INTEGRITY MANAGEMENT SERVICES

702- Where the Rubber Hits the Road: Expert Tips and Techniques to Proactively Assess Your Organization's Compliance with the New Encounter Data Reporting Requirements

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Integrity Management Services, Inc.

Headquartered in Alexandria, Virginia, Integrity Management Services (IntegrityM) is a certified women-owned small business, CMMI Level 3 appraised, ISO 9001:2015 and FISMA compliant organization. IntegrityM was created to support the program integrity efforts of Federal and State government programs, as well as private sector organizations. IntegrityM provides experience and expertise to government programs and private businesses supporting government programs. Results are achieved through analysis and support services, such as statistical and data analysis, compliance audits, investigations, medical review, outreach and education, and software solutions.

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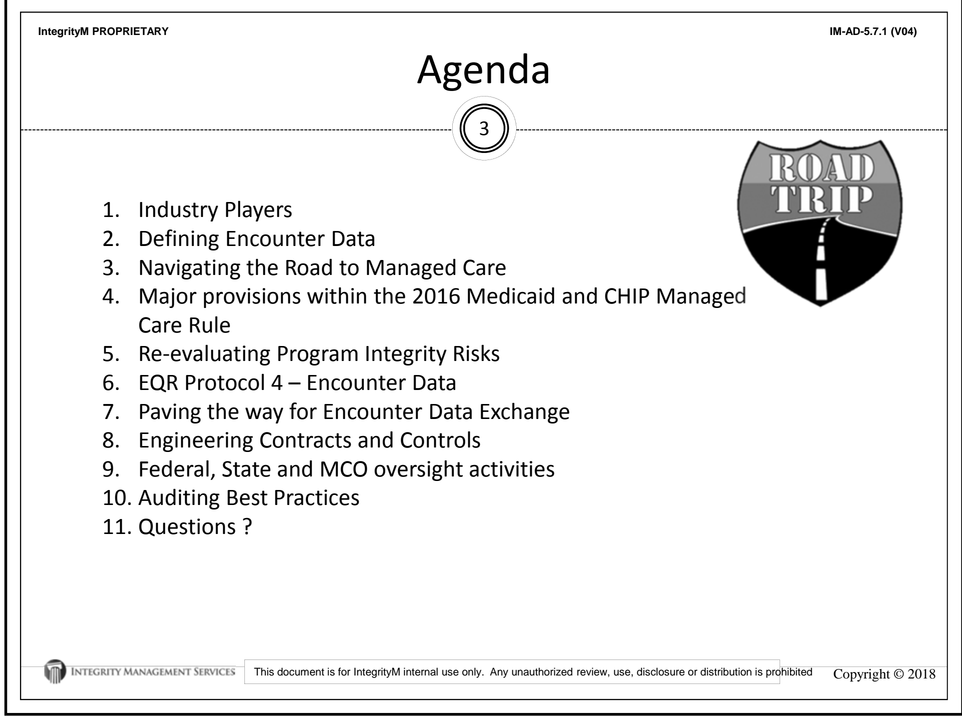
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3. Navigating the Road to Managed Care
4. Major provisions within the 2016 Medicaid and CHIP Managed Care Rule
5. Re-evaluating Program Integrity Risks
6. EQR Protocol 4 – Encounter Data
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8. Engineering Contracts and Controls
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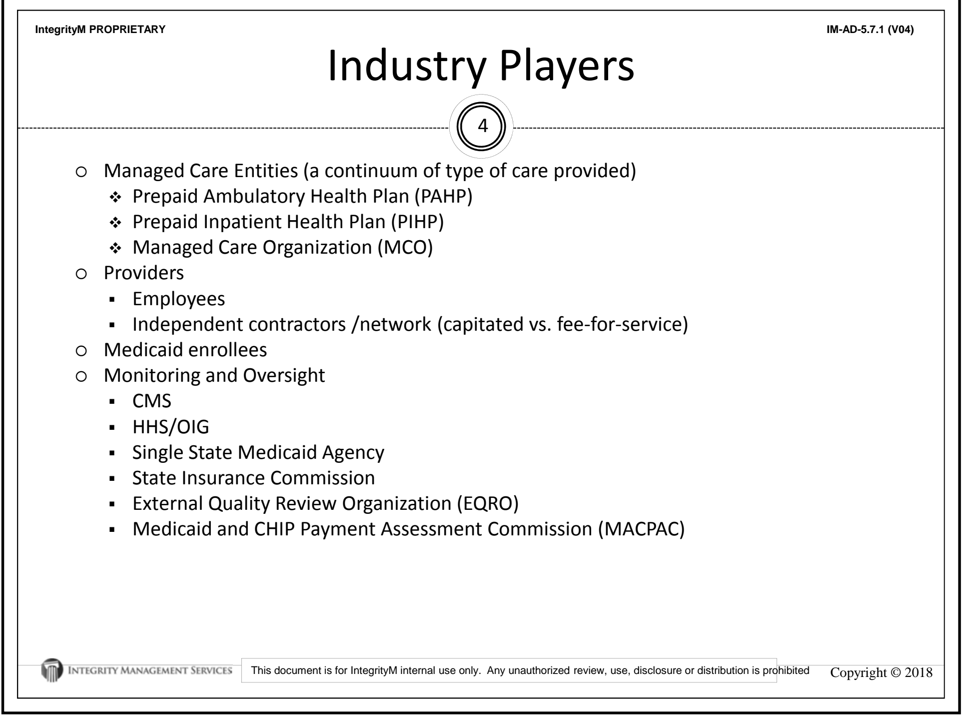
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Industry Players
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Managed Care Entities (a continuum of type of care provided)
Prepaid Ambulatory Health Plan (PAHP)
Prepaid Inpatient Health Plan (PIHP)
Managed Care Organization (MCO)
Providers
Employees
Independent contractors /network (capitated vs. fee-for-service)
Medicaid enrollees
Monitoring and Oversight
CMS
HHS/OIG
Single State Medicaid Agency
State Insurance Commission
External Quality Review Organization (EQRO)
Medicaid and CHIP Payment Assessment Commission (MACPAC)
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Defining Encounter Data

- Encounter data are the records of services delivered to Medicaid beneficiaries enrolled in managed care plans that receive a capitated, per-member-per-month payment. These records allow the Medicaid agency to track the services received by members enrolled in managed care. The State is not responsible for processing a claim or paying the provider for the rendered service. Encounter data typically come from billed claims that providers submit to managed care plans to be paid for their services.
- Encounter data are similar to fee-for-service (FFS) claims data, but encounter data (1) are not tied to per-service payment from the State to the managed care organization (MCO), because the State is not paying for individual services, and (2) do not include a Medicaid-paid amount, although many States collect the amounts MCOs pay providers on the encounter records. MCOs may pay more or less than the Medicaid FFS rate.
- Encounter data are essential for measuring and monitoring managed care plan quality, service utilization, finances and compliance with contract requirements. The data are also a critical source of information used to set capitation rates and perform risk adjustment to account for differences in beneficiary health status across plans.
- Encounter data must be; “Accurate, Complete and Timely”

Source: Encounter Data Toolkit Mathematica Policy Research November 2013 (on CMS' website)

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Where Have We Traveled From And What Is Our Destination?

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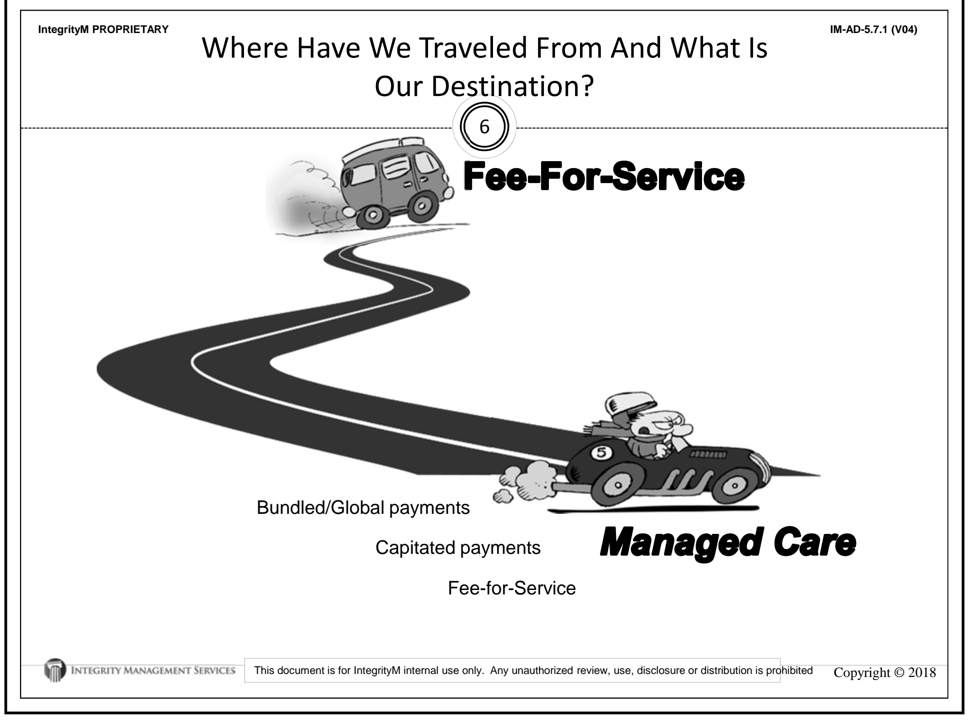

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Navigating the Road to Managed Care

- Managed care is now the primary Medicaid delivery system in 29 States. Nearly half of Federal and State spending on Medicaid in 2015—over $230 billion—was on managed care, and the proportion continues to grow each year (MACPAC 2016a).
- The industry is continuing to develop best of practice approaches to address the complexities of the new (2016) Medicaid Managed Care Regulation
- CMS is in the process of developing sub regulatory guidance (e.g. specific and enforceable encounter data contract language)
- This shift has resulted in emerging awareness and heightened the importance of Program Integrity within both state and managed care organizations, increasing variation in program integrity outlooks and activities
- ***Too early to judge effectiveness of new regulation***

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Major Change Provisions Within the 2016 Medicaid Rule

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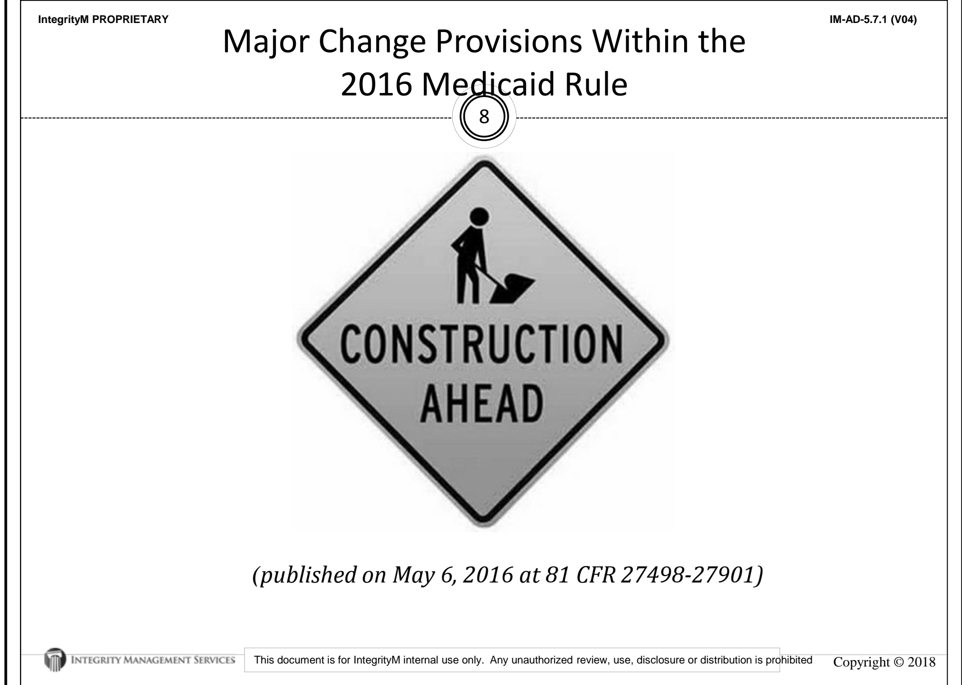

(published on May 6, 2016 at 81 CFR 27498-27901)

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Major Change Provisions Within the 2016 Medicaid Rule

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On April 21, 2016, the Centers for Medicare & Medicaid Services (CMS) issued final regulations that revise and significantly strengthen existing Medicaid managed care rules

- Rule increased Federal expectations of fundamental aspects of State Medicaid Managed Care Programs
- Significant changes include;
  - ❑ Further disbursement of program integrity responsibilities across CMS, States, and MCOs
  - ✓ **Strengthen payment provisions through the assurance of complete, accurate and timely encounter data**
  - ❑ Align Medicaid and CHIP managed care requirements with other major health coverage programs (MA, Marketplaces)
  - ❑ Enhance the beneficiary experience of care and strengthen beneficiary protections
  - ❑ Promote quality of care

https://www.kff.org/medicaid/issue-brief/cmss-final-rule-on-medicaid-managed-care-a-summary-of-major-provisions/

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Adjusting to the "Shift"

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- The Medicaid Program covers more than 20% of the US and accounts for more than 16% of US healthcare spending. For many years Medicaid - like other medical programs - was administered on a FFS basis by States that built their own independent claim payment systems (MMIS). States had access to all of their claims data
- In 2017, 73% of Medicaid beneficiaries were in Managed Care plans
- Recently, states have been shifting to MCOs in an attempt to improve access and quality of care, more stable funding streams, program cost reduction
- This change reduces state access to the data which is now housed by the MCOs
- **The shift presents many new challenges across the industry**

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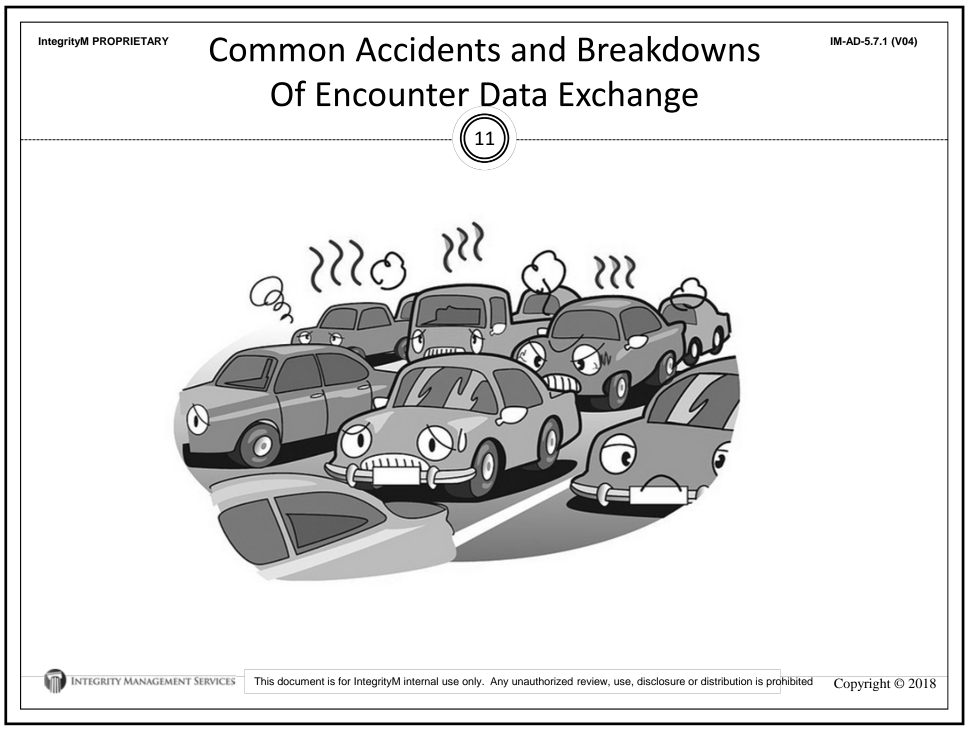

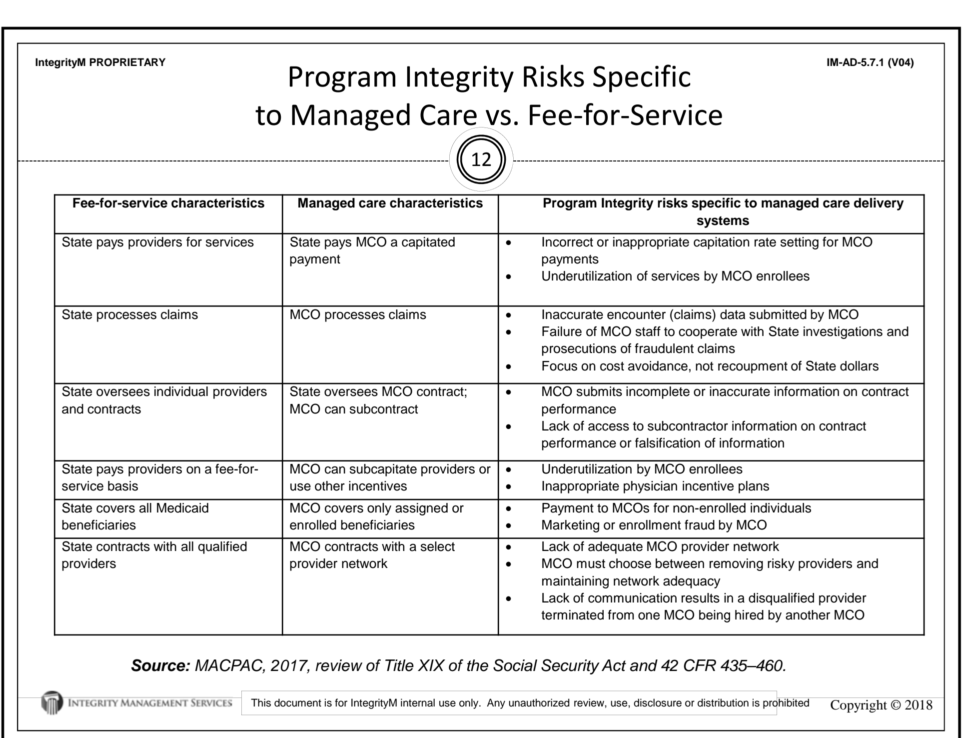

Fee-for-service characteristics	Managed care characteristics	Program Integrity risks specific to managed care delivery systems
State pays providers for services	State pays MCO a capitated payment	• Incorrect or inappropriate capitation rate setting for MCO payments • Underutilization of services by MCO enrollees
State processes claims	MCO processes claims	• Inaccurate encounter (claims) data submitted by MCO • Failure of MCO staff to cooperate with State investigations and prosecutions of fraudulent claims • Focus on cost avoidance, not recoupment of State dollars
State oversees individual providers and contracts	State oversees MCO contract; MCO can subcontract	• MCO submits incomplete or inaccurate information on contract performance • Lack of access to subcontractor information on contract performance or falsification of information
State pays providers on a fee-for-service basis	MCO can subcapitate providers or use other incentives	• Underutilization by MCO enrollees • Inappropriate physician incentive plans
State covers all Medicaid beneficiaries	MCO covers only assigned or enrolled beneficiaries	• Payment to MCOs for non-enrolled individuals • Marketing or enrollment fraud by MCO
State contracts with all qualified providers	MCO contracts with a select provider network	• Lack of adequate MCO provider network • MCO must choose between removing risky providers and maintaining network adequacy • Lack of communication results in a disqualified provider terminated from one MCO being hired by another MCO

Source: *MACPAC, 2017, review of Title XIX of the Social Security Act and 42 CFR 435–460.*

And there are more… Additional Encounter Data Requirements

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- 42CFR, Subchapter C Medical Assistance Programs, Part 438 Subparts A through K.
- Subpart H: "Additional Program Integrity Safeguards." Requires at least once every three years an audit of the accuracy, timeliness and completeness of encounter and financial data submitted by each managed care entity.
- Subpart E:"Quality Measurement and Improvement, External Quality Review." Requires an annual assessment using external quality review(EQR) protocols. There are 8 protocols; 3 mandatory and 5 voluntary. **EQR Protocol 4, entitled "Validation of Encounter Data by the MCO", is a voluntary protocol specifying procedures to be used in assessing the completeness, timeliness and accuracy of encounter data.**

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Subparts E and H Comparisons

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Factor	Sub Part E (EQR)	Sub Part H (Audit)
Frequency	Annual	Every 3 Years
Objectives	Complete, Accurate	Accurate, Complete, and Timely
Report Type	Assessment Report	Audit Report
Requirement	Voluntary	Mandatory
Review Guidance	Parameters	GAGAS

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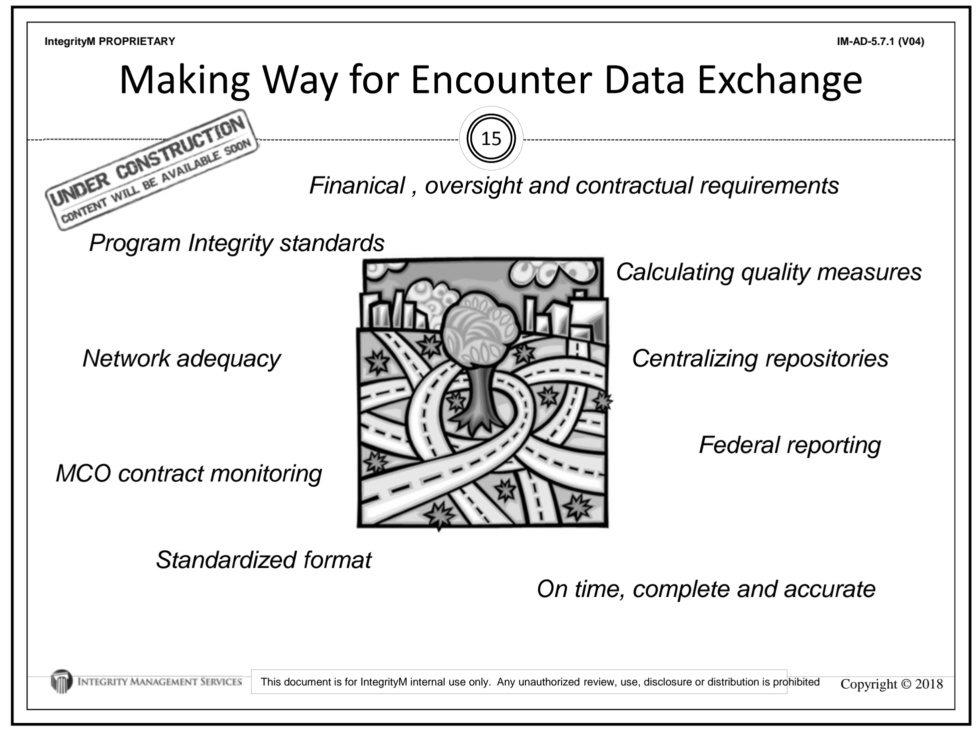
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Making Way for Encounter Data Exchange
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UNDER CONSTRUCTION
CONTENT WILL BE AVAILABLE SOON
Finanical , oversight and contractual requirements
Program Integrity standards
Calculating quality measures
Network adequacy
Centralizing repositories
Federal reporting
MCO contract monitoring
Standardized format
On time, complete and accurate
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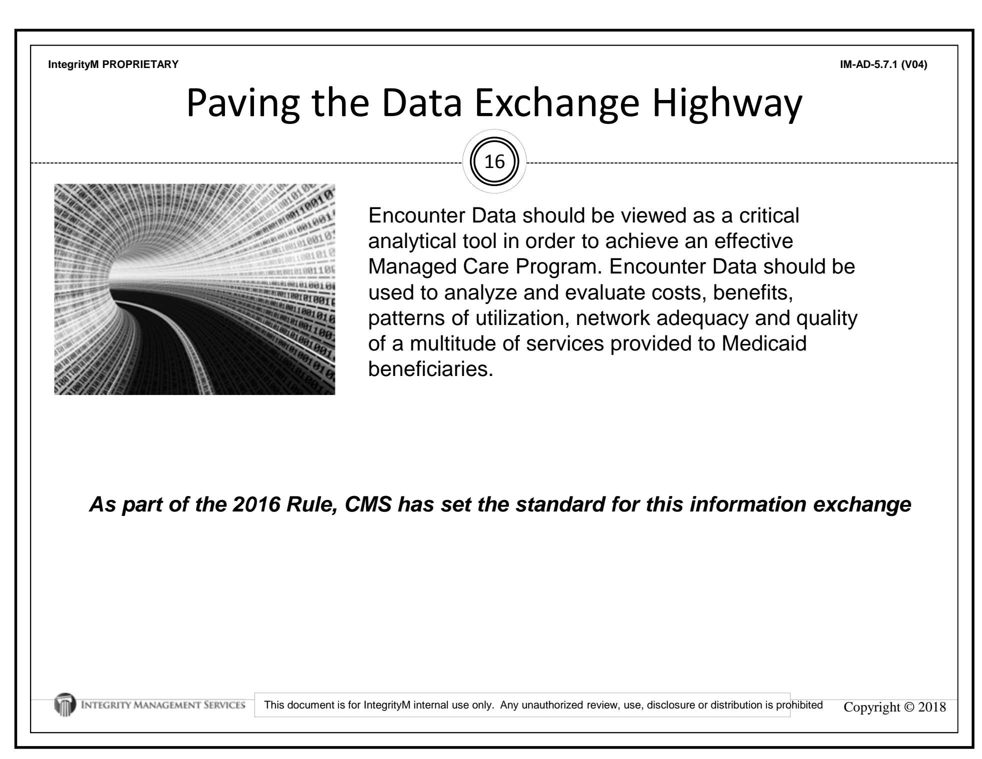
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Paving the Data Exchange Highway
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Encounter Data should be viewed as a critical analytical tool in order to achieve an effective Managed Care Program. Encounter Data should be used to analyze and evaluate costs, benefits, patterns of utilization, network adequacy and quality of a multitude of services provided to Medicaid beneficiaries.
As part of the 2016 Rule, CMS has set the standard for this information exchange
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Engineering Contracts and Controls

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Through their contracts, States must require Managed Care entities to submit encounter data that meet specified form and content standards and criteria for accuracy and completeness, including the following:

- Data includes encounters provided by both fee-for service and capitated providers.
- Tight controls and preventative measures to avoid duplicate payments between fee-for-service providers and capitated payments.
- Requirement for approved data formats when reporting encounter information to the States and Medicaid agency.
- States may also use encounter data for quality review, Federal reporting, policy analysis, measuring network access and adequacy, and MCO contract monitoring

Effective for contracts starting on or after July 1, 2018, the Final Rule conditions Federal matching funds for payments made to MCOs on state reporting of accurate, complete, and timely enrollee encounter data, and set standards for data reporting

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Program Integrity Oversight

Federal Program Integrity Oversight:

- CMCS (Center for Medicaid and CHIP Services); reviews state contract documents and collects managed care encounter data to measure performance, monitor compliance with Federal rules, and support program integrity efforts across states and MCOs
- OFM (Office of Financial Management); measures the rate of improper payments for all CMS programs

State Program Integrity Oversight:

- State based activities, while also contractually binding MCOs to implement program integrity policies and procedures of their own
- Periodically, but no less than every three years, conduct or contract for an independent audit of the accuracy, timeliness, and completeness of the encounter and financial data submitted by or on behalf of each MCO

Medicaid MCO Program Integrity Oversight:

- Implementing activities required by Federal rule, as a condition of contracting with a State, and those initiated by the health plan itself to minimize improper provider payments
- Policies and procedures to detect and prevent fraud, waste, and abuse

https://www.macpac.gov/publication/june-2017-report-to-congress-on-medicaid-and-chip/

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Best Practices for Auditing and Monitoring Encounter Data Standards

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Suggested Audit Planning Strategy

Each audit should proceed logically and systematically to use audit resources efficiently and effectively. Audit work should be broken down into 7 phases, each of which has a bearing on how and to what extent the audit is conducted. The phases are defined as follows:

- **Phase 1 - Selection of Auditee and Scope of Review**
- **Phase 2 - State Agency Background Information**
- **Phase 3 - Initial Risk Evaluation**
- **Phase 4 - MCO Documentation**
- **Phase 5 - Risk Re-evaluation**
- **Phase 6 - Detailed Audit Procedures/Data Verification Using Applicable Segments**
  - **For each segment, the auditor must first determine contractual requirements and determine if the MCO has developed and implemented written policies to address the elements of each segment**
- **Phase 7 – Reporting**

<u>Adhering to GAGAS standards is an important tool in reducing audit risk</u>

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Suggested Audit Segments for Overall Medicaid Managed Care Program Evaluation

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- ***Financial and Encounter Data Controls***
- ***Claims Processing***
- ***Provider Network and Access***
- ***Quality Assessment and Performance Improvement***
- ***Contractual Requirements***
- ***Organization and Structure***
- ***Language and Cultural Competency***
- ***Marketing***
- ***Grievances, Appeals, and Fair Hearings***
- ***Enrollment, Education, and Outreach***
- ***Enrollee Services and Medical Coverage***

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State Agency Contractual Considerations

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Define the following:

- Service and encounter types specific to each program
- Audit vs. assessment
- What is the sample unit? (payment to whom for what?)
- Attributes of accuracy, timeliness and completeness (error definitions)
- Allowable error rates
- Single vs. multiple samples
- Treatment of missing records
- Reporting requirements
- One size will not fit all
- Consider the impact on State Medicaid agencies and managed care entities

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What's on the Horizon?

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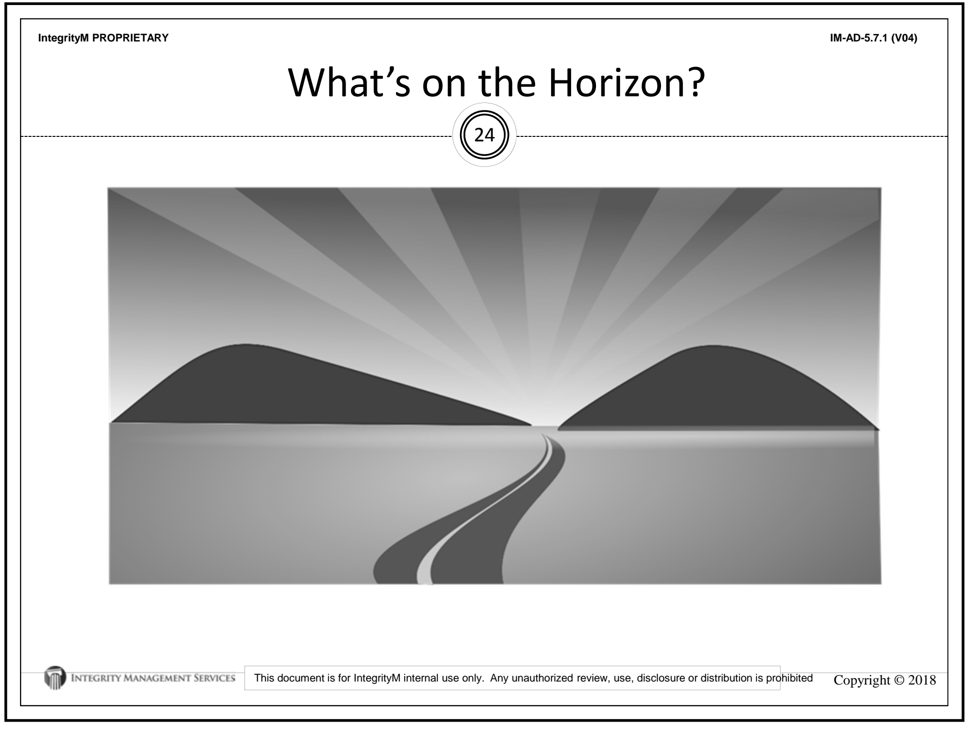

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Best of Practice Guidance

- Best of practice methods on how States validate encounter data for rate setting, how they can encourage managed care organizations to invest in prepayment auditing, and how States and plans can better share provider screening data and measure the effectiveness of specific program integrity practices
- Additional guidance, training, tools and education from regulatory oversight agencies
- Developing best of practice encounter data protocols are big left up to the State's to define. The majority are being built around the re-alignment of Agency resources and patient/service type demographics.
- When determining the need for internal or external consulting resources to support agency efforts with encounter data audit and program evaluation, it is critical that each Managed Care Program within both the State Agency and MCO Entity, take the following into consideration for encounter data evaluation:
  - ✓ Analyzing data output
  - ✓ Standardized audit and investigation protocols
  - ✓ Statistical and quality data analysis
  - ✓ Definition and generation of performance metrics based on the above

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Thank you!

Thank you for attending today's presentation. We'll be happy to answer questions!

For more information, or to contact Jennifer or John please contact info@integritym.com or (703) 683-9600.

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