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MCO CLAIMS DATA CRITICAL TO CMS AND STATE OVERSIGHT OF MEDICAID PROGRAM

INTRODUCTION

In April 2016, Centers for Medicare & Medicaid Services (CMS) finalized the Medicaid Managed Care Rule,[1] which includes new requirements for collection, validation and reporting of encounter claims. These requirements have a wide-ranging impact on states and managed care organizations (MCOs). Originally proposed in April 2015, these new regulations indicate the increased importance of encounter claims reporting for CMS.

The importance of timely, accurate and complete encounter data has grown significantly since the passage of the Affordable Care Act (ACA) in March 2010:

- Medicaid enrollment has increased by 27 percent, adding more than 16 million covered lives to the program. The majority of these new enrollees are receiving benefits from risk-based MCOs.[2]
- Currently, more than 60 percent of all Medicaid beneficiaries are enrolled in comprehensive, risk-based managed care.[3]
- Premium payments to MCOs providing comprehensive services to Medicaid beneficiaries exceed $161 billion dollars, and account for 34 percent of all Medicaid spending.[3,4] For states, CMS and health plans, encounter claims are the best source of information to understand how these billions of dollars are being spent.

Not surprisingly, CMS, states, legislators and other stakeholders have an increased interest in obtaining timely and accurate services and outcomes information related to MCO coverage of Medicaid beneficiaries.

1. Medicaid Managed Care Rule released in CMS-2390-F, which updated 42 CFR Parts 431, 433, 438, 440, 457 and 495.
2. Total Monthly Medicaid and CHIP Enrollment. (n.d.). Retrieved August 05, 2016, from http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/
3. Medicaid Managed Care Enrollment and Program Characteristics, 2014 Retrieved August 05, 2016 from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf
4. Total Medicaid MCO Spending. (n.d.) Retrieved August 05, 2016 from http://kff.org/other/state-indicator/total-medicaid-mco-spending/

The Medicaid Managed Care Rule mandates that states report encounter claims timely, accurately and completely through the Transformed Medicaid Statistical Information System (T-MSIS), which states use to report member and claims data to CMS. CMS indicates that states with deficient encounter data are at risk of losing federal matching funds. Although CMS has had the ability to withhold matching funds when states fail to report encounter data since at least 2010, it has not used this authority.[5] In addition, states have often not enforced their own contracts with MCOs in collecting timely, accurate and complete encounter data. The Office of the Inspector General has been critical of all parties because of the lack of quality encounter data, recommending greater penalties for non-compliance.

The Medicaid Managed Care Rule demonstrates that CMS is increasing scrutiny of encounter data and indicates that CMS is more likely to withhold federal matching funds for non-compliant encounter data in the future. This brief discusses the major regulatory changes related to encounter data, reporting in the Medicaid Managed Care Rule, how states can better monitor and improve the quality of their encounter data and the importance and benefit of having timely, accurate and complete encounter data.

In the Medicaid Managed Care Rule, CMS defines enrollee encounter data as "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, PIHP, or PAHP".

WHAT IS ENCOUNTER DATA USED FOR?

Medicaid, like other payers in the private sector, are data-driven. The primary data points within any Medicaid agency are eligibility and claims data. Without timely, accurate and complete encounter data, state Medicaid agencies cannot perform effective oversight, review or monitoring of their managed care programs.

Encounter data provides detailed information regarding the services provided to Medicaid beneficiaries who receive their services on a capitated basis from managed care organizations. Encounter data are the primary record of the services for which states and the Federal government pay billions of dollars. Without timely, accurate and complete encounter data, states cannot demonstrate to CMS, state legislators and other stakeholders how much they are spending, for whom they are spending and the results of that spending.

In addition to addressing the basic questions of who is getting care at what price, and how much providers are receiving to deliver that care, there is significant value in states collecting accurate and complete encounter data. Encounter data facilitates capitation rate setting, risk adjustment, the evaluation of MCO quality and cost performance, the contribution of value-based purchasing, care management, behavioral health and physical health integration activities, program integrity and policy development. In other words, encounter data allows states to provide better care and determine appropriate payment for that care. Other activities that are supported by encounter data are described in Table 1.

5. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule,§ 1903(i)(25).

Table 1. State Agency Encounter Data Activities

ENCOUNTER DATA ACTIVITY	STATE USAGE	STATE IMPACT WHEN ENCOUNTER DATA DEFICIENT
Federal reporting	Reporting utilization to CMS per federal regulations	Withhold of federal matching funds by CMS
Capitation rate setting	Actuaries use encounter data to calculate capitation rates each year; correctly calculated rates promote "beneficiary access to quality care, efficient expenditure of funds and innovation in the delivery of care"[6]	Potential under- or overstatement of capitation rates
Service verification, utilization patterns and access to care	Review member utilization and analyze members' ability to access care; assess network adequacy	Lack of insight on member's ability to access care and overall quality of care
Evaluate healthcare quality and outcomes	Calculate quality measures to understand MCO quality	Inability to drive managed care quality improvement
Evaluate MCO performance	Evaluate MCO's outcomes, such as evaluating avoidable emergency room (ER) usage, avoidable hospitalizations and readmissions and other performance metrics	Missed opportunity to drive performance goals with MCOs. For example, some states assign a higher percentage of members to better performing MCOs
Hospital and other provider rate setting	Setting prospective rates or performing retrospective cost settling	Under- or over-statement of provider rates
Budgeting	Identifying types of services and types of providers reimbursed through the Medicaid program	Inability to determine how state funds are being used, and report to Legislatures
Program Integrity (Fraud, Waste, Abuse)	Program integrity analysis such as beginning preliminary investigations, reviewing utilization spikes and analyzing outliers	Lack of ability to completely track Fraud, Waste and Abuse across all Medicaid spending
Other state goals	Other goals such as risk adjustment, value-based purchasing and policy development	Inaccurate or incomplete information available to inform policy and other decisions

6. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, Setting Actuarially Sound Capitation Rates for Medicaid Managed Care Programs (CFR §§438.2, 438.4, 438.5, 438.6, and 438.7).

WHAT ARE THE MAJOR NEW RULES THAT AFFECT ENCOUNTER REPORTING?

CMS finalized three requirements relating to encounter claims in the Medicaid Managed Care Rule:

1. §438.818 Enrollee Encounter Data
   - States are at risk for having federal match for MCO capitations withheld when they provide inaccurate or incomplete encounter data to CMS.
   - States must submit claims via T-MSIS.[7]
   - If CMS notifies a state that its encounter data is deficient, the state must work to rectify the data. If it cannot, "CMS will take appropriate steps to defer and/or disallow federal financial participation (FFP) on all or part of an MCO, PIHP or PAHP contract in a manner based on the enrollee and specific service type of the noncompliant data."[8]
2. §438.242 Health Information Systems
   - The state's information system must be able to ensure that encounter claims data are timely, accurate and complete.
   - The MCOs possess a Management / Health Information System that can process, collect and maintain data related to the MCO's management and oversight of its enrollees, such as utilization, claims, grievances and appeals, and disenrollment.
3. §438.66 State Monitoring Requirements
   - The state must have a monitoring system for managed care programs.
   - The state must collect data and use it to improve its managed care programs.
   - The state must assess readiness for each manage care entity.
   - The state must report yearly to CMS on each managed care program.

WHAT METHODS DO STATES USE TO ENSURE TIMELINESS, ACCURACY AND COMPLETENESS OF MCO DATA SUBMISSION?

As a first step to satisfying CMS's requirements for collecting accurate and complete encounter data from MCOs in a timely fashion, states must implement oversight mechanisms to monitor the encounter data they receive. States can independently monitor encounter data performance or engage an External Quality Review (EQR) organization to review encounters.[9] For states engaging an EQR, CMS asserts that EQR "…annual validation alone is probably not adequate."[9] CMS also advises that if states are not using an EQR, they must "…ensure that there is sufficient analytic rigor in the chosen method."[10]

Methods that states use to ensure encounter data quality related to each of three requirements include those outlined in Table 2; we recommend states use some, if not all, of these methods:

When a state finds a MCO's encounter data deficient, the state should work with the MCO to correct issues that result in less than timely, complete and accurate encounter data reporting. Many states write sanctions into contracts to incentivize encounter data compliance. However, some states experienced poor encounter performance when contractual sanctions were too light or when states did not perform strict oversight.

7. Technically, the rule requires encounters to be "submitted in the format required by the Medicaid Statistical Information System or format required by any successor system to the Medicaid Statistical Information System", but T-MSIS is the successor to MSIS. See section, "How Is CMS Measuring Timeliness, Accuracy and Completeness?" which describes T-MSIS.
8. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, CFR §438.242 and §438.818, Discussion of Public Comments.
9. Encounter data validation is an optional activity for an EQR per Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, CFR §438.358, Discussion of Public Comments.
10. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, CFR §438.242 and §38.818, Discussion of Public Comments.

Table 2. Methods for Monitoring and Enforcng Encounter Quality

REQUIREMENT	METHOD TO ENSURE QUALITY
Timeliness	Using the X12 standard 837, states may use the difference between the MCO payment date and stated date of receipt to calculate the timeliness of claims submissions.[11] Alternatively, if that data is not available, states ask the MCOs to generate specific reports regarding the payment date of encounters.
Accuracy	States determine accuracy either prospectively or retrospectively. Prospectively, they can process claims through their Medicaid Management Information System (MMIS), applying a subset of the Fee-For-Service edits and audits, to determine if the claim contains accurate information. If inaccurate, states deny or reject the encounter claim and ask the MCO to fix and resubmit that encounter. Alternatively, states can retroactively review the encounter data, generally through the use of sampling, and determine accuracy and further follow up actions.
Completeness	States compare historical utilization program-wide to utilization as reported in the encounter data for an MCO and across MCOs. States compare financials to encounter data to measure completeness. States can also use audits to determine encounter completeness.

Other methods to assess encounter data quality exist, and it is incumbent upon each state to confirm its mix of policy, procedures and oversight methods for that purpose. One particular area in which states should provide additional scrutiny is MCO sub-capitated services. This has long been a troublesome area for MCOs and states, and CMS calls attention to this area in the Medicaid Managed Care Rule discussion. MCOs have less direct control of these encounters since these claims often are not submitted directly to the MCO for payment (i.e., the MCOs have some of the same challenges the states have in terms of getting timely, accurate and complete encounter data). Consequently, sub-capitated encounter reporting may be problematic and take longer to address. States should consider requiring additional contract requirements for MCOs' sub-capitated arrangements.

MCOs may "sub-capitate" a portion of the services for which they are at-risk to another entity. Under a sub-capitated arrangement, the MCO contracts with another entity, for example, a behavioral health managed care plan, to provide a defined set of services at risk.

A number of other steps can help with accuracy validation. Specifically, states may wish to consider detailed of strategies, such as:

- Use the Medicaid Management Information System (MMIS) to improve encounter accuracy—States can "shadow price" encounter claims at Medicaid Fee-For-Service rates (i.e., determine what payments would have been had they been paid Fee-For-Service) to leverage the existing state infrastructure for improving accuracy at a claim level—the state's MMIS adjudication engine. But when doing so, states will need to carefully consider how to apply MMIS processing rules to encounters. For example:
  - MCOs may pay for services beyond that of Medicaid. These services typically will not have a rate in the MMIS. States must decide how to handle these encounter line items.
  - Not all FFS edits should be dispositioned for encounter claims. For example, FFS Prior Authorization (or Service Authorization) edits should not be disposed for encounters.
- Focus on provider data reported on encounters to enhance encounter accuracy—Deriving the correct Medicaid provider number from the submitted National Provider Identification numbers (NPIs) has proven challenging for both FFS and Encounter claims for many state agencies. State agencies' mapping of NPIs to Medicaid provider identification numbers is often complex and requires special attention to ensure accuracy in associating claims payment to service providers.
- Track duplicate claims separately—Certain states choose to track accuracy issues and duplicative claims independently (having separate contract Service Level Agreements for each). This allows states to focus on improving the quality of encounter claims while also monitoring issues with duplicate encounter submissions.

11. Claims should be sent to the state electronically. The 837I, 837P and 837D are the national standard format for reporting medical claims information.

CMS collects eligibility, enrollment, program, utilization and expenditure information through Medicaid and Statistical Information System (MSIS). States provide CMS with data quarterly. Transformed-MSIS (T-MSIS) replaces MSIS, and it allows CMS to collect additional files and data elements.

HOW IS CMS MEASURING TIMELINESS, ACCURACY AND COMPLETENESS?

CMS considers encounter claims submissions compliant only when states report timely, accurate and complete data through the T-MSIS. Even if states collect encounter data correctly from MCOs, CMS may still assign penalties if the states do not report their encounter data correctly via T-MSIS. CMS states, "We agree that states' effort to collect complete and accurate data from managed care plans is distinct from their MSIS/T-MSIS submissions. However, we are limited in our ability to accept and/or evaluate encounter data outside of MSIS/T-MSIS."[12]

The Medicaid Managed Care Rule also requires states to dedicate proper resources to their T-MSIS development stating, "...some states have not or could not make the investment of resources previously to comply with MSIS/T-MSIS requirements; as proposed and finalized, §438.818 will require them to make that investment".[12]

T-MSIS is the successor to MSIS as the system used by states to report member, claims and other data to CMS. T-MSIS requires states to submit four claim files: Inpatient, Long-Term Care, Outpatient and Prescription Drugs, along with other non-claim files.[13] 310 unique fields (e.g., member, provider, diagnosis, procedure code, etc.) exist among these four files. For T-MSIS validation:

1. CMS first administers an automated review of claims data. Within T-MSIS, many of the rules verify that the dates are logical, submitted values match T-MSIS valid values, and other low-level data integrity validations.[14]
2. CMS performs an additional validation of the submitted data, and CMS engaged an external contractor to conduct subsequent validation to ensure integrity within and among files.

Under MSIS, even if CMS accepted the file, it did not mean that CMS considered the data to be timely, accurate or complete.[15] The Medicaid Managed Care Rule does not specifically define what "accurate" means to CMS. CMS states it expects to release additional guidance.

WHAT CHANGES ARE MCOS LIKELY TO SEE AS A RESULT OF THE MEDICAID MANAGED CARE RULE?

MCOs can expect tighter contracts, greater oversight and monitoring, and an increased focus on encounter reporting. They can expect states to develop more robust processes and procedures for monitoring MCO performance. Several states have already imposed penalties on contracted MCOs for failure to provide timely, accurately and complete encounter reporting. While CMS has not typically withheld state matching funds for deficient encounter performance in the past, CMS has indicated it will use these sanctions to obtain encounter data in the near future. In July 2015, the Office of the Inspector General recommended that "CMS use its authority to withhold appropriate Federal funds from States that fail to submit encounter data to MSIS until those States report encounter data as required."[16] CMS agreed with this recommendation. Additionally, the Medicaid Managed Care Rule details the methodology CMS would use to determine the amount to withhold.[17]

States need to carefully consider their future contract language surrounding encounters. Typically, if a state includes sanctions in the MCO contract for failure to accurately report encounter claims, the sanctions are not at the magnitude of the state's Federal Medical Assistance Percentages (FMAP). For example, one state sanctions MCOs if its encounter accuracy and completeness falls below 98 percent. For every percentage point under 98 percent, the state penalize an MCO 0.25 percent of their capitation rate. In other words, if an MCO does not report encounters, the state's maximum sanction would be 24.5 percent, whereas CMS's maximum penalty would be the state's FMAP rate (50 percent to 74.63 percent depending on the state).[18] Navigant anticipates that states will add contract language that shifts federal penalties to MCOs for noncompliant encounter reporting. At present, many states push federal penalties to vendors with MMIS and other contracts—expect states to follow this model during their next MCO contracting period.

12. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, CFR §438.242 and §438.818, Discussion of Public Comments.
13. The four claims files were reported under MSIS along with an eligible file. T-MSIS adds TPL, Managed Care and Provider files. States must report both encounter and fee-for-service claims.
14. T-MSIS document "7 - t-msis v1_1 to v2_0 validation rules comparison- 2015-11-24" includes the validation rules.
15. CMS presentation on T-MSIS data quality shows that accepted files have gaps in the data: http://www.mesconference.org/wp-content/uploads/2012/08/monday_tmsis_gorman.pdf
16. Not All States Reported Medicaid Managed Care Encounter Data as Required. July 2015, Office of the Inspector General.
17. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, CFR §438.242 and §438.818, Discussion of Public Comments: "We interpreted the statute as providing for a per-enrollee disallowance for a failure to report enrollee encounter data. We believe it is more accurate to calculate the deferral and/or disallowance amount based on the enrollee and the specific service type of the non-compliant data. Using this methodology, only the portion of the capitation payment attributable to that enrollee for the service type of the non- compliant data would be considered for deferral and/or disallowance. For example, if the non-compliant encounter data is for inpatient hospital services, then only the inpatient hospital portion of the capitation payment for that enrollee would be subject to deferral and/or disallowance. We proposed that any reduction in FFP would be effectuated through the processes outlined in §430.40 and §430.42."
18. Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier. (n.d.). Retrieved August 05, 2016, from http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

If CMS does withhold matching funds to states for MCO capitation payments when timely, accurate and complete encounters are not submitted, most states will likely be more aggressive in taking steps to mitigate their risk. Not only are they more likely to pass down financial penalties, but they are also more likely to consider the long-term viability of MCOs that are out of compliance. MCOs that have mastered the encounter data submissions process will be in a more favorable position with states upon contract renewal or re-procurement.

CMS's maximum penalty for encounter claim deficiency would be the state's Federal Medical Assistance Percentages (FMAP) rate (ranging from 50% to 74.63%) for capitations.

The Medicaid Managed Care Rule stipulates the methodology CMS would use to disallow matching funds: "For example, if the non-compliant encounter data is for inpatient hospital services, then only the inpatient hospital portion of the capitation payment for that enrollee would be subject to deferral and/or disallowance"

WHAT'S NEXT?

CMS indicated it will be providing states and MCOs further guidance about encounter "accuracy," beyond the rules established for T-MSIS. Current CMS rules require that "…states submit all of the data elements required by MSIS / T-MSIS, for all of the services, for all of the enrollees enrolled in the states' managed care plans".[19]

While CMS works to define accuracy, states can begin to evaluate their managed care contract requirements for the future. Most new regulations will be enforced for contracts beginning after July 2017 and July 2018.[20] Clear contract requirements and dedicated state staff monitoring and enforcing encounter submissions are key components of an overarching encounter quality strategy. The most important time to mitigate risk is prior to the start of a contract; states should begin review of Service Level Agreements for encounter data reporting well in advance of new contracts with MCOs. States should contractually incentivize MCOs through sanctions and incentives to promote proper encounter reporting.

Independent of the finalized rules, there is significant value for states to collect timely, accurate and complete encounter data. States will likely review their processes and procedures for encounter data collection in preparation of CMS's additional guidance. If states have not yet done this, they may wish to consider dedicating proper resources to ensuring encounter data quality and T-MSIS reporting. As managed care has become a significant portion of most Medicaid programs in recent years, Medicaid policy making must include an understanding of the types of services and providers reimbursed by the Medicaid MCOs.

19. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, CFR §438.242 and §438.818, Discussion of Public Comments.

20. CFR §438.818 - No later than rating period for contracts starting on or after July 1, 2018.
CFR §438.242 - No later than rating period for contracts starting on or after July 1, 2017.
CFR §438.66(a)-(d) - No later than rating period for contracts starting on or after July 1, 2017.
CFR §438.66(e) (Annual program report) - Rating period for contracts that start after the release of CMS guidance.