STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45504 • Olympia, Washington 98504-5503

November 3, 2021

Case ID Number: OPI-MC-2019-00002-UHC

Sent via certified mail

Allan Fisher, President
UnitedHealthcare Community Plan
1111 3rd Avenue, Suite 1100
Seattle, WA 98101

Notice of Revised Final Audit Report and Imposition of Sanctions

Dear Mr. Fisher:

Please find the Revised Final Audit Report for Encounter Data Validation included with this Revised Notice of Final Audit Report and Imposition of Sanctions (Notice) for UnitedHealthcare Community Plan (UHC).

Summary of Audit

The Health Care Authority (HCA), Division of Program Integrity, conducted an Encounter Data Validation audit of encounter claims submitted by UHC. HCA selected a random sample of one-hundred and twenty (120) encounters representing twelve (12) claim types (10 encounters per claim type) from a universe of claims for services rendered to UHC enrollees between January 1, 2018, and December 31, 2018.

HCA analyzed all documentation submitted by UHC and reconsidered findings specified in the HCA Preliminary and Final Audit Reports. The reconsideration resulted in the reversal of 14 findings from category 2, 27 findings from category 3, 8 findings from category 12, 15 findings from category 13, 2 findings from category 14, 2 findings from category 21 and all findings in categories 4, 7, 15 and 16. HCA reduced the number of total findings from 330 to 255. Revised final findings are documented on the attached Revised Final Audit Report.

Summary of Findings

HCA found 255 instances in which UHC provided inaccurate encounter claim data. Findings of inaccuracies are as follows:

- Misrepresentation of payer or payment: 153 findings;
- UHC added/omitted/altered data from inbound HIPAA file: 99 findings; and

- Administrative or adjudication error: 3 findings.

Basis for Sanctions

Section 5 of the Contract[1] requires UHC to "submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA and that adhere to the following data quality standards."

On July 17, 2019, UHC timely submitted encounter data in response to the audit. HCA determined that UHC submitted data that contained at least 255 instances of errors, omitted data, or misrepresented data.

As a result, HCA has determined that UHC altered or omitted claims data from the providers' original claims submissions and provided inaccurate encounter claim data. UHC's actions hindered HCA's ability to ensure encounter data is accurate, truthful, and complete and to conduct its required duties.

Imposition of Sanctions

Based on the conduct described above, HCA is imposing an intermediate sanction against UHC in the amount of **$228,750.00**.

HCA imposes the sanctions in accordance with Section 5 of the Contract. Section 5.20.2.2 provides that HCA "may impose intermediate sanctions in accord with applicable law, including but not limited to 42 C.F.R 438.700, 42 C.F.R 438.702, 42 C.F.R 438.704, 45 C.F.R 92.36(i)(1), 42 C.F.R. 422.208 and 42 C.F.R. 422.210[.]" Under Section 5.20.2.2.4, the sanctions can be imposed against UHC for "[m]isrepresenting or falsifying information that it furnishes to" HCA.

HCA must receive the sanction amount by no later than 30 days after the receipt of this Notice. Failure to remit the sanction amount in a timely manner may result in additional penalties.

Please remit payment to the following address:

Health Care Authority
P.O Box 42691
Olympia, WA 98504-2691

Please include the case number with your remittance.

Dispute Resolution

This notice does not include a restatement of UHC's right to dispute conference since UHC already invoked its right to a dispute process related to the findings at issue. Additionally, UHC has

[1] Section 5.11.2.2 of the Apple Health managed care contract between HCA and UHC, effective January 1, 2018 (Contract), and Section 5.12.2.2 of Amendment 1 to the Contract, effective July 1, 2018.

communicated to HCA that it is withdrawing the request for a dispute conference based in part on the revised findings reflected in this notice.

Sincerely,

Mike Brown
Health Care Authority

Enclosures

cc: Jason McGill, Assistant Director, HCA, MPD
Annette Schuffenhauer, Chief Legal Officer, HCA
Dan Ashby, Section Manager, HCA, FS
Michele Cleary, Executive Assistant, HCA

Washington State Health Care Authority

Revised Final Audit Report

Encounter Data Validation Of UnitedHealthcare Community Plan

Case Number: OPI-MC-2019-00002-UHC

November 3, 2021

Program Integrity Administration

Managed Care Oversight Unit

CMS Directive

The Centers for Medicare and Medicaid Services (CMS) issued a report in June 2018 regarding the need for every State Medicaid agency to have better oversight of their contracted Managed Care Organizations (MCOs). CMS recommends continued efforts to implement proactive data mining and routine audits of validated managed care encounter data to ensure its integrity. The Health Care Authority (HCA) is carrying out its obligations under federal and state law by performing this Encounter Data Validation (EDV) audit.

Authority

HCA conducts encounter validation reviews in accordance with requirements under the United States Code (USC), the Code of Federal Regulations (CFR), the Apple Health Managed Care (AHMC) contract, instructions from HCA's Encounter Data Reporting Guide (EDRG), instructions from the HCA 5010 837 Professional and Institutional Encounter Data Companion Guide, and the National Council for Prescription Drug Program (NCPDP) companion guide.

Process of Encounter Validation Review

The HCA Program Integrity Managed Care Oversight Unit (PIMCO) initiated its first onsite audit with UnitedHealthcare Community Plan (UHC) on July 17, 2019. PIMCO conducted this validation audit and reviewed the encounter data in the following manner:

Random Sample Selection

HCA selected a random sample of one-hundred and twenty (120) encounters representing twelve (12) claim types (10 encounters per claim type) from a universe of claims for services rendered to UHC enrollees between January 1, 2018, and December 31, 2018.

Notice of Intent to Audit

On June 10, 2019, HCA sent a Notice of Intent to Audit (Notice) to UHC. HCA compiled the encounters from the random sample into a list and attached them to the Notice with instructions. For each sample encounter claim, HCA instructed UHC to provide a complete copy of the original and adjudicated MCO network provider claim, including all submitted header and line level detail, as well as claim adjudication information and final paid amounts.

Onsite Visit

On July 17, 2019, HCA met with UHC representatives and representatives from UHC's contractors Northwest Physician's Network (NPN) and Highline Medical Services Organization (HMSO). UHC presented their claims payment processes and demonstrated their claims payment system and encounter claim validation process. Twenty encounter claims from the random sample selection were viewed in the UHC claims payment system.

Documentation Analysis

On July 30, 2019, HCA received from UHC the documentation it had requested in the Notice. HCA analyzed the documents to identify discrepancies between (1) the original AHMC provider claim adjudicated through UHC or their contracted entities' claims payment systems and (2) the encounter claims data reported to HCA by UHC. HCA utilized peer review analytics to review discrepancies found by the initial analyst to corroborate the findings.

Preliminary Audit Report

On August 20, 2020, the results of HCA's analysis were documented and reported in a Preliminary Audit Report.

UHC Response to Findings

On September 22, 2020, UHC submitted additional documentation and comments in response to the findings specified in the HCA Preliminary Audit Report. HCA met with UHC on October 7, 2020 to discuss the findings specified in the HCA Preliminary Audit Report. On October 9, 2020 UHC submitted additional documentation for HCA review.

Final Audit Report and Notice of Sanctions

HCA analyzed all comments and information submitted by UHC and reconsidered findings specified in the HCA Preliminary Audit Report. On April 21, 2021, the results of HCA's analysis were documented and reported in a Final Audit Report. Sanction amounts were assessed based on documented findings, as reflected in the Notice of Sanctions issued April 21, 2021.

UHC Dispute

On May 6, 2021, HCA received from UHC a dispute resolution request related to findings identified in the HCA Final Audit Report. Specifically, UHC disputed items in finding categories 2, 3, 4, 7, 9, 10, 11, 12, 13, 14, 15, 16, 19, 20, and 21.

Revised Final Audit Report

HCA analyzed all documentation submitted by UHC and reconsidered findings specified in the HCA Preliminary and Final Audit Reports. The reconsideration resulted in the reversal of 14 findings from category 2, 27 findings from category 3, 8 findings from category 12, 15 findings from category 13, 2 findings from category 14, 2 findings from category 21 and all findings in categories 4, 7, 15 and 16. HCA reduced the number of total findings from 330 to 255. Revised final findings are documented on the Review Worksheet attached as Appendix B and summarized in the findings section below.

Findings

HCA reviewers defined 24 specific categories in which findings of inaccuracies could be determined. Each finding was assigned and labeled an identifying number from 1 to 24. Inaccuracies were identified in 18 of the 24 categories. A summary table of findings is attached as Appendix A, which includes finding identifier, description, count, and percentage of error rate. In addition, a breakdown of findings per encounter claim is attached as Appendix B, which shows the specific findings identified for each claim, total number of findings per claim, and aggregate number of findings for the sample.

HCA found 255 instances in which UHC (1) altered or omitted claim data from the provider's original claim submission and (2) provided inaccurate encounter claim data to HCA, in violation of Section 5 of the AHMC Contract and the requirements of the EDRG. In some cases, there were multiple inaccuracies found in one sample encounter claim.

Specific findings of inaccuracies are categorized into the following:

Misrepresents Payor or Payment

1). TPL reporting

Requirement: Section 5 of the AHMC Contract[1] instructs the MCO to "submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA and that adhere to the following data quality standards".

Requirement: Section 18.6.2.3 of the Contract[2] instructs the MCO to "include all third-party payments by Enrollee in its regular encounter data and submissions".

Finding: HCA identified one-hundred and fifty-two (152) instances in which the provider's original claim submission did not match the encounter claim file submitted to HCA related to third-party liability (TPL). UHC indicated TPL when a client did not have TPL and/or incorrectly identified TPL payer sequencing. These errors include:

- In seventy-six (76) instances, TPL shown when client does not have TPL.
- In seventy-six (76) instances, TPL payer sequencing was incorrect.

2). Pharmacy paid amounts

Requirement: Section 5 of the AHMC Contract[3] instructs the MCO to "submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA and that adhere to the following data quality standards".

Requirement: The Retail Pharmacy Section of the EDRG states: "Amount Paid – The 'AMOUNT PAID' field (430-DU field name) is a requirement for pharmacy encounters. The amount paid is the amount the MCO paid to the servicing pharmacy".

Finding: HCA identified one (1) instance in which the amount paid as reported on the provider's original claim submission differed from the amount paid on the encounter claim file submitted to HCA.

Added/Omitted/Altered Data From Inbound HIPAA File

1). Provider IDs

Requirement: Section 5 of the AHMC Contract[4] instructs the MCO to "submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA and that adhere to the following data quality standards".

Requirement: Page 11 of the EDRG instructs the MCO to "report the National Provider Identifiers (NPIs) for identification of all Network Billing (Pay-to), Servicing, Attending, Referring, Rendering, and Prescribing providers on all encounters".

Requirement: Page 24 of the EDRG instructs the MCO to "report the NPI and Taxonomy codes for the Billing Provider as instructed in the Encounter Data Companion Guides (Loops 200A PRV and 2010AA NM for 837 files). This must always be for the provider that billed the MCO for the services."

1 Section 5.11.2.2 of the 01/01/2018 AHMC contract and Section 5.12.2.2 of 07/01/2018 Amendment 1.

2 Section 18.6.2.3 of the 01/01/2018 AHMC contract and 07/01/2018 Amendment 1.

3 Section 5.11.2.2 of the 01/01/2018 AHMC contract and Section 5.12.2.2 of 07/01/2018 Amendment 1.

4 Section 5.11.2.2 of the 01/01/2018 AHMC contract and Section 5.12.2.2 of 07/01/2018 Amendment 1.

Finding: HCA identified seventy-five (75) instances in which the provider's original claim submission did not match the encounter claim file submitted to HCA related to provider IDs and/or taxonomy.

- In twenty (20) instances, the MCO Network Billing NPI was altered or omitted.
- In thirty-seven (37) instances, the MCO Network Billing Taxonomy was altered or omitted.
- In sixteen (16) instances, the Attending Provider Taxonomy was altered or omitted.
- In one (1) instance, the Servicing Provider NPI was altered or omitted.
- In one (1) instance, the Servicing Provider Taxonomy was altered or omitted.

2). Other altered or omitted information

Requirement: Section 5 of the AHMC Contract[5] instructs the MCO to "submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA and that adhere to the following data quality standards".

Requirement: AHMC contract sections 5.11.2.2.2[6] and 5.12.2.2.2[7] state as follows:

"Submitted encounters and encounter records shall have all fields required and found on standard healthcare claim billing forms or in electronic healthcare claim formats to support proper adjudication of an encounter. The Contractor shall submit to HCA, without alteration, omission or splitting, all available claim data in its entirety from the provider's original claim submission to the Contractor."

Finding: HCA identified twenty-four (24) instances in which the documentation submitted did not match the encounter claim file submitted to HCA.

- In three (3) instances, admit diagnosis codes were altered or omitted.
- In eleven (11) instances, other diagnosis codes were altered or omitted.
- In one (1) instance, the ICD-10 Procedure Code was altered or omitted.
- In four (4) instances, the service lines were altered.
- In five (5) instances, the service line dates of service were altered.

Administrative or Adjudication Error

1). Other altered or omitted information

Requirement: Section 5 of the AHMC Contract[8] instructs the MCO to "submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA and that adhere to the following data quality standards".

5 Section 5.11.2.2 of the 01/01/2018 AHMC contract and Section 5.12.2.2 of 07/01/2018 Amendment 1.

6 AHMC contract effective 01/01/2018 – 06/30/2018.

7 AHMC Amendment 1 effective 07/01/2018 – 12/31/2018.

8 Section 5.11.2.2 of the 01/01/2018 AHMC contract and Section 5.12.2.2 of 07/01/2018 Amendment 1.

Requirement: AHMC contract sections 5.11.2.2.2[9] and 5.12.2.2.2[10] state as follows:

"Submitted encounters and encounter records shall have all fields required and found on standard healthcare claim billing forms or in electronic healthcare claim formats to support proper adjudication of an encounter. The Contractor shall submit to HCA, without alteration, omission or splitting, all available claim data in its entirety from the provider's original claim submission to the Contractor."

Finding: HCA identified three (3) instances in which the documentation submitted did not match the encounter claim file submitted to HCA.

- In three (3) instances, the HCP 12 segment was incorrect (quantity/paid units).

Conclusion

Governing law is clear that UHC must submit encounter data to HCA that is accurate, complete and truthful. This responsibility is underscored by the requirement that an MCO's Chief Executive Officer or Chief Financial Officer (or designee) certify that the submitted encounter data meets these standards.[11] The importance of accurate encounter data is reflected in the United States Code (USC)[12], federal regulations[13] and is referenced in the AHMC contract.[14] HCA collects and uses encounter data for many purposes, such as:

- Audits
- Investigations
- Identifications of improper payments
- Other program integrity activities
- Federal reporting
- Rate setting and risk adjustment
- Service verification
- Managed care quality improvement program,
- Utilization patterns and access to care
- HCA hospital rate setting
- Pharmacy rebates
- Research studies

Additionally, federal regulations stipulate that federal financial participation for amounts that HCA spends related to MCO contracts is only available if HCA meets certain criteria, including ensuring encounter data from MCOs is validated for accuracy and completeness before HCA submits the data to CMS.[15]

HCA found 255 instances in which UHC (1) altered or omitted claim data from the provider's original claim submission and (2) provided inaccurate encounter claim data to HCA, in violation of governing law, Section 5 of the AHMC contract,

9 AHMC contract effective 01/01/2018 – 06/30/2018.

10 AHMC Amendment 1 effective 07/01/2018 – 12/31/2018.

11 42 CFR 438.606

12 42 USC 1396b(i)(25) and 42 USC 1396b(m)(2)(A)(xi)

13 42 CFR 438.604 and 438.818.

14 AHMC contract Section 5.

15 42 CFR 438.818.

the EDRG and the Companion Guide. The inaccuracies are violations of UHC's contractual responsibilities and hinder HCA's ability to ensure encounter data is accurate, truthful and complete to conduct its own duties, including those activities described above.

References

United States Code (USC)

- **42 USC 1396b(i) Payment for organ transplants; item or service furnished by excluded individual, entity, or physician; other restrictions.**

  Payment under the preceding provisions of this section shall not be made-

  …(25) with respect to any amounts expended for medical assistance for individuals for whom the State does not report enrollee encounter data (as defined by the Secretary) to the Medicaid Statistical Information System (MSIS) in a timely manner (as determined by the Secretary);…

- **42 USC 1396b(m)Medicaid managed care organization" defined; duties and functions of Secretary; payments to States; reporting requirements; remedies.**

  … (2)(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this subchapter to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1396d(a) of this title or for the provision of any three or more of the services described in such paragraphs unless-

  …(xi) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary;…

Code of Federal Regulations (CFR)

- **42 CFR §438.242 Health Information Systems.**

  … (c)*Enrollee encounter data.* Contracts between a State and a MCO…must provide for:

  (1) Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.

  (2) Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs.

  (3) Submission of all enrollee encounter data that the State is required to report to CMS under §438.818.

  (4) Specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.

- **42 CFR §438.242 Health information systems.**

  … (d) *State review and validation of encounter data.* The State must review and validate that the encounter data collected, maintained, and submitted to the State by the MCO… meets the requirements of this section. The State must have procedures and quality assurance protocols to ensure that enrollee encounter data

submitted under paragraph (c) of this section is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO….

- **42 CFR §438.602 State responsibilities.**
  …(e) *Periodic Audits.* The State must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO.

- **42 CFR §438.604 Data, information, and documentation that must be submitted.**
  (a) *Specified data, information, and documentation.* The State must require any MCO... to submit to the State the following data:
  (1) Encounter data in the form and manner described in §438.818.
  (2) Data on the basis of which the State certifies the actuarial soundness of capitation rates to an MCO… under §438.4, including base data described in §438.5(c) that is generated by the MCO…
  (3) Data on the basis of which the State determines the compliance of the MCO… with the medical loss ratio requirement described in §438.8.
  (4) Data on the basis of which the State determines that the MCO… has made adequate provision against the risk of insolvency as required under §438.116.
  (5) Documentation described in §438.207(b) on which the State bases its certification that the MCO… has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in §438.206.
  (6) Information on ownership and control described in §455.104 of this chapter from MCOs… and subcontractors as governed by §438.230.
  (7) The annual report of overpayment recoveries as required in §438.608(d)(3).
  (b) *Additional data, documentation, or information.* In addition to the data, documentation, or information specified in paragraph (a) of this section, an MCO, PIHP, PAHP, PCCM or PCCM entity must submit any other data, documentation, or information relating to the performance of the entity's obligations under this part required by the State or the Secretary.

- **42 CFR §438.606 Source, content and timing of certification.**
  (a) *Source of certification.* For the data, documentation, or information specified in §438.604, the State must require that the data, documentation or information the MCO, PIHP, PAHP, PCCM or PCCM entity submits to the State be certified by either the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

  (b) Content of certification. The certification provided by the individual in paragraph (a) of this section must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in §438.604 is accurate, complete, and truthful.

(c) *Timing of certification.* The State must require the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in §438.604(a) and (b).

- **42 CFR §438.700 Basis for imposition of sanctions.**

(a) Each State that contracts with an MCO must… establish intermediate sanctions (which may include those specified in §438.702) that it may impose if it makes any of the determinations specified in paragraphs (b) through (d) of this section. The State may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(b) A State determines that an MCO acts or fails to act as follows:

(1) Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.

(2) Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

(3) Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

(4) Misrepresents or falsifies information that it furnishes to CMS or to the State.

(5) Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.

(6) Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in §§422.208 and 422.210 of this chapter.

(c) A State determines that an MCO, PCCM or PCCM entity has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

(d) A State determines that—

(1) An MCO has violated any of the other requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations.

(2) A PCCM or PCCM entity has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act, or any implementing regulations.

(3) For any of the violations under paragraphs (d)(1) and (2) of this section, only the sanctions specified in §438.702(a)(3), (4), and (5) may be imposed.

- **42 CFR §438.702 Types of intermediate sanctions.**

(a) The types of intermediate sanctions that a State may impose under this subpart include the following:

(1) Civil money penalties in the amounts specified in §438.704.

(2) Appointment of temporary management for an MCO as provided in §438.706.

(3) Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll.

(4) Suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.

(5) Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

(b) State agencies retain authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in §438.700, as well as additional areas of noncompliance. Nothing in this subpart prevents State agencies from exercising that authority.

- **42 CFR §438.704 Amounts of civil money penalties.**

(a) *General rule.* If the State imposes civil monetary penalties as provided under §438.702(a)(1), the maximum civil money penalty the State may impose varies depending on the nature of the MCO's, PCCM or PCCM entity's action or failure to act, as provided in this section.

(b) *Specific limits.*

(1) The limit is $25,000 for each determination under §438.700(b)(1), (5), (6), and (c).

(2) The limit is $100,000 for each determination under §438.700(b)(3) or (4).

(3) The limit is $15,000 for each beneficiary the State determines was not enrolled because of a discriminatory practice under §438.700(b)(3). (This is subject to the overall limit of $100,000 under paragraph (b)(2) of this section).

(c) *Specific amount.* For premiums or charges in excess of the amounts permitted under the Medicaid program, the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater. The State must deduct from the penalty the amount of overcharge and return it to the affected enrollees.

<u>Apple Health Managed Care (AHMC) Contract 01/01/2018 – 06/30/2018</u>

- Section 5.11.2.2 Submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA and that adhere to the following data quality standards:
- Section 5.11.2.2.2 Submitted encounters and encounter records shall have all fields required and found on standard healthcare claim billing forms or in electronic healthcare claim formats to support proper adjudication of an encounter. The Contractor shall submit to HCA, without alteration, omission or splitting, all available claim data in its entirety from the provider's original claim submission to the Contractor;
- Section 5.11.9 Additional detail can be found in the Encounter Data Reporting Guide published by HCA and incorporated by reference into this Contract
- Section 18.6.2.3 Include all third-party payments by Enrollee in its regular encounter data and submissions.

<u>Apple Health Managed Care (AHMC) Contract 07/01/2018 – 12/31/2018</u>

- Section 5.12.2.2. Submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA and that adhere to the following data quality standards:

- Section 5.12.2.2.2 Submitted encounters and encounter records shall have all fields required and found on standard healthcare claim billing forms or in electronic healthcare claim formats to support proper adjudication of an encounter. The Contractor shall submit to HCA, without alteration, omission or splitting, all available claim data in its entirety from the provider's original claim submission to the Contractor;
- Section 5.12.9 Additional detail can be found in the Encounter Data Reporting Guide published by HCA and incorporated by reference into this Contract
- Section 18.6.2.3 Include all third-party payments by Enrollee in its regular encounter data and submissions.

Encounter Data Reporting Guide (EDRG)

- Pg. 10 Purpose
  - HCA requires encounter data reporting from contracted MCOs, BHOs, and QHHs. Data reporting must include all healthcare, health home and behavioral health services delivered to eligible clients, or as defined in the BHO or QHH Specific Section. Complete, accurate, and timely encounter reporting is the responsibility of each MCO, BHO and QHH lead entity.
- Pg. 11 Provider Identifiers
  - Report the National Provider Identifiers (NPIs) to identify all Billing (Pay-to), Servicing, Attending, Referring, Rendering, Prescriber and other required providers in all provider segments.
- Pg. 22 MCO Claim Types and Format
  - The information on each reported encounter record must include all data billed/transmitted for payment from your service provider or sub-contractor. Do not alter paid claims data when reporting encounters to HCA; e.g., data must not be stripped, or split from the service provider's original claim.
- Pg. 24 MCO Provider Identifiers
  - Report the NPI and Taxonomy codes for the Billing Provider as instructed in the Encounter Data Companion Guides (Loops 200A PRV and 2010AA NM for 837 files). This must always be for the provider that billed the MCO for the services. For pharmacy files, report the servicing provider NPI (Field 201-B1).
- Pg. 37 Retail Pharmacy Required Field
  - Amount Paid – The 'Amount Paid' field (430-DU field name) is a requirement for pharmacy encounters. The amount paid is the amount the MCO paid to the servicing pharmacy.

HCA 5010 837 Professional and Institutional Encounter Data Companion Guide

- Introduction
  - Encounters are not HIPAA named transactions and the 837I and 837P Implementation Guides were used as a foundation to construct the standardized HCA encounter reporting process.
  - Companion Guides are used to clarify the exchange of information on HIPAA transactions between the HCA ProviderOne system and its trading partners. HCA defines trading partners as covered entities that either submit or retrieve HIPAA batch transactions to and from ProviderOne.
  - Companion Guides are intended to supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This Companion Guide describes the technical interface environment with HCA, including connectivity requirements and protocols, and electronic interchange procedures. This guide also

provides specific information on data elements and the values required for transactions sent to or received from HCA.