Amount* data element, the accuracy rate was very low at 9.5 percent. Of note, Aetna-C-submitted the same value for the *Detail Paid Amount* field as the *Header Paid Amount* field in all records.

The image below presents Aetna-C's investigation efforts and explanations from the data discrepancy report.

Table	Discrepancy Item	AET-C's Investigation Efforts and Explanations
Table 1	LTC institutional record omission rate (8.5 percent)	These are LTC encounters that were submitted to the Agency. The ICN number that the Health Plan received back is included. Please have the agency review why they were not included in the file submitted by the Agency.
Table 2	*Secondary Diagnosis Code* accuracy rate (34.0 percent) and omission rate (5.3 percent) for LTC institutional encounters	For the accuracy tab: Agency file - the primary diagnosis is selected first in the encounter submission and the secondary diagnosis codes are ordered alphabetically by diagnosis code after that. In the Health Plan extract the diagnosis codes were ordered by diagnosis sequence number causing a discrepancy between the two. The Health Plan supplied all the Diagnosis codes in the file submitted; the difference is seen in the order only. Not a single diagnosis code is missing in the files from the Health Plan. For the Omit Tab: In cases where the Admit & Primary diagnosis codes were the same the Health Plan file contained both whereas the Agency encounter file de-duplicated the diagnosis codes if they were the same.
Table 3	*Rendering Provider NPI* surplus rate for LTC professional encounters (12.6 percent)	We only sent a Billing Provider in the encounter submitted to the agency. The rendering provider was blank. The agency may populate the Rendering provider to be the same as the billing provider in these cases. These are all sub-capitated vendor encounters (icare, PPL, Modivcare)
Table 3	*Primary Diagnosis Code* surplus rate for LTC professional encounters (11.4 percent)	These are all sub-capitated vendor PPL. Diagnosis was sent as blank in the Health Plan encounter file whereas the agency file is correctly populated.
Table 3	*Secondary Diagnosis Code* accuracy rate for LTC professional encounters (91.7 percent)	Agency file – Diagnosis codes were ordered alphabetically Plan File – Diagnosis codes were ordered by sequence
Table 3	*Procedure Code* surplus rate for LTC professional encounters (11.4 percent)	These are all sub-capitated vendor PPL. Procedure code was sent as blank in the Health Plan encounter file whereas the agency file is correctly populated.
Table 3	*Procedure Code Modifier* accuracy rate (88.5 percent) and surplus rate (11.4 percent) for LTC professional encounters	Modifier Accuracy – These are all sub-capitated vendor Modivcare; the data was pulled from a paid claims file rather than the encounter reporting database because some of the fields required by HSAG were not in the Encounters Reporting database for sub-capitated vendors. Modifier Surplus - These are all sub-capitated vendor PPL. Modifier code was sent as blank in the Health Plan encounter file whereas the agency file is correctly populated.
Table 3	*Units of Service* accuracy rate for LTC professional encounters (86.1 percent)	Most of these are sub-capitated vendor PPL. Units of service was sent as blank in the Health Plan encounter file whereas the agency file is correctly populated. The ones that begin with FL in the TCN number the difference is due to rounding to the next whole number in the Health Plan file whereas the agency sent decimals in the units of service
Table 3	*Header Paid Amount* accuracy rate for LTC professional encounters (90.4 percent)	Agency file has Total Billed amount as Amount Paid Header. The Health plan submitted the Amount Paid from the Header. The ones showing zero on the Health Plan file are sub-capitated vendors (PPL, iCARE,)
Table 3	*Detail Paid Amount* accuracy rate for LTC professional encounters (9.5 percent)	Agency file has header paid amount as the detail paid amount. The Health plan submitted the detail amount paid. The ones showing zero on the Health Plan file are sub-capitated vendors (PPL, iCARE,)

Long-Term Care Record and Plan of Care Review Results

LTC Record and Plan of Care Documentation Submissions

Table B-4 shows the LTC record and plan of care document submission status for Aetna-C, detailing the number of LTC records and plan of care documents requested as well as the number and percentage of LTC records and plan of care documents submitted by Aetna-C as indicated in its submitted tracking sheets.

Table B-4—LTC Record and Plan of Care Submissions: Aetna-C

Plan	Number of Records/ Documents Requested	LTC Record Submitted		Plan of Care Document Submitted	
		N	Percent	N	Percent
AET-C	172	95	55.2%	172	100%
All Plans	**1,453**	**1,075**	**74.0%**	**1,331**	**91.6%**

Table B-5 highlights the key reasons LTC records and plan of care documents were not submitted by Aetna-C.

Table B-5—Reasons for Missing LTC Record and Plan of Care Documentation: Aetna-C

LTC Record			Plan of Care Document		
Reason	Count	Percent	Reason	Count	Percent
Non-responsive provider or provider did not respond in a timely manner.	55	71.4%	NA	—	—
Enrollee is a patient of the practice; however, no documentation was available for requested dates of service.	17	22.1%			
Facility is permanently closed; unable to procure LTC record documentation.	3	3.9%			
LTC record not located at this facility; location unknown.	2	2.6%			
Total	**77**	**100%**	**Total**	**—**	**—**

"—" Indicates that there were no missing plans of care; therefore, there were no reasons to report.

Note: NA indicates not applicable since there were no missing reasons to report.

Encounter Data Completeness

Table B-6 displays the LTC record omission and encounter data omission rates for each key data element for Aetna-C. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and numerator:

- LTC record omission rate: The denominator for the LTC record omission rate is the number of diagnosis codes identified in the Agency's electronic encounter data, and the numerator is the number of diagnosis codes identified in the Agency's electronic encounter data that were not found (i.e., not supported) in the enrollees' LTC records.

  In the analysis, when no LTC records were submitted for a sampled date of service, all other key data elements associated with that date of service were treated as LTC record omissions.
- Encounter data omission rate: The denominator for the encounter data omission rate is the number of diagnosis codes identified in the enrollees' LTC records, and the numerator is the number of diagnosis codes from the enrollees' LTC records that were not found in the Agency's electronic encounter data.

For both rates, lower values indicate better performance.

Table B-6—Encounter Data Completeness Summary: Aetna-C

Data Element	LTC Record Omission*			Encounter Data Omission*		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Date of Service	167	75	44.9%			
Diagnosis Code	814	592	72.7%	222	0	0.0%
Procedure Code	132	37	28.0%	95	0	0.0%
Procedure Code Modifier	31	1	3.2%	30	0	0.0%

* Lower rates indicate better performance.

Note: Cells shaded in gray indicate the study indicator is not applicable for a data element.

Encounter Data Accuracy

Table B-7 displays the element accuracy rates for each key data element and the all-element accuracy rates for Aetna-C. Encounter data accuracy was evaluated for dates of service that existed in both the Agency's electronic encounter data and the LTC records and had values present in both data sources for the evaluated data element. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and the numerator:

- Denominator: The denominator for the accuracy rate is the number of diagnosis codes associated with dates of service that existed in both the Agency's electronic encounter data and the enrollees' LTC records. In addition, both data sources had values for the *Diagnosis Code* data element.

- Numerator: The numerator for the accuracy rate is the number of diagnosis codes in the denominator that were correctly coded based on the enrollees' LTC records submitted for the study.

Table B-7 also presents the all-element accuracy rate which denotes the percentage of dates of service present in both the Agency's encounter data and the LTC records with the same values (i.e., no LTC record omission, no encounter data omission, and codes were coded correctly) for **all** key data elements. The denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service with the same values for all key data elements.

Table B-7—Encounter Data Accuracy Summary: Aetna-C

Data Element	Denominator	Numerator	Rate	Main Error Type
Diagnosis Code	222	221	99.5%	Inaccurate Code (100%) Specificity Error (0.0%)
Procedure Code	95	95	100%	Inaccurate Code (NA) Lower Level of Services in LTC Records (NA) Higher Level of Services in LTC Records (NA)
Procedure Code Modifier	30	30	100%	—
All-Element Accuracy	92	78	84.8%	—

"—" denotes that the error type analysis was not applicable to a given data element.

Note: NA indicates all codes were coded accurately; therefore, there were no error types to report.

Plan of Care Document Review

HSAG reviewed the submitted plan of care documentation and evaluated whether the LTC services reported in the encounters were supported by enrollees' plans of care. HSAG reviewed plan of care documentation for alignment with authorization dates, scheduled services, units of service, and service providers. As such, the plan of care review component of the study answered the following questions:

- *Was there a valid plan of care? If so, was the plan of care document signed?*
- *For a plan of care with an appropriate signature, was the selected date of service within the effective dates of the plan of care?*
- *For a plan of care where the selected date of service was within the effective dates of the plan of care:*
  - *Was there a servicing provider documented in the plan of care? If so, was the servicing provider identified in the LTC record supported by the plan of care?*
  - *Were the procedure codes documented in the LTC record supported by the plan of care?*
  - *Were the number of units documented in the LTC record supported by the plan of care?*

Table B-8 presents findings from the review of plan of care documentation for Aetna-C.

Table B-8—Plan of Care Document Review Summary: Aetna-C

Plan of Care Document Reviewed Items	N
Date of service identified in encounter data	167
Valid plan of care submission	22
– Plan of care document was from provider	19
– Plan of care document was from the plan	103
Plan of documentation was signed	103
Selected dates of service were within the effective dates of the plan of care documents	102
Servicing providers were documented	102
Documented servicing providers support provider information in the LTC records	27
Documented procedures support procedures identified in the LTC records	27
Documented number of units support the units identified in the LTC records	27

Appendix C: Results for Humana Medical Plan, Inc.

This appendix contains the comparative analysis and LTC record and plan of care review results and findings for Humana Medical Plan, Inc. (Humana-C/HUM-C).

Comparative Analysis

This section presents Humana-C's results for comparative analysis. Based on study findings from the comparative analysis component, HSAG initiated follow-up activities designed to assist the plans in addressing major encounter data issues identified from this study. First, HSAG distributed the data discrepancy reports to each plan, which included a description of key issues for the plans to review. Additionally, samples of encounters highlighting identified issues were also distributed to further assist the plans in reviewing the results.

Second, the plans were required to submit written responses on any required resolutions or follow-up items identified and noted in the discrepancy reports. These next sections present the comparative analysis results as reported in the data discrepancy report for Humana-C. Additionally, the images of Humana-C's responses based on its investigation efforts on the example discrepant records are provided at the end of this appendix.

Record Completeness

There are two aspects of record completeness—record omission and record surplus. A record omission occurs when a record is present in the plan's submitted data files for the study but not in the Agency's data files. Similarly, a record surplus occurs when a record is present in the Agency's data files but not in the plan's submitted data files. The Agency encounter data are considered relatively complete when the record omission and record surplus rates are low.

Table C-1 displays the percentage of records present in the Humana-C-submitted files that were not found in the Agency-submitted files (record omission) and the percentage of records present in the Agency-submitted files but not present in the Humana-C-submitted files (record surplus) for the LTC encounters. **Lower rates indicate better performance for both record omission and record surplus**.

Table C-1—Record Omission and Surplus

Encounter Type	Omission (Missing in the Agency's Files)	Surplus (Missing in Plan Files)
LTC Professional	2.6%	3.8%
LTC Institutional	7.0%	8.9%

Key Findings: Table C-1

- There were no issues noted regarding the record omission and surplus rates of 2.6 percent and 3.8 percent, respectively, for the LTC professional encounters.
- The record omission and surplus rates for LTC institutional encounters were high at 7.0 percent and 8.9 percent, respectively.
  - HSAG was not able to identify any pattern(s) or the root cause for the records identified as an omission. Of note, among records identified as an omission, 10.9 percent included *Enrollee ID* and *Dates of Service* combined values that were also found among records identified as surplus.
  - HSAG was not able to identify any pattern(s) or the root cause for the records identified as surplus. Of note, among records identified as surplus, 13.7 percent included *Enrollee ID* and *Dates of Service* combined values that were also found among records identified as an omission.

Data Element Completeness and Accuracy

Data element completeness measures were based on the number of records that matched in both the Agency's data files and the plan's data files. Element-level completeness is evaluated based on element omission and element surplus rates. The element omission rate represents the percentage of records with values present in the plan's submitted data files but not in the Agency's data files. Similarly, the element surplus rate reports the percentage of records with values present in the Agency's data files but not in the plan's submitted data files. The data elements are considered relatively complete when they have low element omission and surplus rates.

Data element accuracy is limited to those records present in both data sources with values present in both data sources. Records with values missing in both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element.

For records that matched in both the Agency-submitted files and the plan-submitted files, the percentage of records with values absent in both data sources was also calculated as supplemental information. It is important to note that for element absent, in general, lower rates would be preferred, indicating fewer records had values not populated in both data sources. However, higher rates do not necessarily indicate poor performance since some data elements are not required for every encounter transaction. Some examples include data elements that are characterized by situational reporting requirements—e.g., secondary diagnosis code, procedure code modifier.

LTC Institutional Encounters

Table C-2 displays Humana-C's data element omission, surplus, absent, and accuracy rates for the LTC institutional encounters.

Table C-2—Data Element Completeness and Accuracy for LTC Institutional Encounters

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	100%
Header Service From Date	0.0%	0.0%	0.0%	99.6%
Header Service To Date	0.0%	0.0%	0.0%	99.5%
Detail Service From Date	0.0%	<0.1%	0.0%	99.6%
Detail Service To Date	0.0%	<0.1%	0.0%	99.8%
Admission Date	0.0%	<0.1%	0.5%	100%
Billing Provider NPI	0.0%	0.0%	0.0%	98.8%
Attending Provider NPI	2.4%	0.6%	<0.1%	94.6%
Referring Provider NPI	0.4%	0.0%	99.6%	NA[2]
Primary Diagnosis Code	<0.1%	0.0%	0.0%	>99.9%
Secondary Diagnosis Code[1]	<0.1%	0.0%	8.5%	32.6%
Procedure Code	<0.1%	<0.1%	23.8%	>99.9%
Procedure Code Modifier	<0.1%	<0.1%	29.7%	>99.9%
Units of Service	0.0%	0.0%	0.0%	39.9%
Primary Surgical Procedure Code	0.0%	0.0%	>99.9%	100%
NDC	<0.1%	0.0%	>99.9%	NA[2]
Revenue Code	0.0%	0.0%	0.0%	>99.9%
DRG	0.0%	<0.1%	>99.9%	NA[2]
Header Paid Amount	0.0%	0.0%	0.0%	32.4%
Detail Paid Amount	<0.1%	<0.1%	0.5%	99.6%

[1] Calculated for *Secondary Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table C-2

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC institutional encounter data elements evaluated.
- The LTC institutional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Humana-C-submitted data), except for the accuracy rates associated with the *Attending Provider NPI*, *Secondary Diagnosis Code*, *Units of Service*, and *Header Paid Amount* fields.
  - For the *Attending Provider NPI* data element, the accuracy rate was at 94.6 percent. HSAG was not able to identify any pattern(s) or the root cause for the discrepancy.
  - The accuracy rate for the *Secondary Diagnosis Code* data element was very low at 32.6 percent. It appears that the order of the secondary diagnosis codes differed between Humana-C-submitted data and the Agency-submitted data. When the *Secondary Diagnosis Code* values were

compared to the values of other submitted diagnosis codes, the Agency-submitted diagnosis code appeared 100 percent of the time in Humana-C-submitted data. Similarly, the Humana-C-submitted *Secondary Diagnosis Code* values appeared 91.6 percent of the time in the Agency-submitted data for these mismatches.

- The accuracy rate for the *Units of Service* data element was very low at 39.9 percent. For more than 99.9 percent of the values that did not match, the Agency-submitted data had a value of "0."
- The Humana-C accuracy rate for the *Header Paid Amount* data element was very low at 32.4 percent. Among records in which the values of this data element did not match, it appears that the Humana-C-submitted detail paid amounts generally did not sum to the header paid amount, while the Agency-submitted detail paid amounts generally did sum to the header paid amount.

LTC Professional Encounters

Table C-3 displays Humana-C's data element omission, surplus, absent, and accuracy rates for the LTC professional encounters.

Table C-3—Data Element Completeness and Accuracy for LTC Professional Encounters

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	0.0%	99.8%
Header Service To Date	0.0%	0.0%	0.0%	99.9%
Detail Service From Date	0.0%	0.0%	0.0%	>99.9%
Detail Service To Date	0.0%	0.0%	0.0%	>99.9%
Billing Provider NPI	<0.1%	0.0%	0.0%	97.2%
Rendering Provider NPI	<0.1%	99.8%	<0.1%	93.0%
Referring Provider NPI	0.1%	<0.1%	99.9%	NA[2]
Primary Diagnosis Code	<0.1%	0.0%	<0.1%	>99.9%
Secondary Diagnosis Code[1]	1.0%	0.0%	98.1%	47.9%
Procedure Code	<0.1%	0.0%	0.0%	>99.9%
Procedure Code Modifier	0.0%	0.0%	84.4%	>99.9%
Units of Service	0.0%	0.0%	0.0%	99.2%
NDC	<0.1%	0.0%	>99.9%	NA[2]
Header Paid Amount	<0.1%	0.0%	0.0%	99.6%
Detail Paid Amount	0.0%	<0.1%	<0.1%	99.8%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table C-3

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC professional encounter data elements evaluated except the surplus rate for the *Rendering Provider NPI* data element.
  - The surplus rate for the *Rendering Provider NPI* data element was high at 99.8 percent. Among records with NPIs identified as surplus for this data element, the *Rendering Provider NPI* values were the same as the *Billing Provider NPI* values within the Agency-submitted data. Therefore, it is likely that the *Rendering Provider NPI* values in the Agency's data were created based on the *Billing Provider NPI* values during the Agency's internal processing.
- The LTC professional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Humana-C-submitted data), except for the accuracy rates associated with the *Rendering Provider NPI* and *Secondary Diagnosis Code* data elements.
  - For the *Rendering Provider NPI* data element, the accuracy rate was at 93.0 percent. HSAG was not able to identify any pattern(s) or the root cause for the discrepancy.
  - The accuracy rate for the *Secondary Diagnosis Code* data element was very low at 47.9 percent. It appears that the order of the secondary diagnosis codes differed between the Humana-C-submitted data and the Agency-submitted data. When the *Secondary Diagnosis Code* values were compared to the values of other submitted diagnosis codes, the Agency-submitted *Secondary Diagnosis Code* values appeared 100 percent of the time in the Humana-C-submitted data. Similarly, the Humana-C-submitted *Secondary Diagnosis Code* values appeared 62.3 percent of the time in the Agency-submitted data for these mismatches.

The image below presents Humana-C's investigation efforts and explanations from the data discrepancy report.

Table	Discrepancy Item	HUM-C's Investigation Efforts and Explanations
Table 1	LTC institutional record omission rate (7.0 percent) and surplus rate (8.9 percent)	Identified that the query used to pull the encounters for the study contributed to the omission and surplus rate. Humana is willing to resubmit an updated file for HSAG's review.
Table 2	*Attending Provider NPI* accuracy rate for LTC institutional encounters (94.6 percent)	Reconfirmed the correct NPI on the encounter was exactly the information submitted by the provider on the claim. We cannot comment on the provider that the Agency has – i.e., encounter claim example: (58820202790910566), the Agency's NPI (1003051533) is an organizational NPI. An organizational provider wouldn't be accurate for an attending provider NPI.
Table 2	*Secondary Diagnosis Code* accuracy rate for LTC institutional encounters (32.6 percent)	After review, it was found that the discrepancy was due to the ordering of the diagnosis codes within our encounter reporting systems. We have enhanced our encounter reporting database to more accurately reflect the secondary diagnosis code. Humana is willing to resubmit an updated file for HSAG's review.
Table 2	*Units of Service* accuracy rate for LTC institutional encounters (39.9 percent)	Re-validated data; found that the units were submitted correctly on the encounters; therefore, we cannot comment on the root cause of the discrepancy.
Table 2	*Header Paid Amount* accuracy rate for LTC institutional encounters (32.4 percent)	The EDV study occurred before an encounters system enhancement resulting in the discrepancy. Humana is willing to resubmit an updated file for HSAG's review.
Table 3	*Rendering Provider NPI* surplus rate (99.8 percent) and accuracy rate (93.0 percent) for LTC professional encounters	Re-validated data; found that the Plan Rendering Provider NPI still shows accurately against what was submitted on encounters. There are some issues noted on the Humana side where the paper claims were keyed incorrectly, however in reviewing some of the Agency rendering NPI's – these appear to be either non-valid Medicaid approved NPI's, or organizational NPI's and cannot be found in the Rendering NPI field (encounter claim examples: 58820203030015846, 58820203300127567, 58820201600138973)
Table 3	*Secondary Diagnosis Code* accuracy rate for LTC professional encounters (47.9 percent)	After review, it was found that the discrepancy was due to the ordering of the diagnosis codes within our encounter reporting systems. We have enhanced our encounter reporting database to more accurately reflect the secondary diagnosis code. Humana is willing to resubmit an updated file for HSAG's review.

Long-Term Care Record and Plan of Care Review Results

LTC Record and Plan of Care Documentation Submissions

Table C-4 shows the LTC record and plan of care document submission status for Humana-C, detailing the number of LTC records and plan of care documents requested as well as the number and percentage of LTC records and plan of care documents submitted by Humana-C as indicated in its submitted tracking sheets.

Table C-4—LTC Record and Plan of Care Submissions: Humana-C

Plan	Number of Records/ Documents Requested	LTC Record Submitted		Plan of Care Document Submitted	
		N	Percent	N	Percent
HUM-C	183	172	94.0%	178	97.3%
All Plans	**1,453**	**1,075**	**74.0%**	**1,331**	**91.6%**

Table C-5 highlights the key reasons LTC records and plan of care documents were not submitted by Humana-C.

Table C-5—Reasons for Missing LTC Record and Plan of Care Documentation: Humana-C

LTC Record			Plan of Care Document		
Reason	Count	Percent*	Reason	Count	Percent
Other	5	45.5%	Enrollee is a patient of the practice; however, no documentation is available.	5	100%
LTC record not located at this facility; location unknown.	3	27.3%			
Enrollee is a patient of the practice; however, no documentation was available for requested dates of service.	2	18.2%			
Facility is permanently closed; unable to procure LTC record documentation.	1	9.1%			
Total	**11**	**100%**	**Total**	**5**	**100%**

* Due to rounding, the sum of the percentages may not equal 100 percent.

Encounter Data Completeness

Table C-6 displays the LTC record omission and encounter data omission rates for each key data element for Humana-C. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and numerator:

- LTC record omission rate: The denominator for the LTC record omission rate is the number of diagnosis codes identified in the Agency's electronic encounter data, and the numerator is the number of diagnosis codes identified in the Agency's electronic encounter data that were not found (i.e., not supported) in the enrollees' LTC records.

  In the analysis, when no LTC records were submitted for a sampled date of service, all other key data elements associated with that date of service were treated as LTC record omissions.
- Encounter data omission rate: The denominator for the encounter data omission rate is the number of diagnosis codes identified in the enrollees' LTC records, and the numerator is the number of diagnosis codes from the enrollees' LTC records that were not found in the Agency's electronic encounter data.

For both rates, lower values indicate better performance.

Table C-6—Encounter Data Completeness Summary: Humana-C

Data Element	LTC Record Omission*			Encounter Data Omission*		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Date of Service	155	20	12.9%			
Diagnosis Code	719	231	32.1%	488	0	0.0%
Procedure Code	144	13	9.0%	131	0	0.0%
Procedure Code Modifier	39	8	20.5%	31	0	0.0%

* Lower rates indicate better performance.

Note: Cells shaded in gray indicate the study indicator is not applicable for a data element.

Encounter Data Accuracy

Table C-7 displays the element accuracy rates for each key data element and the all-element accuracy rates for Humana-C. Encounter data accuracy was evaluated for dates of service that existed in both the Agency's electronic encounter data and the LTC records and had values present in both data sources for the evaluated data element. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and the numerator:

- Denominator: The denominator for the accuracy rate is the number of diagnosis codes associated with dates of service that existed in both the Agency's electronic encounter data and the enrollees' LTC records. In addition, both data sources had values for the *Diagnosis Code* data element.

- Numerator: The numerator for the accuracy rate is the number of diagnosis codes in the denominator that were correctly coded based on the enrollees' LTC records submitted for the study.

Table C-7 also presents the all-element accuracy rate which denotes the percentage of dates of service present in both the Agency's encounter data and the LTC records with the same values (i.e., no LTC record omission, no encounter data omission, and codes were coded correctly) for **all** key data elements. The denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service with the same values for all key data elements.

Table C-7—Encounter Data Accuracy Summary: Humana-C

Data Element	Denominator	Numerator	Rate	Main Error Type
Diagnosis Code	488	482	98.8%	Inaccurate Code (100%) Specificity Error (0.0%)
Procedure Code	131	129	98.5%	Inaccurate Code (100%) Lower Level of Services in LTC Records (0.0%) Higher Level of Services in LTC Records (0.0%)
Procedure Code Modifier	31	30	96.8%	—
All-Element Accuracy	135	102	75.6%	—

"—" denotes that the error type analysis was not applicable to a given data element.

Plan of Care Document Review

HSAG reviewed the submitted plan of care documentation and evaluated whether the LTC services reported in the encounters were supported by enrollees' plans of care. HSAG reviewed plan of care documentation for alignment with authorization dates, scheduled services, units of service, and service providers. As such, the plan of care review component of the study answered the following questions:

- *Was there a valid plan of care? If so, was the plan of care document signed?*
- *For a plan of care with an appropriate signature, was the selected date of service within the effective dates of the plan of care?*
- *For a plan of care where the selected date of service was within the effective dates of the plan of care:*
  - *Was there a servicing provider documented in the plan of care? If so, was the servicing provider identified in the LTC record supported by the plan of care?*
  - *Were the procedure codes documented in the LTC record supported by the plan of care?*
  - *Were the number of units documented in the LTC record supported by the plan of care?*

Table C-8 presents findings from the review of plan of care documentation for Humana-C.

Table C-8—Plan of Care Document Review Summary: Humana-C

Plan of Care Document Reviewed Items	N
Date of service identified in encounter data	155
Valid plan of care submission	152
– Plan of care document was from provider	2
– Plan of care document was from the plan	150
Plan of documentation was signed	71
Selected dates of service were within the effective dates of the plan of care documents	70
Servicing providers were documented	70
Documented servicing providers support provider information in the LTC records	62
Documented procedures support procedures identified in the LTC records	62
Documented number of units support the units identified in the LTC records	63

Appendix D: Results for Molina Healthcare of Florida, Inc.

This appendix contains the comparative analysis and LTC record and plan of care review results and findings for Molina Healthcare of Florida, Inc. (Molina-C/Molina-C).

Comparative Analysis

This section presents Molina-C's results for comparative analysis. Based on study findings from the comparative analysis component, HSAG initiated follow-up activities designed to assist the plans in addressing major encounter data issues identified from this study. First, HSAG distributed the data discrepancy reports to each plan, which included a description of key issues for the plans to review. Additionally, samples of encounters highlighting identified issues were also distributed to further assist the plans in reviewing the results.

Second, the plans were required to submit written responses on any required resolutions or follow-up items identified and noted in the discrepancy reports. These next sections present the comparative analysis results as reported in the data discrepancy report for Molina-C. Additionally, the images of Molina-C's responses based on its investigation efforts on the example discrepant records are provided at the end of this appendix.

Record Completeness

There are two aspects of record completeness—record omission and record surplus. A record omission occurs when a record is present in the plan's submitted data files for the study but not in the Agency's data files. Similarly, a record surplus occurs when a record is present in the Agency's data files but not in the plan's submitted data files. The Agency encounter data are considered relatively complete when the record omission and record surplus rates are low.

Table D-1 displays the percentage of records present in the Molina-C-submitted files that were not found in the Agency-submitted files (record omission) and the percentage of records present in the Agency-submitted files but not present in the Molina-C-submitted files (record surplus) for the LTC encounters. **Lower rates indicate better performance for both record omission and record surplus**.

Table D-1—Record Omission and Surplus

Encounter Type	Omission (Missing in the Agency's Files)	Surplus (Missing in Plan Files)
LTC Professional	1.5%	2.1%
LTC Institutional	15.9%	4.1%

Key Findings: Table D-1

- There were no issues noted regarding the record omission and surplus rates of 1.5 percent and 2.1 percent, respectively, for the LTC professional encounters.
- While there were no issues noted regarding the record surplus rate of 4.1 percent for the LTC institutional records, the record omission rate was high at 15.9 percent (i.e., more than 5.0 percent). HSAG was not able to determine the pattern(s) or root cause of the records identified as surplus. Of note, however, 76.9 percent of the records identified as omissions had a value of "0" for the *Header Paid Amount* data element.

Data Element Completeness and Accuracy

Data element completeness measures were based on the number of records that matched in both the Agency's data files and the plan's data files. Element-level completeness is evaluated based on element omission and element surplus rates. The element omission rate represents the percentage of records with values present in the plan's submitted data files but not in the Agency's data files. Similarly, the element surplus rate reports the percentage of records with values present in the Agency's data files but not in the plan's submitted data files. The data elements are considered relatively complete when they have low element omission and surplus rates.

Data element accuracy is limited to those records present in both data sources with values present in both data sources. Records with values missing in both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element.

For records that matched in both the Agency-submitted files and the plan-submitted files, the percentage of records with values absent in both data sources was also calculated as supplemental information. It is important to note that for element absent, in general, lower rates would be preferred, indicating fewer records had values not populated in both data sources. However, higher rates do not necessarily indicate poor performance since some data elements are not required for every encounter transaction. Some examples include data elements that are characterized by situational reporting requirements—e.g., secondary diagnosis code, procedure code modifier.

LTC Institutional Encounters

Table D-2 displays Molina-C's data element omission, surplus, absent, and accuracy rates for the LTC institutional encounters.

Table D-2—Data Element Completeness and Accuracy for LTC Institutional Encounters

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	100%
Header Service From Date	0.0%	0.0%	0.0%	100%
Header Service To Date	0.0%	0.0%	0.0%	97.1%

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Detail Service From Date	0.0%	0.0%	0.0%	100%
Detail Service To Date	0.0%	0.0%	0.0%	100%
Admission Date	<0.1%	0.0%	0.0%	100%
Billing Provider NPI	0.0%	0.0%	0.0%	98.4%
Attending Provider NPI	21.7%	0.0%	2.2%	90.6%
Referring Provider NPI	4.1%	0.0%	95.9%	NA[2]
Primary Diagnosis Code	0.0%	0.0%	0.0%	100%
Secondary Diagnosis Code[1]	0.0%	0.0%	16.7%	100%
Procedure Code	0.0%	0.0%	35.9%	100%
Procedure Code Modifier	0.0%	0.0%	39.2%	100%
Units of Service	0.0%	0.0%	0.0%	82.8%
Primary Surgical Procedure Code	0.0%	0.0%	100%	NA[2]
NDC	0.0%	0.0%	100%	NA[2]
Revenue Code	0.0%	0.0%	0.0%	100%
DRG	0.0%	0.0%	100%	NA[2]
Header Paid Amount	0.0%	0.0%	0.0%	100%
Detail Paid Amount	0.0%	0.0%	0.0%	100%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table D-2

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC institutional encounter data elements evaluated except the omission rate for the *Attending Provider NPI* data element.
  - The omission rate for the *Attending Provider NPI* data element was high at 21.7 percent. Among records with NPIs identified as an omission for this data element, 46.2 percent of the NPIs had a value of "1689850182."
- The LTC institutional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Molina-C-submitted data), except for accuracy rates associated with the *Attending Provider NPI* and *Units of Service* data elements.
  - The accuracy rate for the *Attending Provider NPI* data element was at 90.6 percent. It appears that, in most instances, the *Attending Provider NPI* values submitted by Molina-C and the Agency-submitted *Attending Provider NPI* values corresponded to the same provider. This was determined by drawing a random sample of records in which the Molina-C-submitted and Agency-submitted *Attending Provider NPI* values did not match; obtaining details for each *Attending Provider NPI* value from the National NPI Registry; and comparing the provider

name, specialty, and address information. Of note, among these records, the Molina-C-submitted *Attending Provider NPI* values appeared to be associated with individual providers, while the Agency-submitted *Attending Provider NPI* values were most often associated with organizational providers.

– The accuracy rate for the *Units of Service* data element was low at 82.8 percent. Among the values that did not match for this data element, 88.5 percent in the Agency-submitted data had a value of "0."

LTC Professional Encounters

Table D-3 displays Molina-C's data element omission, surplus, absent, and accuracy rates for the LTC professional encounters.

Table D-3—Data Element Completeness and Accuracy for LTC Professional Encounters

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	100%
Header Service From Date	0.0%	0.0%	0.0%	99.2%
Header Service To Date	0.0%	0.0%	0.0%	98.7%
Detail Service From Date	0.0%	0.0%	0.0%	100%
Detail Service To Date	0.0%	0.0%	0.0%	100%
Billing Provider NPI	0.0%	0.0%	0.0%	99.1%
Rendering Provider NPI	0.0%	0.0%	0.0%	99.1%
Referring Provider NPI	3.5%	0.0%	82.8%	99.1%
Primary Diagnosis Code	0.0%	0.0%	0.0%	>99.9%
Secondary Diagnosis Code[1]	1.5%	0.0%	97.6%	99.1%
Procedure Code	0.0%	0.0%	0.0%	100%
Procedure Code Modifier	<0.1%	<0.1%	66.3%	100%
Units of Service	0.0%	0.0%	0.0%	98.6%
NDC	<0.1%	0.0%	>99.9%	NA[2]
Header Paid Amount	0.0%	0.0%	0.0%	93.7%
Detail Paid Amount	0.0%	0.0%	0.0%	93.9%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table D-3

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC professional encounter data elements evaluated.

- The LTC professional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Molina-C-submitted data), except for the accuracy rates associated with the *Header Paid Amount* and *Detail Paid Amount* data elements.
  - The Molina-C accuracy rate for the *Header Paid Amount* data element was at 93.7 percent. Among records in which the values of this data element did not match, Molina-C submitted data with a value of "0" for 97.0 percent of the records.
  - The accuracy rate for the *Detail Paid Amount* data element was at 93.9 percent. It appears that for 99.5 percent of records in which the detail paid amount was different between the two data sources (i.e., Agency- and Molina-C-submitted data), Molina-C-submitted data with a value of "0" for the *Detail Paid Amount*.

The images below present Molina-C's investigation efforts and explanations from the data discrepancy report.

Table	Discrepancy Item	MOL-C's Investigation Efforts and Explanations
Table 1	LTC institutional record omission rate (15.9 percent)	Molina has completed the review and investigation into this reported issue. We have validated the data on the original encounter submitted to AHCA via FMMIS as well as the extract submitted to HSAG. We can confirm that of the samples shared by HSAG, 95.5% of claims were submitted to FMMIS, as confirmed by the presence of ICN and the LTC TPID these were submitted to. However, a very small percentage (4.5%) of encounters, on the sample file, were originally submitted to FMMIS as MMA by the TPID used instead of LTC. These encounters were later corrected/Adjusted on FMMIS to the LTC TPID, but that was after the HSAG cutoff date of 7/31/2021. Molina has a prepared a file with detailed information about these submissions to AHCA (for the sample claims) and can submit the file if requested by HSAG.

Table	Discrepancy Item	MOL-C's Investigation Efforts and Explanations
Table 2	*Units of Service* accuracy rate for LTC institutional encounters (82.8 percent)	For most claims that were part of the sample file, Molina can confirm that the claims were submitted to ACHA/FMMIS as well as HSAG extract as per the requirements. We have rechecked the units of service information for both the original encounter submitted and HSAG extract and we are able to confirm that the data on both the sources match, for most of the records. However, Molina has noticed that the Agency reported units matches with the Length Of Stay or duration of these claims in totality of the claim, although not at the line level. Unit%20Examples.docx e.g. Molina has a prepared a file with detailed information about these submissions to AHCA (for the sample claims) and can submit the file if requested by HSAG.
Table 3	*Detail Paid Amount* accuracy rate for LTC professional encounters (93.9 percent)	Molina's investigation into this issue shows that the example claims are being correctly reported on the original encounter submitted to FMMIS as well as the HSAG extract. Detail paid amount information on both sources appear to match. It does appear that, for the sample shared by HSAG, the amount reported by the agency is the line charge amount reported by Molina and not the paid amount reported by Molina. Example Claim: 20113137772 Discrepancy document mentions Line 1 should have Paid Amount = 12.00, but that is the Line charge amount, not the paid amount. The paid amount for this line is 0.00 (Charge Amt 12 – Adj Amt 12 = 0), which was reported on encounter to FMMIS as well as HSAG. Molina has a prepared a file with detailed information about these submissions to AHCA (for the sample claims) and can submit the file if requested by HSAG.

Table	Discrepancy Item	MOL-C's Investigation Efforts and Explanations
Table 3	*Header Paid Amount* accuracy rate for LTC professional encounters (93.7 percent)	Molina's investigation into this issue shows that the example claims are being correctly reported on the original encounter submitted to FMMIS as well as the HSAG extract. Header paid amount information on both sources appear to match. It does appear that, for the sample shared by HSAG, the amount reported by the agency is the Header charge amount reported by Molina and not the paid amount. Example Claim: 20106228455 Discrepancy document mentions claim should have Header Paid Amount = 31.50, but that is the charge amount, not the paid amount. The paid amount for claim is 0.00 (Charge Amt 31.50 – Adj Amt 31.50 = 0), which was reported on encounter to FMMIS as well as HSAG. Molina has a prepared a file with detailed information about these submissions to AHCA (for the sample claims) and can submit the file if requested by HSAG.

Table	Discrepancy Item	MOL-C's Investigation Efforts and Explanations
Table 2	*Attending Provider NPI* omission rate (21.7 percent) and accuracy rate (90.6 percent) for LTC institutional encounters	For 'Omission Rate' example claims, Molina has validated the information that was reported on the original encounter submitted to FMMIS as well as the HSAG extract. Molina can confirm that for the HSAG provided samples, information for attending provider NPI matches on both sources. As such, Molina is not able to identify the root cause for missing attending provider NPI information from Agency's data set. For the 'Accuracy Rate' example claims, Molina has validated the information that was reported on the original encounter submitted to FMMIS as well as the HSAG extract. Molina can confirm that for the HSAG provided samples, information for attending provider NPI matches on both sources. As such, Molina is not able to identify the exact root cause for discrepancy with the attending provider NPI information on Agency's data set. However, additional research on these NPIs have resulted in below findings. **Additional findings:** In case of Attending provider accuracy issue, it appears that the samples from HSAG account to a total of 11 unique providers/records. There are two separate scenarios the Health plan identified: Scenario 1: The Health Plan submitted Attending NPI and the AHCA provided NPIs are different but they both point to the same provider and who has the same Medicaid ID number with the Agency. e.g. Claim TCN: 20052273988 Attending NPI Submitted by Molina to FMMIS and HSAG Extract is, [redacted]. The Attending NPI from Agency is [redacted]. Both NPIs belong to the same provider and, are registered with the Agency under the same Medicaid ID number [redacted]. Scenario 2: The Health Plan submitted Attending NPI and the AHCA provided NPIs are different, but they both point to the same provider and who has different Medicaid ID number with the Agency under the two distinct NPIs. e.g. Claim TCN: 20087251562 Attending NPI Submitted by Molina to FMMIS and on HSAG Extract is, [redacted] which is enrolled with Medicaid ID [redacted] with Agency. The Attending NPI from Agency is [redacted] with inactive Medicaid ID [redacted]. It looks like both these NPI and the corresponding Medicaid IDs belong to the same provider, [redacted]. Molina has a prepared a file with detailed information about these submissions to AHCA (for the sample claims) and can submit the file if requested by HSAG.

Long-Term Care Record and Plan of Care Review Results

LTC Record and Plan of Care Documentation Submissions

Table D-4 shows the LTC record and plan of care document submission status for Molina-C, detailing the number of LTC records and plan of care documents requested as well as the number and percentage of LTC records and plan of care documents submitted by Molina-C as indicated in its submitted tracking sheets.

Table D-4—LTC Record and Plan of Care Submissions: Molina-C

Plan	Number of Records/ Documents Requested	LTC Record Submitted		Plan of Care Document Submitted	
		N	Percent	N	Percent
MOL-C	183	150	82.0%	132	72.1%
All Plans	**1,453**	**1,075**	**74.0%**	**1,331**	**91.6%**

Table D-5 highlights the key reasons LTC records and plan of care documents were not submitted by Molina-C.

Table D-5—Reasons for Missing LTC Record and Plan of Care Documentation: Molina-C

LTC Record			Plan of Care Document		
Reason	Count	Percent	Reason	Count	Percent
LTC record not located at this facility; location unknown.	17	51.5%	Plan of care not located at this facility; location unknown.	19	37.3%
Enrollee was not a patient of the practice.	6	18.2%	Other	17	33.3%
Non-responsive provider or provider did not respond in a timely manner.	4	12.1%	Enrollee was not a patient of the practice.	6	11.8%
Enrollee is a patient of the practice; however, no documentation was available for requested dates of service.	3	9.1%	Enrollee is a patient of the practice; however, no documentation is available.	5	9.8%
Other	3	9.1%	Non-responsive provider or provider did not respond in a timely manner.	4	7.8%
Total	**33**	**100%**	**Total**	**51**	**100%**

Encounter Data Completeness

Table D-6 displays the LTC record omission and encounter data omission rates for each key data element for Molina-C. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and numerator:

- LTC record omission rate: The denominator for the LTC record omission rate is the number of diagnosis codes identified in the Agency's electronic encounter data, and the numerator is the number of diagnosis codes identified in the Agency's electronic encounter data that were not found (i.e., not supported) in the enrollees' LTC records.

  In the analysis, when no LTC records were submitted for a sampled date of service, all other key data elements associated with that date of service were treated as LTC record omissions.
- Encounter data omission rate: The denominator for the encounter data omission rate is the number of diagnosis codes identified in the enrollees' LTC records, and the numerator is the number of diagnosis codes from the enrollees' LTC records that were not found in the Agency's electronic encounter data.

For both rates, lower values indicate better performance.

Table D-6—Encounter Data Completeness Summary: Molina-C

Data Element	LTC Record Omission*			Encounter Data Omission*		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Date of Service	150	2	1.3%			
Diagnosis Code	355	33	9.3%	322	0	0.0%
Procedure Code	215	12	5.6%	203	0	0.0%
Procedure Code Modifier	47	21	44.7%	26	0	0.0%

* Lower rates indicate better performance.

Note: Cells shaded in gray indicate the study indicator is not applicable for a data element.

Encounter Data Accuracy

Table D-7 displays the element accuracy rates for each key data element and the all-element accuracy rates for Molina-C. Encounter data accuracy was evaluated for dates of service that existed in both the Agency's electronic encounter data and the LTC records and had values present in both data sources for the evaluated data element. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and the numerator:

- Denominator: The denominator for the accuracy rate is the number of diagnosis codes associated with dates of service that existed in both the Agency's electronic encounter data and the enrollees' LTC records. In addition, both data sources had values for the *Diagnosis Code* data element.
- Numerator: The numerator for the accuracy rate is the number of diagnosis codes in the denominator that were correctly coded based on the enrollees' LTC records submitted for the study.

Table D-7 also presents the all-element accuracy rate which denotes the percentage of dates of service present in both the Agency's encounter data and the LTC records with the same values (i.e., no LTC record omission, no encounter data omission, and codes were coded correctly) for **all** key data elements. The denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service with the same values for all key data elements.

Table D-7—Encounter Data Accuracy Summary: Molina-C

Data Element	Denominator	Numerator	Rate	Main Error Type
Diagnosis Code	322	319	99.1%	Inaccurate Code (100%) Specificity Error (0.0%)
Procedure Code	203	201	99.0%	Inaccurate Code (0.0%) Lower Level of Services in LTC Records (100%) Higher Level of Services in LTC Records (0.0%)
Procedure Code Modifier	26	26	100%	—
All-Element Accuracy	148	126	85.1%	—

"—" denotes that the error type analysis was not applicable to a given data element.

Plan of Care Document Review

HSAG reviewed the submitted plan of care documentation and evaluated whether the LTC services reported in the encounters were supported by enrollees' plans of care. HSAG reviewed plan of care documentation for alignment with authorization dates, scheduled services, units of service, and service providers. As such, the plan of care review component of the study answered the following questions:

- *Was there a valid plan of care? If so, was the plan of care document signed?*
- *For a plan of care with an appropriate signature, was the selected date of service within the effective dates of the plan of care?*
- *For a plan of care where the selected date of service was within the effective dates of the plan of care:*
  - *Was there a servicing provider documented in the plan of care? If so, was the servicing provider identified in the LTC record supported by the plan of care?*
  - *Were the procedure codes documented in the LTC record supported by the plan of care?*
  - *Were the number of units documented in the LTC record supported by the plan of care?*

Table D-8 presents findings from the review of plan of care documentation for Molina-C.

Table D-8—Plan of Care Document Review Summary: Molina-C

Plan of Care Document Reviewed Items	N
Date of service identified in encounter data	150
Valid plan of care submission	59
– Plan of care document was from provider	34
– Plan of care document was from the plan	25
Plan of documentation was signed	45
Selected dates of service were within the effective dates of the plan of care documents	45
Servicing providers were documented	43
Documented servicing providers support provider information in the LTC records	30
Documented procedures support procedures identified in the LTC records	30
Documented number of units support the units identified in the LTC records	33

Appendix E: Results for Simply Healthcare Plans, Inc.

This appendix contains the comparative analysis and LTC record and plan of care review results and findings for Simply Healthcare Plans, Inc. (Simply-C/SIM-C).

Comparative Analysis

This section presents Simply-C's results for comparative analysis. Based on study findings from the comparative analysis component, HSAG initiated follow-up activities designed to assist the plans in addressing major encounter data issues identified from this study. First, HSAG distributed the data discrepancy reports to each plan, which included a description of key issues for the plans to review. Additionally, samples of encounters highlighting identified issues were also distributed to further assist the plans in reviewing the results.

Second, the plans were required to submit written responses on any required resolutions or follow-up items identified and noted in the discrepancy reports. These next sections present the comparative analysis results as reported in the data discrepancy report for Simply-C. Additionally, the images of Simply-C's responses based on its investigation efforts on the example discrepant records are provided at the end of this appendix.

Record Completeness

There are two aspects of record completeness—record omission and record surplus. A record omission occurs when a record is present in the plan's submitted data files for the study but not in the Agency's data files. Similarly, a record surplus occurs when a record is present in the Agency's data files but not in the plan's submitted data files. The Agency encounter data are considered relatively complete when the record omission and record surplus rates are low.

Table E-1 displays the percentage of records present in the Simply-C-submitted files that were not found in the Agency-submitted files (record omission) and the percentage of records present in the Agency-submitted files but not present in the Simply-C-submitted files (record surplus) for the LTC encounters. **Lower rates indicate better performance for both record omission and record surplus**.

Table E-1—Record Omission and Surplus

Encounter Type	Omission (Missing in the Agency's Files)	Surplus (Missing in Plan Files)
LTC Professional	6.5%	2.1%
LTC Institutional	26.5%	25.7%

Key Findings: Table E-1

- While there were no issues noted regarding the record surplus rate of 2.1 percent for the LTC professional encounters, the record omission rate was high at 6.5 percent (i.e., more than 5.0 percent). Among records identified as an omission, 59.3 percent of records had missing *ICN*s.
- The record omission and surplus rates for LTC institutional encounters were very high at 26.5 percent and 25.7 percent, respectively.
  - Among records identified as an omission, 64.6 percent of records had missing *ICN*s, and 68.5 percent of records had combinations of *Enrollee ID*, *Dates of Service*, and *Procedure Code* that were also found among records identified as surplus.
  - Similarly, among records identified as surplus, 74.7 percent of records had combinations of *Enrollee ID*, *Dates of Service*, and *Procedure Code* that were also found among records identified as an omission.

Data Element Completeness and Accuracy

Data element completeness measures were based on the number of records that matched in both the Agency's data files and the plan's data files. Element-level completeness is evaluated based on element omission and element surplus rates. The element omission rate represents the percentage of records with values present in the plan's submitted data files but not in the Agency's data files. Similarly, the element surplus rate reports the percentage of records with values present in the Agency's data files but not in the plan's submitted data files. The data elements are considered relatively complete when they have low element omission and surplus rates.

Data element accuracy is limited to those records present in both data sources with values present in both data sources. Records with values missing in both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element.

For records that matched in both the Agency-submitted files and the plan-submitted files, the percentage of records with values absent in both data sources was also calculated as supplemental information. It is important to note that for element absent, in general, lower rates would be preferred, indicating fewer records had values not populated in both data sources. However, higher rates do not necessarily indicate poor performance since some data elements are not required for every encounter transaction. Some examples include data elements that are characterized by situational reporting requirements—e.g., secondary diagnosis code, procedure code modifier.

LTC Institutional Encounters

Table E-2 displays Simply-C's data element omission, surplus, absent, and accuracy rates for the LTC institutional encounters.

Table E-2—Data Element Completeness and Accuracy for LTC Institutional Encounters

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	0.0%	98.3%
Header Service To Date	0.0%	0.0%	0.0%	97.7%
Detail Service From Date	0.0%	0.0%	0.0%	100%
Detail Service To Date	0.0%	0.0%	0.0%	100%
Admission Date	0.0%	0.0%	3.9%	>99.9%
Billing Provider NPI	0.0%	0.0%	0.0%	99.8%
Attending Provider NPI	1.4%	<0.1%	13.3%	94.7%
Referring Provider NPI	1.6%	0.0%	98.4%	100%
Primary Diagnosis Code	0.0%	0.0%	0.0%	31.4%
Secondary Diagnosis Code[1]	3.9%	0.0%	8.8%	17.9%
Procedure Code	0.0%	0.0%	26.6%	100%
Procedure Code Modifier	<0.1%	0.0%	44.0%	>99.9%
Units of Service	0.0%	0.0%	0.0%	77.0%
Primary Surgical Procedure Code	0.0%	<0.1%	99.9%	1.1%
NDC	0.6%	0.0%	99.4%	NA[2]
Revenue Code	0.0%	0.0%	0.0%	100%
DRG	<0.1%	0.1%	99.7%	7.2%
Header Paid Amount	0.0%	0.0%	0.0%	>99.9%
Detail Paid Amount	0.0%	0.0%	0.0%	100%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table E-2

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC institutional encounter data elements evaluated.
- The LTC institutional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Simply-C-submitted data), except for the accuracy rates associated with the *Attending Provider NPI*, *Primary Diagnosis Code*, *Secondary Diagnosis Code*, *Units of Service*, *Primary Surgical Procedure Code*, and *DRG* data elements.
  - For the *Attending Provider NPI* data element, the accuracy rate was at 94.7 percent. Among records in which the two data sources (i.e., Agency- and Simply-C-submitted data) did not match for this data element, it appears that, in most circumstances, the *Attending Provider NPI* values submitted by Simply-C and the Agency-submitted *Attending Provider NPI* values corresponded

to the same provider. This was determined by drawing a random sample of records in which the Simply-C-submitted and the Agency-submitted *Attending Provider NPI* values did not match; obtaining details for each *Attending Provider NPI* value from the National NPI Registry; and comparing the provider name, specialty, and address information. Of note, among these records, the Simply-C-submitted *Attending Provider NPI* values appeared to be associated with individual providers, while the Agency-submitted *Attending Provider NPI* values were most often associated with organizational providers.

- The accuracy rate for the *Primary Diagnosis Code* and *Secondary Diagnosis Code* data elements were very low at 31.4 percent and 17.9 percent, respectively. It appears that the order of the diagnosis codes differed between the Simply-C-submitted data and the Agency-submitted data. When the *Primary Diagnosis Code* values were compared to the values of other submitted diagnosis codes, the Agency-submitted *Primary Diagnosis Code* values appeared more than 99.9 percent of the time in the Simply-C-submitted data. Similarly, the Simply-C-submitted *Primary Diagnosis Code* values appeared 84.2 percent of the time in the Agency-submitted data for these mismatches. Additionally, when the *Secondary Diagnosis Code* values were compared to the values of other submitted diagnosis codes, the Agency-submitted *Secondary Diagnosis Code* values appeared more than 99.9 percent of the time in the Simply-C-submitted data. Likewise, the Simply-C-submitted *Secondary Diagnosis Code* values appeared 91.4 percent of the time in the Agency-submitted data for these mismatches.
- The accuracy rate for the *Units of Service* data element was low at 77.0 percent. For 97.4 percent of values that did not match, the Simply-submitted units of service had the same values as the Agency-submitted billed units of service. Additionally, among these records (i.e., Simply-C-submitted units of service having the same values as the Agency-submitted billed units of service), 97.4 percent of the Agency-submitted units of service had a value of "0."
- For the *Primary Surgical Procedure Code* data element, the accuracy rate was very low at 1.1 percent. It appears that the order of the surgical procedure codes differed between the Agency-submitted data and Simply-C-submitted data. Of note, 91.9 percent of the *Primary Surgical Procedure Code* values in the Simply-C-submitted data appeared in one of the surgical procedure codes in the Agency-submitted data.
- The accuracy rate for the *DRG* data element was very low at 7.2 percent. HSAG was not able to determine the pattern(s) or root cause of the discrepancy. However, it is likely that the differences in the *DRG* values were due to each source (i.e., the Agency- and Simply-C-submitted data), populating this data element with different DRG classifications, such as MS-DRG or AP-DRG.

LTC Professional Encounters

Table E-3 displays Simply-C's data element omission, surplus, absent, and accuracy rates for the LTC professional encounters.

Table E-3—Data Element Completeness and Accuracy for LTC Professional Encounters

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	0.0%	99.4%
Header Service To Date	0.0%	0.0%	0.0%	99.8%
Detail Service From Date	0.0%	0.0%	0.0%	100%
Detail Service To Date	0.0%	0.0%	0.0%	100%
Billing Provider NPI	<0.1%	0.0%	0.0%	96.3%
Rendering Provider NPI	0.0%	94.0%	<0.1%	97.0%
Referring Provider NPI	1.0%	0.0%	81.6%	96.0%
Primary Diagnosis Code	0.0%	0.0%	0.0%	96.9%
Secondary Diagnosis Code[1]	3.8%	0.0%	94.7%	25.7%
Procedure Code	0.0%	0.0%	0.0%	100%
Procedure Code Modifier	<0.1%	<0.1%	66.8%	>99.9%
Units of Service	0.0%	0.0%	0.0%	97.9%
NDC	<0.1%	0.0%	>99.9%	NA[2]
Header Paid Amount	0.0%	0.0%	0.0%	99.5%
Detail Paid Amount	0.0%	0.0%	0.0%	100%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table E-3

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC professional encounter data elements evaluated except the surplus rate for the *Rendering Provider NPI* data element.
  - The surplus rate for the *Rendering Provider NPI* data element was very high at 94.0 percent. Among NPIs identified as surplus for this data element, the NPIs were the same as the *Billing Provider NPI* values within the Agency-submitted data. Therefore, it is likely that the *Rendering Provider NPI* values in the Agency's data were created based on the *Billing Provider NPI* values during the Agency's internal processing.
- The LTC professional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Simply-C-submitted data), except for the accuracy rates associated with the *Secondary Diagnosis Code* data element.
  - The accuracy rate for the *Secondary Diagnosis Code* data element was very low at 25.7 percent. It appears that the order of the secondary diagnosis codes differed between the Simply-C-submitted data and the Agency-submitted data. When the *Secondary Diagnosis Code* values

were compared to the values of other submitted diagnosis codes, the Agency-submitted *Secondary Diagnosis Code* values appeared 100 percent of the time in the Simply-C-submitted data. Similarly, the Simply-C-submitted *Secondary Diagnosis Code* values appeared 80.7 percent of the time in the Agency-submitted data for these mismatches.

The image below presents Simply-C's investigation efforts and explanations from the data discrepancy report.

Table	Discrepancy Item	SIM-C's Investigation Efforts and Explanations
Table 1	LTC professional record omission rate (6.5 percent)	After review of a number of records, we believe this data should be included in the Agency data
Table 1	LTC institutional record omission rate (26.5 percent) and surplus rate (25.7 percent)	After review of a number of records, most have been recouped and voided however the void was processed after the July report date. Therefore the plan data included the data where we believe the agency data excluded this data even though in July 2021, the claims were accepted and present in the population.
Table 2	*Attending Provider NPI* accuracy rate for LTC institutional encounters (94.7 percent)	**Plan data correct** After review of adjudication and units present on the encounter, the plan data is the correct data and is the data submitted on the 837 to agency
Table 2	*Primary Diagnosis Code* accuracy rate for LTC institutional encounters (31.4 percent)	**Agency Data correct** After a review of the data, the agency data matches the claim received and encounter submitted. The plan data appears to have lost diagnosis sequence on report generation. This is a report generation defect.
Table 2	*Secondary Diagnosis Code* accuracy rate for LTC institutional encounters (17.9 percent)	**Agency Data correct** After a review of the data, the agency data matches the claim received and encounter submitted. The plan data appears to have lost the submitted diagnosis sequence on report generation. This is a report generation defect.
Table 2	*Units of Service* accuracy rate for LTC institutional encounters (77.0 percent)	**Plan data correct** After review of adjudication and units present on the encounter, the plan data is the correct data and is the data submitted on the 837 to agency
Table 2	*Primary Surgical Procedure Code* accuracy rate for LTC institutional encounters (1.1 percent)	**Agency Data correct** After a review of the data, the agency data matches the claim received and encounter submitted. The plan data appears to have lost the submitted procedure code sequence on report generation. This is a report generation defect.
Table 2	*DRG Code* accuracy rate for LTC institutional encounters (7.2 percent)	**Plan data correct** After review of adjudication and units present on the encounter, the plan data is the correct data and is the data submitted on the 837 to agency
Table 3	*Rendering Provider NPI* surplus rate for LTC professional encounters (94.0 percent)	**Both data sets correct** For 837 data, where the rendering provider is not explicitly reported, it is implicitly same as billing provider. For plan data, the rendering provider was not present on these encounters, and with the agency data, the NPI is duplicated same as billing. For reporting purposes, both are correct. One is implicit where the agency data has explicitly reported and therefore assume the Agency data is correct.
Table 3	*Secondary Diagnosis Code* accuracy rate for LTC professional encounters (25.7 percent)	**Agency Data correct** After a review of the data, the agency data matches the claim received and the encounter submitted. The plan data appears to have submitted lost code sequence on report generation. This is a report generation defect.

Long-Term Care Record and Plan of Care Review Results

LTC Record and Plan of Care Documentation Submissions

Table E-4 shows the LTC record and plan of care document submission status for Simply-C, detailing the number of LTC records and plan of care documents requested as well as the number and percentage of LTC records and plan of care documents submitted by Simply-C as indicated in its submitted tracking sheets.

Table E-4—LTC Record and Plan of Care Submissions: Simply-C

Plan	Number of Records/ Documents Requested	LTC Record Submitted		Plan of Care Document Submitted	
		N	Percent	N	Percent
SIM-C	183	178	97.3%	183	100%
All Plans	**1,453**	**1,075**	**74.0%**	**1,331**	**91.6%**

Table E-5 highlights the key reasons LTC records and plan of care documents were not submitted by Simply-C.

Table E-5—Reasons for Missing LTC Record and Plan of Care Documentation: Simply-C

LTC Record			Plan of Care Document		
Reason	Count	Percent	Reason	Count	Percent
Facility is permanently closed; unable to procure LTC record documentation.	2	40.0%	NA	—	—
Other	2	40.0%			
Non-responsive provider or provider did not respond in a timely manner.	1	20.0%			
Total	**5**	**100%**	**Total**	**—**	**—**

"—" Indicates that there were no missing plans of care; therefore, there were no reasons to report.

Note: NA indicates not applicable since there were no missing reasons to report.

Encounter Data Completeness

Table E-6 displays the LTC record omission and encounter data omission rates for each key data element for Simply-C. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and numerator:

- LTC record omission rate: The denominator for the LTC record omission rate is the number of diagnosis codes identified in the Agency's electronic encounter data, and the numerator is the number of diagnosis codes identified in the Agency's electronic encounter data that were not found (i.e., not supported) in the enrollees' LTC records.

  In the analysis, when no LTC records were submitted for a sampled date of service, all other key data elements associated with that date of service were treated as LTC record omissions.
- Encounter data omission rate: The denominator for the encounter data omission rate is the number of diagnosis codes identified in the enrollees' LTC records, and the numerator is the number of diagnosis codes from the enrollees' LTC records that were not found in the Agency's electronic encounter data.

For both rates, lower values indicate better performance.

Table E-6—Encounter Data Completeness Summary: Simply-C

Data Element	LTC Record Omission*			Encounter Data Omission*		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Date of Service	163	3	1.8%			
Diagnosis Code	360	33	9.2%	327	0	0.0%
Procedure Code	217	8	3.7%	209	0	0.0%
Procedure Code Modifier	50	12	24.0%	38	0	0.0%

* Lower rates indicate better performance.

Note: Cells shaded in gray indicate the study indicator is not applicable for a data element.

Encounter Data Accuracy

Table E-7 displays the element accuracy rates for each key data element and the all-element accuracy rates for Simply-C. Encounter data accuracy was evaluated for dates of service that existed in both the Agency's electronic encounter data and the LTC records and had values present in both data sources for the evaluated data element. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and the numerator:

- Denominator: The denominator for the accuracy rate is the number of diagnosis codes associated with dates of service that existed in both the Agency's electronic encounter data and the enrollees' LTC records. In addition, both data sources had values for the *Diagnosis Code* data element.
- Numerator: The numerator for the accuracy rate is the number of diagnosis codes in the denominator that were correctly coded based on the enrollees' LTC records submitted for the study.

Table E-7 also presents the all-element accuracy rate which denotes the percentage of dates of service present in both the Agency's encounter data and the LTC records with the same values (i.e., no LTC record omission, no encounter data omission, and codes were coded correctly) for **all** key data elements. The

denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service with the same values for all key data elements.

Table E-7—Encounter Data Accuracy Summary: Simply-C

Data Element	Denominator	Numerator	Rate	Main Error Type
Diagnosis Code	327	326	99.7%	Inaccurate Code (100%) Specificity Error (0.0%)
Procedure Code	209	206	98.6%	Inaccurate Code (100%) Lower Level of Services in LTC Records (0.0%) Higher Level of Services in LTC Records (0.0%)
Procedure Code Modifier	38	38	100%	—
All-Element Accuracy	160	139	86.9%	—

"—" denotes that the error type analysis was not applicable to a given data element.

Plan of Care Document Review

HSAG reviewed the submitted plan of care documentation and evaluated whether the LTC services reported in the encounters were supported by enrollees' plans of care. HSAG reviewed plan of care documentation for alignment with authorization dates, scheduled services, units of service, and service providers. As such, the plan of care review component of the study answered the following questions:

- *Was there a valid plan of care? If so, was the plan of care document signed?*
- *For a plan of care with an appropriate signature, was the selected date of service within the effective dates of the plan of care?*
- *For a plan of care where the selected date of service was within the effective dates of the plan of care:*
  - *Was there a servicing provider documented in the plan of care? If so, was the servicing provider identified in the LTC record supported by the plan of care?*
  - *Were the procedure codes documented in the LTC record supported by the plan of care?*
  - *Were the number of units documented in the LTC record supported by the plan of care?*

Table E-8 presents findings from the review of plan of care documentation for Simply-C.

Table E-8—Plan of Care Document Review Summary: Simply-C

Plan of Care Document Reviewed Items	N
Date of service identified in encounter data	163
Valid plan of care submission	163
– Plan of care document was from provider	0

Plan of Care Document Reviewed Items	N
– Plan of care document was from the plan	163
Plan of documentation was signed	162
Selected dates of service were within the effective dates of the plan of care documents	162
Servicing providers were documented	157
Documented servicing providers support provider information in the LTC records	148
Documented procedures support procedures identified in the LTC records	152
Documented number of units support the units identified in the LTC records	152

Appendix F: Results for Wellcare of Florida d/b/a Staywell Health Plan of Florida, Inc.

This appendix contains the comparative analysis and LTC record and plan of care review results and findings for Wellcare of Florida d/b/a Staywell Health Plan of Florida, Inc. (Staywell-C/STW-C).

Comparative Analysis

This section presents Staywell-C's results for comparative analysis. Based on study findings from the comparative analysis component, HSAG initiated follow-up activities designed to assist the plans in addressing major encounter data issues identified from this study. First, HSAG distributed the data discrepancy reports to each plan, which included a description of key issues for the plans to review. Additionally, samples of encounters highlighting identified issues were also distributed to further assist the plans in reviewing the results.

Second, the plans were required to submit written responses on any required resolutions or follow-up items identified and noted in the discrepancy reports. These next sections present the comparative analysis results as reported in the data discrepancy report for Staywell-C. Additionally, the images of Staywell-C's responses based on its investigation efforts on the example discrepant records are provided at the end of this appendix.

Record Completeness

There are two aspects of record completeness—record omission and record surplus. A record omission occurs when a record is present in the plan's submitted data files for the study but not in the Agency's data files. Similarly, a record surplus occurs when a record is present in the Agency's data files but not in the plan's submitted data files. The Agency encounter data are considered relatively complete when the record omission and record surplus rates are low.

Table F-1 displays the percentage of records present in the Staywell-C-submitted files that were not found in the Agency-submitted files (record omission) and the percentage of records present in the Agency-submitted files but not present in the Staywell-C-submitted files (record surplus) for the LTC encounters. **Lower rates indicate better performance for both record omission and record surplus**.

Table F-1—Record Omission and Surplus

Encounter Type	Omission (Missing in the Agency's Files)	Surplus (Missing in Plan Files)
LTC Professional	4.0%	2.0%
LTC Institutional	10.3%	4.5%

Key Findings: Table F-1

- There were no issues noted regarding the record omission and surplus rates of 4.0 percent and 2.0 percent, respectively, for the LTC professional encounters.
- While there were no issues noted regarding the record surplus rate of 4.5 percent for the LTC institutional encounters, the record omission rate was high at 10.3 percent (i.e., more than 5.0 percent). Further analysis revealed that 92.8 percent of records identified as an omission had a claim status of "denied."

Data Element Completeness and Accuracy

Data element completeness measures were based on the number of records that matched in both the Agency's data files and the plan's data files. Element-level completeness is evaluated based on element omission and element surplus rates. The element omission rate represents the percentage of records with values present in the plan's submitted data files but not in the Agency's data files. Similarly, the element surplus rate reports the percentage of records with values present in the Agency's data files but not in the plan's submitted data files. The data elements are considered relatively complete when they have low element omission and surplus rates.

Data element accuracy is limited to those records present in both data sources with values present in both data sources. Records with values missing in both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element.

For records that matched in both the Agency-submitted files and the plan-submitted files, the percentage of records with values absent in both data sources was also calculated as supplemental information. It is important to note that for element absent, in general, lower rates would be preferred, indicating fewer records had values not populated in both data sources. However, higher rates do not necessarily indicate poor performance since some data elements are not required for every encounter transaction. Some examples include data elements that are characterized by situational reporting requirements—e.g., secondary diagnosis code, procedure code modifier.

LTC Institutional Encounters

Table F-2 displays Staywell-C's data element omission, surplus, absent, and accuracy rates for the LTC institutional encounters.

Table F-2—Data Element Completeness and Accuracy for LTC Institutional Encounters

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	100%
Header Service From Date	0.0%	0.0%	0.0%	93.6%
Header Service To Date	0.0%	0.0%	0.0%	99.0%

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Detail Service From Date	0.0%	0.0%	0.0%	100%
Detail Service To Date	0.0%	0.0%	0.0%	100%
Admission Date	0.4%	1.4%	<0.1%	91.2%
Billing Provider NPI	0.0%	0.0%	0.0%	98.6%
Attending Provider NPI	1.9%	0.0%	<0.1%	96.4%
Referring Provider NPI	2.1%	0.0%	97.9%	100%
Primary Diagnosis Code	<0.1%	0.0%	0.0%	99.1%
Secondary Diagnosis Code[1]	7.7%	0.0%	0.0%	0.5%
Procedure Code	0.2%	0.0%	22.3%	100%
Procedure Code Modifier	<0.1%	0.0%	29.7%	100%
Units of Service	0.0%	0.0%	0.0%	29.4%
Primary Surgical Procedure Code	0.0%	0.0%	>99.9%	100%
NDC	<0.1%	0.0%	>99.9%	NA[2]
Revenue Code	0.0%	0.0%	0.0%	99.7%
DRG	<0.1%	<0.1%	99.9%	95.7%
Header Paid Amount	0.0%	0.0%	0.0%	100%
Detail Paid Amount	0.0%	0.0%	0.0%	100%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table F-2

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC institutional encounter data elements evaluated except the omission rate for the *Secondary Diagnosis Code* data element.
  - The omission rate for the *Secondary Diagnosis Code* data element was high at 7.7 percent. Of note, Staywell-C populated more secondary diagnosis codes than the Agency in 94.9 percent of records.
- The LTC institutional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Staywell-C-submitted data), except for the accuracy rates associated with the *Header Service From Date*, *Admission Date*, *Secondary Diagnosis Code*, and *Units of Service* data elements.
  - For the *Header Service From Date* data element, the accuracy rate was at 93.6 percent. All records associated with claims in which the Staywell-C-submitted *Header Service From Date* values were not the same as the Agency-submitted *Header Service From Date* values were

examined. In 99.6 percent of these claims, there were more records associated with a given *ICN* in the Staywell-C-submitted data than in the Agency-submitted data, and the earliest *Detail Dates of Service* in the Staywell-C submitted data for each *ICN* were earlier than the earliest dates in the corresponding Agency-submitted data.

- The accuracy rate for the *Admission Date* data element was at 91.2 percent. Among records with the Staywell-C-submitted admission dates not the same as the Agency-submitted admission dates, 99.8 percent of the Agency-submitted *Admission Date* values were earlier than the Agency-submitted *Header Service From Date* values.
- The accuracy rate for the *Secondary Diagnosis Code* data element was very low at 0.5 percent. It appears that the order of the secondary diagnosis codes differed between the Staywell-C-submitted data and the Agency-submitted data. When the *Secondary Diagnosis Code* values were compared to the values of other submitted diagnosis codes, the Agency-submitted *Secondary Diagnosis Code* values appeared 100 percent of the time in Staywell-C-submitted data. Similarly, the Staywell-C-submitted *Secondary Diagnosis Code* values appeared 78.4 percent of the time in the Agency-submitted data for these mismatches.
- For the *Units of Service* data element, the accuracy rate was very low at 29.4 percent. For 99.3 percent of the mismatches, the Agency-submitted units of service had a value of "0."

LTC Professional Encounters

Table F-3 displays Staywell-C's data element omission, surplus, absent, and accuracy rates for the LTC professional encounters.

Table F-3—Data Element Completeness and Accuracy for LTC Professional Encounters

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	100%
Header Service From Date	0.0%	0.0%	0.0%	99.6%
Header Service To Date	0.0%	0.0%	0.0%	99.8%
Detail Service From Date	0.0%	0.0%	0.0%	100%
Detail Service To Date	0.0%	0.0%	0.0%	100%
Billing Provider NPI	0.0%	0.0%	0.0%	99.5%
Rendering Provider NPI	0.0%	98.0%	0.0%	93.6%
Referring Provider NPI	0.5%	<0.1%	90.9%	93.8%
Primary Diagnosis Code	<0.1%	0.0%	0.0%	99.7%
Secondary Diagnosis Code[1]	2.5%	0.0%	93.8%	96.2%
/Procedure Code	<0.1%	0.0%	0.0%	100%
Procedure Code Modifier	<0.1%	0.0%	61.0%	100%

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Units of Service	0.0%	0.0%	0.0%	97.8%
NDC	<0.1%	0.0%	>99.9%	NA[2]
Header Paid Amount	0.0%	0.0%	<0.1%	99.7%
Detail Paid Amount	<0.1%	0.0%	0.0%	>99.9%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table F-3

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC professional encounter data elements evaluated except the surplus rate for the *Rendering Provider NPI* data element.
  - The surplus rate for the *Rendering Provider NPI* data element was high at 98.0 percent. Among NPIs identified as surplus for this data element, more than 99.9 percent of the NPIs were the same as the *Billing Provider NPI* values within the Agency-submitted data. Therefore, it is likely that the *Rendering Provider NPI* values in the Agency's data were created based on the *Billing Provider NPI* values during the Agency's internal processing.
- The LTC professional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Staywell-C-submitted data), except for the accuracy rates associated with the *Rendering Provider NPI* and *Referring Provider NPI* data elements.
  - For the *Rendering Provider NPI* data element, the accuracy rate was at 93.6 percent. However, among records for this data element in which the values did not match between the two data sources (i.e., Agency- and Staywell-C-submitted data), the Agency-submitted *Rendering Provider NPI* values were the same as the Agency-submitted *Billing Provider NPI* values for 94.7 percent of encounters.
  - The accuracy rate for *Referring Provider NPI* data element was at 93.8 percent. Upon further investigation, it appears that for records in which this data element did not match, the providers were generally the same but with different NPIs. This was determined by drawing a random sample of records in which the Staywell-C-submitted and the Agency-submitted *Attending Provider NPI* values did not match; obtaining details for each *Attending Provider NPI* value from the National NPI Registry; and comparing the provider name, specialty, and address information.

The images below present Staywell-C's investigation efforts and explanations from the data discrepancy report.

Table	Discrepancy Item	STW-C's Investigation Efforts and Explanations
Table 1	LTC institutional record omission rate (10.3 percent)	• While there were no issues noted regarding the record surplus for LTC institutional encounters with a rate of 4.5 percent, the record omission rate was high at 10.3 percent (i.e., more than 5.0 percent). Further analysis revealed that 92.8 percent of records identified as an omission had a claim status of denied. - Follow up with Agency required on missing records
Table 2	*Secondary Diagnosis Code* omission rate (7.7 percent) and accuracy rate (0.5 percent) for LTC institutional encounters	DX2 Code Accuracy Rate - **Reference – STW_INSTIT_DX2_Acc** On the examples provided, is it noticed that HSAG is comparing Admitting / Reason for Visit (diagnosis type ABJ/APR) reported by the plan to First Other Diagnosis Codes (ABF) on Agency data. This mismatch is leading to accuracy drop. All values under ***Plan_Dx2*** field are Admitting/Reason for Visit (ABJ/APR) Code whereas all values under ***Agency_DX2*** field map to First Other Diagnosis Codes (ABF) submitted on the encounters. Plan compared ABF diagnosis codes submitted on encounters to the value reported on ***Agency_DX2*** field. There is a 100% match. ~~~~~~ DX2 Code Omission - **Reference – STW_INSTIT_DX2_Omit** As observed and explained in the above notes, First Other Diagnosis code (diagnosis type ABF) values are captured under ***Agency_Dx2*** field And Admitting / Reason for Visit (diagnosis type ABJ/APR) are captured under ***Plan_DX2 field.*** Since none of the examples had any Other diagnosis codes (diagnosis type ABF) reported on them, ***Agency_DX2*** is showing null values.
Table 2	*Header Service From Date* accuracy rate for LTC institutional encounters (93.6 percent)	**Reference - STW_INSTIT_HFDOS_Acc** Plan reported header level first date of service as HFDOS. Agency reported line level first date of service as HFDOS when compared with Plan data.

Table	Discrepancy Item	STW-C's Investigation Efforts and Explanations
Table 2	*Admission Date* accuracy rate for LTC institutional encounters (91.2 percent)	**Reference - STW_INSTIT_ADMITDATE_Acc** Plan reported header level first date of service as admission date.
Table 2	*Units of Service* accuracy rate for LTC institutional encounters (29.4 percent)	**Reference - STW_INSTIT_UNITS_Acc** Unit value reported on the encounter matches Plan reported unit value. Follow up required with Agency
Table 3	*Rendering Provider NPI* surplus rate (98.0 percent) and accuracy rate (93.6 percent) for LTC professional encounters	**Reference - STW_NONINSTIT_RENDPROVNPI_Surp** **Surplus Rate** Billing and Rendering NPI is the same on the encounters. Only billing has been submitted. All Rendering NPI values reported under ***Agency_RendProvNPI*** match the billing NPI submitted by the Plan. In the following examples where Plan's Billing NPI is not matching **Agency_RendProvNPI**, it is noticed that both NPIs belong to the same provider. **Reference - STW_NONINSTIT_RENDPROVNPI_Acc** **Accuracy Rate** Rendering NPI captured under ***Agency_RendProvNPI*** matches the Billing NPI that Plan reported on the encounter. It is observed that both Plan reported Rendering NPI and Agency reported Rendering NPI belong to the same provider though there is a NPI mismatch on examples. Follow up with Agency required to understand the mismatch
Table 3	*Referring Provider NPI* accuracy rate for LTC professional encounters (93.8 percent)	**Reference - STW_NONINSTIT_REFERPROVNPI_Acc** It is observed that ***Plan_ReferProvNPI*** values are not matching ***Agency_ReferProvNPI*** on any examples. Plan has not reported the NPIs found under ***Agency_ReferProvNPI*** on encounters. On verifying PML, both the NPIs belong to the same provider. Follow up required with Agency.

Long-Term Care Record and Plan of Care Review Results

LTC Record and Plan of Care Documentation Submissions

Table F-4 shows the LTC record and plan of care document submission status for Staywell-C, detailing the number of LTC records and plan of care documents requested as well as the number and percentage of LTC records and plan of care documents submitted by Staywell-C as indicated in its submitted tracking sheets.

Table F-4—LTC Record and Plan of Care Submissions: Staywell-C

Plan	Number of Records/ Documents Requested	LTC Record Submitted		Plan of Care Document Submitted	
		N	Percent	N	Percent
STW-C	183	87	47.5%	150	82.0%
All Plans	**1,453**	**1,075**	**74.0%**	**1,331**	**91.6%**

Table F-5 highlights the key reasons LTC records and plan of care documents were not submitted by Staywell-C.

Table F-5—Reasons for Missing LTC Record and Plan of Care Documentation: Staywell-C

LTC Record			Plan of Care Document		
Reason	Count	Percent	Reason	Count	Percent*
Non-responsive provider or provider did not respond in a timely manner.	62	64.6%	Non-responsive provider or provider did not respond in a timely manner.	19	57.6%
Enrollee is a patient of the practice; however, no documentation was available for requested dates of service.	17	17.7%	Enrollee is a patient of the practice; however, no documentation is available.	7	21.2%
Other	10	10.4%	Other	3	9.1%
Enrollee was not a patient of the practice.	6	6.3%	Enrollee was not a patient of the practice.	2	6.1%
Facility is permanently closed; unable to procure LTC record documentation.	1	1.0%	Plan of care not located at this facility; location unknown.	2	6.1%
Total	**96**	**100%**	**Total**	**33**	**100%**

* Due to rounding, the sum of the percentages may not equal 100 percent.

Encounter Data Completeness

Table F-6 displays the LTC record omission and encounter data omission rates for each key data element for Staywell-C. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and numerator:

- LTC record omission rate: The denominator for the LTC record omission rate is the number of diagnosis codes identified in the Agency's electronic encounter data, and the numerator is the number of diagnosis codes identified in the Agency's electronic encounter data that were not found (i.e., not supported) in the enrollees' LTC records.

  In the analysis, when no LTC records were submitted for a sampled date of service, all other key data elements associated with that date of service were treated as LTC record omissions.
- Encounter data omission rate: The denominator for the encounter data omission rate is the number of diagnosis codes identified in the enrollees' LTC records, and the numerator is the number of diagnosis codes from the enrollees' LTC records that were not found in the Agency's electronic encounter data.

For both rates, lower values indicate better performance.

Table F-6—Encounter Data Completeness Summary: Staywell-C

Data Element	LTC Record Omission*			Encounter Data Omission*		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Date of Service	157	63	40.1%			
Diagnosis Code	489	290	59.3%	199	0	0.0%
Procedure Code	210	79	37.6%	131	0	0.0%
Procedure Code Modifier	70	28	40.0%	42	0	0.0%

* Lower rates indicate better performance.

Note: Cells shaded in gray indicate the study indicator is not applicable for a data element.

Encounter Data Accuracy

Table F-7 displays the element accuracy rates for each key data element and the all-element accuracy rates for Staywell-C. Encounter data accuracy was evaluated for dates of service that existed in both the Agency's electronic encounter data and the LTC records and had values present in both data sources for the evaluated data element. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and the numerator:

- Denominator: The denominator for the accuracy rate is the number of diagnosis codes associated with dates of service that existed in both the Agency's electronic encounter data and the enrollees' LTC records. In addition, both data sources had values for the *Diagnosis Code* data element.
- Numerator: The numerator for the accuracy rate is the number of diagnosis codes in the denominator that were correctly coded based on the enrollees' LTC records submitted for the study.

Table F-7 also presents the all-element accuracy rate which denotes the percentage of dates of service present in both the Agency's encounter data and the LTC records with the same values (i.e., no LTC record omission, no encounter data omission, and codes were coded correctly) for **all** key data elements. The denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service with the same values for all key data elements.

Table F-7—Encounter Data Accuracy Summary: Staywell-C

Data Element	Denominator	Numerator	Rate	Main Error Type
Diagnosis Code	199	198	99.5%	Inaccurate Code (100%) Specificity Error (0.0%)
Procedure Code	131	131	100%	Inaccurate Code (NA) Lower Level of Services in LTC Records (NA) Higher Level of Services in LTC Records (NA)
Procedure Code Modifier	42	41	97.6%	—
All-Element Accuracy	94	59	62.8%	—

"—" denotes that the error type analysis was not applicable to a given data element.

Note: NA indicates all codes were coded accurately; therefore, there were no error types to report.

Plan of Care Document Review

HSAG reviewed the submitted plan of care documentation and evaluated whether the LTC services reported in the encounters were supported by enrollees' plans of care. HSAG reviewed plan of care documentation for alignment with authorization dates, scheduled services, units of service, and service providers. As such, the plan of care review component of the study answered the following questions:

- *Was there a valid plan of care? If so, was the plan of care document signed?*
- *For a plan of care with an appropriate signature, was the selected date of service within the effective dates of the plan of care?*
- *For a plan of care where the selected date of service was within the effective dates of the plan of care:*
  - *Was there a servicing provider documented in the plan of care? If so, was the servicing provider identified in the LTC record supported by the plan of care?*
  - *Were the procedure codes documented in the LTC record supported by the plan of care?*
  - *Were the number of units documented in the LTC record supported by the plan of care?*

Table F-8 presents findings from the review of plan of care documentation for Staywell-C.

Table F-8—Plan of Care Document Review Summary: Staywell-C

Plan of Care Document Reviewed Items	N
Date of service identified in encounter data	157
Valid plan of care submission	67
– Plan of care document was from provider	37
– Plan of care document was from the plan	30
Plan of documentation was signed	48
Selected dates of service were within the effective dates of the plan of care documents	42
Servicing providers were documented	40
Documented servicing providers support provider information in the LTC records	32
Documented procedures support procedures identified in the LTC records	31
Documented number of units support the units identified in the LTC records	31

Appendix G: Results for Sunshine State Health Plan, Inc.

This appendix contains the comparative analysis and LTC record and plan of care review results and findings for Sunshine State Health Plan, Inc. (Sunshine-C/SUN-C).

Comparative Analysis

This section presents Sunshine-C's results for comparative analysis. Based on study findings from the comparative analysis component, HSAG initiated follow-up activities designed to assist the plans in addressing major encounter data issues identified from this study. First, HSAG distributed the data discrepancy reports to each plan, which included a description of key issues for the plans to review. Additionally, samples of encounters highlighting identified issues were also distributed to further assist the plans in reviewing the results.

Second, the plans were required to submit written responses on any required resolutions or follow-up items identified and noted in the discrepancy reports. These next sections present the comparative analysis results as reported in the data discrepancy report for Sunshine-C. Additionally, the images of Sunshine-C's responses based on its investigation efforts on the example discrepant records are provided at the end of this appendix.

Record Completeness

There are two aspects of record completeness—record omission and record surplus. A record omission occurs when a record is present in the plan's submitted data files for the study but not in the Agency's data files. Similarly, a record surplus occurs when a record is present in the Agency's data files but not in the plan's submitted data files. The Agency encounter data are considered relatively complete when the record omission and record surplus rates are low.

Table G-1 displays the percentage of records present in the Sunshine-C-submitted files that were not found in the Agency-submitted files (record omission) and the percentage of records present in the Agency-submitted files but not present in the Sunshine-C-submitted files (record surplus) for the LTC encounters. **Lower rates indicate better performance for both record omission and record surplus**.

Table G-1—Record Omission and Surplus

Encounter Type	Omission (Missing in the Agency's Files)	Surplus (Missing in Plan Files)
LTC Professional	2.2%	2.4%
LTC Institutional	5.9%	3.4%

Key Findings: Table G-1

- There were no issues noted regarding the record omission and surplus rates of 2.2 percent and 2.4 percent, respectively, for the LTC professional encounters.
- While there were no issues noted regarding the record surplus rate of 3.4 percent for the LTC institutional encounters, the omission rate was high at 5.9 percent (i.e., more than 5.0 percent). HSAG was not able to identify any pattern(s) or the root cause for the discrepancy.

Data Element Completeness and Accuracy

Data element completeness measures were based on the number of records that matched in both the Agency's data files and the plan's data files. Element-level completeness is evaluated based on element omission and element surplus rates. The element omission rate represents the percentage of records with values present in the plan's submitted data files but not in the Agency's data files. Similarly, the element surplus rate reports the percentage of records with values present in the Agency's data files but not in the plan's submitted data files. The data elements are considered relatively complete when they have low element omission and surplus rates.

Data element accuracy is limited to those records present in both data sources with values present in both data sources. Records with values missing in both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element.

For records that matched in both the Agency-submitted files and the plan-submitted files, the percentage of records with values absent in both data sources was also calculated as supplemental information. It is important to note that for element absent, in general, lower rates would be preferred, indicating fewer records had values not populated in both data sources. However, higher rates do not necessarily indicate poor performance since some data elements are not required for every encounter transaction. Some examples include data elements that are characterized by situational reporting requirements—e.g., secondary diagnosis code, procedure code modifier.

LTC Institutional Encounters

Table G-2 displays Sunshine-C's data element omission, surplus, absent, and accuracy rates for the LTC institutional encounters.

Table G-2—Data Element Completeness and Accuracy for LTC Institutional Encounters

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	100%
Header Service From Date	0.0%	0.0%	0.0%	>99.9%
Header Service To Date	0.0%	0.0%	0.0%	>99.9%
Detail Service From Date	0.0%	0.0%	0.0%	100%
Detail Service To Date	0.0%	0.0%	0.0%	100%

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Admission Date	<0.1%	<0.1%	0.7%	100%
Billing Provider NPI	0.0%	1.4%	0.0%	97.5%
Attending Provider NPI	3.2%	0.0%	0.0%	95.3%
Referring Provider NPI	1.5%	0.0%	98.5%	NA[2]
Primary Diagnosis Code	0.0%	0.0%	0.0%	100%
Secondary Diagnosis Code[1]	1.9%	<0.1%	8.5%	>99.9%
Procedure Code	0.0%	0.0%	36.4%	100%
Procedure Code Modifier	<0.1%	0.0%	99.5%	100%
Units of Service	0.0%	0.0%	0.0%	70.5%
Primary Surgical Procedure Code	0.0%	0.0%	>99.9%	100%
NDC	0.2%	0.0%	99.8%	NA[2]
Revenue Code	0.0%	0.0%	0.0%	100%
DRG	82.4%	<0.1%	17.5%	0.0%
Header Paid Amount	0.0%	0.0%	0.0%	98.7%
Detail Paid Amount	0.0%	0.0%	0.0%	100%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table G-2

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC institutional encounter data elements evaluated except the omission rate for the *DRG* data element.
  - The omission rate for the *DRG* data element was very high at 82.4 percent. HSAG was not able to identify any pattern(s) or the root cause for the discrepancy.
- The LTC institutional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Sunshine-C-submitted data), except for the accuracy rates associated with the *Units of Service* and *DRG* data elements.
  - For the *Units of Service* data element, the accuracy rate was low at 70.5 percent. For 79.9 percent of the values that did not match for this data element, the Sunshine-C-submitted data had a value of "0."
  - The accuracy rate was very low for the *DRG* data element at 0.0 percent. Upon further review, it was discovered that among records in which the Sunshine-C-submitted *DRG* values did not match the Agency-submitted *DRG* values, the Sunshine-C-submitted *DRG* values were consistently four digits in length, while the Agency-submitted *DRG* values were three digits. The first three digits of the Sunshine-C-submitted *DRG* values matched the Agency-submitted *DRG* values for 96.5 percent of these DRGs.

LTC Professional Encounters

Table G-3 displays Sunshine-C's data element omission, surplus, absent, and accuracy rates for the LTC professional encounters.

Table G-3—Data Element Completeness and Accuracy for LTC Professional Encounters

Key Data Element	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	0.0%	56.5%
Header Service To Date	0.0%	0.0%	0.0%	56.5%
Detail Service From Date	0.0%	0.0%	0.0%	100%
Detail Service To Date	0.0%	0.0%	0.0%	100%
Billing Provider NPI	<0.1%	0.9%	0.0%	96.7%
Rendering Provider NPI	<0.1%	97.1%	<0.1%	99.1%
Referring Provider NPI	4.4%	0.0%	91.2%	95.5%
Primary Diagnosis Code	0.0%	0.0%	0.0%	98.4%
Secondary Diagnosis Code[1]	5.1%	0.0%	93.0%	99.9%
Procedure Code	0.0%	0.0%	0.0%	100%
Procedure Code Modifier	<0.1%	0.0%	89.0%	100%
Units of Service	0.0%	0.8%	0.0%	98.3%
NDC	<0.1%	0.0%	>99.9%	NA[2]
Header Paid Amount	0.0%	0.0%	0.0%	>99.9%
Detail Paid Amount	0.0%	0.0%	0.0%	100%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table G-3

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC professional encounter data elements evaluated except the omission rate for the *Secondary Diagnosis Code* data element and the surplus rate for the *Rendering Provider NPI* data element.
  - The omission rate for the *Secondary Diagnosis Code* data element was high at 5.1 percent. HSAG was not able to identify the pattern(s) or root cause of the discrepancy.
  - The surplus rate for the *Rendering Provider NPI* data element was very high at 97.1 percent. Among NPIs identified as surplus for this data element, more than 99.9 percent of the NPIs were the same as the *Billing Provider NPI* values within the Agency-submitted data. Therefore, it is likely that the *Rendering Provider NPI* values in the Agency's data were created based on the *Billing Provider NPI* values during the Agency's internal processing.

- The LTC professional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Sunshine-C-submitted data), except for the accuracy rates associated with the *Header Service From Date* and *Header Service To Date* data elements.
  - For the *Header Service From Date* and *Header Service To Date* data elements, the accuracy rates were very low at 56.5 percent for both data elements. For records in which the Sunshine-C-submitted *Header Service From Date* and *Header Service To Date* values did not match the Agency-submitted values for these data elements, more than 99.9 percent of encounters were associated with one-line claims. Of note, the Sunshine-C-submitted header dates of service for these records often spanned multiple days, while the Agency-submitted header dates of service were typically for the same day. In reviewing the records where the Sunshine-C-submitted *Header Service From Date* and *Header Service To Date* values did not match the Agency-submitted values for these data elements, a pattern emerges where several records in sequence share the same *Enrollee ID*, *Detail Dates of Service*, *Primary Diagnosis Code*, and *Billing Provider NPI* in both the Sunshine-C-submitted data and the Agency-submitted data; please refer to Table G-4 for an illustration. Within each of these records, the Sunshine-C-submitted and Agency-submitted *ICN* is the same, but each row was submitted with an *ICN* that differs slightly from the row that proceeds it and the row that follows it. In the Sunshine-C-submitted data, the header dates of service are the same across a sequence of rows, while each distinct detail date of service is associated with a different line number that falls within the range of the header dates of service. In contrast, in the Agency-submitted data, the header dates of service are the same as the detail dates of service and the line number is always "1." This pattern suggests that Sunshine-C initially treated these lines as a single claim before assigning them different *ICN*s. For lines with different *ICN*s, the Agency treated each as a distinct claim and populated the header dates of service to match the detail dates of service and set the line numbers to "1."

Table G-4—Illustration of Mismatches in *Header Service To Date* and *Header Service From Date*

Sunshine-C and Agency[1]			SUN-C			Agency		
ICN	Detail Service To Date	Detail Service From Date	Header Service From Date	Header Service To Date	Line Number	Header Service From Date	Header Service To Date	Line Number
1234567890123	9/1/2021	9/1/2021	9/1/2021	9/7/2022	2	9/1/2021	9/1/2021	1
1234567890135	9/2/2021	9/2/2021	9/1/2021	9/7/2022	3	9/2/2021	9/2/2021	1
1234567890144	9/3/2021	9/3/2021	9/1/2021	9/7/2022	4	9/3/2021	9/3/2021	1
1234567890151	9/4/2021	9/4/2021	9/1/2021	9/7/2022	5	9/4/2021	9/4/2021	1
1234567890158	9/5/2021	9/5/2021	9/1/2021	9/7/2022	6	9/5/2021	9/5/2021	1
1234567890168	9/6/2021	9/6/2021	9/1/2021	9/7/2022	7	9/6/2021	9/6/2021	1
1234567890173	9/7/2021	9/7/2021	9/1/2021	9/7/2022	8	9/7/2021	9/7/2021	1

[1] In addition to the *ICN* and *Detail Service To Date* and *Detail Service From Date* values, both data sources had the same *Enrollee ID*, *Primary Diagnosis Code*, and *Billing Provider NPI* values.

The image below presents Sunshine-C's investigation efforts and explanations from the data discrepancy report.

Table	Discrepancy Item	SUN-C's Investigation Efforts and Explanations
Table 1	LTC institutional record omission rate (5.9 percent)	Encounter LTC records were submitted in the SUN-C files and have confirmed received responses from State. Will need to inquire with Agency on why encounters were missing from Agency data files.
Table 2	*DRG Code* omission rate (82.4 percent) and accuracy rate (0.0 percent) for LTC institutional encounters	Per Agency communication, it is not required to be sent but the data file is providing what was billed on the claim while the Agency will processed based on rules within the FL Medicaid System. This is related to the omission. The accuracy, the Plan_DRG reported is 4 digits while Agency_DRG is three digits which is the same as the first three of the Plan_DRG. The 4th digit is being cut off by the Agency and will need to follow up and confirm this is appropriate.
Table 2	*Units of Service* accuracy rate for LTC institutional encounters (70.5 percent)	Agency unit's column matches what was sent on the outbound encounter. This appears to be a data pull issue and a fix will be implemented prior to the next data pull.
Table 3	*Secondary Diagnosis Code* omission rate for LTC professional encounters (5.1 percent)	Data was provided in the encounter submission for the study to match what was provided on the outbound encounter. Appears the same diag was not captured by State. This appears to be a data pull issue and a fix will be implemented prior to the next data pull.
Table 3	*Rendering Provider NPI* surplus rate for LTC professional encounters (97.1 percent)	Rendering NPI captured under Agency_RendProvNPI matches the Billing NPI reported and submitted on the encounter. Appears the Agency is copying the billing NPI to the rendering NPI field when no rendering is sent on the outbound encounter and can HSAG confirm with the Agency?
Table 3	*Header Service From Date* accuracy rate for LTC professional encounters (56.5 percent)	Date reported in Agency_HLDOS is the correct from date for the applicable line, the DOS reported in the Plan_HLDOS is truly the DOS for the whole claim.
Table 3	*Header Service To Date* accuracy rate for LTC professional encounters (56.5 percent)	Date reported in Agency_HFDOS is the correct from date for the applicable line, the DOS reported in the Plan_HFDOS is truly the beginning DOS for the entire claim.

Long-Term Care Record and Plan of Care Review Results

LTC Record and Plan of Care Documentation Submissions

Table G-5 shows the LTC record and plan of care document submission status for Sunshine-C, detailing the number of LTC records and plan of care documents requested as well as the number and percentage of LTC records and plan of care documents submitted by Sunshine-C as indicated in its submitted tracking sheets.

Table G-5—LTC Record and Plan of Care Submissions: Sunshine-C

Plan	Number of Records/ Documents Requested	LTC Record Submitted		Plan of Care Document Submitted	
		N	Percent	N	Percent
SUN-C	183	90	49.2%	167	91.3%
All Plans	**1,453**	**1,075**	**74.0%**	**1,331**	**91.6%**

Table G-6 highlights the key reasons LTC records and plan of care documents were not submitted by Sunshine-C.

Table G-6—Reasons for Missing LTC Record and Plan of Care Documentation: Sunshine-C

LTC Records			Plan of Care Document		
Reason	Count	Percent*	Reason	Count	Percent*
Non-responsive provider or provider did not respond in a timely manner.	51	54.8%	Non-responsive provider or provider did not respond in a timely manner.	10	62.5%
Enrollee is a patient of the practice; however, no documentation was available for requested dates of service.	21	22.6%	Enrollee is a patient of the practice; however, no documentation is available.	4	25.0%
Other	12	12.9%	Other	1	6.3%
LTC record not located at this facility; location unknown.	6	6.5%	Plan of care not located at this facility; location unknown.	1	6.3%
Facility is permanently closed; unable to procure LTC record documentation.	2	2.2%			
Enrollee was not a patient of the practice.	1	1.1%			
Total	**93**	**100%**	**Total**	**16**	**100%**

* Due to rounding, the sum of the percentages may not equal 100 percent.

Encounter Data Completeness

Table G-7 displays the LTC record omission and encounter data omission rates for each key data element for Sunshine-C. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and numerator:

- LTC record omission rate: The denominator for the LTC record omission rate is the number of diagnosis codes identified in the Agency's electronic encounter data, and the numerator is the number of diagnosis codes identified in the Agency's electronic encounter data that were not found (i.e., not supported) in the enrollees' LTC records.

  In the analysis, when no LTC records were submitted for a sampled date of service, all other key data elements associated with that date of service were treated as LTC record omissions.
- Encounter data omission rate: The denominator for the encounter data omission rate is the number of diagnosis codes identified in the enrollees' LTC records, and the numerator is the number of diagnosis codes from the enrollees' LTC records that were not found in the Agency's electronic encounter data.

For both rates, lower values indicate better performance.

Table G-7—Encounter Data Completeness Summary: Sunshine-C

Data Element	LTC Record Omission*			Encounter Data Omission*		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Date of Service	169	66	39.1%			
Diagnosis Code	797	475	59.6%	322	0	0.0%
Procedure Code	145	41	28.3%	105	1	1.0%
Procedure Code Modifier	1	1	100%	NA	NA	NA

* Lower rates indicate better performance.

Note: Cells shaded in gray indicate the study indicator is not applicable for a data element.

NA indicates there were no procedure code modifiers identified in the LTC records; therefore, there were no rates to report.

Encounter Data Accuracy

Table G-8 displays the element accuracy rates for each key data element and the all-element accuracy rates for Sunshine-C. Encounter data accuracy was evaluated for dates of service that existed in both the Agency's electronic encounter data and the LTC records and had values present in both data sources for the evaluated data element. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and the numerator:

- Denominator: The denominator for the accuracy rate is the number of diagnosis codes associated with dates of service that existed in both the Agency's electronic encounter data and the enrollees' LTC records. In addition, both data sources had values for the *Diagnosis Code* data element.
- Numerator: The numerator for the accuracy rate is the number of diagnosis codes in the denominator that were correctly coded based on the enrollees' LTC records submitted for the study.

Table G-8 also presents the all-element accuracy rate which denotes the percentage of dates of service present in both the Agency's encounter data and the LTC records with the same values (i.e., no LTC record omission, no encounter data omission, and codes were coded correctly) for **all** key data elements. The

denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service with the same values for all key data elements.

Table G-8—Encounter Data Accuracy Summary: Sunshine-C

Data Element	Denominator	Numerator	Rate	Main Error Type
Diagnosis Code	322	321	99.7%	Inaccurate Code (100%) Specificity Error (0.0%)
Procedure Code	104	103	99.0%	Inaccurate Code (100%) Lower Level of Services in LTC Records (0.0%) Higher Level of Services in LTC Records (0.0%)
Procedure Code Modifier	NA	NA	NA	—
All-Element Accuracy	103	84	81.6%	—

"—" denotes that the error type analysis was not applicable to a given data element.
Note: NA indicates there were no procedure code modifiers present in both sources; therefore, there were no accuracy rates to report.

Plan of Care Document Review

HSAG reviewed the submitted plan of care documentation and evaluated whether the LTC services reported in the encounters were supported by enrollees' plans of care. HSAG reviewed plan of care documentation for alignment with authorization dates, scheduled services, units of service, and service providers. As such, the plan of care review component of the study answered the following questions:

- *Was there a valid plan of care? If so, was the plan of care document signed?*
- *For a plan of care with an appropriate signature, was the selected date of service within the effective dates of the plan of care?*
- *For a plan of care where the selected date of service was within the effective dates of the plan of care:*
  - *Was there a servicing provider documented in the plan of care? If so, was the servicing provider identified in the LTC record supported by the plan of care?*
  - *Were the procedure codes documented in the LTC record supported by the plan of care?*
  - *Were the number of units documented in the LTC record supported by the plan of care?*

Table G-9 presents findings from the review of plan of care documentation for Sunshine-C.

Table G-9—Plan of Care Document Review Summary: Sunshine-C

Plan of Care Document Reviewed Items	N
Date of service identified in encounter data	169
Valid plan of care submission	121

Plan of Care Document Reviewed Items	N
– Plan of care document was from provider	35
– Plan of care document was from the plan	86
Plan of documentation was signed	106
Selected dates of service were within the effective dates of the plan of care documents	104
Servicing providers were documented	103
Documented servicing providers support provider information in the LTC records	47
Documented procedures support procedures identified in the LTC records	46
Documented number of units support the units identified in the LTC records	46

Appendix H: Results for UnitedHealthcare of Florida, Inc.

This appendix contains the comparative analysis and LTC record and plan of care review results and findings for UnitedHealthcare of Florida, Inc. (United-C/UNI-C).

Comparative Analysis

This section presents United-C's results for comparative analysis. Based on study findings from the comparative analysis component, HSAG initiated follow-up activities designed to assist the plans in addressing major encounter data issues identified from this study. First, HSAG distributed the data discrepancy reports to each plan, which included a description of key issues for the plans to review. Additionally, samples of encounters highlighting identified issues were also distributed to further assist the plans in reviewing the results.

Second, the plans were required to submit written responses on any required resolutions or follow-up items identified and noted in the discrepancy reports. These next sections present the comparative analysis results as reported in the data discrepancy report for United-C. Additionally, the images of United-C's responses based on its investigation efforts on the example discrepant records are provided at the end of this appendix.

Record Completeness

There are two aspects of record completeness—record omission and record surplus. A record omission occurs when a record is present in the plan's submitted data files for the study but not in the Agency's data files. Similarly, a record surplus occurs when a record is present in the Agency's data files but not in the plan's submitted data files. The Agency encounter data are considered relatively complete when the record omission and record surplus rates are low.

Table H-1 displays the percentage of records present in the United-C-submitted files that were not found in the Agency-submitted files (record omission) and the percentage of records present in the Agency-submitted files but not present in the United-C-submitted files (record surplus) for the LTC encounters. **Lower rates indicate better performance for both record omission and record surplus**.

Table H-1—Record Omission and Surplus

Encounter Type	Omission (Missing in the Agency's Files)	Surplus (Missing in Plan Files)
LTC Professional	0.4%	6.3%
LTC Institutional	1.3%	2.3%

Key Findings: Table H-1

- While there were no issues noted regarding the record omission rate of 0.4 percent for the LTC professional encounters, the record surplus rate was high at 6.3 percent (i.e., more than 5.0 percent). HSAG was not able to determine the pattern(s) or root cause of the records identified as surplus. Of note, 40.2 percent of these records were missing the billing provider NPI and 42.8 percent of these records had a billing provider NPI of "1669915047."
- There were no issues noted regarding the record omission and surplus rates of 1.3 percent and 2.3 percent, respectively, for the LTC institutional encounters.

Data Element Completeness and Accuracy

Data element completeness measures were based on the number of records that matched in both the Agency's data files and the plan's data files. Element-level completeness is evaluated based on element omission and element surplus rates. The element omission rate represents the percentage of records with values present in the plan's submitted data files but not in the Agency's data files. Similarly, the element surplus rate reports the percentage of records with values present in the Agency's data files but not in the plan's submitted data files. The data elements are considered relatively complete when they have low element omission and surplus rates.

Data element accuracy is limited to those records present in both data sources with values present in both data sources. Records with values missing in both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element.

For records that matched in both the Agency-submitted files and the plan-submitted files, the percentage of records with values absent in both data sources was also calculated as supplemental information. It is important to note that for element absent, in general, lower rates would be preferred, indicating fewer records had values not populated in both data sources. However, higher rates do not necessarily indicate poor performance since some data elements are not required for every encounter transaction. Some examples include data elements that are characterized by situational reporting requirements—e.g., secondary diagnosis code, procedure code modifier.

LTC Institutional Encounters

Table H-2 displays United-C's data element omission, surplus, absent, and accuracy rates for the LTC institutional encounters.

Table H-2—Data Element Completeness and Accuracy for LTC Institutional Encounters

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	100%
Header Service From Date	0.0%	0.0%	0.0%	99.8%
Header Service To Date	0.0%	0.0%	0.0%	94.6%

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Detail Service From Date	0.0%	0.0%	0.0%	73.2%
Detail Service To Date	0.0%	0.0%	0.0%	68.5%
Admission Date	0.3%	0.0%	3.7%	100%
Billing Provider NPI	0.0%	0.0%	0.0%	98.6%
Attending Provider NPI	2.4%	<0.1%	<0.1%	95.0%
Referring Provider NPI	3.0%	0.0%	97.0%	100%
Primary Diagnosis Code	0.0%	0.0%	0.0%	100%
Secondary Diagnosis Code[1]	0.0%	0.0%	14.1%	100%
Procedure Code	0.0%	0.0%	83.4%	100%
Procedure Code Modifier	<0.1%	0.0%	96.3%	100%
Units of Service	0.0%	0.0%	0.0%	91.6%
Primary Surgical Procedure Code	0.0%	0.0%	97.9%	100%
NDC	0.4%	0.0%	99.6%	NA[2]
Revenue Code	0.0%	0.0%	0.0%	100%
DRG	<0.1%	2.7%	96.3%	0.0%
Header Paid Amount	0.0%	0.0%	0.0%	99.9%
Detail Paid Amount	0.0%	0.0%	0.0%	100%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table H-2

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC institutional encounter data elements evaluated.
- The LTC institutional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and United-C-submitted data), except for the accuracy rates associated with the *Header Service To Date*, *Detail Service From Date*, *Detail Service To Date*, *Units of Service*, and *DRG* fields.
  - For the *Header Service To Date* data element, the accuracy rate was at 94.6 percent. For records in which the values of this data element did not match, the United-C-submitted data had one-day header dates of service for 70.3 percent of records, while the Agency-submitted data had header dates of service that spanned a period of more than a week for 70.1 percent of records.
  - The accuracy rates for the *Detail Service From Date* and *Detail Service To Date* data elements were low at 73.2 percent and 68.5 percent, respectively. Among records in which the *Detail Service From Date* values did not match, the United-C-submitted *Detail Dates of Service* values spanned a single day for 95.6 percent of records, while the Agency-submitted *Detail Dates of Service* values spanned more than a single day for 100 percent of these records. For records with

mismatches on the *Detail Service To Date* data element, the results were 94.6 percent and more than 99.9 percent, respectively.

- For the *Units of Service* data element, the accuracy rate was at 91.6 percent. For 98.7 percent of the values that did not match for this data element, the Agency-submitted data had a value of "0."
- For the *DRG* data element, the accuracy rate was very low at 0.0 percent. United-C noted that it populated this data element with APR-DRG, which has a standard length of four digits. However, the Agency-submitted data populated this data element with three-digit values. Of note, when the first three digits were compared, there was a 100 percent match.

LTC Professional Encounters

Table H-3 displays United-C's data element omission, surplus, absent, and accuracy rates for the LTC professional encounters.

Table H-3—Data Element Completeness and Accuracy for LTC Professional Encounters

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	100%
Header Service From Date	0.0%	0.0%	0.0%	99.4%
Header Service To Date	0.0%	0.0%	0.0%	99.8%
Detail Service From Date	0.0%	0.0%	0.0%	>99.9%
Detail Service To Date	0.0%	0.0%	0.0%	>99.9%
Billing Provider NPI	0.0%	0.0%	0.0%	99.4%
Rendering Provider NPI	0.0%	88.7%	0.0%	97.7%
Referring Provider NPI	2.1%	0.0%	78.9%	93.2%
Primary Diagnosis Code	0.0%	0.0%	0.0%	99.0%
Secondary Diagnosis Code[1]	6.3%	0.0%	84.7%	94.9%
Procedure Code	0.0%	0.0%	0.0%	100%
Procedure Code Modifier	<0.1%	0.0%	29.4%	100%
Units of Service	0.0%	0.0%	0.0%	98.2%
NDC	<0.1%	0.0%	>99.9%	NA[2]
Header Paid Amount	0.0%	0.0%	0.0%	>99.9%
Detail Paid Amount	0.0%	0.0%	0.0%	100%

[1] Calculated for *Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table H-3

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC professional encounter data elements evaluated except the omission rate for the *Secondary Diagnosis Code* data element and the surplus rate for the *Rendering Provider NPI* data element.
  - The omission rate for the *Secondary Diagnosis Code* data element was high at 6.3 percent. No pattern was identified for this omission; however, the United-C-submitted data had more secondary diagnosis codes than the Agency-submitted data for 58.0 percent of records.
  - The surplus rate for the *Rendering Provider NPI* data element was very high at 88.7 percent. Among NPIs identified as surplus for this data element, the NPIs were the same as the *Billing Provider NPI* values within the Agency-submitted data. Therefore, it is likely that the *Rendering Provider NPI* values in the Agency's data were created based on the *Billing Provider NPI* values during the Agency's internal processing.
- The LTC professional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and United-C-submitted data), except for accuracy rates associated with the *Referring Provider NPI* and *Secondary Diagnosis Code* data elements.
  - For the *Referring Provider NPI* data element, the accuracy rate was at 93.2 percent. HSAG was not able to identify any pattern(s) or the root cause for the discrepancy.
  - The accuracy rate for the *Secondary Diagnosis Code* data element was at 94.9 percent. It appears that the order of the secondary diagnosis codes differed between the United-C-submitted data and the Agency-submitted data. When the *Secondary Diagnosis Code* values were compared to the values of other submitted diagnosis codes, the Agency-submitted *Secondary Diagnosis Code* values appeared 100 percent of the time in the United-C-submitted data. Similarly, the United-C-submitted *Secondary Diagnosis Code* values appeared 60.7 percent of the time in the Agency-submitted data for these mismatches.

The images below present United-C's investigation efforts and explanations from the data discrepancy report.

Table	Discrepancy Item	UNI-C's Investigation Efforts and Explanations
Table 1	LTC professional record surplus rate (6.3 percent)	Upon review, the majority of examples do not have svc_lob = 'LTC' that we use as a criteria for LTC , some encounters found with different than *S- original, V -void, or W - replacement submitted flag on dtl table which was the reason of exclusion (claim_id 354074920)* Most of the encounters where not LTC services and for that reason were excluded from the previous submission.
Table 2	*Header Service To Date* accuracy rate for LTC institutional encounters (94.6 percent)	Upon review, Statement_to_dt on header_inst_table should be used. An update to the logic to use this date versus claim thru date will improve this alignment We were able to identify the cause of discrepancies in majority of examples provided and updated our logic for future reporting.
Table 2	*Detail Service From Date* accuracy rate for LTC institutional encounters (73.2 percent)	**Statement_FROM_dt on header_inst_table should be used**, in majority of encounters checked Statement_FROM_dt = claim_FROM_dt but found in three examples provided by the state statement_ Statement_FROM_dt _dt <> claim_FROM_dt and Agency data matches statement_FROM_dt (ICN 7021173114497, 7020236007769, 7020099106624) We were able to identify the cause of discrepancies in majority of examples provided and updated our logic for future reporting.
Table 2	*Detail Service To Date* accuracy rate for LTC institutional encounters (68.5 percent)	Upon review, an update to the logic to use Statement_to_dt on header_inst table should be used, in majority of encounters checked statement_to_dt = claim_thru_dt, currently found on the report however it does not match all. We were able to identify the cause of discrepancies in majority of examples provided and updated our logic for future reporting.
Table 2	*Units of Service* accuracy rate for LTC institutional encounters (91.6 percent)	We were not able to replicate this finding.The majority of the examples match to Agency Data by units_allowed (quantity is currently used in the logic) but 96 examples do not match and could not find any other field in Nemis to match with what the Agency has supplied in the file. We were able to identify the cause of discrepancies in majority of examples provided and updated our logic for future reporting. There is still small number of examples where we were unable to find matching values between Nemis and Agency's examples.
Table 2	*DRG Code* accuracy rate for LTC institutional encounters (0.0 percent)	Upon review, the agency is using only first 3 char of DRG code vs whole DRG code in our dataset, to be formatted to match Agency requirements We were able to identify the cause of discrepancies and updated our logic for future reporting.
Table 3	*Secondary Diagnosis Code* omission rate (6.3 percent) and accuracy rate (94.9 percent) for LTC professional encounters	Upon review, the logic will need to be changed to use DIAG_CODE_PONT_2 on detail table and link to correct DIAGNOSIS code on header table which will match diagnosis reported on Agency file. We were able to identify the cause of discrepancies and updated our logic for future reporting.

Table	Discrepancy Item	UNI-C's Investigation Efforts and Explanations
Table 3	*Rendering Provider NPI* surplus rate for LTC professional encounters (88.7 percent)	Upon review, the logic will need to be updated to pull in the bill NPI if Rend NPI is null will need to be applied. We were able to identify the cause of discrepancies and updated our logic for future reporting.
Table 3	*Referring Provider NPI* accuracy rate for LTC professional encounters (93.2 percent)	No findings. We were not able to replicate the submitted Agency's Ref Prov NPI do not match to any values in Nemis. Our report matches records in Nemis We reviewed the finding but were unable to find the cause. Values provided in the our report match records in Nemis. We could not match values provided on the examples to values in Nemis.

Long-Term Care Record and Plan of Care Review Results

LTC Record and Plan of Care Documentation Submissions

Table H-4 shows the LTC record and plan of care document submission status for United-C, detailing the number of LTC records and plan of care documents requested as well as the number and percentage of LTC records and plan of care documents submitted by United-C as indicated in its submitted tracking sheets.

Table H-4—LTC Record and Plan of Care Submissions: United-C

Plan	Number of Records/ Documents Requested	LTC Record Submitted		Plan of Care Document Submitted	
		N	Percent	N	Percent
UNI-C	183	128	69.9%	166	90.7%
All Plans	**1,453**	**1,075**	**74.0%**	**1,331**	**91.6%**

Table H-5 highlights the key reasons LTC records and plan of care documents were not submitted by United-C.

Table H-5—Reasons for Missing LTC Record and Plan of Care Documentation: United-C

LTC Records			Plan of Care Documents		
Reason	Count	Percent	Reason	Count	Percent
Non-responsive provider or provider did not respond in a timely manner.	44	80.0%	Other	11	64.7%

LTC Records			Plan of Care Documents		
Reason	Count	Percent	Reason	Count	Percent
Other	4	7.3%	Enrollee is a patient of the practice; however, no documentation is available.	3	17.6%
Enrollee is a patient of the practice; however, no documentation was available for requested dates of service.	3	5.5%	Plan of care not located at this facility; location unknown.	3	17.6%
LTC record not located at this facility; location unknown.	3	5.5%			
Enrollee was not a patient of the practice.	1	1.8%			
Total	**55**	**100%**	**Total**	**17**	**100%**

Encounter Data Completeness

Table H-6 displays the LTC record omission and encounter data omission rates for each key data element for United-C. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and numerator:

- LTC record omission rate: The denominator for the LTC record omission rate is the number of diagnosis codes identified in the Agency's electronic encounter data, and the numerator is the number of diagnosis codes identified in the Agency's electronic encounter data that were not found (i.e., not supported) in the enrollees' LTC records.

  In the analysis, when no LTC records were submitted for a sampled date of service, all other key data elements associated with that date of service were treated as LTC record omissions.
- Encounter data omission rate: The denominator for the encounter data omission rate is the number of diagnosis codes identified in the enrollees' LTC records, and the numerator is the number of diagnosis codes from the enrollees' LTC records that were not found in the Agency's electronic encounter data.

For both rates, lower values indicate better performance.

Table H-6—Encounter Data Completeness Summary: United-C

Data Element	LTC Record Omission*			Encounter Data Omission*		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Date of Service	174	50	28.7%			
Diagnosis Code	603	315	52.2%	288	0	0.0%
Procedure Code	187	39	20.9%	148	0	0.0%

Data Element	LTC Record Omission*			Encounter Data Omission*		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Procedure Code Modifier	130	27	20.8%	103	0	0.0%

* Lower rates indicate better performance.

Note: Cells shaded in gray indicate the study indicator is not applicable for a data element.

Encounter Data Accuracy

Table H-7 displays the element accuracy rates for each key data element and the all-element accuracy rates for United-C. Encounter data accuracy was evaluated for dates of service that existed in both the Agency's electronic encounter data and the LTC records and had values present in both data sources for the evaluated data element. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and the numerator:

- Denominator: The denominator for the accuracy rate is the number of diagnosis codes associated with dates of service that existed in both the Agency's electronic encounter data and the enrollees' LTC records. In addition, both data sources had values for the *Diagnosis Code* data element.
- Numerator: The numerator for the accuracy rate is the number of diagnosis codes in the denominator that were correctly coded based on the enrollees' LTC records submitted for the study.

Table H-7 also presents the all-element accuracy rate which denotes the percentage of dates of service present in both the Agency's encounter data and the LTC records with the same values (i.e., no LTC record omission, no encounter data omission, and codes were coded correctly) for **all** key data elements. The denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service with the same values for all key data elements.

Table H-7—Encounter Data Accuracy Summary: United-C

Data Element	Denominator	Numerator	Rate	Main Error Type
Diagnosis Code	288	285	99.0%	Inaccurate Code (66.7%) Specificity Error (33.3%)
Procedure Code	148	148	100%	Inaccurate Code (NA) Lower Level of Services in LTC Records (NA) Higher Level of Services in LTC Records (NA)
Procedure Code Modifier	103	103	100%	—
All-Element Accuracy	124	105	84.7%	—

"—" denotes that the error type analysis was not applicable to a given data element.

Note: NA indicates all codes were coded accurately; therefore, there were no error types to report.

Plan of Care Document Review

HSAG reviewed the submitted plan of care documentation and evaluated whether the LTC services reported in the encounters were supported by enrollees' plans of care. HSAG reviewed plan of care documentation for alignment with authorization dates, scheduled services, units of service, and service providers. As such, the plan of care review component of the study answered the following questions:

- *Was there a valid plan of care? If so, was the plan of care document signed?*
- *For a plan of care with an appropriate signature, was the selected date of service within the effective dates of the plan of care?*
- *For a plan of care where the selected date of service was within the effective dates of the plan of care:*
  - *Was there a servicing provider documented in the plan of care? If so, was the servicing provider identified in the LTC record supported by the plan of care?*
  - *Were the procedure codes documented in the LTC record supported by the plan of care?*
  - *Were the number of units documented in the LTC record supported by the plan of care?*

Table H-8 presents findings from the review of plan of care documentation for United-C.

Table H-8—Plan of Care Document Review Summary: United-C

Plan of Care Document Reviewed Items	N
Date of service identified in encounter data	174
Valid plan of care submission	165
– Plan of care document was from provider	38
– Plan of care document was from the plan	127
Plan of documentation was signed	134
Selected dates of service were within the effective dates of the plan of care documents	132
Servicing providers were documented	132
Documented servicing providers support provider information in the LTC records	89
Documented procedures support procedures identified in the LTC records	89
Documented number of units support the units identified in the LTC records	88

Appendix I: Results for Florida Community Care, LLC

This appendix contains the comparative analysis and LTC record and plan of care review results and findings for Florida Community Care, LLC (Florida Community Care-L/FCC-L).

Comparative Analysis

This section presents Florida Community Care-L's results for comparative analysis. Based on study findings from the comparative analysis component, HSAG initiated follow-up activities designed to assist the plans in addressing major encounter data issues identified from this study. First, HSAG distributed the data discrepancy reports to each plan, which included a description of key issues for the plans to review. Additionally, samples of encounters highlighting identified issues were also distributed to further assist the plans in reviewing the results.

Second, the plans were required to submit written responses on any required resolutions or follow-up items identified and noted in the discrepancy reports. These next sections present the comparative analysis results as reported in the data discrepancy report for Florida Community Care-L. Additionally, the images of Florida Community Care-L's responses based on its investigation efforts on the example discrepant records are provided at the end of this appendix.

Record Completeness

There are two aspects of record completeness—record omission and record surplus. A record omission occurs when a record is present in the plan's submitted data files for the study but not in the Agency's data files. Similarly, a record surplus occurs when a record is present in the Agency's data files but not in the plan's submitted data files. The Agency encounter data are considered relatively complete when the record omission and record surplus rates are low.

Table I-1 displays the percentage of records present in the Florida Community Care-L-submitted files that were not found in the Agency-submitted files (record omission) and the percentage of records present in the Agency-submitted files but not present in the Florida Community Care-L-submitted files (record surplus) for the LTC encounters. **Lower rates indicate better performance for both record omission and record surplus**.

Table I-1—Record Omission and Surplus

Encounter Type	Omission (Missing in the Agency's Files)	Surplus (Missing in Plan Files)
LTC Professional	3.3%	2.9%
LTC Institutional	1.1%	0.4%

Key Findings: Table I-1

- There were no issues noted regarding the record omission and surplus rates of 3.3 percent and 2.9 percent, respectively, for the LTC professional encounters.
- There were no issues noted regarding the record omission and surplus rates of 1.1 percent and 0.4 percent, respectively, for the LTC institutional encounters.

Data Element Completeness and Accuracy

Data element completeness measures were based on the number of records that matched in both the Agency's data files and the plan's data files. Element-level completeness is evaluated based on element omission and element surplus rates. The element omission rate represents the percentage of records with values present in the plan's submitted data files but not in the Agency's data files. Similarly, the element surplus rate reports the percentage of records with values present in the Agency's data files but not in the plan's submitted data files. The data elements are considered relatively complete when they have low element omission and surplus rates.

Data element accuracy is limited to those records present in both data sources with values present in both data sources. Records with values missing in both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element.

For records that matched in both the Agency-submitted files and the plan-submitted files, the percentage of records with values absent in both data sources was also calculated as supplemental information. It is important to note that for element absent, in general, lower rates would be preferred, indicating fewer records had values not populated in both data sources. However, higher rates do not necessarily indicate poor performance since some data elements are not required for every encounter transaction. Some examples include data elements that are characterized by situational reporting requirements—e.g., secondary diagnosis code, procedure code modifier.

LTC Institutional Encounters

Table I-2 displays Florida Community Care-L's data element omission, surplus, absent, and accuracy rates for the LTC institutional encounters.

Table I-2—Data Element Completeness and Accuracy for LTC Institutional Encounters

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	100%
Header Service From Date	0.0%	0.0%	0.0%	99.2%
Header Service To Date	0.0%	0.0%	0.0%	98.9%
Detail Service From Date	0.0%	0.0%	0.0%	100%
Detail Service To Date	0.0%	0.0%	0.0%	100%

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Admission Date	0.0%	0.0%	68.5%	100%
Billing Provider NPI	0.0%	0.0%	0.0%	4.4%
Attending Provider NPI	17.0%	0.0%	69.5%	98.6%
Referring Provider NPI	0.0%	0.0%	100%	NA[2]
Primary Diagnosis Code	0.0%	0.0%	0.0%	>99.9%
Secondary Diagnosis Code[1]	4.8%	0.0%	2.3%	4.7%
Procedure Code	0.0%	0.0%	29.8%	100%
Procedure Code Modifier	<0.1%	0.0%	31.6%	100%
Units of Service	0.0%	0.0%	0.0%	31.2%
Primary Surgical Procedure Code	0.0%	0.0%	100%	NA[2]
NDC	0.0%	0.0%	100%	NA[2]
Revenue Code	0.0%	0.0%	0.0%	97.7%
DRG	<0.1%	0.0%	>99.9%	NA[2]
Header Paid Amount	0.0%	0.0%	0.0%	31.4%
Detail Paid Amount	0.0%	0.0%	0.0%	32.3%

[1] Calculated for *Secondary Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table I-2

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC institutional encounter data elements evaluated except the omission rate for the *Attending Provider NPI* data element.
  - The omission rate for the *Attending Provider NPI* data element was very high at 17.0 percent. HSAG was not able to identify any pattern(s) or the root cause for the discrepancy.
- The LTC institutional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Florida Community Care-L-submitted data), except for the accuracy rates associated with the *Billing Provider NPI*, *Secondary Diagnosis Code*, *Units of Service*, *Header Paid Amount*, and *Detail Paid Amount* data elements.
  - For the *Billing Provider NPI* data element, the accuracy rate was very low at 4.4 percent. HSAG was not able to identify any pattern(s) or the root cause for the discrepancy.
  - The accuracy rate for the *Secondary Diagnosis Code* data element was very low at 4.7 percent. It appears that the order of the secondary diagnosis codes differed between the Florida Community Care-L-submitted data and the Agency-submitted data. When the *Secondary Diagnosis Code* values were compared to the values of other submitted diagnosis codes, the Agency-submitted *Secondary Diagnosis Code* values appeared 100 percent of the time in the Florida Community Care-L-submitted data. Similarly, the Florida Community Care-L-submitted *Secondary*

Diagnosis Code values appeared 97.8 percent of the time in the Agency-submitted data for these mismatches. Of note, the Florida Community Care-L data submission included at least one more diagnosis code for 84.5 percent of records with a *Secondary Diagnosis Code* mismatch.

- The accuracy rate for the *Units of Service* data element was very low at 31.2 percent. For more than 99.9 percent of the values that did not match, the Agency-submitted data had a value of "0."
- Florida Community Care-L had very low accuracy rates of 31.4 percent and 32.3 percent, respectively, for the *Header Paid Amount* and *Detail Paid Amount* data elements. HSAG was not able to identify any pattern(s) or the root cause for the discrepancies.

LTC Professional Encounters

Table I-3 displays Florida Community Care-L's data element omission, surplus, absent, and accuracy rates for the LTC professional encounters.

Table I-3—Data Element Completeness and Accuracy for LTC Professional Encounters

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Enrollee ID	0.0%	0.0%	0.0%	100%
Header Service From Date	0.0%	0.0%	0.0%	99.1%
Header Service To Date	0.0%	0.0%	0.0%	99.4%
Detail Service From Date	0.0%	0.0%	0.0%	100%
Detail Service To Date	0.0%	0.0%	0.0%	100%
Billing Provider NPI	0.0%	0.0%	0.0%	12.6%
Rendering Provider NPI	0.0%	0.0%	0.0%	13.0%
Referring Provider NPI	0.0%	0.0%	100%	NA[2]
Primary Diagnosis Code	0.0%	0.0%	0.0%	95.6%
Secondary Diagnosis Code[1]	5.6%	0.0%	93.7%	39.1%
Procedure Code	0.0%	0.0%	0.0%	100%
Procedure Code Modifier	<0.1%	0.0%	73.5%	100%
Units of Service	0.0%	0.0%	0.0%	98.1%
NDC	<0.1%	0.0%	>99.9%	NA[2]
Header Paid Amount	4.4%	0.0%	0.0%	97.3%
Detail Paid Amount	4.4%	0.0%	0.0%	97.4%

[1] Calculated for *Secondary Diagnosis Code 2* only.
[2] NA indicates not applicable since no records had values present in both data sources.

Key Findings: Table I-3

- The data element omission and surplus rates were low (i.e., at or lower than 5.0 percent) for all LTC professional encounter data elements evaluated except the omission rate for the *Secondary Diagnosis Code* data element.
  - The omission rate for the *Secondary Diagnosis Code* data element was high at 5.6 percent. HSAG was not able to identify any pattern(s) or the root cause for the discrepancy.
- The LTC professional data element accuracy rates were high (i.e., at least 95.0 percent) for all evaluated data elements that had values populated in both sources (i.e., Agency- and Florida Community Care-L-submitted data), except for the accuracy rates associated with the *Billing Provider NPI*, *Rendering Provider NPI*, and *Secondary Diagnosis Code* data elements.
  - For the *Billing Provider NPI* and *Rendering Provider NPI* data elements, the accuracy rates were very low at 12.6 percent and 13.0 percent, respectively. HSAG was not able to identify any pattern(s) or the root cause for the discrepancies. However, among records for these data elements in which values did not match between the two data sources (i.e., Agency- and Florida Community Care-L-submitted data), the *Rendering Provider NPI* values were the same as the *Billing Provider NPI* values for 99.5 percent of records.
  - The accuracy rate for the *Secondary Diagnosis Code* data element was very low at 39.1 percent. It appears that the order of the secondary diagnosis codes differed between the Florida Community Care-L-submitted data and the Agency-submitted data. When the *Secondary Diagnosis Code* values were compared to the values of other submitted diagnosis codes, the Agency-submitted *Secondary Diagnosis Code* values appeared 100 percent of the time in the Florida Community Care-L-submitted data. Similarly, the Florida Community Care-L-submitted *Secondary Diagnosis Code* values appeared 89.7 percent of the time in the Agency-submitted data for these mismatches.

The image below presents Florida Community Care-L's investigation efforts and explanations from the data discrepancy report.

Table	Discrepancy Item	FCC-L's Investigation Efforts and Explanations
Table 2	*Attending Provider NPI* omission rate for LTC institutional encounters (17.0 percent)	Our encounter program did not begin submitting attending provider NPI until April of 2022. Therefore, the agency would not have the attending provider NPI reflected in this report in their records.
Table 2	*Billing Provider NPI* accuracy rate for LTC institutional encounters (4.4 percent)	This was a reporting error that was not pulling the proper billing NPI into the EDV report. However, the encounter 837 was submitted with the same billing NPI in the state's examples. The report has been corrected to reflect the proper Billing NPI.
Table 2	*Secondary Diagnosis Code* accuracy rate for LTC institutional encounters (4.7 percent)	This was a reporting error that was not sending the DX codes in the proper order. However, the encounter 837 was submitted with the same DX code in the state's example. The report has been corrected.
Table 2	*Units of Service* accuracy rate for LTC institutional encounters (31.2 percent)	These are due to encounter rejections. The encounter was sent with the same units provided in this report. These encounters will be resubmitted.
Table 2	*Header Paid Amount* accuracy rate for LTC institutional encounters (31.4 percent)	These are all crossover encounters. The paid amount we submitted reflects the Medicaid paid dollars. What the agency has in their examples is the Medicare dollars.
Table 2	*Detail Paid Amount* accuracy rate for LTC institutional encounters (32.3 percent)	These are all crossover encounters. The paid amount we submitted reflects the Medicaid paid dollars. What the agency has in their examples is the Medicare dollars
Table 3	*Secondary Diagnosis Code* omission rate (5.6 percent) and accuracy rate (39.1 percent) for LTC professional encounters	These are due to encounter rejections. The encounter was sent with the same DX codes provided in this report. The report has been corrected.
Table 3	*Billing Provider NPI* accuracy rate for LTC professional encounters (12.6 percent)	This was a reporting error that was not pulling the proper billing NPI into the EDV report. However, the encounter 837 was submitted with the same billing NPI in the state's examples. The report has been corrected to reflect the proper Billing NPI.
Table 3	*Rendering Provider NPI* accuracy rate for LTC professional encounters (13.0 percent)	This was a reporting error that was not pulling the proper rendering NPI from our encounter files. However, the encounter 837 was submitted with the same rendering NPI in the state's examples. The report has been corrected to reflect the proper Rendering NPI.

Long-Term Care Record and Plan of Care Review Results

LTC Record and Plan of Care Documentation Submissions

Table I-4 shows the LTC record and plan of care document submission status for Florida Community Care-L, detailing the number of LTC records and plan of care documents requested as well as the number and percentage of LTC records and plan of care documents submitted by Florida Community Care-L as indicated in its submitted tracking sheets.

Table I-4—LTC Record and Plan of Care Submissions: Florida Community Care-L

Plan	Number of Records/ Documents Requested	LTC Record Submitted		Plan of Care Document Submitted	
		N	Percent	N	Percent
FCC-L	183	175	95.6%	183	100%
All Plans	**1,453**	**1,075**	**74.0%**	**1,331**	**91.6%**

Table I-5 highlights the key reasons LTC records and plan of care documents were not submitted by Florida Community Care-L.

Table I-5—Reasons for Missing LTC Record and Plan of Care Documentation: Florida Community Care-L

LTC Record			Plan of Care Document		
Reason	Count	Percent	Reason	Count	Percent
Non-responsive provider or provider did not respond in a timely manner.	8	100%	NA	—	—
Total	**8**	**100%**	**Total**	**—**	**—**

"—" Indicates that there were no missing plans of care; therefore, there were no reasons to report.

Note: NA indicates not applicable since there were no missing reasons to report.

Encounter Data Completeness

Table I-6 displays the LTC record omission and encounter data omission rates for each key data element for Florida Community Care-L. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and numerator:

- LTC record omission rate: The denominator for the LTC record omission rate is the number of diagnosis codes identified in the Agency's electronic encounter data, and the numerator is the number of diagnosis codes identified in the Agency's electronic encounter data that were not found (i.e., not supported) in the enrollees' LTC records.

In the analysis, when no LTC records were submitted for a sampled date of service, all other key data elements associated with that date of service were treated as LTC record omissions.

- Encounter data omission rate: The denominator for the encounter data omission rate is the number of diagnosis codes identified in the enrollees' LTC records, and the numerator is the number of diagnosis codes from the enrollees' LTC records that were not found in the Agency's electronic encounter data.

For both rates, lower values indicate better performance.

Table I-6—Encounter Data Completeness Summary: Florida Community Care-L

Data Element	LTC Record Omission*			Encounter Data Omission*		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Date of Service	178	11	6.2%			
Diagnosis Code	721	184	25.5%	537	0	0.0%
Procedure Code	134	2	1.5%	132	0	0.0%
Procedure Code Modifier	17	1	5.9%	16	0	0.0%

* Lower rates indicate better performance.

Note: Cells shaded in gray indicate the study indicator is not applicable for a data element.

Encounter Data Accuracy

Table I-7 displays the element accuracy rates for each key data element and the all-element accuracy rates for Florida Community Care-L. Encounter data accuracy was evaluated for dates of service that existed in both the Agency's electronic encounter data and the LTC records and had values present in both data sources for the evaluated data element. Using the *Diagnosis Code* data element as an example, the list below shows the specifications for the denominator and the numerator:

- Denominator: The denominator for the accuracy rate is the number of diagnosis codes associated with dates of service that existed in both the Agency's electronic encounter data and the enrollees' LTC records. In addition, both data sources had values for the *Diagnosis Code* data element.
- Numerator: The numerator for the accuracy rate is the number of diagnosis codes in the denominator that were correctly coded based on the enrollees' LTC records submitted for the study.

Table I-7 also presents the all-element accuracy rate which denotes the percentage of dates of service present in both the Agency's encounter data and the LTC records with the same values (i.e., no LTC record omission, no encounter data omission, and codes were coded correctly) for **all** key data elements. The denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service with the same values for all key data elements.

Table I-7—Encounter Data Accuracy Summary: Florida Community Care-L

Data Element	Denominator	Numerator	Rate	Main Error Type
Diagnosis Code	537	537	100%	Inaccurate Code (NA) Specificity Error (NA)
Procedure Code	132	131	99.2%	Inaccurate Code (100%) Lower Level of Services in LTC Records (0.0%) Higher Level of Services in LTC Records (0.0%)
Procedure Code Modifier	16	16	100%	—
All-Element Accuracy	167	154	92.2%	—

"—" denotes that the error type analysis was not applicable to a given data element.

Note: NA indicates all codes were coded accurately; therefore, there were no error types to report.

Plan of Care Document Review

HSAG reviewed the submitted plan of care documentation and evaluated whether the LTC services reported in the encounters were supported by enrollees' plans of care. HSAG reviewed plan of care documentation for alignment with authorization dates, scheduled services, units of service, and service providers. As such, the plan of care review component of the study answered the following questions:

- *Was there a valid plan of care? If so, was the plan of care document signed?*
- *For a plan of care with an appropriate signature, was the selected date of service within the effective dates of the plan of care?*
- *For a plan of care where the selected date of service was within the effective dates of the plan of care:*
  - *Was there a servicing provider documented in the plan of care? If so, was the servicing provider identified in the LTC record supported by the plan of care?*
  - *Were the procedure codes documented in the LTC record supported by the plan of care?*
  - *Were the number of units documented in the LTC record supported by the plan of care?*

Table I-8 presents findings from the review of plan of care documentation for Florida Community Care-L.

Table I-8—Plan of Care Document Review Summary: Florida Community Care-L

Plan of Care Document Reviewed Items	N
Date of service identified in encounter data	178
Valid plan of care submission	171
– Plan of care document was from provider	3
– Plan of care document was from the plan	168

Plan of Care Document Reviewed Items	N
Plan of documentation was signed	157
Selected dates of service were within the effective dates of the plan of care documents	156
Servicing providers were documented	133
Documented servicing providers support provider information in the LTC records	122
Documented procedures support procedures identified in the LTC records	121
Documented number of units support the units identified in the LTC records	143