The Ohio Department of Medicaid's Methodology for Covered Families & Children (MAGI), Aged, Blind, or Disabled (ABD), and Adult Extension (Group VIII) Encounter Data Quality Measures

Provider Agreement Effective July 1, 2018 through June 30, 2019

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Volume Measures

Purpose

The purpose of the encounter data volume measures is to monitor each MCP's encounter data submissions to ensure that the data is complete and that the number of encounters, which are submitted monthly, meet minimum volume standards.

Volume measures are calculated quarterly, by service category.

Service category groupings are based on cost report service classification logic from ODM's Actuary, Milliman.

When a claim line item is identified for a particular service category, the entire claim (i.e. all line items submitted on the claim) is included in that service category. Service counts are determined by unduplicating, by Managed Care Plan, Medicaid recipient ID and date of service (i.e. 'discharge date' for Inpatient).

All volume measures are calculated at either the detail or header level, according to the methodology.

Member Months

Member months are determined using files of members agreed upon by ODM and the Managed Care Plans as having been enrolled with the plan for the month in question. Those files will be generated as follows:

1) ODM will generate a recipient master file, showing the recipient's managed care plan enrollment for that member month as stored in MITS.
2) On a quarterly basis, ODM will send each Managed Care Plan a list of these recipients to validate against the plans' enrollment records.
3) Each plan will return to ODM the list of recipients according to the file specifications dictated in *ODM's Medicaid Managed Care/MyCare Plan Quarterly Enrollment File for Quality Measures*.

Encounter Data Quality Volume Approaches

ABD Adult Approach

The ABD Adult Volume measure is an Ohio specific data quality measure and therefore, does not have applicable national benchmarks to assist standard setting. The performance target is set based on Ohio program experience and expectations. Each MCP will have its own minimum performance standard that is distinct from each of the other plans for each category of service. The minimum performance standard for each MCP for each category of service is based on a weighted formula derived from that MCP's rates for a duration of six quarters, using a multiplicative factor of the weighted formula to set a MCP specific standard for that category of service. This approach takes into consideration the MCP performance baseline and potential seasonal effects, as well as allowing for differences between MCP's in enrollment size and business strategy.

ABD Child Approach

The ABD Child Volume measure is an Ohio specific data quality measure and therefore, does not have applicable national benchmarks to assist standard setting. The performance target is set based on Ohio program experience and expectations. Each MCP will have its own minimum performance standard that is distinct from each of the other MCPs for each category of service. The minimum performance standard for each MCP for each category of service is based on a weighted formula derived from that MCP's rates for a duration of six quarters, using a multiplicative factor of the weighted formula to set a MCP specific standard for that category of service. This approach takes into consideration the MCP performance baseline and potential seasonal effects, as well as allowing for differences between MCPs in enrollment size and business strategy.

CFC/MAGI Approach

The CFC/MAGI Volume measure is an Ohio specific data quality measure and therefore, does not have applicable national benchmarks to assist standard setting. The performance target is set based on Ohio program experience and expectations. Each MCP will have its own minimum performance standard that is distinct from each of the other MCPs for each category of service. The minimum performance standard for each MCP for each category of service is based on a weighted formula derived from that MCP's rates for a duration of six quarters, using a multiplicative factor of the weighted formula to set a MCP specific standard for that category of service. This approach takes into consideration the MCP performance baseline and potential seasonal effects, as well as allowing for differences between MCPs in enrollment size and business strategy.

Adult Extension Approach

The Adult Extension Volume measure is an Ohio specific data quality measure and therefore, does not have applicable national benchmarks to assist standard setting. The performance target is set based on

Ohio program experience and expectations. Each MCP will have its own minimum performance standard that is distinct from each of the other MCPs for each category of service. The minimum performance standard for each MCP for each category of service is based on a weighted formula derived from that MCP's rates for a duration of six quarters, using a multiplicative factor of the weighted formula to set a MCP specific standard for that category of service. This approach takes into consideration the MCP performance baseline and potential seasonal effects, as well as allowing for differences between MCPs in enrollment size and business strategy.

Inpatient Hospital

This measure calculates the utilization rate for general/acute inpatient services: the number of admissions per 1,000 member months. Newborn/delivery and mental health inpatient stays are excluded. Nursing Facility stays are also excluded for Medicaid Managed Care Encounter Data Volume Reports; this category is only included in the MyCare Ohio Encounter Data Volume report..

COS ID	COS Description	Service Classification Logic	Measurement
COS01	Inpatient — Medical/Surgical	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1,2] = 001-532, 580-639, 650-724, 791-952 OR DRG_CD_27 [1] = 001–761, 789–794, 799–872, 901– 989)	Admits per 1,000 MM
COS07	Inpatient — Other Inpatient	All remaining CLAIM_TYPE = I [4] not excluded below	Admits per 1,000 MM
Exclusions:			
COS02	Inpatient — Psychiatric/SA	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1] = 740-776 OR DRG_CD_27 [1] = 876–897)	Visits per 1,000 MM
COS03	Inpatient — Delivery	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1] = 540-542, 560 OR DRG_CD_27 [1] = 765–768, 774–776)	Deliveries per 1,000 MM
COS04	Inpatient — Well Newborn	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1] = 640 OR DRG_CD_27 [1] = 795)	Deliveries per 1,000 MM
COS05	Inpatient — Delivery — Other	CLAIM_TYPE = I [4] AND (DRG_CD-31 [1] = 544-546, 561-566 OR DRG_CD_27 [1] = 769–770, 777–782)	Deliveries per 1,000 MM

Numerator: Admissions X 1,000

Admissions = encounters unduplicated by recipient ID and last date of the inpatient stay.

Denominator: Member Months

Data Source: Institutional Encounters

Behavioral Health

This measure calculates the behavioral health utilization rate: behavioral health visits per 1,000 member months.

A behavioral health visit is defined as a non-institutional behavioral health visit, an institutional outpatient behavioral health visit, or an institutional inpatient behavioral health stay. The encounters used to calculate the numerator are unduplicated by recipient ID and date of service.

COS ID	COS Description	Service Classification Logic	Measurement
COS02	Inpatient — Psychiatric/Substance Abuse	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1] = 740-776 OR DRG_CD_27 [1] = 876–897)	Visits per 1,000 MM
COS13	Outpatient – Behavioral Health	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE = 01, 02 AND Rev_Cd = 671, 900, 904, 906-907, 911-916, 918-919, 1002 AND Modifier = HE AND Rev_Cd = 450-459 nowhere else on the claim	Visits per 1,000 MM
COS36	Other — Mental Health/Substance Abuse	CLAIM_TYPE = M [6] AND (BILL_PRVDR_TYPE = 84, 95 OR Proc = 90785, 90791, 90792, 90801–90899, 96101-96120, G0396-G0397, G0409-G0411, H0001–H0044, H0046–H2037, H5010–H5025, T1016, Z0802–Z0819	Visits per 1,000 MM

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Emergency Department

This measure calculates an emergency department (ED) utilization rate: ED visits per 1,000 member months. It includes all encounters with the codes(s) specified below.

COS ID	COS Description	Service Classification Logic	Measurement
COS15	ER — Emergency Room	CLAIM_TYPE = O [7] AND Rev_Cd = 450-459	Visits per 1,000 MM
COS16	ER — Surgery	CLAIM_TYPE O [7] AND Rev_Cd = 360–379, 490–499, 720–729 AND Rev_Cd = 450-459 somewhere else on the claim	Visits per 1,000 MM
COS17	ER — Ambulatory Surgery Center	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE = 46 AND Rev_Cd = 450-459 somewhere else on the claim	Visits per 1,000 MM
COS18	ER — Cardiovascular	CLAIM_TYPE = O [7] AND Rev_Cd = 480–489, 730–749 AND Rev_Cd = 450-459 somewhere else on the claim	Visits per 1,000 MM
COS19	ER — PT/OT/ST	CLAIM_TYPE = O [7] AND Rev_Cd = 420–449 AND Rev_Cd = 450-459 somewhere else on the claim	Visits per 1,000 MM
COS20	ER — Clinic	CLAIM_TYPE = O [7] AND Rev_Cd = 510–519 AND Rev_Cd = 450-459 somewhere else on the claim	Visits per 1,000 MM
COS21	ER — Other	All remaining CLAIM_TYPE = O [7] AND (Rev_Cd not in 300–319, 320–359, 400–409, 610–619, 971, 972–974, 976–979, 983, 985–986) AND Rev_Cd = 450-459 somewhere else on the claim	Visits per 1,000 MM
COS22	ER — ER Professional	CLAIM_TYPE = M [6] AND Proc = 99281–99288	Visits per 1,000 MM

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Dental

This measure calculates the utilization rate for dental services: dental visits per 1,000 member months. Emergency department visits for dental related diagnoses are included in the Emergency Department measure and are not included in this measure.

COS ID	COS Description	Service Classification Logic	Measurement
COS39	Other — Dental	(CLAIM_TYPE = D [3]) OR (CLAIM_TYPE = M [6] AND Proc = DXXXX)	Visits per 1,000 MM

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Vision

This measure calculates the utilization rate for vision services: vision visits per 1,000 member months. Emergency department visits for vision-related diagnoses are included in the Emergency Department measure and are not included in this measure. Codes for eyeglass frames and lenses, contact lenses, ocular prosthetics and other vision aids are not included in this measure.

COS ID	COS Description	Service Classification Logic	Measurement
COS40	Other — Vision — Optometric	CLAIM_TYPE = M [6] AND Proc = 92002–92499, V0000–V2629, V2786-V2999, W2004–W2014, W2048, S0580	Visits per 1,000 MM

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and last date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Primary & Specialist Care

This measure calculates a utilization rate for primary and specialist care services: visits per 1,000 member months. Included are all physician office, clinic, and hospital outpatient evaluation and management services provided by general practice providers and specialists.

COS ID	COS Description	Service Classification Logic	Measurement
COS23	Professional — Surgery	(CLAIM_TYPE = M [6] AND Proc = 10000–11971, 11975–11983, 12001–36299, 36400–58999, 59420, 59425, 59426, 60000–69999, X3960) OR (CLAIM_TYPE = M [6] AND Proc = 11972–11974, 11984–12000, 36300–36399 AND Modifier = 80)	Visits per 1,000 MM
COS24	Professional — Anesthesia	CLAIM_TYPE = M [6] AND (Any Proc with the following modifiers: AA, AD, QK, QS, QX, QY, QZ) OR (Proc = 00100–01999)	Visits per 1,000 MM
COS25	Professional — Obstetrics	CLAIM_TYPE = M [6] AND Proc = 59000–59414, 59430–59999	Visits per 1,000 MM
COS26	Professional — Office Visits/Consults	(CLAIM_TYPE = O [7] AND Rev_Cd = 985–986 AND Rev_Cd = 450-459 nowhere else on the claim) OR (CLAIM_TYPE = M [6] AND Proc =99201–99215, 99241–99275,99499)	Visits per 1,000 MM
COS27	Professional — Inpatient Visits	CLAIM_TYPE = M [6] AND Proc = 99217–99239, 99291–99297, 99301–99313, 99356, 99357, 99431–99440, 99460–99465, 99468–99486, X9331-X9335, X9360	Visits per 1,000 MM
COS28	Professional — Periodic Exams	CLAIM_TYPE = M [6] AND Proc = 99381–99397, 99401–99429, S0610, S0612	Visits per 1,000 MM
COS29	Professional — Immunizations & Injection	CLAIM_TYPE = M [6] AND Proc = 90281–90749, 90780, 90781, 90799, J0120–J9999, G0008, G0009, G0010, Q0138, W0703–W0731, X0701–X0799	Visits per 1,000 MM
COS30	Professional — Physical Medicine	(CLAIM_TYPE = O [7] AND Rev_Cd =976–979 AND Rev_Cd = 450-459 nowhere else on the claim) OR (CLAIM_TYPE = M [6] AND Proc = 97010–97799, Q0103, Q0104, Z5831, Z7210, Z7217, Z7225, Z7226)	Visits per 1,000 MM
COS31	Professional — Professional Misc. Services	(CLAIM_TYPE = O [7] AND Rev_Cd =983 AND Rev_Cd = 450-459 nowhere else on the claim) OR (CLAIM_TYPE = M [6] AND Proc = 90901–90999, 91010–91299, 92502–92700, 92920–93998, 94002–94799, 95004–97009, 97800-99199, 99315–99318, 99324–99340, S1040, S9083)	Visits per 1,000 MM

Numerator: Visits X 1,000
Visits = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Pharmacy

This measure calculates utilization rate for drugs: prescriptions per 1,000 member months.

COS ID	COS Description	Service Classification Logic	Measurement
COS38	Pharmacy — Retail	CLAIM_TYPE = P [8] or Q[10]	Scripts per 1,000 MM

Numerator: Prescriptions X 1,000

Prescriptions = encounters unduplicated by managed care plan, recipient ID, date of service, and NDC code

Denominator: Member Months

Data Source: Pharmacy encounters

Durable Medical Equipment (DME)

This measure calculates the Durable Medical Equipment (DME) utilization rate per 1,000 member months.

COS ID	COS Description	Service Classification Logic	Measurement
COS44	Other — Supplies & DME	CLAIM_TYPE = M [6] AND Proc = A4190–A9999, B4034–B5200, B9000–B9999, E0000–E9999, K0001–K9999, L0000–L9999, T4525–T4528, T4533–T4535, T4541, V2630-V2785, XX001–XX010, Y2064, Y2067, Y9101, Y9102, Y9106, Y9107, Y9110-Y9120, Y9127, Y9131–Y9163, Y9165–Y9188, Z7007–Z7050	Services per 1,000 MM

Numerator: Services X 1,000

Services = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Non-institutional encounters

Deliveries – *Reporting Only*

This measure calculates the rate of deliveries per 1,000 member months.

COS ID	COS Description	Service Classification Logic	Measurement
COS03	Inpatient — Delivery	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1] = 540-542, 560 OR DRG_CD_27 [1] = 765–768, 774–776)	Deliveries per 1,000 MM
COS04	Inpatient — Well Newborn	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1] = 640 OR DRG_CD_27 [1] = 795)	Deliveries per 1,000 MM
COS05	Inpatient — Delivery — Other	CLAIM_TYPE = I [4] AND (DRG_CD-31 [1] = 544-546, 561-566 OR DRG_CD_27 [1] = 769–770, 777–782)	Deliveries per 1,000 MM

Numerator: Deliveries X 1,000

Deliveries = encounters unduplicated by managed care plan, recipient ID and date of service

Denominator: Member Months of Females

Data Source: Institutional encounters

Outpatient

This measure calculates the rate of outpatient visits per 1,000 member months. It includes outpatient clinic, surgical center, and therapy type services received in an outpatient hospital setting, excluding emergency department visits and Behavioral Health outpatient hospital visits.

COS ID	COS Description	Service Classification Logic	Measurement
COS08	Outpatient — Surgery	CLAIM_TYPE = O [7] AND Rev_Cd = 360–379, 490–499, 720–729 AND Rev_Cd = 450-459 nowhere else on the claim	Visits per 1,000 MM
COS09	Outpatient — Ambulatory Surgery Center	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE = 46 AND Rev_Cd = 450-459 nowhere else on the claim	Visits per 1,000 MM
COS10	Outpatient — Cardiovascular	CLAIM_TYPE = O [7] AND Rev_Cd = 480–489, 730–749 AND Rev_Cd = 450-459 nowhere else on the claim	Visits per 1,000 MM
COS11	Outpatient — PT/OT/ST	CLAIM_TYPE = O [7] AND Rev_Cd = 420–449 AND Rev_Cd = 450-459 nowhere else on the claim	Visits per 1,000 MM
COS12	Outpatient — Clinic	CLAIM_TYPE = O [7] AND (Rev_Cd = 510–519 AND Rev_Cd = 450-459 nowhere else on the claim) OR Rev_Cd = 520–529	Visits per 1,000 MM
COS14	Outpatient — Other	All remaining CLAIM_TYPE = O [7] AND Rev_Cd not in 300–319, 320–359, 400–409, 610–619, 971, 972–974, 976–979, 983, 985–986 AND Rev_Cd = 450-459 nowhere else on the claim	Visits per 1,000 MM

Numerator: Visits X 1,000
Visits = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Notes:

[1] APR—DRG grouper 31 shall be applied to all inpatient claims. For situations where the claim could not be grouped due to outdated or invalid diagnosis code, MS—DRG grouper 27 may be applied.

[2] Note that there are gaps in the APR-DRG numbering system. For example, there are no DRGs with the numbers 533-539, 543, 547-559, 567-579, 641-649, 725-739, or 777-790.

[3] CLAIM_TYPE = D shall be applied to claims submitted on the 837-D file.

[4] CLAIM_TYPE = I shall be applied to claims submitted on the 837-I file with facility type codes (CLM05-1) equal to 011X or 012X.

[5] CLAIM_TYPE = L shall be applied to claims submitted on the 837-I file with facility type codes (CLM05-1) equal to 021X-029X, 051X-059X, or 061X-069X.

[6] CLAIM_TYPE = M shall be applied to claims submitted on the 837-P file.

[7] CLAIM_TYPE = O shall be applied to claims submitted on the 837-I file with facility type codes (CLM05-1) equal to 013X-019X, 031X-039X, 041X-049X, 071X-079X, 081X-089X, or 091X-099X.

[8] CLAIM_TYPE = P shall be applied to claims submitted on the NCPDP file.

[9] Information on eligibility for Respite Services can be found at the following website: http://archrespite.org/respite-locator-service-state-information/167-ohio-info.

[10] CLAIM_TYPE = Q shall also be applied to the pharmacy measure, however it is not listed in Milliman's original Cost Report Categorical Logic.

Incomplete Rendering Provider Data

Measure: The percentage of rendering providers reported on encounters without individual-level Medicaid and/or Reporting provider numbers as identified in MITS.*

Dates: Date of Service on the line-level procedure, in the measurement period described in Appendix L of the Medicaid Managed Care Provider Agreement.

Numerator: The number of line-level procedures in the denominator that do not have individual-level Medicaid and/or Reporting provider numbers as identified in MITS associated with an NPI as submitted on the encounter.

In order to be identified in MITS, a Provider NPI must match an NPI found in MITS' Provider Master File. Each managed care plan should ensure that rendering provider NPIs being submitted to MITS are in the Provider Master File. Managed care plans are encouraged to work with providers and with ODM's Provider Enrollment area to ensure accurate provider enrollment information in MITS.

Denominator: The number of line-level procedures reported on professional 837 EDI transactions and accepted in MITS, excluding the following categories of procedures:

-Anesthesia CPT codes within the range:
    -00100-01999
-Radiology CPT codes within the range:
    -70010-79999
-Pathology and Laboratory CPT codes within the range:
    -80047-89398; also 36415, 36416, 36420,36425
    -Laboratory HCPCPs codes that begin with S or Q; also 99001, G0103, G0123, G0431, G0434, P9604, G6030-G6058, G0477-G0438

All provider types are included in the denominator, even those for which a Rendering Provider NPI is not required to be submitted. If a Rendering Provider NPI is blank upon submission of an encounter to MITS, then as described in the process below, MITS will populate the Billing Provider NPI as the Rendering Provider NPI. If the Billing Provider NPI matches an NPI in MITS Provider Master File, then the Rendering Provider NPI will be considered in compliance for this measure.

*Rendering Provider Information: Rendering provider information may be provided on an encounter at either the claim- or the line-level; or the encounter may be submitted with only one provider in the billing provider data element. The rendering provider information retained by ODJFS will be as follows:

1. If the rendering provider is submitted on the encounter at the line-level, the line-level rendering provider information is retained;
2. If the rendering provider is only submitted at the claim-level or partially on the line-level, the claim-level rendering provider information is retained for any line item without a rendering provider;
3. If only the billing provider is submitted at the claim-level, without any rendering provider, the claim-level billing provider information is retained for all of the line items.

Data Source: Encounter Data

NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers

Measure: The percentage of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions with an NPI provider number in the billing provider EDI data fields that do not have a Medicaid or Reporting Provider Number in MITS.

For this measure, an individual encounter/claim is considered an EDI transaction.

Dates: Date of Service on the encounter/claim at the header level, in the measurement period described in Appendix L of the Medicaid Managed Care Provider Agreement.

Numerator: The number of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions submitted and accepted in MITS where the NPI submitted on the encounter is not associated with a Medicaid or Reporting Provider Number in MITS.

Denominator: The number of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions submitted and accepted in MITS with dates of service during the quarter.

In order to be identified in MITS, a Provider NPI must match an NPI found in MITS' Provider Master File. Each managed care plan should ensure that billing provider NPIs being submitted to MITS are in the Provider Master File. Managed care plans are encouraged to work with providers and with ODM's Provider Enrollment area to ensure accurate provider enrollment information in MITS.

Data Source: Encounter Data

NPI Provider Number for Ordering, Referring and Prescribing Providers.

Measure: The percentage of EDI transactions with qualifying billing provider types and specialties with an NPI provider number in the ordering/referring/prescribing provider EDI data field that do not have a Medicaid or Reporting Provider Number in MITS. Please refer to the "NPI Provider Number for Ordering, Referring and Prescribing Providers" section of the ODM Encounter Data Quality Measures document for SFY2019 for the qualifying billing provider type and specialties.

Measurement Period: The report periods for SFY 2018 and SFY 2019 contract periods are listed in Table 3 above. Results for the ORP measure will not be calculated for SFY 18. Results for SFY19 will be informational only. Results for SFY 19 and SFY 20 will be used to set a baseline for SFY 2021. Beginning in SFY21, this measure will be used to determine compliance.

Rejected Encounters (Measure 1 and Measure 2)

The percentage of encounters submitted to ODM that are rejected.

Numerator: The number of encounters that are rejected (meet a Threshold error).

Denominator: The number of submitted encounters in MITS (including those with a Paid, Threshold, and Informational status). A separate denominator will be calculated for each of the following file types: EDI 837 I, EDI 837 P, EDI 837 D, and NCPDP D.0.

Data Source: Encounter Data

Measure 2 (only applies to MCPs that have had Medicaid membership for one year or less):

For MCPs with less than one year of operation within the program, results are calculated and performance is monitored monthly. The report period varies depending on when the MCP began participation. The first reporting month begins with the third month of enrollment. The report period only extends throughout the MCP's first year of operation within the program. Measure 2 will not be calculated for SFY 2015.

This measure (both 1 and 2) is calculated per MCP and includes all members serviced by the MCP.

Acceptance Rate (only applies to MCPs that have had Medicaid membership for one year or less)

The number of acceptable encounters submitted to ODM for the month.

Numerator: The number of acceptable encounters.

Denominator: MCP membership per 1,000 Member Months. A separate denominator will be calculated for each of the following file types: EDI 837 I, EDI 837 P, EDI 837 D, and NCPDP D.0.

Data Source: Encounter Data

Encounter Data Accuracy Studies (Measure 1 and Measure 2)

Purpose of Studies:

Measure 1: The purpose of this study is to assess whether the payments made to a Managed Care Plan (MCP) for the delivery of a newborn have corresponding delivery records and medical record documentation to substantiate the delivery payment.

Measure 2: The purpose of this study is to assess the accuracy and completeness of payment data submitted on the encounter claims. The study will compare payment data stored in the MCPs' claim systems with payment data submitted to and accepted by ODJFS.

Methods:
The studies will be conducted by the External Quality Review Organization during contract year 2015. The methods will be developed once the studies are initiated and the draft methods will be shared with the MCPs to obtain comment and input. The methods will be posted to the website once they are finalized.

Measure 1 will be calculated per MCP and include all CFC members serviced by the MCP, as applicable.

Measure 2 will be calculated per MCP and include all members serviced by the MCP (CFC and ABD membership, as applicable).

Encounter Data Submission Procedure

The MCP must submit encounter data files to ODM per the specified schedule and within the allotted amount established in the ODM Encounter Data Submission Specifications.

The MCP must submit a letter of certification, using the form required by ODM, with each encounter data file in the ODM-specified medium format.

The letter of certification must be signed by the MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCP's CEA or CFO.

Timeliness of Encounter Data Submission

Measure: The percentage of encounters that are submitted to ODM and accepted within 35 calendar days of the month in which they were paid. (e.g., claims paid by the MCP in January 2018 would be reported after March 7th 2018)

Numerator: The number of claims submitted and accepted into MITS within 35 calendar days of the month in which they were paid by the MCP in the reporting month.

Denominator: The number of claims paid by the MCP in the reporting month.

NOTE: The term "submitted and accepted into MITS" means it's prior to adjudication in MITS and, therefore, does not account for the final adjudication status of the encounter.

Measure: The percentage of the MCP's total monthly paid pharmacy encounters that are submitted to ODM and accepted within 15 calendar days of the date the MCP's PBM adjudicates the claim. This includes claims that were paid at zero dollars, if zero dollars is the correct payment.

Numerator: The number of pharmacy claims submitted and accepted into MITS within 15 calendar days of the month in which they were paid by the MCP in the reporting month.

Denominator: The total number of pharmacy encounters accepted by ODM in the reporting month.

MCPs shall report NCPDP encounter data submission lag time on a monthly basis to ODM. Results may be subject to an audit by ODM and/or its designee.

Measurement Periods for NCPDP Measure: For SFY2018: Monthly beginning with September 2017, through June 2018. For SFY2019: Monthly from July 2018 through June 2019.

Data Quality Standard for NCPDP Measure: ODM will develop a data quality standard based on data submitted by the MCPs beginning with September 2017 payment dates. ODM expects to notify the plans and implement the standard with the January 1st 2019 Provider Agreement update. Until the standard is implemented, this measure will be information only.

Encounter Submissions per Encounter Schedule

Measure: The percent of encounters listed on the Encounter Data Submission Schedule as the minimum amount for that month that were submitted to ODM and accepted.

Numerator: The number of encounters submitted and accepted into MITS per claim type as required in the denominator.

Denominator: The minimum number of encounters per claim type required to be submitted during the month per the Encounter Data Submission Schedule.

NOTE: The term "submitted and accepted into MITS" means it's prior to adjudication in MITS and, therefore, does not account for the final adjudication status of the encounter.

The Ohio Department of Medicaid Managed Care's Encounter Data Submission Schedule: For SFY 2018: April 2018, May 2018 and June 2018. For SFY2019: July 2018 to June 2019.

- Mondays – CareSource; Molina
- Tuesdays – United; Buckeye
- Wednesdays – Paramount; CareSource
- Thursdays – As Needed with ODM Permission

ODM's Required Minimum Number of Encounters by MCP to be Submitted and Accepted into MITS within each Calendar Month

Managed Care Provider	Institutional/Professional	NCPDP (RX)	Dental
CareSource	750,000	1,000,000	32,000
United Health Care	275,000	320,000	15,000
Molina	222,000	312,000	14,000
Buckeye	160,000	240,000	10,000
Paramount	176,000	172,000	9,600