State of New Hampshire

Department of Health and Human Services and the Department of Insurance Comprehensive Healthcare Information System

Annual Quality Assurance and Completeness Report

Fiscal Year 2022: July 2021 – June 2022

Prepared: August 19th, 2022

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Introduction

The State of New Hampshire's Department of Health and Human Services (DHHS) and the New Hampshire Insurance Department (NHID) requested that Milliman, Inc. (Milliman) on an annual basis provide, "a single overview report that summarizes and assesses the quality and completeness of the data, in regards, to its use for analytic tasks. The report shall include assessments of quality of data elements and records collected, any inconsistencies in quality and completeness among Carriers, and potential solutions to improve the data. The report shall be in a format appropriate for public release. After approval by DHHS it shall be posted by the Contractor on the public website in the same location as a companion to the Data Dictionary.[1]"

Milliman met the DHHS/NHID's request for fiscal year 2022. This report covers the known data quality and completeness issues (e.g., inconsistencies in quality and completeness across carriers) encountered in the fiscal year 2022, with recommendations for remediation through the creation of extracts incurred through March 2022, paid through March 2022.

[1] Page 34 of the NH CHIS contract, Section K.

Validation Process

For fiscal year 2022, Milliman has processed four consolidated data sets. Milliman and the DHHS/NHID have continued to meet and discuss the data validation process at key milestones (see *Process Workflow* on page 4). These have included:

1. **Source File Processing:** NH CHIS healthcare processors continue to process their files through the MedInsight Preprocessor. The Preprocessor hashes identifiable fields (PHI/PII) in the data submitter's files, prior to the file submission to Milliman. Milliman's data management process continues to validate the data using the MedInsight "File, Field, and Quality Checks" (FFQCs) system. The FFQC system is an automated process for file intake and the submission and ruling of exemptions. The FFQC have field edits and quality measures, each with thresholds that have been determined by the DHHS/NHID. Only those files that have been processed through the Preprocessor, passed the FFQCs or received an exemption on any failed FFQCs, have been loaded into the MedInsight tables. Milliman and the DHHS/NHID have reviewed the status of the file inventory prior to the processing of the data sets, through the September 2021 processing.

2. **Source to Staging:** Approved files from Step 1 were loaded into the staging database. Milliman reconciled financial and membership data between the staging database and the source files. Slight variations in the data were found, in particular, due to issues with duplicate eligibility records and orphaned claims. These issues have been discussed with DHHS/NHID. New FFQC Quality checks were created to report duplicate eligibility before data was brought into the staging database. Healthcare processors with high percentages of orphaned claims were contacted to resolve discrepancies between member reporting in the eligibility file compared to member reporting in the claim files – Any discrepancies in member reporting causes orphaned claims. Milliman reduced the number of duplicates with the September 2021 consolidated dataset. Orphaned claims continue to improve and lessen as healthcare processors resolve member reporting between eligibility and claim data.

3. **Engines/Analytics:** After loading the Milliman staging tables (Step 2), Milliman ran and reviewed primary analytic engine data outcomes. The results of the key engine, the Health Cost Guidelines Grouper (HCG) reconciled with the staging tables. The Chronic Condition Hierarchical Group (CCHG) analytic engine was reviewed for reasonability.

4. **Portal/Cubes/Reports/Dashboards:** Milliman validated the data contained in the analytic portal using the approved staging tables from Step 3.

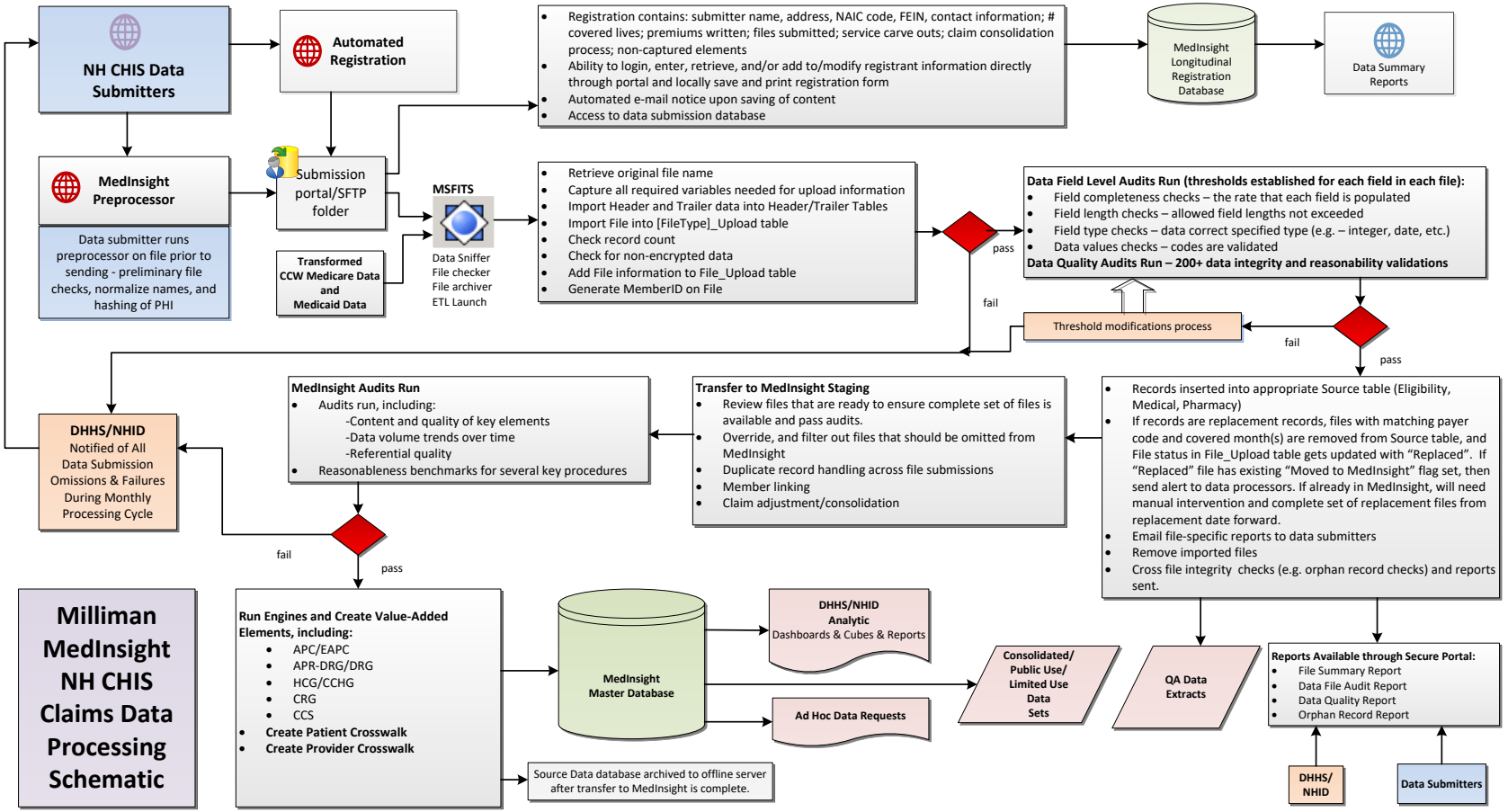
5. **Extracts (Consolidated, Limited Use and Public Use):** Milliman ran the tests required in the *Quality Assurance Methods for Extracts* document for each iteration of the cubes. These included tests on field efficiency of coding, population, value validity, consistency

and reasonableness of data, and referential integrity. Milliman communicated with the DHHS/NHID on any extract inquiries and made modifications, as necessary.

Milliman has worked with the DHHS/NHID and the healthcare processors to improve and mitigate open data issues by having regular meetings with the healthcare processors. Milliman and the DHHS/NHID have discussed the gaps and anomalies in the data with several healthcare processors. The known open items with recommendations/options for resolution are described in the *Quality and Completeness of Data* section.

As indicated above, Milliman and the DHHS/NHID have partnered throughout each stage of the NH CHIS data validation process for all the consolidated data sets. The chart on the next page outlines the NH CHIS process and shows the flow of information with validations at a more detailed level. This report reflects the last data set that Milliman processed for our fiscal year.

Process Workflow



Quality and Completeness of Data

As mentioned in *Validation Process*, Milliman reviewed the data at various steps throughout data processing. Although the data issues improved, Milliman and the DHHS/NHID continue to find data gaps and aberrations throughout the 2022 fiscal year data sets. Milliman, the DHHS/NHID, and the healthcare processors are working on researching and remedying these issues. Cost models and persistency analysis have been used to evaluate the data during Validation Process (Steps 2 – 5).

This report provides a consolidation of Milliman's and the DHHS/NHID findings by validation area with recommendations for mitigation and/or resolution. This document reflects Milliman's and the DHHS/NHID observations in generating four data sets reflected in this report. The findings in this report are representative of conclusions for those extracts.

No.	Validation Area	Data Quality/Data Completeness	Milliman Mitigation Strategies/Resolution(s)
1	Source	For each data set, data quality and data completeness has continued to improve however, missing and failed files still exist. The NH CHIS website report shows the gaps with any files paid through September 2021 and processed through September 2021. See *Addendum A* for an overview of the missing and failed source file statuses listed alphabetically by healthcare processor.	An automated Failed and Missing File Notifications email is sent weekly to all healthcare claims processors for failed and missing files.

No.	Validation Area	Data Quality/Data Completeness	Milliman Mitigation Strategies/Resolution(s)
2	Source	Milliman received resubmitted source files from several healthcare processors. The resubmissions were necessary to correct and improve data quality.	1) Matthew Thornton (NHT0139) and Anthem (NHC0065) resubmitted 2021 ME files to correctly populate Coverage Type. 2) Matthew Thornton (NHT0139) and Anthem (NHC0065) resubmitted 2019 ME files to current, to correctly populate ME203 Member Assigned PCP. 3) Amerihealth (NHC0776) resubmitted dental claims from 2020 – April 2021 to correct orphaned claims. 4) Symphonix (NHC0753) resubmitted dental claims from 2019 – March 2021 to correct orphaned claims. 5) UHC Medicare (NHC0752) resubmitted dental claims from 2019 – March 2021 to correct orphaned claims. 6) Humana (NHC0152, NHC0153, NHC0154) resubmitted ME files from 2016 – February 2021, to correct pharmacy coverage reporting. Humana had incorrectly reported that they had pharmacy coverage. 7) Tufts (NHC0615) incorrectly reports they have dental coverage. Since this Tufts payer code has merged with Harvard Pilgrim, this will be resolved after the merger. 8) Express Scripts (NHT0503) resubmitted pharmacy claim files to report denials. 9) Express Scripts (NHT0503) resubmitted 2019 – 2021 eligibility files to correct rolling 3 month submission issues. 10) CIGNA (NHC0030) resubmitted 2021 pharmacy claim files to correctly report reversals. 11) Harvard Pilgrim (NHC0213) resubmitted 2016 to current medical claim files to correct incomplete file submissions.

No.	Validation Area	Data Quality/Data Completeness	Milliman Mitigation Strategies/Resolution(s)
3	Source	Final version for pharmacy claims continues to be difficult for some healthcare processors to report.	At the yearly healthcare processors meeting, payers provided some insight to the difficulty of reporting final pharmacy claims. Determining the final claims for pharmacy can be quite difficult based on how the payer receives and stores the claims data in their data warehouse. The 2021 NH Rule change, added the version number and prescription number to the pharmacy claim file layout which aids in reporting final version for pharmacy claims.
3	Source	Orphaned Claims between claim files and the enrollment files for the reporting period	Orphaned claims exist when the member in the claim is not found in the enrollment file or the members date of service is not between the effective and term dates of the enrollment data. MedInsight is creating a custom orphaned claims report for source files from the payers. This will allow issues to be resolved earlier rather than waiting for a quarterly refresh to complete and then have the payers to resolve.

<table>
<tr><th>No.</th><th>Validation Area</th><th>Data Quality/Data Completeness</th><th>Milliman Mitigation Strategies/Resolution(s)</th></tr>
<tr><td>4</td><td>Staging</td><td>The same Member ID has been found for different members.
<table>
<tr><th>RULE_CODE</th><th>RULE_DESCRIPTION</th></tr>
<tr><td>MID1</td><td>DEFAULT RULE - (CONTRACT NUMBER IF AVAIL OTHERWISE SUBSCIBER SSN) + SEQUENCE NUMBER</td></tr>
<tr><td>MID2</td><td>(SUBSCRIBER SSN IF AVAIL OTHERWISE CONTRACT) + SEQUENCE NUMBER</td></tr>
<tr><td>MID3</td><td>(CONTRACT IF AVAIL OTHERWISE SUBSCRIBER SSN) + GENDER + DOB</td></tr>
<tr><td>MID4</td><td>(SUBSCRIBER SSN IF AVAIL OTHERWISE CONTRACT) + GENDER + DOB</td></tr>
<tr><td>MID5</td><td>MEMBER CONTRACT NUMBER OTHERWISE (SUBSCRIBER SSN IF AVAIL OTHERWISE CONTRACT) + GENDER + DOB</td></tr>
<tr><td>MID6</td><td>(SUBSCRIBER SSN IF AVAIL OTHERWISE CONTRACT) + DOB</td></tr>
</table></td><td>Member ID’s are not reported in the eligibility or claim files.
Therefore, Member ID’s are derived based on logic from the REF Processing Table (See table on the left). Each healthcare processor is assigned the Member ID logic (i.e. MID1) based on their ability to populate necessary Member ID fields. Payers respond to questions in their NH CHIS registration to determine the correct Member ID rule code to use.

If the healthcare processors populate any of the Member ID logic the same for different members (same subscriber), then the same member ID could exist for different members.

Milliman reviews problematic healthcare processor submissions as necessary to determine if the proper Member ID logic is used or there are healthcare processors reporting issues. If there are high occurrences of orphaned claims or if the payer has changed the way they are populating key Member ID fields, then payer submissions would be reviewed.</td></tr>
</table>

No.	Validation Area	Data Quality/Data Completeness	Milliman Mitigation Strategies/Resolution(s)
5	Engines	Member Month Key and Person Key population.	The MedInsight Engines create member month keys for each unique Member ID + YearMonth + Coverage (MM, RX, DC). The Person Key population is a custom process which maintains a person's unique key through quarterly processes. If this process doesn't work correctly, then the Member Month Key is not created correctly. Milliman has created a custom reconciliation that reviews the counts of non-zero member month keys by payers and between the prior and current quarterly refresh. This insures the custom person key process has executed properly. An additional person key custom recon has been created to report: • Person keys are unique for a person, using the members First Name, Last Name, and Date of Birth.
6	Portal/ Cubes/ Reports/ Dashboards	Usability of the User Defined Definitions (UDD's) and User Defined Fields (UDFs)	All of the UDF's and UDD's are now present in the NH CHIS MedInsight Portal and can be queried using the Query Express application.
7	Extracts	DHHS has found member gender uncapitalized.	Milliman has updated their process to ensure the member gender is always capitalized.

2021 NHID Rule Change (Effective 2/1/2021)

- Ins 4006.03 Included Records and Data Requirements
  - Claims shall be reported for out of network providers.
  - Claims shall be included when a member has exceeded benefits.
  - Claims must include patient liability on claims.
- New fields are added to the end of file layouts.
- New File, Field, and Quality checks were created.
- NH CHIS Preprocessor was updated for the file layout changes.

2022 Fiscal Year Extracts

Consolidated Extracts

The following are details of the 2022 fiscal year Consolidated extracts and shipment dates.

- Q2 2021 for data loaded through June 2021
  - Extract process began August 2021.
  - Extracts shipped to NHID September 2021.
- Q3 2021 for data loaded through September 2021.
  - Extract process began November 2021.
  - Extracts shipped to NHID December 2021.
- Q4 2021 for data loaded through December 2021.
  - Extract process began February 2022.
  - Extracts shipped to NHID April 2022.
- Q1 2022 for data loaded through March 2022.
  - Extract process began May 2022.
  - Extracts shipped to NHID June 2022.

Limited Use Extracts

Limited Use Extracts were provided *seven (9)* times for the 2022 fiscal year. These requests can be found at NH CHIS Limited Use Requests.

Public Use Extracts

Public Use Extracts were provided *27* times for the 2022 fiscal year. These requests can be found at NH CHIS Public Use Requests.

2022 NHCHIS Registration

52 payers submitted their yearly 2022 NH CHIS registration.

2022 Fiscal Year CHIS Payer Updates

Payers Mergers and Acquisitions

- Tufts Health Freedom Insurance Company (NHC0620) was acquired by United Health Care (UHC). Since UHC acquired the Tufts Tax ID, UHC has been submitting monthly NHC0620 payer files since August 2021.

- Tufts Benefits Administrators (NHC0615) has merged with Harvard Pilgrim. The new company is named Point32Health. The data merger will not occur until 2023. Tufts continues to submit monthly files file until 2023.

New CHIS Payers/Payer Codes

- AETNA Med Supp (NHC0012)

- Dentegra Group Ins (NHC0520). This payer code was created to aggregate file submissions for the payers below:

    - NHC0148 Delta Dental Insurance
    - NHC0630 DD of California
    - NHC0632 DD of NY
    - NHC0633 DD of Pennsylvania
    - NHC0500 (B/C) Dentegra

- CIGNA East & West (NHC0030). This payer code was created to aggregate file submissions for the payers below:
  - NHC0025 CIGNA West
  - NHC0025E CIGNA East

- UHC Med Supp (NHC0423S)

- OptumRX (NHT0172). This payer stopped reporting in 2016 however met the requirements to report.

- Tufts Insurance Company (TIC) (NHC0610). This payer code currently only applies to group retiree products issued in NH: Medicare Part D and Medicare Supplement, and self-insured groups with retiree plans issued in NH.

Sunsetted (Closed for Business) CHIS Payers

- CIGNA Behavioral Health (NHT0043)
- Symphonix (NHC0753)

CHIS Payers no longer submitting – Does not meet the 10,000 deminimus

- Humana Insurance (NHC0152)
- Arcadian Health (NHC0153)
- Humana Dental (NHC0154)

Data Caveat Details

The following are detail caveats of the data that are currently being worked on by the data suppliers. Some of them are referenced at higher level in the items listed above.

With the release of the information, the NH DHHS, the NHID, and Milliman want to provide the following known caveats:

1. **Anthem:** Anthem transferred to a new database in 2013 and some of their information was not consistent with historical data prior to January 2013. Anthem has now reloaded historical data to improve consistency. All 2009 and prior data is under the payer codes NHC0065 and NHT0139. 2010 and forward data is under the newer sub-payer codes NHC0065M, NHC0065P, NHC0065V, NHC0065U and NHT0139M and NHT0139P.

2. **Express Scripts/Medco:** Express Scripts and Medco merged in April 2012. Prior to this timeframe Express Scripts had not submitted their data to the NHCHIS. They transitioned their data to a common platform over time into 2013. Their data was merged before but now, Express Scripts/Medco has resubmitted the historical data from their old system prior to the merger in April, 2012. The payer codes are NHT0260 and NHT0503.

3. **Minuteman:** Pharmacy Claims have Quantity overstated because the payer implied decimal by adding 00 at the end of the field. The payer code is NHC0720.

4. **United Health Care (UHC)**: Currently the payer has three significant data issues. These issues affect payer codes NHT0478 United Healthcare Services, NHC0423 United Healthcare Insurance and NHC0752 United Healthcare Insurance – Medicare & Retirement. Because of these issues, achieving the final version for claims cannot be accomplished.

    a. Service Line's are randomly reported on a claim.
    b. Claim ID's are re-used.
    c. Adjustments are reported as reversals.

5. **Carve-Outs:** Pharmacy Benefit Management (PBMs) and Behavioral Health entities per Administrative Rule He-W 950 should only provide information to the NH CHIS for accounts where they act as a Third-Party Administrator or hold the premium. These entities have, in some recent cases, also been submitting information for accounts where they provide their services to the healthcare claim processors, but the healthcare claim processors hold the premiums – they should not be submitting information in these situations. This has led to a data issue:

a. There may be duplicate records due to the primary healthcare claims processor and the carve-out entity both submitting information. With the resubmission of the data due to 3a, the duplicate record issue is hopefully in the process of being resolved. Based on our conversations with the carve-out entities, it may not be as prevalent as initially noted. We do believe there is a potential overlap with Cigna Behavioral Health.

6. **Provider Information:** Milliman and the DHHS/NHID have worked to improve the roll-up of the facility information for New Hampshire and the major border facilities in the data sets. In addition, Milliman has worked to eliminate situations where individual providers show as organizations in the Public Use extract.

7. **Missing/Failed Files:** When Milliman creates the consolidated extracts for the DHHS/NHID, they reflect data submitted as of a point in time. To know which files were in a failed or missing status for this set of Limited Use extracts, go the NHCHIS website (https://nhchis.com). Select “Data Status” (on right) and then push “Proceed to Report” (top left). Select “Data Status” on the left hand side, and then select “Proceed to Report” at the top right. Once in the report, select “Data Warehouse Load Date” of ‘N/A’ and End Date of June 2022. Select only “Missing” and “Failed” from “Data Warehouse Status.” This will provide you a list of the files not imported into the extracts.

Summary

Milliman's focus over the 2022 fiscal year has been: 1) Resolving payer source data issues; 2) Creating quality reconciliation to flag issues before the quarterly extracts are delivered; 3) Obtaining missing files and improved data sets. Milliman has been working with the healthcare processors to mitigate these gaps.

Milliman has cited other known issues in the *Quality and Completion of Data* section. Milliman will work with the DHHS/NHID to resolve the issues that can be resolved through changes to the process.