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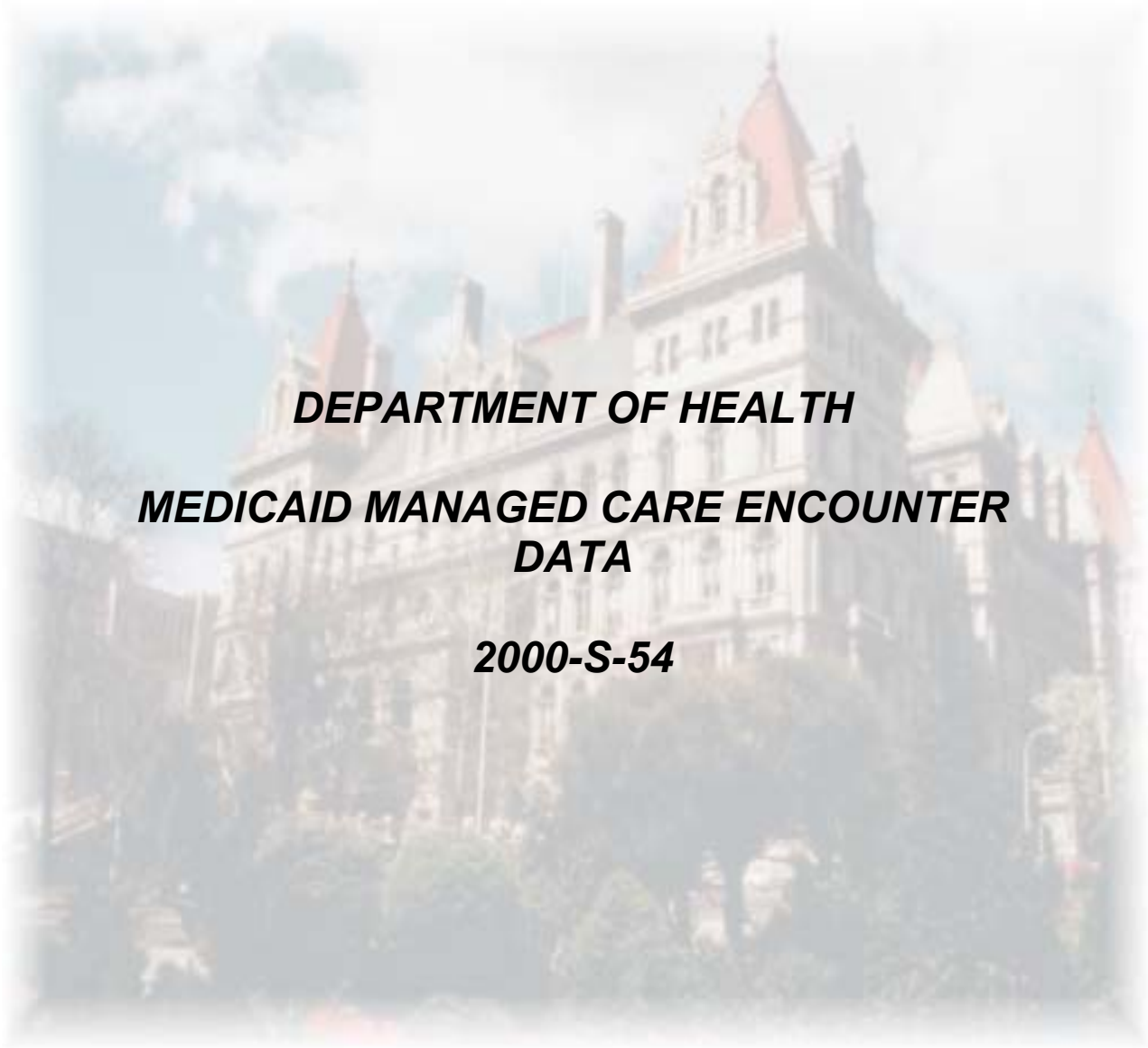

DEPARTMENT OF HEALTH

MEDICAID MANAGED CARE ENCOUNTER DATA

2000-S-54

DIVISION OF MANAGEMENT AUDIT AND
STATE FINANCIAL SERVICES

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Report 2000-S-54

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Novello:

The following is our report on the Department of Health's policies, procedures and practices for obtaining and evaluating Medicaid managed care encounter data, for the period January 1, 1999 through December 31, 2000.

This audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section I of the State Constitution and Article II, Section 8 of the State Finance Law. Major contributors to this report are listed in Appendix A.

Office of the State Comptroller
Division of Management Audit
and State Financial Services

March 29, 2002

EXECUTIVE SUMMARY

DEPARTMENT OF HEALTH
MEDICAID MANAGED CARE ENCOUNTER DATA

SCOPE OF AUDIT

To provide quality health care in a cost-effective manner, the Department of Health (Health) has implemented Medicaid managed care, paying managed care organizations (MCOs) a monthly flat fee for each enrollee, rather than a fee for each medical service provided. Monthly, MCO's are required to submit information to Health on encounters - professional face-to-face contacts or transactions between an enrollee and a medical service provider. Health implemented the Medicaid Encounter Data System (MEDS) to collect, monitor and report encounter data. For the calendar year ended December 31, 2000, Health reported spending about $1.25 billion on Medicaid managed care payments for nearly 682,000 enrollees.

Our audit addressed the following question about Health's oversight of managed care encounter data, for the period January 1, 1999 through December 31, 2000:

- Has Health adequately planned and implemented effective processes to ensure: MCOs submit encounter data completely and timely; accepted encounter data is accurate and reliable; and encounter data is used to aid in monitoring Medicaid managed care?

This audit of was part of a joint audit of Medicaid encounter data that was initiated by the National State Auditors Association, of which New York State is a member.

Audit Observations and Conclusions

We found that Health has taken an active role in establishing policies and procedures to ensure that MCOs collect and submit encounter data. However, we found that Health needs to strengthen controls to improve the completeness, timeliness, accuracy and use of encounter data.

A strategic plan is a formal implementation plan that includes long-range goals, detailed work schedules, and time estimates with milestones for monitoring implementation progress. We found that Health has not formally developed a

strategic plan to facilitate continual planning, monitoring and evaluating of the integrity and use of encounter data. Use of a formal strategic plan would allow Health to more effectively address the issues that we raise in our report. (See pp. 7-8)

Complete encounter data would provide Health with records of all enrollees' medical services and help stakeholders to make better informed decisions about Medicaid managed care. We found that Health needs to improve encounter data completeness by reducing the instances of unreported and undocumented encounters by MCOs, ensuring that MCOs correct and resubmit rejected encounter records in a timely manner, and strengthening controls over MCO reporting of inpatient encounter records. (See pp. 9-12)

Prompt encounter data submission by MCOs can provide stakeholders with up-to-date information about enrollees' medical services. However, during our audit Health had no requirement that MCOs submit encounter records within a certain timeframe after the date of service. As a result, MCOs had no incentive to improve submission timeliness. (See pp. 13-14)

To be useful, encounter data must include valid and consistent information relating to the actual medical services provided. However, in 18 percent of the encounter records we tested, we could not determine the medical provider who provided the services. We also identified inconsistencies in the way medical service information was recorded on the encounter records. (See pp. 14-18)

Our audit identified additional potential uses of encounter data. For example, by analyzing pharmacy fee-for-service claims and associated encounter records, we determined that the extent of unreported encounters ranged from 17 to 29 percent. We identified $876,000 in duplicate payments where Medicaid and an MCO each paid for an enrollee's inpatient stay. We identified an additional $2.9 million in potential duplicate payments for inpatients that Health needs to investigate. (See pp. 19-23)

We made 16 recommendations to Health on ways to improve the integrity and use of encounter data.

Comments of Officials

Health Department officials generally agreed with our recommendations and indicated actions planned or taken to implement them. A complete copy of Health's response is included as Appendix C. Appendix D contains State Comptroller's Notes, which address matters contained in Health's response.

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INTRODUCTION

Background

The Department of Health (Health) is responsible for administering the State's Medical Assistance program (Medicaid) and the Medicaid Management Information System (MMIS). MMIS is a computerized Medicaid claims processing and payment system. The State is integrating managed care into Medicaid. Medicaid managed care is intended to provide quality health care to low-income and disabled citizens in a cost-effective manner. Managed care organizations (MCOs) receive a monthly payment for each enrollee through a process known as capitation. In return, the MCOs must ensure that each enrollee has a primary care provider and adequate access to quality health care and needed medical services. MCOs enter into contracts with local social services districts (local districts) for delivering these services to Medicaid enrollees.

For the calendar year ended December 31, 2000, New York's Medicaid program spent about $1.25 billion on managed care payments for nearly 682,000 Medicaid enrollees. As of September 2001, there were more than 755,000 enrollees in Medicaid managed care, although up to approximately 2.1 million persons have been designated as potential enrollees for the program. There are 37 MCOs that participate in the State's Medicaid managed care program.

MCOs are contractually obligated to submit information on enrollee medical services, known as encounters, to Health monthly. An encounter is a professional face-to-face contact or transaction between an enrollee and provider who delivers services. Encounter data is comprised of the services rendered during the contact. For the State's managed care program, encounters include: visits to a physician or other medical provider; inpatient stays in medical, mental health or substance abuse facilities; and purchases of durable medical equipment or hearing aids.

In July 1997, the Federal Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration, approved New York State to establish a

statewide mandatory Medicaid managed care program, known as the Partnership Plan. The terms and conditions of the Partnership Plan identified some broad-based goals for encounter data:

- Establish a minimum data set identifying specific enrollee, provider and medical service information;
- Require MCOs to provide complete, timely and accurate encounter data for all enrollees;
- Develop a work plan showing how encounter data would be implemented, collected, monitored and used to pursue health care quality improvement; and
- Develop a plan to validate completeness and accuracy of encounter data on an ongoing basis.

As a result, Health established a work plan that generally identified how the State would meet the Federal goals. Additionally, in June 1999, CMS provided states with guidelines (CMS guidelines) suggesting both general and specific methods on how states can strategically plan and implement encounter data systems and then use the data in monitoring and evaluating their Medicaid managed care programs. In addition to encounter data, Health undertakes other aspects of quality monitoring and management, including quality assurance reporting requirements (QARR); the Provider Network Data System; patient satisfaction surveys; quality improvement initiatives; focused clinical studies; annual surveillance surveys; quarterly financial and operations reports; and complaint investigations.

In 1996, Health developed the Medicaid Encounter Data System (MEDS), a computerized system for collecting, processing and reporting encounter data. Health's Office of Managed Care (OMC) is responsible for maintaining MEDS and for monitoring and analyzing encounter data submissions from MCOs. OMC is also responsible for providing support to local districts and MCOs. During the calendar year 2000, MEDS accepted about six million encounter records.

The potential uses of encounter data can be summarized into four major groups of activities: utilization and access monitoring; financial analysis and rate setting; quality assurance; and future planning. Utilization and access monitoring of medical services aids in understanding how well the managed care programs are performing relating to cost and

ensuring enrollees are receiving appropriate care. Nationally, encounter data is considered to be very important in determining the financial viability of MCOs and in negotiating capitation rates. While some states use encounter data to set capitation rates, New York State does not. Quality assurance can help ensure high standards are maintained through: analyses to detect underutilization of services; review of treatment patterns by diagnoses; monitoring of selected procedures; detection of fraud and abuse; and profiling of physicians for quality and appropriateness of care provided. According to national experts, future planning for the managed care program can be enhanced by using encounter data to: identify areas for study affecting state policy; identify future program costs and areas for long-run cost containment; and provide external information as needed.

Audit Scope, Objectives and Methodology

We audited Health's policies, procedures and practices for obtaining and evaluating Medicaid managed care encounter data, for the period January 1, 1999 through December 31, 2000. The objectives of our performance audit were to determine whether Health has adequately planned and implemented effective processes to ensure that: MCOs submit encounter data completely and timely; accepted encounter data is accurate and reliable; and encounter data is used to aid in monitoring Medicaid managed care. Our audit methodology is detailed in Appendix B.

In conducting this audit, we participated in a joint audit of issues related to Medicaid encounter data. This joint audit was initiated by the National State Auditors Association (NSAA), of which New York State is a member. Each year, the NSAA selects a single audit topic of national scope and importance, and invites member states to participate in a joint audit effort to obtain information about specific aspects of the audit topic. One of the participating states, in this case, New York, coordinates the states' audit efforts and combines all the state reports into a single joint report. The final report will be presented to the NSAA Audit Performance Committee and shared with states that participated in the joint audit. Taking part in this joint audit requires New York and each of the other three participating states (New Mexico, Pennsylvania and Tennessee) to select

and implement specific objectives and steps from the audit topic selected by the NSAA.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess Health's operations that are included in our audit scope. Further, these standards require that we understand Health's internal control structure and compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence that supports transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We used a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, finite audit resources are used to identify where and how improvements can be made. Thus, we devote little audit effort to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of Health Officials to Audit

Draft copies of this report were provided to Health officials for their review and comment. Their comments have been considered in preparing this report and are included as Appendix C. Appendix D contains State Comptroller's Notes, which address certain matters contained in the Health Department's response.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and leaders of the Legislature and fiscal committees, advising what steps were taken to implement the

recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

ENCOUNTER DATA

Encounter data can be an important source of comparative information for Health, local districts and MCOs to conduct a variety of assessment and quality improvement activities relating to Medicaid managed care. Therefore, it is essential to ensure complete, timely and accurate submission of encounter data.

We found that Health has established extensive policies and procedures to meet the broad-based Federal goals to ensure that MCOs collect and submit encounter data. Since 1996, Health officials have taken an active role in the development and operation of MEDS. Among other accomplishments, Health has: defined encounter data, how it is to be reported, and how often it should be reported; distributed encounter data requirements to MCOs through written manuals and through the Internet; designed a process for collecting encounter data from MCOs and distributing it to stakeholders; established controls to ensure that MCOs submit encounter data each month; continued to monitor compliance with submission requirements and notify MCOs that are not in compliance for a given month; distributed encounter data to stakeholders through hard copy reports and the Internet; and used encounter data to report Well Child visits. However, we found that Health has not formally developed a strategic plan to facilitate continual planning, monitoring and evaluating of the integrity and use of encounter data. We also found that Health needs to strengthen controls over encounter data submissions from MCOs to improve their completeness, timeliness and accuracy. In addition, we identified potential additional uses of encounter data that would enhance Health's ability to monitor the quality of care provided to enrollees and the propriety of Medicaid payments to providers.

Strategic Planning for Encounter Data

Planning is integral to any project implementation effort. A strategic plan is a formal implementation plan that includes long-range goals, detailed work schedules, and time estimates with milestones for monitoring implementation progress.

Utilization of a strategic plan increases the probability that all relevant aspects of project development will be addressed. Such a formalized plan is necessary to guide implementation, measure progress and report to management and other interested stakeholders. Several authoritative sources, including CMS guidelines, a private consultant hired by Health, and national experts, promote the use of a strategic plan for implementing and maintaining encounter data. However, we found that Health has not developed a formal strategic plan for encounter data.

Health officials told us that they have held informal discussions regarding a strategic plan and were involved in planning activities and goals relating to data quality improvement and use, but that they have never developed a formal plan. As a result, we found that some of Health's informal planning efforts were not adequate to maximize improvement in the completeness, timeliness, accuracy and use of encounter data. For example, in 1998 Health hired a consultant to improve encounter data quality. This consultant worked with Health in developing methods, known as Data Quality Improvement Plans (Plans), to improve MCOs' encounter data submission. However, we found that Health did not follow up to ensure the MCOs had implemented these Plans and improved data quality or needed additional assistance to improve. Had a strategic plan been in place, there would have been documented steps identifying follow-up and additional activities to be taken.

We found that Health needs to take action to improve the integrity and use of encounter data. A strategic plan would help ensure that Health has the most complete, timely and accurate encounter data, and facilitate its use in assisting to effectively manage the Medicaid managed care program. With such a plan, Health will be better positioned to effectively address the issues that we raise in our report.

Recommendation

1. Develop and implement a formal strategic plan for encounter data.

Completeness of Encounter Data Submission

The terms and conditions of the Partnership Plan require Health to collect and monitor encounter data from MCOs. Complete encounter data would provide Health with records of each service and procedure provided to Medicaid managed care enrollees and would enable stakeholders to make more informed decisions about the program. We found that encounter data completeness could be improved by reducing the instances of unreported and undocumented encounters, ensuring the timely correction and resubmission of rejected encounter records, and strengthening controls over reporting of inpatient encounter records.

Health officials told us that unreported encounters ranged from 8 to 18 percent. We tested the completeness of reported encounter data for a judgment sample of 200 Medicaid managed care enrollees with 1,764 accepted encounter records. These enrollees were in 8 MCOs throughout the State. We used the MCOs' medical and administrative records to identify any medical services with no accepted encounter records. We identified 597 additional encounters in this documentation that should have been reported to MEDS. As a result, the sampled enrollees' 1,764 encounter records are understated by 34 percent (597), far in excess of the 8 to 18 percent range estimated by Health. Five of the 8 MCOs had unreported encounters ranging from 28 to 115 percent of their accepted encounter records.

It is possible that the MCOs could have submitted additional encounter records to MEDS after we began our review, because Health had no requirement for MCOs to submit encounter records within a certain timeframe after the date of service. In addition, MEDS could have rejected the encounter records for these services, and the MCOs may not have corrected and resubmitted them by the time of our review. Since Health had no process to track rejected records and monitor their correction and resubmission by the MCOs, as discussed later in our report, we were unable to determine whether any of the unreported encounters were actually submitted and rejected.

Health officials also indicated that the MCOs might not have reported claims for medical service by medical providers as "encounters" if the MCOs denied payment of the claims for an administrative reason, such as late submission. However, this

situation would be contrary to Health's requirement that MCOs report encounters for all services covered in the Medicaid managed care benefit package by all providers rendering services. Health officials told us that in order to have complete records of medical service, they require MCOs to report encounters regardless of whether the MCOs paid the claims or denied them for administrative reasons.

Moreover, for the 200 sampled enrollees, we found that MCOs could not support 664 (38 percent) of the 1,764 encounter records with medical or administrative records. Four of the 8 MCOs were unable to document from 44 to 65 percent of their encounter records. Health officials acknowledged that they have also experienced difficulty in obtaining medical records from MCOs for their own studies and that this is an ongoing concern for them.

Submitted encounter records that fail Health's editing standards are not accepted into MEDS and are considered to be rejected records. After MCOs submit their encounter records each month, Health provides MCOs with submission information, concerning both accepted and rejected encounter records. MCOs may resubmit rejected records as they correct them. CMS guidelines recommend that states consider establishing a timeframe for MCOs to correct and resubmit rejected encounter records. We found that Health has no requirement regarding the timeliness of resubmission. Health officials do not agree with the need to establish a timeliness standard for resubmission of rejected records. According to Health officials, they want MCOs to focus their efforts on getting encounter records to pass all MEDS edits the first time. Health has helped to facilitate MCOs' efforts to get their encounter records to pass MEDS edits by allowing MCOs to test their encounter records and correct errors prior to submitting their records for processing.

In July 2001, Health officials established an acceptance standard of 95 percent of all encounter records submitted. While we agree with the establishment of this acceptance standard, we believe there should be a requirement for MCOs to timely correct and resubmit rejected encounter records to ensure this data is not lost. Our analysis of the acceptance of all encounter records submitted to MEDS showed an improving acceptance rate that ranged from 35 percent of submissions in January 1999 to 70 percent of submissions in December 2000.

Notwithstanding the improvement, this acceptance rate is significantly less than Health's 95 percent standard and, therefore, procedures are needed to ensure that rejected records are resubmitted in a timely manner.

Another way to realize improvement in correcting and resubmitting rejected records in a timely manner is to offer incentives to MCOs. Health officials indicated that MCOs have difficulty correcting rejected records because, in many cases, MCOs must obtain medical information from the medical provider. Since the medical provider has often already been paid by the MCO for the service, the provider has little incentive to submit corrected information promptly. Health has not established incentives to increase correction and resubmission of rejected records. We noted, however, that Health and MCOs have used incentives in other aspects of the managed care program. For example, under the mandatory Medicaid managed care program, Health has implemented a process to award increased enrollment to MCOs that have demonstrated high quality of care. Also, one MCO, Fidelis Care New York, offers a quality incentive program based on QARR measures in such areas as preventive care, wellness and provider access. In our judgment, Health should consider offering similar incentives to MCOs as a way to improve correction and resubmission of rejected encounter records.

In addition, as a good data management practice, rejected encounter records should be identifiable in such a way that Health can account for them when they have been resubmitted. MEDS rejected 2.7 million records (16 percent) from processing during our audit period. However, we found that due to MEDS limitations, Health had no process to track and report on rejected encounter records that have been resubmitted. Additionally, although Health officials have the ability to identify and monitor resubmission of rejected encounter records on an ad hoc basis, they have not done so. Officials stated that they would consider devising a systemic method of doing this, but the necessary changes could not take place until later in the development of the replacement Medicaid system, known as eMedNY. However, since eMedNY is not expected to be implemented until at least 2003, Health needs to develop a process to monitor resubmission of rejected encounter records during the interim.

Additionally, to ensure complete and accurate encounter data, national experts on managed care recommend that states establish incremental standards for encounter data reporting by MCOs that can be assessed, re-evaluated and adjusted as needed. Incremental standards are a way to achieve improvement through periodic strengthening of performance benchmarks.

Encounter records that successfully pass edits are accepted into MEDS. For inpatient encounters, we found that Health's standard is for MCOs to have only one record accepted each month, regardless of the MCOs' enrollment or the number of inpatient encounters. This standard has remained unchanged since Health established it in 1997. In contrast, Health has established incremental standards for the Physician and Other Provider encounter type.

Health officials stated they had not increased the inpatient encounter reporting requirement because MCOs with low numbers of enrollees may not have an inpatient encounter each month. However, our analysis showed that during the period of our audit, January 1999 through December 2000, MEDS accepted an average of 52 inpatient encounter records each month from the 11 small MCOs (enrollment count less than 10,000), and a monthly average of 257 inpatient encounter records from the 26 large MCOs. These results indicate that Health's requirement of at least one accepted inpatient encounter record each month is too low, even for the small MCOs. With such a low compliance standard for inpatient encounters, MCOs could have had significantly fewer encounter records accepted and still be in compliance.

Recommendations

2. Work with MCOs that have higher rates of unreported and undocumented encounters to improve the completeness of submission.

3. Establish a requirement for MCOs to timely correct and resubmit rejected encounter records.

4. Evaluate the feasibility of offering incentives to MCOs for timely correcting and resubmitting rejected encounter records.

Recommendations (Cont'd)

5. Develop a method to identify and monitor the resubmission of rejected encounter records.

6. Establish incremental standards for inpatient encounters.

Timeliness of Encounter Data Submission

Encounter data that is submitted promptly can provide stakeholders with up-to-date information about the medical services being rendered to managed care enrollees. CMS guidelines and national experts, as well as a private consultant hired by Health, recommend Health define and enforce a submission timeframe for all encounters that is associated with the date of service. Health's private consultant indicated that when setting submission timeframes, Health should consider any circumstances that would affect the MCOs' ability to meet the submission timeframe, as well as how the encounter data is to be used.

We found Health has no requirement that MCOs submit encounter records within a certain timeframe after the date of service. In addition, Health does not restrict submissions of encounter records based on the age of the data. Without a submission timeframe requirement, MCOs have no incentive to submit encounter records in a timely manner, which can also negatively affect completeness of data. The lack of a restriction limiting MEDS from accepting old encounter data puts Health at risk of receiving data that would be of limited use for program monitoring or evaluation, even if the data is accurate and complete. Further, the longer the time period from the service date to encounter submission, the more difficult it becomes to correct rejected encounter records.

Health officials explained that initially they had not established a timeliness requirement because they wanted to develop an historical encounter database from when they first started collecting encounter data from MCOs in September 1996. We recognize the need for such a database and agree that Health's actions at the start of its encounter data system were appropriate. However, the encounter data collection process is no longer in a start-up phase, and we believe it is now time for

Health officials to establish timeliness standards for encounter data submissions.

Health officials stated their belief that most encounter records are submitted within six months after the service date. They indicated that this timeframe seems reasonable when considering the various administrative and programmatic steps involved during encounter record submission. We analyzed the timeliness of encounter record submission and found that the Health officials' statement was reasonably accurate. During our audit period January 1999 through December 2000, MEDS accepted about 9.7 million encounter records, and 7.7 million (80 percent) of these records were submitted to MEDS within six months after the service date. However, we also found that nearly 5.6 million (57 percent) of these encounter records were submitted within three months after the service date. While the percentage of encounter records submitted within six months of the service date is substantial, we believe that MCOs could have submitted more of their encounter records even earlier, had Health used incremental standards and worked toward a goal of three months or better.

In response to our preliminary findings on this matter, Health officials indicated they would implement a monitoring system to provide feedback to MCOs on the timeliness of encounter data submissions, with a goal of receiving 80 percent of all records within three months of the service date by Fall 2002.

Recommendation

7. Establish incremental timeliness standards for MCOs to submit encounter data.

Accuracy and Reliability of Accepted Encounter Data

To be accurate and reliable, encounter data must include valid and consistent information relating to the actual services provided. In encounter records for a sample of enrollees, we found that selected information was transferred to encounter records from medical records in a reasonably accurate manner. However, we also found that encounter data accuracy and reliability could be improved by strengthening controls to ensure that diagnosis and procedure codes within encounter records

are consistent, and that only valid provider identifiers are accepted.

For our judgment sample of 200 Medicaid managed care enrollees, we tested the accuracy of 1,082 encounter records. (We were unable to test all 1,764 accepted encounter records for various reasons, such as the MCOs did not submit medical or administrative records for all encounters.) For one test, we judgmentally selected 16 information fields within the encounter records that we considered essential for identifying enrollees, providers and the services rendered. We traced the data in these fields to the supporting medical or administrative record. For another test, we determined whether the diagnoses and procedures indicated in the encounter records were logically consistent. Since diagnosis and procedure information was present in all 1,764 encounter records for the enrollees in our sample, we did not use medical or administrative records for this test.

Of the 1,082 encounter records we reviewed, we found that 219 records (20 percent) had one or more fields in error; that is, information was transferred incorrectly from the medical or administrative record to the encounter record. However, of the 16 information fields tested, only the primary procedure field was in error at a rate in excess of 10 percent. We identified 120 (11 percent) of the 1,082 records where the primary procedure field data differed from the medical or administrative record. For example, in one encounter record, the primary procedure field showed "drawing blood for specimen" while the medical record showed "return for repeat pap smear." The medical record did not indicate any procedures for drawing blood. However, we found the encounter data in our sample for the remaining 15 information fields was reasonably accurate.

Consistency of diagnosis and procedure information on encounter records is important for quality assurance activities related to medical services. However, the MEDS update process does not include edits to check the consistency between diagnosis and procedure codes.

We found that 230 (13 percent) of the 1,764 encounter records examined had an inconsistent procedure associated with the diagnosis. For example, one encounter record indicated a diagnosis of "normal delivery," but had a dental procedure of "bitewings – four films" listed. We noted that three MCOs had

encounter records with inconsistent diagnosis and procedure codes ranging from about 18 to 20 percent of their accepted records.

To identify medical providers in Medicaid managed care, Health requires that each encounter record accepted into MEDS have a provider identification number (provider ID) or a New York State professional license number (license number). Provider IDs and license numbers are used to report Physician and Other Provider type encounters in the following six categories of service (categories of service identify the type of service a provider renders): physician services; podiatrist services; clinical psychologist and social worker; therapists; nursing services; and nurse practitioner and nurse midwife. We tested the accuracy of Health's encounter data and the effectiveness of the edit process for Physician and Other Provider type encounters to be able to identify the medical provider performing the service in the six categories of service previously listed. We selected these six categories because: 1) the providers are individuals, in which case either the provider ID or license number would need to be correct to identify the individual; or, 2) the providers were associated with a hospital or clinic, where the provider ID would identify the facility and a correct license number would identify the individual. For our two-year audit period ended December 31, 2000, there were more than 5.4 million Physician and Other Provider type encounter records accepted into MEDS for these categories of service. We used computer-assisted auditing techniques to determine whether the provider ID and license numbers were valid. The validity of these fields is important in performing analysis of encounter data for health care quality improvement purposes, where identification of the provider is needed.

Based on our testing, we identified 992,851 encounter records (18 percent) where we could not determine the actual medical provider by using the provider ID or professional license number on the encounter record. This condition resulted because either: 1) the provider ID was either generic, blank or invalid and the license number was either blank or invalid; or 2) the provider was a hospital or clinic and the license number of the individual provider of service was blank or invalid. The generic provider ID is used to report encounters involving out-of-network providers (in-state or out-of-state) for whom unique provider IDs are unknown. However, when a blank or invalid license number

accompanies a generic provider ID, the specific provider cannot be determined. Specifically, our audit found:

- 741,544 encounter records had a generic provider ID and a blank or an invalid license number.

- 223,540 encounter records had a hospital or clinic provider ID and a blank or invalid license number. Since many physicians and other medical providers render services in hospitals or clinics, without a valid license number we cannot determine the specific provider.

- 27,767 encounter records had a blank or invalid provider ID and a blank or invalid license number.

Although MCOs are supposed to include valid provider IDs and license numbers in their Physician and Other Provider encounter records, we found the associated MEDS edits check only for spaces (blanks) in the provider ID and the license number fields. However, these fields are not subject to a check on the validity of the data being entered. For example, we identified 6,096 accepted encounters where the provider ID was blank and the license number was zero (0).

In addition, the category of service should be consistent with the provider type code (a code that identifies a provider's major classification under Medicaid; for example, a clinic, hospital, physician or therapist), and the provider specialty code (a code identifying a provider's medical, dental, clinic or program specialty; for example, dermatology, internal medicine, physical therapy or oral surgery). These codes are derived from MMIS provider information files. We used computer-assisted auditing techniques to determine whether the category of service was consistent with the provider type. The consistency of these fields is important in performing analysis of encounter data for health care quality improvement purposes, where the type of service the provider renders is needed. We identified 246,214 encounter records (5 percent) where the category of service reported on the record was inconsistent with the provider type. For example, 1,069 encounter records had a category of service indicating podiatrist services and a provider type indicating an optometrist. We found there is no edit during MEDS updating to verify whether the category of service is consistent with the provider type or provider specialty.

Health officials stated that populating the MEDS database was a question of getting the most complete and timely record of health care possible versus getting incomplete or no data at all. Although we understand Health's objectives for expanding the MEDS database, we believe that because MEDS now contains and monthly is receiving a significant amount of records Health officials must strengthen controls to ensure the accuracy of the accepted data, which will enhance its future use.

The quality of encounter data submitted by MCOs is of substantial importance. When the provider cannot be identified and service-related information is inconsistent, the encounter records cannot be used for provider-specific analysis, such as studies of underutilization, treatment by diagnosis, questionable procedure use, fraud and abuse, and physician profiling.

In response to our preliminary findings, Health officials indicated that these issues should be addressed by the implementation of new standards associated with the Federal Health Insurance Portability and Accountability Act (HIPAA) and eMedNY. However, with implementation of both these projects not expected until at least 2003, the problems identified during the audit will continue without improvements in MEDS editing.

Recommendations

8. Work with MCOs that have higher rates of inconsistent diagnosis and procedure codes to improve accuracy.

9. Implement edits to check the validity of data in the provider ID and license number fields and prevent encounter records with blank or invalid provider IDs and license numbers from being updated to MEDS.

10. Implement an edit to ensure consistency between the category of service on encounter data, provider type and provider specialty.

11. Assess other MEDS edits and modify as necessary to ensure that important encounter record fields cannot be updated with inaccurate or inconsistent information.

Use of Encounter Data

While we found that Medicaid encounter data has gaps in completeness, timeliness and accuracy, we believe these conditions do not preclude using encounter data for certain aspects of monitoring managed care. Health, MCOs and local districts have implemented some appropriate uses of encounter data. However, we identified additional potential uses of encounter data, in conjunction with Medicaid fee-for-service claims information, that could enhance the ability of stakeholders to monitor managed care for quality of care to enrollees and for duplicate payments to providers. As encounter data quality improves through strategic planning, stakeholders should identify additional uses for the data.

Health officials indicated they use encounter data to produce reports for service utilization monitoring and comparison of enrollee service usage by MCO, local district and region. Health also uses encounter data to monitor the phase-in of mandatory Medicaid managed care and to conduct ad hoc clinical studies and analysis. Beginning in 2000, Health used encounter data to publicly report Well-Child visits in QARR.

Six of the eight MCOs we surveyed in our audit indicated that they use encounter data reports from Health to verify the accuracy of individual enrollee information; compare present and past performance; compare their performance with other MCOs' performance; compare Health's encounter data reports to internally-generated data; and identify rejected encounter records for correction and resubmission.

Thirteen of the 15 (87 percent) local districts we surveyed reported that they use Medicaid managed care encounter data from Health. These local districts reported that they use the encounter data to compare performance between MCOs and to statewide averages, and to evaluate service data for trends and volume comparisons. Local district officials indicated they use encounter data to: monitor the encounters per enrollee per month and per year; ensure MCOs comply with State requirements for submission of encounter data; and monitor MCOs for quality assurance. The local districts also reported that encounter data reports from Health aided the decision-making process for MCO contract renewals.

We analyzed accepted encounter records to identify additional potential uses of encounter data to monitor quality of care and the appropriateness of Medicaid payments. We believe Health should consider the uses we identified and develop others to improve monitoring the quality of Medicaid managed care and the propriety of Medicaid payments.

As recommended in the CMS guidelines, to effectively monitor the Medicaid managed care program, state Medicaid agencies need to use encounter records and other sources of data in program management, including fee-for-service claims. Inter-linking these sources of information aids in monitoring, managing and evaluating Medicaid managed care programs in a comprehensive manner.

Encounter records should be submitted for all covered managed care services, such as physician visits. Services that are not covered under Medicaid managed care are considered to be "carved-out" and are paid through Medicaid as fee-for-service. Pharmacy services were carved-out of Medicaid managed care in August 1998.

Health officials indicated that, generally, there should be an encounter record of physician visits for enrollees where an original pharmacy prescription was written. These officials also indicated that all original prescriptions must be filled at a pharmacy within 60 days of the encounter.

Health officials also identified several situations where there may not be an encounter record or fee-for-service claim associated with fee-for-service pharmacy claims:

- The encounter record was either not submitted or not accepted. Health officials told us approximately 8 to 18 percent of all encounters are missing, whereas all pharmacy claims are submitted to Medicaid to be paid.

- Drugs may be prescribed through a telephone call, and therefore no encounter is reported.

- The refill indicator on the pharmacy claim may erroneously designate a prescription as an original, when it is actually a refill. A refill would not require a physician visit.

- A physician outside of the enrollee's MCO provider network may write a prescription for that enrollee. However, out-of-network physician encounters are not reported.

- Theft of a physician's prescription pad, resulting in false prescriptions that are filled and claimed.

- An enrollee requests a called-in prescription from the physician prior to an appointment that is not kept.

To test the completeness of Health's encounter data, we sampled 278 pharmacy claims, selected on a statistical basis. Our objective was to determine whether there were any encounter records or other paid Medicaid fee-for-service claims rendered within the 60 days prior to the pharmacy claim order date. If any encounter record or fee-for-service claim met this criterion, we considered it to be associated with the pharmacy claim. We did not, however, attempt to identify any encounter records or fee-for-service claims that occurred more than 60 days after the pharmacy claims' order date, since Medicaid would not pay for these pharmacy claims.

We found that the underreporting of encounters could be significantly higher than the 8 to 18 percent range estimated by Health. Based on our testing results, we determined, with 95 percent confidence, that from 741,459 (17 percent) to 1,229,817 (29 percent) pharmacy claims of the population of 4,277,187 pharmacy claims had no associated encounter records or other fee-for-service claims within the 60 days prior to the pharmacy claim order date. For example, one enrollee had a pharmacy claim with an order date of September 27, 2000. However, there were no associated encounter records or fee-for-service claims for the 60-day period July 30 through September 27, 2000 for this enrollee. In contrast, another enrollee had a pharmacy claim with a February 9, 2000 order date. We found there was an associated encounter record for this enrollee on January 16, 2000, 24 days prior to the pharmacy claim's order date.

While we understand that the situations identified by Health can contribute to some of the missing encounter records or fee-for-service claims associated with a pharmacy claim, Health officials were unable to provide any analysis to demonstrate the degree to which these situations take place. We believe that

Health officials also need to consider the possibility that physicians may be giving prescriptions to managed care enrollees without providing a medical exam or that potentially abusive pharmacy billing practices are occurring.

During the audit, Health officials indicated they would be most concerned about any Medicaid managed care enrollees where we identified 20 or more pharmacy claims and no associated encounter records or fee-for-service claims. Upon further analysis, we identified 4,298 Medicaid managed care enrollees during our audit period, with no reported encounter records or fee-for-service claims. However, each of these enrollees had more than 20 paid pharmacy claims during their enrollment period, including 7 enrollees that had over 200 pharmacy claims. The following table summarizes our results.

Table 1: ENROLLEES WITH MORE THAN 20 PHARMACY CLAIMS AND NO ENCOUNTER RECORDS OR OTHER FEE-FOR-SERVICE CLAIMS

PHARMACY CLAIMS	ENROLLEES	PERCENTAGE
21-50	3,513	81.73 %
51-100	657	15.29 %
101-200	121	2.82 %
Over 200	7	0.16 %
TOTAL	4,298	100.00 %

The lack of reported encounter records associated with original pharmacy claims should be an indicator for Health to conduct further analysis and investigation. We believe Health officials could use our analysis as a starting point for follow-up. Health officials responded that since our audit, they have taken steps to identify these situations and notify MCOs.

MEDS has both Medicaid encounter record and fee-for-service claims data available, but Health officials stated that they had not used this information to monitor duplicate payments between the fee-for-service component of Medicaid and the Medicaid managed care program. These officials indicated that a lack of both staff resources and coordination and communication between Health's Office of Managed Care and Office of Medicaid Management are possible reasons for not doing so.

We used accepted encounter records to analyze and identify duplicate payments for inpatient hospital stays for Medicaid managed care enrollees. A duplicate payment occurs when fee-for-service Medicaid and an MCO both make payment for the same service and day to the same provider for an enrollee. Patterns of duplicate payments could be indicative of abusive billing practices by providers. For the two-year period ended December 31, 2000, we matched inpatient encounter records with paid inpatient fee-for-service claims. From this match, we identified 401 paid inpatient claims, totaling about $4 million in potential overpayments, that had a matching encounter record. The matched inpatient claims and records had the same enrollee, provider, beginning and ending dates of service, and the same or similar services. We selected a judgment sample of 30 of these inpatient claims, totaling $1.1 million, with matching encounter records from three MCOs (10 encounter records from each MCO). Our selection was designed to obtain a cross-section of inpatient services and payment amounts.

For these 30 claims, we sent the three MCOs a mailing to determine if the MCOs paid, denied, voided or had no record of the claims. Based on their responses, we determined that the MCOs had made payments to the providers for 20 of these claims (67 percent). Therefore, these providers received duplicate payments from the MCOs and Medicaid. For these 20 claims, Medicaid overpaid the providers by $876,000. Health officials stated that they would investigate any potential overpayment issues.

The following table shows our calculation of the potential overpayments.

Table 2: RESULTS OF INPATIENT CLAIMS SAMPLE REVIEW

	Claims			No Record	Total	Potential	Value of
MCO	Paid	Denied	Voided	of Claim	Claims	Recovery	All Claims
A	3	6	1	0	10	$192,518	$305,205
B	8	1	1	0	10	$589,671	$709,484
C	9	0	0	1	10	$93,789	$98,721
Sample Total	20	7	2	1	30	$875,978	$1,113,410
Claims Not Sampled					371		$2,889,923
Total All Claims					401		$4,003,333

Recommendations

12. Determine the reasons why original pharmacy claims for Medicaid managed care enrollees lack supporting encounter records or fee-for-service claims. Analyze and determine those situations that should be referred to the Office of the Attorney General.

13. Investigate the potential inpatient overpayments identified in this report and recover identified overpayments. Make referrals as necessary to the Office of the Attorney General.

14. Develop a process for using encounter data to identify duplicate inpatient payments.

15. Compare fee-for-service claims data and encounter data on an ongoing basis to identify quality of care and overpayment issues.

16. Identify and develop additional uses of encounter data to improve monitoring of the Medicaid managed care program.

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Appendix A

AUDIT METHODOLOGY

To accomplish our objectives we performed the following:

- Reviewed Federal and State laws, rules, and regulations that apply to encounter data collection and reporting.

- Researched material from independent sources to identify criteria for evaluating Health's controls over encounter data collection and reporting.

- Developed a methodology to select a judgment sample of 200 Medicaid managed care enrollees enrolled at eight selected MCOs (Americhoice of New York; Buffalo Community Health; Capital District Physicians' Health Plan (CDPHP); Fidelis Care New York; Health First; Preferred Care; St. Barnabas/Partners in Health; and WellCare of New York) out of a population of 681,704 enrollees as of December 2000. In selecting these enrollees, we considered their geographic locations and ages. We included enrollees from urban, suburban and rural areas, whom we expected to receive frequent medical services, such as children aged 0 to 2, females of childbearing ages 16 to 35 years and enrollees over age 55. These enrollees were members of 8 MCOs throughout the State. The enrollees had 1,764 encounter records that were accepted into MEDS during the two-year audit period ended December 2000. We extracted these encounter records from MEDS in April 2001. We then reviewed the enrollees' medical records or administrative records used by providers to bill MCOs, to verify that enrollee information and service-related data was transferred correctly from the medical or administrative records to the encounter records. We looked for any medical services documented in these records that were not included in MEDS for both enrollees with accepted encounter records and enrollees with no accepted encounter records during our audit period. We used a registered nurse as a consultant to assist us with this review and to determine whether the diagnoses and procedures within the encounter records were logically consistent.

- Developed computer programs to: analyze trends of MCO compliance with encounter data submission requirements and identify MCOs that frequently fail to comply; determine how many encounter records are accepted by MEDS in relation to the acceptance thresholds set by Health; analyze the volume of rejected encounter records during the audit period; and determine the timeliness of encounter data submissions.

- Developed computer programs to match paid inpatient Medicaid fee-for-service claims with inpatient encounter records for managed care enrollees. From this match, we developed a methodology to select a sample of claims and then determine whether the MCOs also paid the providers for the same services, resulting in duplicate payments.

- Developed computer programs to examine the accuracy and reliability of certain information included in encounter records.

- Selected a statistical sample of paid pharmacy fee-for-service claims for Medicaid managed care enrollees. We reviewed this sample of claims to determine whether there were any associated encounter records that would show enrollees received health care services in conjunction with the pharmacy claims.

- Developed a methodology to select and survey a judgment sample of MCO's by mail (Americhoice of New York; CDPHP; Buffalo Community Health; Fidelis Care New York; Health First; Preferred Care; St. Barnabas/Partners in Health; and, WellCare of New York) from a population of 37 participating MCOs. We considered the MCO's geographic locations and enrollment size to select a variety of MCO's from throughout New York State. We asked MCO officials whether Health provides guidance to ensure the MCO staffs are properly trained in submitting complete and accurate encounter data; how the MCOs give providers training regarding encounter data submissions; what the MCOs do to detect and deter provider fraud and what guidance Health gives them in this matter; whether the MCOs have their own criteria to follow for encounter data submissions, from provider to MCO and from MCO to Health; and how the MCOs use encounter data.

- From the 42 local districts throughout New York State that participate in Medicaid managed care, we developed a methodology to select a judgment sample of 15 local districts throughout New York State, based on geographic location and total Medicaid population enrolled in managed care: Albany, Broome, Cattaraugus, Erie, Herkimer, Monroe, Nassau, New York City, Oneida, Onondaga, Putnam, Suffolk, Tioga, Washington, and Westchester. These local districts had nearly 90 percent of the Medicaid managed care enrollees in New York State. We developed a survey to ask local district officials to describe: their use of encounter data reports to monitor Medicaid managed care; problems in using encounter data; awareness of any limitations affecting encounter data reliability and usefulness; effectiveness as user-friendly source of encounter information; the assistance they receive from Health; and suggestions for improving encounter data reporting.

- We did not assess or analyze the system development process or methodology of implementing MEDS.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

February 20, 2002

Kevin M. McClune
Audit Director
Office of the State Comptroller
Alfred E. Smith State Office Building
Albany, New York 12236

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 2000-S-54 entitled "Medicaid Managed Care Encounter Data."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix C

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
2000-S-54 Entitled
"Medicaid Managed Care Encounter Data"

The following are the Department of Health's (DOH) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2000-S-54 entitled "Medicaid Managed Care Encounter Data".

General Comments

The Department appreciates the review and recommendations of the OSC to enhance the Department's ongoing data quality improvement efforts to collect complete, valid, and timely encounter data to monitor the Medicaid managed care program in New York. However, during discussions of preliminary findings, the Department informed OSC that the data being used by OSC for the audit was estimated to contain 35% fewer encounter records than were available in the Office of Managed Care (OMC) data warehouse. This discrepancy between what was actually submitted by managed care plans and the data obtained by OSC for the audit has resulted in a significant overstatement by OSC of the issues. Rather than present our own analyses disputing the OSC findings, which have in fact been shared previously with OSC, the Department will address the recommendations as presented.

* Note 1

Overall, the Department believes that it has demonstrated a continuous and concerted effort towards improving and making full use of the encounter data collected. The Department also believes it is a national leader in collection, validation, methods of data quality improvement, systems development, and reporting and uses of encounter data to monitor managed care plans and quality of care. Furthermore, the Department believes its efforts have resulted in the development of one of the most complete, accurate, and useful encounter data systems in the nation. However, it has been the experience of all states across the nation that encounter data collection has been a complex undertaking. Due to the variety of influences on validity and completeness of encounter data, the Department must continue to be constantly vigilant in assuring data quality. The Department fully expects that issues will continue to surface and that monitoring and data quality improvement efforts will always be a substantial part of the project.

* See State Comptroller's Notes, Appendix D

The Department's response to the specific recommendations in the report are provided below:

Recommendation #1:

Develop and implement a formal strategic plan for encounter data.

Response #1:

The Department has developed a strategic plan with goals and objectives through 2004. The strategic plan has been posted to the Department's secure Intranet Health Provider Network website and has been distributed to managed care plans. In addition to data quality goals, the plan focuses on analytic activities that involve grouping the data by episode of care and clinical risk. The implementation of these groups will enhance the clinical relevance of the data and facilitate advanced analysis of health services research issues.

Recommendation #2:

Work with MCOs that have higher rates of unreported and undocumented encounters to improve the completeness of submission.

Response #2:

Medicaid Encounter Data System (MEDS) Project staff works with plans on a continuing basis to address plan specific issues in encounter data reporting completeness, quality, and specificity. These efforts have included face-to-face meetings each year for the last three years with executive staff of managed care plans with performance and utilization rates that are significantly below statewide benchmarks. These meetings have resulted in effective action plans that have improved performance and data reporting and will continue annually. In addition, enrollee specific feedback was provided to all managed care plans in the second half of 2000 in order to improve service and encounter data collection for enrollees in the 1st year of life. Enrollee specific information continues to be provided on request so plans may determine where information system or provider reporting problems may continue to exist. Furthermore, an intranet application is being developed and will be deployed in the first quarter of 2002 to provide a convenient and secure platform for electronic and continuous sharing of enrollee level information.

Recommendation #3:

Establish a requirement for MCOs to timely correct and resubmit rejected encounter records.

Response #3:

As noted by OSC, the goal of the MEDS project is to eliminate record rejections. As of July 2001 plans must achieve a monthly record acceptance rate of 95%. Plans failing to meet this standard each month are required to submit an action plan that includes substantial testing before the next production submission. The testing process allows plans to correct records before they are sent as a formal production submission. As a result, for each of the last three monthly submissions in 2001, the percent of records accepted has exceeded 95% for an average of 96.4% of all records submitted being accepted. The Department believes that efforts to increase the percent of records accepted is a more cost efficient and effective strategy for the Department and managed care plans than developing expensive and staff intensive systems to correct rejected records after the submission or monitor the resubmission of previously rejected records.

* *Note 2*

Recommendation #4:

Evaluate the feasibility of offering incentives to MCOs for timely correcting and resubmitting rejected encounter records.

Response #4:

The Department believes that managed care plans should be rewarded for good performance. As such, the Department has implemented an incentive program to reward plans with good performance on health care quality measures with a higher percentage of the auto-assigned population. The Department is also pursuing the possibility of financial incentives for health care delivery of good quality. Well Child measures derived from submitted encounter data play a significant role in both algorithms designed to award quality performance. The fact that Well Child measures are now calculated by the Department using encounter data has resulted in vigorous activity by managed care plans to continue to improve encounter data reporting. MEDS Project staff has supported these efforts by providing detailed analysis of enrollee service histories to assist plans in identifying under-reported services.

* *Note 3*

Recommendation #5:

Develop a method to identify and monitor the resubmission of rejected encounter records.

* See State Comptroller's Notes, Appendix D

Response #5:

As previously stated in response to Recommendation #3, the Department's goal is to eliminate record rejections. The Department believes that establishing a reporting compliance standard of a 95% record acceptance rate is having the desired effect toward achievement of this goal. MEDS Project staff is actively involved in monitoring compliance with the standard and test submission results, and working with plans that fail to meet the standard. In addition, the Department again stresses that any recommendation by OSC that would involve systems changes or new systems development at Computer Sciences Corporation is not feasible at the current time. Priorities at CSC are focused on the eMedNY redesign of the Medicaid Management Information System and implementing the federal HIPAA regulations. Changes to any MEDS processing routines must await the completion of this critical work.

* Note 2

Recommendation #6:

Establish incremental standards for inpatient encounters.

Response #6:

The Department will consider implementation of an incremental standard for inpatient encounters. At the present time the Department is in the process of comparing inpatient encounter rates reported by the plans as part of the annual Quality Assurance Reporting Requirements (QARR) with rates reported in MEDS. The Department expects to send letters of inquiry to plans that have non-comparable rates between the two reporting systems. Based on the results of the comparison and responses of plans, the Department will consider the need for an inpatient-reporting standard.

Recommendation #7:

Establish incremental timeliness standards for MCOs to submit encounter data.

Response #7:

The Department is providing monthly feedback to managed care plans on the percent of records submitted within three months of the date of service. Since implementing this feedback project in July 2001, the percent of all records submitted within three months has increased from 59.0% in the first half of 2001 to 63.6% in the 3rd quarter, and 74.1% in the last quarter of 2001. In addition, over half the managed care plans consistently exceed the goal of 80% of their records submitted within three months of the date of service. Based on these results the Department does not foresee the need for a formal

* Note 4

Response #7 (cont'd):

timeliness standard. In addition, the Department will not consider setting a submission timeframe requirement that would reject encounters from previous time periods. Much of the analysis performed by the Department is focused on services used over extended periods of time. Using data warehousing technology, the MEDS database is refreshed on a monthly basis and analyses are easily updated to include new data submitted. The Department sees no advantage in not accepting historical encounters if submitted and believes managed care plans are sending encounter records as soon as possible.

Recommendation #8:

Work with MCOs that have higher rates of inconsistent diagnosis and procedure codes to improve accuracy.

Response #8:

The Department will look into purchasing software or developing clinically appropriate methods that will identify inconsistent diagnosis and procedure code combinations and work with plans to improve accuracy.

Recommendation #9:

Implement edits to check the validity of data in the provider ID and license number fields and prevent encounter records with blank or invalid provider Ids and license numbers from being updated to MEDS.

Response #9:

The Department is working with plans with the highest number of invalid provider IDs to educate them on all the resources and processes the Department has established to assure appropriate ID numbers are provided on encounter records. These include Intranet provider look-up files, processes for requesting IDs, updated provider master files for plan downloading and use, and upon request the Department will match plan provider records to available provider IDs. In addition, the Department is working to increase collaboration of managed care plan MEDS and Provider Relation staffs to facilitate sharing of updated provider information.

* *Note 5*

* See State Comptroller's Notes, Appendix D

Recommendation #10:

Implement an edit to ensure consistency between the category of service on encounter data, provider type and provider specialty.

Response #10:

The Department will assess the feasibility of implementing an edit that checks the consistency between category of service, provider type and specialty.

Recommendation #11:

Assess other MEDS edits and modify as necessary to ensure that important encounter record fields cannot be updated with inaccurate or inconsistent information.

Response #11:

The Department will assess the feasibility of implementing other edits that increase the accuracy of the data accepted into the system.

Recommendation #12:

Determine the reasons why original pharmacy claims for Medicaid managed care enrollees lack supporting encounter records or fee-for-service claims. Analyze and determine those situations that should be referred to the Office of the Attorney General.

Response #12:

On at least an annual basis, the Department will request detailed analysis from managed care plans on enrollees identified by the Department that are receiving prescription pharmaceuticals with no evidence of a professional services encounter. In 2001, the Department asked plans to provide information on enrollees receiving 20 or more prescriptions without evidence of another encounter. The 20 prescriptions criterion was chosen in order to permit an efficient and manageable analysis to be performed by plan Medical Directors. In the opinion of the plan Medical Directors, the analysis proved to be a valuable exercise and uncovered information system and provider encounter data reporting issues.

* *Note 6*

* See State Comptroller's Notes, Appendix D

Recommendation #13:

Investigate the potential inpatient overpayments identified in this report and recover identified overpayments. Make referrals as necessary to the Office of the Attorney General.

Response #13:

The Department has not yet confirmed that hospitals have been inappropriately billing both managed care plans and Medicaid for the same inpatient stay nor can it duplicate the number or level of potential overpayments suggested by OSC. The Department's analysis suggests the issue may involve timing of retroactive enrollments for newborns and behavioral health services which are carved out of plan benefit packages being utilized by SSI recipients. Appropriate referrals to the Attorney General will be made if any such cases of overpayment are identified.

* Note 7

Recommendation 14:

Develop a process for using encounter data to identify duplicate inpatient payments.

Response #14:

The Department will encourage use of Medicaid claims and managed care encounter data by appropriate staff to identify and prevent inappropriate billing by hospitals for services received by managed care enrollees.

Recommendation #15:

Compare fee-for-service claims data and encounter data on an ongoing basis to identify quality of care and overpayment issues.

Response #15:

The Department will encourage use of Medicaid claims and managed care encounter data by appropriate staff to identify quality of care issues and prevent inappropriate billing for services received by managed care enrollees. OMC staff has, in fact, devoted numerous days and resources in joint application design and design review sessions over the past two years to assure that encounter data is appropriately incorporated into eMedNY systems. The eMedNY decision support applications will provide much more accessible information to Medicaid Program staff charged with fraud and abuse and service utilization review responsibilities.

* See State Comptroller's Notes, Appendix D

Recommendation #16:

Identify and develop additional uses of encounter data to improve monitoring of the Medicaid managed care program.

Response #16:

The Department will continue to seek appropriate uses for encounter data and is currently analyzing episodes of care and clinical risk grouping of the data to provide more detailed knowledge of the process of health services delivery, quality, and appropriateness by clinical condition.

State Comptroller's Notes

1. Encounter records are maintained in two different systems within the Health Department. Computer Sciences Corporation (CSC), the Medicaid fiscal agent, maintains accepted encounter data on MEDS. OMC uses the MEDS encounter data information to maintain a data warehouse. After meeting with both Health and CSC officials during the audit, we determined that the encounter data maintained on MEDS was more complete than the encounter data on OMC's data warehouse. Hence, the data we used for this audit provides a reasonable basis for our findings, conclusions and recommendations.

2. During the audit period, encounter data acceptance ranged from 35 to 70 percent. Although the audit found that Health has a process in place for MCOs to correct and resubmit rejected records, Health's lack of both a requirement related to the timely resubmission of rejected records and the ability to identify and monitor resubmitted rejected encounter records has resulted in the potential loss of a significant amount of encounter data. Until Health implements an incremental standard that achieves 100 percent acceptance of encounter records, we believe Health should have cost effective processes in place to identify and monitor the timely resubmission of rejected encounter records.

3. Health's response addresses rewards for good performance, but does not address implementing incentives for timely correction and resubmission of rejected records. In our judgment, Health officials should consider offering MCOs incentives for the timely correction and resubmission of rejected encounter records.

4. We agree with Health's process of providing monthly feedback to MCOs on encounter data submission timeliness and Health's working toward achieving an 80 percent submission rate for encounter data within 3 months of service date. However, the 80 percent goal is informal. To help ensure that MCOs meet the 80 percent goal and continue to improve the timeliness of encounter data submission, Health should formalize the goal and establish incremental standards and monitoring through the strategic plan. Further, Health officials should consider the establishment of a submission timeframe requirement once they have developed a strategic plan and determined if and how they intend to use older encounter data (that is complete and accurate).

5. Health officials agree that blank or invalid provider IDs and license numbers in encounter records is a problem. However, if Health does not implement edits to check the validity of this information as recommended, and instead works with the MCOs to resolve this problem, we believe Health will still need to test the encounter data periodically to determine if there has been improvement.

6. We commend Health officials for working with MCO medical directors to resolve encounter data reporting issues. However, as stated in the report, it is also possible that physicians may be giving prescriptions to managed care enrollees without providing a medical exam or that potentially abusive pharmacy billing practices are occurring. Therefore, we believe Health officials should extend their analysis to include providers and pharmacies in order to resolve these potentially abusive and/or quality of care related concerns.

7. During the audit, we provided Health officials with all of the documentation and methodology related to our findings and conclusions regarding the actual and potential duplicate payments for inpatient services. In our sample, we determined that MCOs did not report any instances where these payments were related to timing differences. Health officials should be able to evaluate the claim and encounter information that we provided to assist in identifying and recovering overpayments.