What Gets Measured Gets Managed: Medicaid Encounter Data Quality| White Paper

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Introduction

Medicaid provides health care coverage to approximately 70 million beneficiaries nationwide.[1] In federal fiscal year (FFY) 2016, total state and federal Medicaid spending exceeded $548 billion, 49 percent of which was directed to Medicaid managed care (MMC) programs.[2] Of the $269 billion directed toward MMC programs in FFY 2016, 95 percent of those expenditures were paid to comprehensive risk-based managed care organizations (MCOs).[3] As states and the federal government confront fiscal challenges due to mounting Medicaid expenditures, the uncertainty of Federal health care reform, and the quickly approaching Federal penalties for incomplete encounter data due to begin in 2018, MCOs must prepare to contend with consequences associated with poor quality ratings. In addition to quality measurement, encounter data is the basis for: rate setting, risk adjustment, program integrity, compliance, performance measurement, and value-based purchasing, all of which are important components in the MMC environment.[4]

Encounter Data Defined

Data generated from fee-for-service (FFS) payment systems produce "claims data", while data generated by full-risk capitated payment systems produce "encounter data"[5] which creates a claims data record without a paid amount due to capitation arrangements. Medicaid enrollee encounter data refers to the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a MCO, Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) that is subject to the requirements of §438.242 and §438.818 (Sections in the 2016 Final Medicaid Managed Care Regulation),[6] as illustrated in Table 1.

Table 1: Key Components of the Final Medicaid Managed Care Rule Addressing Encounter Data[7]

Section	Description
§438.66	State monitoring requirements
§438.242	Health Information Systems
§438.358	Activities Related to External Quality Review
§438.818	Enrollee Encounter Data
§438.5(c)	Rate Setting

Quality Encounter Data Submissions in Medicaid Managed Care

[1] GAO. (2017). Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements. Retrieved from http://www.gao.gov/assets/690/681924.pdf.
[2] HMA. (2017). Medicaid Managed Care Spending in 2016. Retrieved from https://www.healthmanagement.com/blog/medicaid-managed-care-spending-2016/.
[3] Ibid.
[4] Ibid.
[5] Reck, J. and Yalowich, R. (2016). Understanding Medicaid Claims and Encounter Data and Their Use in Payment Reform. NASHP. Retrieved from http://www.nashp.org/wp-content/uploads/2016/03/Claims-Brief.pdf.
[6] CMS. (2016).Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Retrieved from https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.
[7] Table 1 Source: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program- chip-programs-medicaid-managed-care-chip-delivered/.

In May 2016, The Centers for Medicare and Medicaid Services (CMS) published a final rule in which encounter data reporting and submission requirements are key components. As indicated in Table 2, effective July 1, 2017, states and MCOs must be in compliance with new encounter data standards.[8]

Table 2: Snapshot of Key Medicaid Managed Care Encounter Data Submission Requirements

Issue Area	Summary of Select Regulations on Encounter Data
Provider Entities Required to Submit Encounter Data	• All managed care entities and managed care programs, including managed long-term services and supports (MLTSS) programs, and providers who are paid by a Managed Care Entity (MCE) on a capitated basis.
Encounter Data Submission Elements	• States are required to submit validated encounter data to CMS in a standardized format in a complete, timely, and accurate manner (In the format required by the Medical Statistical Information System).
Non-Compliance Penalties	• All state Medicaid enrollee encounter data set-submissions to CMS must be fully compliant with federal standards. • If a states' encounter data submissions are not compliant with CMS standards (if the data is not complete, accurate and submitted in a timely manner), federal financial participation (FFP) will be withheld in proportion to the capitation payment attributable to *service type or enrollee group* with non-compliant data. For example, if 10 percent of a capitation payment were attributable to non-compliant data, then 10 percent of federal financial participation would be withheld or deferred. → (See Appendix A for information and distinctions regarding withholds).
Applicability Period	• States must submit complete and accurate encounter data to CMS effective **July 1, 2017**. This provision is applicable to all state contracts with MCEs and all sub-capitated providers. • CMS will withhold federal financial participation if states are not in compliance with the final rule for contracts beginning on or after **July 1, 2018**.

Source: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered/.

Background

Medicaid has traditionally operated as a FFS payment system whereby state Medicaid agencies pay providers directly for services provided to Medicaid beneficiaries. In this arrangement, health care providers subsequently bill the Medicaid program directly by submitting claims data.[9] Conversely, in capitated payment systems, state Medicaid agencies do not provide direct payments to providers. In this arrangement, state Medicaid agencies pay MCOs on a per-member-per month (PMPM) basis. In turn, MCOs pay providers within their defined network to provide health care to beneficiaries.

Data are the Details from which Information is Derived

When Medicaid was largely administered through FFS arrangements, states had access to claims data through state-built data warehouses or through Administrative Service Organization (ASO) administrators.[10] As of September 2016, 39 states contract with MCOs[11] and the majority of Medicaid beneficiaries are enrolled in MMC.[12] MCOs store encounter data in their own repositories. The shift in the administration of Medicaid benefits from state Medicaid agencies to MCOs has diminished the states' and federal government's exposure

[8] Houchens, P. and Cunningham, J. (2016). New CMS Managed Care Regulations Potential Impacts to PIHPs. Milliman. Retrieved from https://www.macmhb.org/sites/default/files/attachments/files/New%20CMS%20Managed%20Care%20Regulations%207.1.16%20FF.pdf.
[9] Claims data provides an overview of the inpatient services, outpatient services, pharmacy benefits and home health care benefits received by Medicaid beneficiaries.
[10] Gerstorff, J.and Gibson, S. (2016). Medicaid Encounter Data: The Next National Data Set. The Society of Actuaries. Retrieved from http://us.milliman.com/uploadedFiles/insight/2017/medicaid-encounter-data.pdf.
[11] KaiserFamilyFoundation. (2016). Total Medicaid MCO Enrollment. Retrieved from http://kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[12] Gerstorff, J.and Gibson, S. (2016). Medicaid Encounter Data: The Next National Data Set. The Society of Actuaries. Retrieved from http://us.milliman.com/uploadedFiles/insight/2017/medicaid-encounter-data.pdf.

to Medicaid encounter data.[13] Without access to these data, states do not have adequate information to effectively: develop actuarially sound capitation rates, review patient service utilization rates, quantify the value of providing a service on a mandatory versus a voluntary basis, calculate quality measures, and measure the extent to which quality and performance benchmarks are being met by health plans.[14]

Challenges in Reporting Encounter Data for Managed Care Organizations

MCOs face challenges in reporting quality encounter data. Common challenges include, but are not limited to:

- **File Formats** - Encounter data is typically submitted in the CMS HIPPA-Compliant 837-file format for institutional, professional and dental services, while the National Council for Prescription Drug Programs (NCPDP) file format is the submission method for prescription drug data. MCOs that operate in numerous states face complications when state file format standards differ or when a state deviates from standard use of the data fields in the 837-file format.[15]
    - There are approximately 1,000 fields on the 837-file format and there are several 837-file format-versions, to include state proprietary versions.[16]
- **Rejected Encounters** - Variation in states' utilization of specified data fields in compliant file formats increases the probability that encounter data will be rejected.[17] Furthermore, in most states, eligibility for Medicaid reimbursement requires providers to register and possess a National Provider Identifier (NPI) in order to be listed on a state's roster of Medicaid providers. Encounters are verified by a state by cross-referencing a provider's NPI with the roster. However, not all states require providers to be on the state's roster as a prerequisite for MCO reimbursement. Encounters can also be rejected because legacy state-run information systems, which were designed for FFS claims data, are frequently not compatible with encounter data. Finally, retro-member adjustments - state decisions to retroactively dis-enroll members from an MCO for various reasons - also account for MCO encounter data rejections as they may cause timing issues for encounter submissions if the member does not appear as eligible in the state's system.[18]
- **Incomplete or Late Provider Submissions** - There are instances whereby providers in an MCO's network fail to submit encounter data to the MCO in a timely fashion, or at all. These instances occur for multiple reasons and include but are not limited to: a lack of knowledge among providers about their encounter data submission responsibilities, variances in data submission requirements for providers contracting with numerous MCOs, contractual variations in data submission requirements among providers in an MCO's network, and incompatible technological infrastructures.[19]

To mitigate challenges associated with collecting, reporting and submitting encounter data, CMS expanded its existing Medicaid Statistical Information System (MSIS) which was the system used to collect data for the Medicaid program as well as the Children's Health Insurance (CHIP) program. The new system, referred to as the Transformed Medicaid Statistical Information System (T-MSIS), is intended to streamline and standardize

[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Cunningham, J., Lewis, M. T., and Houchens, P., R. (2016). Encounter data standards: Implications for State Medicaid agencies and managed care entities from final Medicaid Managed Care Rule. Retrieved from http://www.milliman.com/insight/2016/Encounter-data-standards-Implications-for-state-Medicaid-agencies-and-managed-care-entities-from-final-Medicaid-managed-care-rule/.

FFS and encounter data submission processes. To further improve and expand upon the T-MSIS data repository, the 2016 Final Medicaid Managed Care Rule requires additional encounter data fields. These fields include: recipient and provider information, service and diagnostic information, payment information from third parties, and service and payment dates.[20]

What Gets Measured Gets Managed: Managing Medicaid Quality Ratings

Medicaid encounter data is the single most important tool for determining the quality of health care being provided to a health plans' members.[21] Encounter data is used by states to compare performance across health plans. Encounter-based performance measures, such as the Healthcare Effectiveness Data and Information Set (HEDIS) measures, are used for quality monitoring and include various quality measures that have been maintained and defined by the National Committee for Quality Assurance (NCQA).[22] For example, Medicaid recipients are screened for lead exposure, and when a beneficiary is screened the appointment is considered an encounter. If the encounter is not accurately reported and submitted, the patient encounter data cannot be collected and reported for use in larger HEDIS quality reporting,[23] which is often reflected in a health plans' receipt of poor overall quality scores. Notably, the Final Medicaid Managed Care Rule also requires states to use encounter data for setting capitation rates. For these reasons, the federal government established a set of regulations that mandate quality Medicaid encounter data are adequately reported, as illustrated in Table 3.

Table 3: Encounter Data Submission Mandates for Monitoring Quality in Medicaid Managed Care

Quality Management Requirements	▪ States must conduct initial reviews and validate the encounter data submissions of each MCO operating in the state for accuracy and completeness before submitting the data to CMS; conduct independent audits of MCO encounter data submissions every three years; and use MCO audited financial data for the purposes of providing feedback and improving MCO performance. ▪ States must also utilize monitoring systems and annually document and report on the encounter data submissions of each MCO. ▪ Validation of MCE-reported encounter data is a mandatory External Quality Review (ERQ) activity. ERQ activities include analyzing and evaluating aggregated information on quality, timeliness, and access to the health care services that an MCO or its contractors provide to Medicaid beneficiaries.

Source: http://www.milliman.com/insight/2016/Encounter-data-standards-Implications-for-state-Medicaid-agencies-and-managed-care-entities-from-final-Medicaid-managed-care-rule/.

Best Practices for MCOs to Achieve Quality Encounter Data Benchmarks

The timely and accurate submission of quality encounter data is a requirement, not an option. To date, states have incentivized improved encounter data submissions among MCOs by: (1) using encounter data in rate setting, (2) risk adjusting capitation rates, and (3) including contract provisions that impose penalties, such as the loss of enrollment in the auto-assignment process[24] (See Appendix B). Whereas the federal government requires states to submit encounter data in a standardized format, states have discretion in dictating components of encounter data policy, such as defining the ways in which MCO encounter data is validated for

[20] Houchens, P. and Cunningham, J. (2016). New CMS Managed Care Regulations Potential Impacts to PIHPs. Milliman. Retrieved from https://www.macmhb.org/sites/default/files/attachments/files/New%20CMS%20Managed%20Care%20Regulations%207.1.16%20FF.pdf.
[21] Gerstorff, J.and Gibson, S. (2016). Medicaid Encounter Data: The Next National Data Set. The Society of Actuaries. Retrieved from http://us.milliman.com/uploadedFiles/insight/2017/medicaid-encounter-data.pdf.
[22] Ibid.
[23] Ibid.
[24] Ibid.

completeness and accuracy.[25] As a best practice, MCOs are collaborating with government partners to establish state-specific encounter data validation standards.

Achieving Quality Encounter Data Benchmarks: The Importance of Provider Incentives

'Best practice' MCOs understand that encounter data is used by states to calculate quality measures and to discern MCO quality.[26] As such, MCOs have begun to employ operational strategies and best practices (See Appendix C) to incent timely and accurate provider claims submissions and to ensure all submitted provider claims can be converted into accepted encounters.[27] Specifically, best practice MCOs:

- Offer incentive payments to network providers for meeting encounter data submission benchmarks;[28]
- Financially invest in technology, provider outreach and provider education;[29]
- Include requirements for submitting "clean" claims in their provider contracts and manuals;[30] and
- Reject claims submitted by providers with missing information (If allowable by the state).[31]

Conclusion

Nationwide, states are engaging in value based payment and delivery reform efforts to reduce health care costs and to enhance health care quality in their Medicaid programs.[32] These efforts cannot be achieved without the availability of timely and accurate Medicaid encounter data, the basis upon which quality is measured[33] and the single most comprehensive source of beneficiary-level service utilization information.[34] As such, MCOs must prepare for increased state oversight and monitoring. Finally, MCOs should utilize industry best practices to avoid costly, state-sanctioned non-compliance penalties associated with the CMS' new encounter data submission standards.

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[25] Ibid.
[26] Navigant. (2016). MCO claims Data Critical to CMS and State Oversight of Medicaid Program. Retrieved from https://www.navigant.com/insights/healthcare/2016/medicaid-and-chip-final-managed-care-rule.
[27] Gerstorff, J. and Gibson, S. (2016). Medicaid Encounter Data: The Next National Data Set. The Society of Actuaries. Retrieved from http://us.milliman.com/uploadedFiles/insight/2017/medicaid-encounter-data.pdf.
[28] Hardesty, A. and Yegian, J. (2015). Encounter Data: Issues and Implications for California's Capitated, Delegated Market. Retrieved from http://www.iha.org/sites/default/files/resources/issue-brief-encounter-data-2015.pdf.
[29] Gerstorff, J. and Gibson, S. (2016). Medicaid Encounter Data: The Next National Data Set. The Society of Actuaries. Retrieved from http://us.milliman.com/uploadedFiles/insight/2017/medicaid-encounter-data.pdf.
[30] Ibid.
[31] Ibid.
[32] Reck, J. and Yalowich, R. (2016). Understanding Medicaid Claims and Encounter Data and Their Use in Payment Reform. NASHP. Retrieved from http://www.nashp.org/wp-content/uploads/2016/03/Claims-Brief.pdf.
[33] Gerstorff, J. and Gibson, S. (2016). Medicaid Encounter Data: The Next National Data Set. The Society of Actuaries. Retrieved from http://us.milliman.com/uploadedFiles/insight/2017/medicaid-encounter-data.pdf.
[34] Houchens, P. and Cunningham, J. (2016). New CMS Managed Care Regulations Potential Impacts to PIHPs. Milliman. Retrieved from https://www.macmhb.org/sites/default/files/attachments/files/New%20CMS%20Managed%20Care%20Regulations%207.1.16%20FF.pdf.

Appendix A

The 2016 Final Rule makes the distinction between a withhold arrangement, subject to the requirements at §438.6(b)(3), and a penalty that a state would impose on a managed care plan via its contract.

Withhold Arrangement	Penalty
A withhold arrangement is tied to meeting performance targets specified in the contract that are designed to drive managed care plan performance in ways distinct from the general operational requirements under the contract. For example, states may use withhold arrangements (or incentive arrangements) for specified quality outcomes or for meeting a percentage of network providers that are paid in accordance with a value-based purchasing model. The targets for a withhold arrangement are distinct from general operational requirements under the contract.	A penalty, on the other hand, is an amount of the capitation payment that is withheld unless the managed care plan satisfies an operational requirement under the contract and is not subject to the requirements at §438.6(b)(3). For example, a state may withhold a percentage of the capitation payment to penalize a managed care plan that does not submit timely enrollee encounter data. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

Source: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered/.

Appendix B

State Strategies to Ensure Timely and Accurate Encounter Data Submissions

Strategy	Description
Using Encounter Data For Rate Setting	States are relying on encounter data for the source of base data to produce MCO capitation rates. Incomplete or inaccurate encounter data submission can lead to capitation rates that do not appropriately reflect the managed Medicaid program.
Risk Adjusting Capitation Rates	The adoption of risk-adjusted capitation rates provides incentives for MCOs to improve their encounter data, since the data supports the calculation of beneficiary risk scores. The core tenet of risk adjustment is to recognize disproportionate shares of risk among MCOs and better match payment to risk profile. A byproduct of risk adjustment is heightened MCO awareness to submit encounter data that ensures that their MCO-specific risk score fully reflects their experience.
Contract Provisions	States improve their encounter data with well-thought-out financial and operational contract requirements. These include financial penalties for not meeting certain service-level agreement (SLA) requirements. These penalties could be in the form of: • Liquidated damages; • Unearned capitation rate withholds; • Loss of incentive payments; and/or • Loss of enrollment in the auto-assignment process.

Source: http://us.milliman.com/uploadedFiles/insight/2017/medicaid-encounter-data.pdf.

Appendix C

Best Practices for Managed Care Entities to Create and Submit Timely and Accurate Encounter Data

Strategy	Description
Ownership	Establish ownership and accountability in a formal manner. Best practice organizations establish strong cross-functional teams to support the encounter data process.
Financial Reconciliation	Conduct routine financial reconciliation of encounter data submissions to the plan's general ledger because of the impact of encounter data on risk adjustment and premium revenue. If submitted encounter data does not include dollar amounts (e.g., in capitated arrangements), establish protocols to assign prices based on Medicaid fee schedules or other standardized pricing.
Collaboration	Work collaboratively with state officials to influence encounter submission specifications. Partner with other MCEs to ensure specifications make sense.
Provider and Vendor Data	Ensure that provider and vendor contracts require timely and high-quality submissions of claims and encounters. Provide problem resolution and feedback on encounter submission issues to providers and vendors. As CMS had focused on data quality concurrent with an expansion of new provider types who must submit data (e.g., MLTSS providers), managing vendors and delegates has taken on new importance for MCEs. Incentivizing provider performance to meet the encounter data submission benchmarks and conducting outreach and education are also strategies recognized as best practices.
Information Systems Architecture	Incorporate encounter data collection, management, and submission requirements into overarching system architecture and design. Invest in technology enhancements to support new and emerging requirements.
Technical Processes	Create a technical infrastructure to support encounter submission processing and quality review. Audit encounters submissions before submission, to identify issues up front.
Quality Improvement	Put a data quality improvement process in place to continually improve all data within the organization. Ensure that encounter submission errors are tracked and aggregated and that patterns are reviewed as sources for potential data quality improvements.
Documentation	Ensure that processes are well documented and teams fully staffed, and that cross-training has occurred so processes are not reliant on small number of staff.
Monitoring	Ensure that encounter submission processes are tracked and metrics are available throughout the organization, that completeness is reviewed by comparing encounters with financial reports.

Source: http://us.milliman.com/uploadedFiles/insight/2017/medicaid-encounter-data.pdf.