Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID MANAGED CARE ENCOUNTER DATA: COLLECTION AND USE

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EXECUTIVE SUMMARY

OBJECTIVE

To determine the extent to which States and the Centers for Medicare & Medicaid Services (CMS) are collecting and using Medicaid managed care encounter data.

BACKGROUND

From 2000 to 2006, combined Federal and State Medicaid expenditures increased from $207 billion to $322 billion. In response to this growth, States have increasingly used Medicaid managed care to deliver services to beneficiaries. As of 2006, 65 percent of the 45.6 million Medicaid beneficiaries were receiving all or part of their health care services through Medicaid managed care. Encounter data are the primary records of Medicaid services provided to beneficiaries enrolled in capitated Medicaid managed care.

The Balanced Budget Act of 1997 requires that Medicaid claims submitted to CMS "on or after January 1, 1999, provide for electronic transmission of claims data in the format specified by the Secretary [of Health and Human Services] and consistent with the MSIS [Medicaid Statistical Information System] (including detailed individual enrollee encounter data and other information that the Secretary may find necessary)." As the only national database of Medicaid claims and beneficiary eligibility information, the MSIS is used by CMS to manage, analyze, and disseminate information on Medicaid beneficiaries, services, and payments. The MSIS data are also widely used for research and policy analysis by both public and private organizations, and may be used for detecting fraud, waste, and abuse. The MSIS must include encounter data to be representative of Medicaid beneficiaries and services.

This study is based on (1) a review of the most recent complete MSIS quarterly data submission for each State at the time of our review, (2) 1998 State MSIS Application Forms, and (3) structured interviews with State Medicaid agency staff in the 40 States providing services through capitated Medicaid managed care and with CMS officials.

FINDINGS

States reported collecting and using encounter data. State Medicaid agency staff in all 40 States with capitated Medicaid managed care

reported that they collect encounter data from managed care organizations (MCO). To ensure successful collection, all 40 States have established reporting requirements that dictate the format, frequency, and/or validation expectations for the data. Almost all States have established incentives and/or sanctions to encourage MCOs to report encounter data. Most States are using the encounter data that they collect to manage their Medicaid managed care programs and reported that they would welcome additional guidance and technical assistance from CMS, collaboration with CMS and other States, and information about how other States are using the data.

Usefulness of the MSIS is limited because CMS does not enforce encounter data requirements. CMS accepted the most recent MSIS submissions without encounter data from 15 of the 40 States, despite the Balanced Budget Act of 1997 and "State Medicaid Manual" requirements. CMS staff indicated that they have provided all States with the MSIS reporting requirements, which include the requirement to submit encounter data. Reporting practices mostly mirror the 1998 MSIS Application Forms that provided a description of States' intent with regard to MSIS submissions, including reporting encounter data. CMS has taken no formal action specific to encounter data since that time and has no graduated sanctions or penalties against States that do not fully comply with MSIS reporting requirements. The absence of encounter data from States with Medicaid managed care limits the usefulness of the MSIS.

RECOMMENDATIONS

We recommend that CMS:

Clarify existing Federal requirements that States include encounter data in MSIS submissions. CMS could accomplish this by first issuing comprehensive guidance that emphasizes Federal requirements for including encounter data in the MSIS, issuing national standards for encounter data included in the MSIS, and outlining its expectations regarding MSIS submissions with regard to encounter data (e.g., inclusion, format, frequency, and validation). CMS could also provide States with technical assistance and/or facilitate encounter data discussions among States to ensure that States understand the Federal requirements and submit data that meet quality expectations. Technical assistance may assist States with regard to successful encounter data collection and reporting practices, quality control measures, and ways to overcome any systems limitations.

Enforce existing Federal requirements that States include encounter data in MSIS submissions. Once CMS has provided States with encounter data guidance and technical assistance, it could develop edit checks to ensure the completeness and quality of encounter data.

Seek legislative authority to impose sanctions against States that fail to meet the MSIS reporting requirements for encounter data. CMS could seek legislative authority to withhold Federal financial participation for capitated payments and/or levy graduated fines and penalties against States that fail to meet MSIS reporting requirements for encounter data.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our first two recommendations and outlined the actions it would take to clarify and enforce existing Federal encounter data reporting requirements. CMS stated that it did not concur at this time with our third recommendation to seek legislative authority to impose sanctions against States that fail to meet the MSIS reporting requirements for encounter data.

CMS stated that it will (1) issue a State Medicaid Director letter to States that use managed care to clarify Medicaid managed care encounter data reporting requirements, (2) inform States that CMS staff will be available to provide technical assistance, (3) utilize State Technical Advisory Groups to collaborate with States on best practices, and (4) establish an Encounter Data Workgroup.

CMS also stated it intends to increase efforts to consistently enforce all Federal encounter data reporting requirements and will review current authorities to determine areas where it can strengthen authorities to improve encounter data reporting.

CMS did not concur, at this time, with our recommendation to seek legislative authority to impose sanctions against States. CMS stated that it wants to first pursue efforts that address our first two recommendations before considering seeking sanction authority. We agree that CMS should address our first two recommendations as an initial step, but continue to support our third recommendation should CMS efforts not result in States' reporting encounter data as required.

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OBJECTIVE

To determine the extent to which States and the Centers for Medicare & Medicaid Services (CMS) are collecting and using Medicaid managed care encounter data.

BACKGROUND

The Growth of Medicaid Managed Care

From 2000 to 2006, Federal Medicaid expenditures increased from $118 billion to $180 billion and State Medicaid expenditures increased from $89 billion to $142 billion.[1] In 2006, Medicaid expenditures accounted for almost one-quarter of all States' expenditures.[2] In response to the growth in Medicaid expenditures, States have increasingly used Medicaid managed care to deliver services to beneficiaries.[3] From 2000 to 2006, enrollment in Medicaid managed care grew 59 percent, from 18.8 million to 29.8 million beneficiaries. As of 2006, 65 percent of the 45.6 million Medicaid beneficiaries were receiving all or part of their health care services through Medicaid managed care.[4] See Appendix A for States' Medicaid managed care enrollment and plan types.[5]

Capitated Medicaid Managed Care

States utilize a variety of managed care arrangements to provide Medicaid services to eligible beneficiaries. In the most common arrangement (i.e., capitated Medicaid managed care), State Medicaid programs pay managed care plans a fixed rate per enrolled Medicaid beneficiary in exchange for services included in the plan. States receive Federal financial participation (FFP) for these capitated payments

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[1] Department of Health and Human Services, "Budget in Brief," 2002, and "Budget in Brief," 2008. Available online at http://www.hhs.gov/budget/docbudget.htm. Accessed on June 3, 2008.

[2] National Association of State Budget Officers, "2006 State Expenditure Report," 2007. Available online at http://www.nasbo.org/publications.php. Accessed on June 3, 2008.

[3] Managed care is a health care delivery system that aims to maximize efficiency by negotiating rates, coordinating care, and managing use of services.

[4] At the time of our review, all States had enrolled at least a portion of their Medicaid population in managed care, with the exception of Alaska and Wyoming.

[5] CMS surveys States annually to collect Medicaid managed care enrollment statistics and program characteristics and publishes that information in the "Medicaid Managed Care Enrollment Report" and the "National Summary of State Medicaid Managed Care Programs."

rather than for each individual service, which is how FFP is determined for fee-for-service claims. FFP is the Federal Government's share of an approved State cost for operating a Medicaid program.

Encounter data are detailed information regarding the services provided to Medicaid beneficiaries enrolled in capitated managed care. Like Medicaid claims for services provided on a fee-for-service basis, encounter data are the primary record of services provided to Medicaid beneficiaries enrolled in capitated Medicaid managed care. However, unlike Medicaid fee-for-service claims, States do not receive FFP for encounter data claims. States receive FFP for capitated payments for services provided through Medicaid managed care.

Managed care organizations (MCO) that contract with States to provide Medicaid services are required to maintain health information systems. These systems must be able to collect data on Medicaid beneficiaries, provider characteristics, and services using encounter data or other State-specified methods. MCOs are required to ensure that data received from Medicaid providers are accurate and complete.[6]

The Medicaid Statistical Information System

The Medicaid Statistical Information System (MSIS) was created to establish a primary source of Medicaid data at the Federal level for maintaining a single, accurate, and comprehensive Medicaid database that may be used to:

- produce regular statistical reports;
- support research into important policy, quality and effectiveness of care, and epidemiological issues; and
- support detecting fraud, waste, and abuse regarding the Medicaid program.[7]

The Balanced Budget Act of 1997 amended section 1903(r) of the Social Security Act to require that Medicaid claims submitted to CMS "on or after January 1, 1999, provide for electronic transmission of claims data in the format specified by the Secretary [of Health and Human Services] and consistent with the MSIS (including detailed individual enrollee encounter data and other information that the Secretary may find

[6] 42 CFR § 438.242(b)(2).

[7] 53 Fed. Reg. 26674 (July 14, 1988).

necessary)."[8] The MSIS is the only national database of Medicaid claims and beneficiary eligibility information. CMS uses MSIS to manage, analyze, and disseminate information on Medicaid beneficiaries, services, and payments. The MSIS data are also widely used for research and policy analysis by both public and private organizations, and may be used for detecting fraud, waste, and abuse.[9]

The CMS "State Medicaid Manual" provides guidance and requires that States meet the MSIS systems and data specifications.[10] To implement the MSIS, CMS issued the "MSIS Tape Specification and Data Dictionary" and the "MSIS Participation Guide," which contain instructions on the files that States are required to report.[11] More specifically, the data dictionary requires that claim files include encounter claims to the extent that they are routinely received by the State. The "MSIS Participation Guide" included an MSIS Application Form that each State was required to complete and submit to CMS by September 30, 1998. The information required in the application generally outlined States' claims data systems, the fields that they would use, and a description of the types of data that they would provide in their MSIS submissions. Although the applications did not serve as an approval mechanism, they did describe States' intentions with regard to MSIS submissions, including any exceptions to comprehensive reporting (e.g., the absence of encounter data).[12]

Medicaid Integrity and Program Management

As mandated by the Deficit Reduction Act of 2005, CMS established a Comprehensive Medicaid Integrity Plan (CMIP) to combat Medicaid fraud, waste, and abuse.[13] In the CMIP, CMS notes that it must determine how to calculate return on investment for program integrity strategies aimed at managed care. CMS also notes that it must provide guidance on how to ensure Medicaid integrity in a managed care delivery system and help States develop more sophisticated approaches

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[8] Balanced Budget Act of 1997, P.L. No. 105-33, § 4753(a)(1) (codified at 42 U.S.C. § 1396b(r)).

[9] "MSIS Overview." Available online at http://www.cms.hhs.gov/MSIS/01_Overview.asp#TopOfPage. Accessed on June 3, 2008.

[10] CMS, "State Medicaid Manual" (Pub. No. 45), Chapter 2, § 2700.2(B).

[11] CMS, "MSIS State Participation Procedures Manual." Available online at http://www.cms.hhs.gov/MSIS/. Accessed on June 3, 2008.

[12] CMS, "State Medicaid Manual" (Pub. No. 45), Chapter 2, § 2700.2(D).

[13] Deficit Reduction Act of 2005, P.L. No 109-171, § 6034(a) (codified at 42 U.S.C. § 1396u-6).

to addressing fraud and abuse in the managed care environment.[14] As part of CMIP, CMS announced plans to use the MSIS data as a source of Medicaid information to maximize fraud, waste, and abuse detection activities by providing a single, integrated source of timely and quality Medicaid data.

Other Studies

Thomson Medstat, an organization that contracts with CMS to conduct analyses and provide guidance on a broad range of policy issues, reviewed 2001 and 2002 encounter data from MSIS submissions and indicated that the absence of encounter data prevents CMS, States, and even MCOs from determining Medicaid service utilization by beneficiaries.[15] A 2006 report from the Government Accountability Office found that CMS has not incorporated the MSIS into its oversight of States' claims or other systems projects intended to improve its analytic capabilities.[16]

METHODOLOGY

Scope

This study focused on Medicaid managed care encounter data for services provided in 39 States and the District of Columbia (hereinafter referred to as States) that have capitated Medicaid managed care arrangements. We excluded Alaska and Wyoming because they do not offer Medicaid managed care. We excluded an additional nine States (Arkansas, Idaho, Louisiana, Maine, Mississippi, Montana, New Hampshire, Oklahoma, and South Dakota) that provided Medicaid managed care services only through primary care case management arrangements or prepaid ambulatory health plans because these

[14] CMS, Center for Medicaid and State Operations, Medicaid Integrity Group, "Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program," FY 2007-2011, August 2007. Available online at http://www.cms.hhs.gov/DeficitReductionAct/Downloads/CMIPupdateaugust2007final.pdf. Accessed on June 4, 2008.

[15] Thomson Medstat, "Cross-State MSIS Encounter Data Quality Feedback Report," March 28, 2006.

[16] Government Accountability Office, "Medicaid Financial Management: Steps Taken To Improve Federal Oversight but Other Actions Needed To Sustain Efforts," GAO-06-705, June 2006.

entities are not subject to the same administrative requirements as other capitated managed care plans.[17]

The mixed methods used to conduct this evaluation included the review and analysis of data in States' MSIS submissions, States' MSIS Application Forms, structured interviews with State Medicaid agency staff, and structured interviews with CMS staff. This evaluation did not assess the completeness, accuracy, or timeliness of the encounter data collected by the States and/or reported to CMS in MSIS.

Data Collection and Analysis

Medicaid Managed Care Encounter Data. We obtained the most recent complete quarterly MSIS data submissions from CMS for the 40 States that provide Medicaid services through capitated Medicaid managed care.[18] The claims data varied by time period based on the most recent complete data submission in the MSIS for each State. We determined the extent to which States included encounter data in their most recent MSIS submissions to CMS by searching for a "3" in the claim type field.[19]

MSIS Application Forms. We obtained State MSIS Application Forms required by and submitted to CMS in 1998 by each of the 51 States. We limited our review to the 40 States that provided Medicaid services through capitated Medicaid managed care at the time of our review. We reviewed State responses to application questions and compared the information provided in the applications to current MSIS encounter data reporting practices.

Interviews with State Medicaid agency staff. We conducted structured telephone interviews with State Medicaid agency staff in all 40 States with capitated managed care to determine why States did or did not include Medicaid managed care encounter data in their most recent MSIS submission. We also determined:

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[17] See 42 CFR § 438.242 (describing health information system requirements that apply only to MCOs and Prepaid Inpatient Health Plans).

[18] MSIS complete files as of June 1, 2007. There are no edit checks specific to encounter data. To be considered complete, submitted MSIS data files (i.e., eligibility, long-term care, pharmacy, inpatient, and other) must meet CMS's edit criteria for fee-for-service claims.

[19] Encounter data are to be reported in the MSIS with a "3" in the claim type field as specified in the "MSIS Tape Specification and Data Dictionary," updated February 2007. Available online at http://www.cms.hhs.gov/MSIS/Downloads/msisdd05.zip. Accessed on September 8, 2008.

- the extent to which States required or encouraged MCOs to report encounter data to the States,
- any barriers that States experienced in collecting encounter data from MCOs,
- whether nonreporting States anticipated including encounter data in their MSIS submissions to CMS and when,
- the extent to which States use encounter data, and
- how encounter data could be improved to meet States' needs.

Interviews with CMS staff. We conducted structured interviews with CMS staff responsible for implementation and oversight of the MSIS and with CMS's Office of Research, Development, and Information. Through these interviews, we determined how CMS is using Medicaid managed care encounter data, whether reported data meet its needs, what potential uses exist for the data, and how encounter data could be improved to meet current and future needs.

Standards

This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

States reported collecting and using encounter data

State Medicaid agency staff in all 40 States with capitated Medicaid managed care reported that they collect encounter data from MCOs. To ensure successful collection, all 40 States have established reporting requirements that dictate the format, frequency, and/or validation expectations for the data. Almost all States have established incentives and/or sanctions to encourage MCOs to report encounter data. Most States are using the encounter data that they collect to manage their Medicaid managed care programs and would welcome additional guidance from CMS and information about how other States are using the data.

All 40 States have established reporting requirements for MCOs

States' contractual agreements with MCOs dictate the format, frequency, and/or validation expectations for encounter data. See Table 1 for the number of States that have each type of reporting requirement. See Appendix B for an overview of reporting requirements established by each State for Medicaid managed care encounter data.

Table 1: Reporting Requirements for Medicaid Managed Care Encounter Data

Type of Requirement	Number of States
Format	40
Frequency	38
Validation	33
Attestation only	21
Edits only	4
Attestation and edits	8

Source: Office of Inspector General (OIG) analysis of interview responses, 2008.

Thirty-four States have implemented incentives and/or sanctions regarding MCOs' reporting of encounter data

Thirty-four States have established various incentives and/or sanctions to encourage MCOs to submit encounter data to the States. Incentives may include rewards for plans meeting all encounter data reporting requirements. Sanctions may serve as punitive measures or as deterrents for failure to meet encounter data reporting requirements. States described efforts to encourage MCOs to report encounter data as

incentives and/or sanctions. For example, a plan could receive full capitated payments for reporting encounter data (described as an incentive by some States) or reduced payments for failing to report encounter data (described as a sanction by some States). See Table 2 for the incentives and/or sanctions that States have established.

Table 2: State-Established Incentives and/or Sanctions

	Number of States
Financial inducements and/or penalties	26
Rate setting	13
Automatic enrollment/assignment	7
Performance measures	7
Medicaid Fraud Control Units referral	4
Suspension or termination of contract	3
Other (nonspecific)	3

Source: OIG analysis of interview responses, 2008.

Financial incentives and sanctions described by Medicaid State agency staff include withholding a percentage of the capitated payments for failure to report encounter data, charging managed care plans a daily fee for failure to report encounter data, and basing pay for performance on the receipt and quality of encounter data. Automatic enrollment assignments include enrolling or suspending enrollment of beneficiaries into a managed care plan based on the plan's submission of encounter data. Performance measures include publishing performance information on State Web sites and publishing report cards based on managed care plan performance. See Appendix C for an overview of incentives and sanctions established by each State.

Thirty-nine States use the encounter data that they collect

State Medicaid agency staff reported using the encounter data received from MCOs in a variety of ways to meet State-established goals. Thirty-nine of the forty States reported using encounter data to better understand and administer their Medicaid programs. See Table 3 for the most common State uses.

Table 3: States' Most Common Uses for Medicaid Managed Care Encounter Data

	Number of States
Quality assurance	34
Rate setting	33
Service utilization	33
Early and Periodic Screening, Diagnosis, and Treatment reporting	29
Program trending	25
Healthcare Effectiveness Data and Information Set measures	23
Monitoring immunizations	18
Monitoring expenditures	16

Source: OIG analysis of interview responses, 2008.

See Appendix D for an overview of each State's most common uses of Medicaid managed care encounter data.

States reported using encounter data for additional purposes, including measuring managed care plan and physician performance, producing ad hoc reports, detecting fraud and abuse, formulating and implementing health care policies, comparing Medicaid managed care and commercial managed care plan performance, gathering beneficiary demographic information, and/or capturing health outcomes (e.g., laboratory results).

State Medicaid agency staff in 28 States reported successfully using encounter data. The staff in one State remarked that they "cannot imagine living without encounter data; the data are the lifeblood of the agency." State Medicaid agency staff in another State reported that "Encounter data are the foundation for our State to achieve its objectives across the board."

In contrast, Medicaid agency staff in 11 States reported difficulty in using encounter data. Staff in six States attributed this difficulty to State system limitations. Staff in four States noted receiving inconsistent and/or flawed data (e.g., problems with particular fields, such as the provider or beneficiary identification) from MCOs.

One State provided no specific reason for its difficulty in using encounter data.

Twenty-five States want additional guidance for encounter data

State Medicaid agency staff reported a desire to know how other States are using the data and how those uses might transfer to their own programs. They noted that working with other States that are more advanced in collecting, reporting, and using encounter data could improve their understanding and use of the data. Additionally, State Medicaid agency staff in 25 States noted that they would welcome more guidance from CMS (e.g., national standards regarding encounter data), and/or collaboration with CMS and other States. However, State Medicaid agency staff in a few States indicated that any new guidance or requirements should not hinder State flexibility and that reporting encounter data should be optional. See Table 4 for the number of States that want additional guidance and/or collaboration.

Table 4: Twenty-Five States Want Additional Guidance and/or Collaboration

	Number of States
Guidance only	12
Collaboration only	4
Guidance and collaboration	9

Source: OIG analysis of interview responses, 2008.

Usefulness of the MSIS is limited because CMS does not enforce encounter data requirements

CMS accepted the most recent MSIS submissions without encounter data from 15 of the 40 States, despite the Balanced Budget Act and "State Medicaid Manual" requirements. CMS staff indicated that they have provided all States with the MSIS reporting requirements, which include the requirement to submit encounter data. Reporting practices mostly mirror the 1998 MSIS Application Forms, and CMS has taken no formal action specific to encounter data since that time. The absence of encounter data from some States with Medicaid managed care limits the usefulness of the MSIS.

Not all States submit encounter data as required

Fifteen States did not include encounter data in their most recent MSIS submissions at the time of our review (June 1, 2007). State Medicaid agency staff for 11 of these nonreporting States indicated that they were not aware of any requirements to include encounter data in the MSIS. For 9 of the 15 nonreporting States, staff anticipate including the data in future submissions but offered no timeframes for when this reporting might occur. In the remaining six nonreporting States, staff do not anticipate including the data in their MSIS submissions.

For the 25 States that did report encounter data in their most recent MSIS submissions, State Medicaid agency staff said that they included the data based on Federal requirements (e.g., "MSIS Operations Manual," specific waiver requirements, or the direction of CMS) and/or individual State initiatives.

CMS does not enforce encounter data reporting requirements and its enforcement options are limited

CMS staff indicated that they are not satisfied with the completeness, quality, or usefulness of encounter data submitted by States, yet they accept MSIS submissions that do not include the encounter data, as required. CMS does not enforce the current MSIS reporting requirements or subject encounter data to the same edit checks and/or quality reviews as fee-for-service claims data. CMS staff indicated that unlike fee-for-service claims and capitated payments, encounter data are not linked to FFP, making enforcement difficult. Further, CMS does not have graduated sanctions or penalties against States that do not fully comply with MSIS reporting requirements (e.g., absence of encounter data).

States' 1998 MSIS Application Forms mostly mirror current reporting practices

The 1998 MSIS Application Forms for all of the 15 nonreporting States indicated that these States would not include encounter data in their MSIS submissions. Of the 25 reporting States, 23 indicated that they would include encounter data on their 1998 MSIS Application Forms. Two reporting States indicated on their applications that they would not include encounter data in their MSIS submissions, yet they included encounter data in their most recent submissions. See Appendix E for an overview of States' current encounter data submissions in the MSIS and the 1998 MSIS Application Form responses regarding the inclusion of encounter data in the MSIS.

The 1998 MSIS Application Forms served as the only formal CMS request for information from States as to how they intended to comply with MSIS reporting requirements, including encounter data. Despite the growth in Medicaid managed care since 1998, CMS has taken no formal action to request updated information from States, issue guidance to States, or develop edit checks for encounter data.

The lack of encounter data in MSIS submissions from some States limits its usefulness

The absence of encounter data in the MSIS creates an incomplete picture of Medicaid overall and Medicaid managed care specifically, thereby limiting the intended uses of the MSIS. CMS staff responsible for implementation and oversight of the MSIS and staff at CMS's Office of Research, Development, and Information explained that the absence of encounter data in the MSIS restricts their use of the data. CMS staff would like to progress toward more useful data and explained that without encounter data, the Medicaid managed care picture is incomplete. CMS staff indicated that they "need encounter data to be able to measure what we are paying for."

RECOMMENDATIONS

All 40 States providing services through capitated Medicaid managed care collect encounter data, and almost all of these States use the data to administer their Medicaid programs. However, CMS accepted MSIS submissions from 15 States that did not include encounter data, thereby failing to enforce the MSIS encounter data reporting requirements for these States. As the only national database of Medicaid claims and beneficiary eligibility information, the MSIS data are widely used for research and policy analysis and may also be used for detecting fraud, waste, and abuse by both public and private organizations. However, to be used as intended, the MSIS must include encounter data to represent the more than 65 percent of the Medicaid population enrolled in Medicaid managed care.

To strengthen enforcement of the MSIS requirements, we recommend that CMS:

Clarify Existing Federal Requirements That States Include Encounter Data in MSIS Submissions

CMS could accomplish this by first issuing (1) comprehensive guidance that emphasizes Federal requirements for including encounter data in the MSIS, (2) national standards for encounter data included in the MSIS, and (3) its expectations regarding MSIS submissions with regard to encounter data (e.g., inclusion, format, frequency, and validation). CMS could also provide States with technical assistance and/or facilitate encounter data discussions among States to ensure that States understand the Federal requirements and submit data that meet quality expectations. Technical assistance may assist States with regard to successful encounter data collection and reporting practices, quality control measures, and ways to overcome any systems limitations.

Enforce Existing Federal Requirements That States Include Encounter Data in MSIS Submissions

Once CMS has clarified existing Federal requirements that States include encounter data in MSIS submissions, it could develop edit checks to ensure that States comply with those requirements and that the data are complete and meet quality expectations.

Seek Legislative Authority To Impose Sanctions Against States That Fail To Meet the MSIS Reporting Requirements for Encounter Data

CMS could seek legislative authority to withhold FFP for capitated payments and/or levy graduated fines and penalties against States that fail to meet MSIS reporting requirements for encounter data.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our first two recommendations and outlined the actions it would take to clarify and enforce existing Federal requirements that require States to include encounter data in MSIS submissions. CMS stated that it did not concur at this time with our third recommendation to seek legislative authority to impose sanctions against States that fail to meet the MSIS reporting requirements for encounter data.

CMS stated that it will issue a State Medicaid Director letter to all States that use managed care to clarify Medicaid managed care encounter data reporting requirements and inform States that CMS staff will be available to provide technical assistance with encounter data submissions. CMS will utilize State Technical Advisory Groups to collaborate with States on best practices for encounter data submissions and establish an Encounter Data Workgroup to address additional issues.

CMS also stated that it intends to increase efforts to consistently enforce all Federal requirements for Medicaid managed care encounter data reporting and will review current authorities to determine areas where it can strengthen authorities to improve managed care encounter data reporting.

CMS did not concur, at this time, with our recommendation to seek legislative authority to impose sanctions against States that fail to meet the MSIS reporting requirements for encounter data. CMS stated that it wants to first pursue efforts that address our first two recommendations before considering seeking sanction authority. We agree that CMS should address our first two recommendations as an initial step, but continue to support our third recommendation should CMS efforts not result in States' reporting encounter data as required.

We did not make any changes to the report based on CMS's written comments. For the full text of CMS's comments, see Appendix F.

State Medicaid Managed Care Enrollment and Plan Types as of June 30, 2006[20]

State	Percentage of Beneficiaries in Managed Care	Types of Managed Care Plans							
		Number of Commercial MCOs	Number of Medicaid-Only MCOs	Number of PIHPs	Number of PAHPs	Number of PACE Programs	Number of PCCMs	Number of HIOs	Number of Others
AK*	0.00%	0	0	0	0	0	0	0	1
AL	63.30%	0	0	2	0	0	1	0	0
AR	83.02%	0	0	0	1	0	1	0	0
AZ	89.60%	0	25	1	0	0	0	0	0
CA	50.34%	24	2	1	13	4	0	4	1
CO	95.10%	0	2	6	0	1	1	0	0
CT	75.59%	2	2	0	0	0	0	0	0
DC	67.76%	0	3	1	0	0	0	0	0
DE	76.48%	0	1	0	0	0	0	0	1
FL	65.49%	13	1	3	5	1	1	0	2
GA	97.67%	0	1	1	1	0	1	0	0
HI	79.99%	2	1	2	0	0	0	0	1
IA	86.51%	1	0	1	0	0	1	0	0
ID	81.42%	0	0	0	0	0	1	0	0
IL	7.26%	1	2	0	0	0	0	0	0
IN	72.09%	0	5	0	0	0	1	0	0
KS	57.03%	0	1	0	0	1	1	0	0
KY	92.37%	0	1	0	1	0	1	0	0
LA	71.15%	0	0	0	0	0	1	0	0
MA	60.43%	2	2	1	0	6	1	0	0
MD	69.96%	0	7	0	0	1	0	0	0
ME	66.70%	0	0	0	0	0	1	0	0
MI	84.85%	4	11	18	0	1	0	0	0
MN	63.65%	6	3	0	0	0	0	0	0
MO	99.53%	3	4	0	1	1	0	0	0
MS	10.21%	0	0	0	1	0	0	0	0

[20] See Glossary on page 28 for terms and abbreviations used in Appendix A.

State Medicaid Managed Care Enrollment and Plan Types as of June 30, 2006 (Continued)

State	Percentage of Beneficiaries in Managed Care	Types of Managed Care Plans							
		Number of Commercial MCOs	Number of Medicaid-Only MCOs	Number of PIHPs	Number of PAHPs	Number of PACE Programs	Number of PCCMs	Number of HIOs	Number of Others
MT	66.86%	0	0	0	0	0	1	0	0
NC	64.90%	1	0	2	0	0	2	0	0
ND	55.62%	0	1	0	0	0	1	0	0
NE	80.85%	1	0	0	0	0	1	0	1
NH	74.87%	0	0	0	1	0	0	0	0
NJ	69.41%	2	3	0	0	0	0	0	0
NM	65.19%	2	1	1	0	1	0	0	0
NV	82.39%	2	0	0	1	0	0	0	0
NY	61.12%	20	19	12	1	4	4	0	1
OH	39.91%	0	8	0	0	2	0	0	0
OK	85.90%	0	0	0	2	0	1	0	0
OR	90.34%	2	11	9	8	1	1	0	1
PA	86.32%	11	0	28	1	4	1	0	0
RI	65.84%	2	1	0	0	1	0	0	0
SC	20.19%	0	2	0	2	1	1	0	0
SD	98.25%	0	0	0	1	0	1	0	0
TN	100.00%	4	4	2	0	1	0	0	2
TX	68.55%	8	2	1	0	2	2	0	0
UT	86.89%	0	0	12	1	0	1	0	0
VA	63.22%	5	2	0	1	0	1	0	0
VT	64.70%	0	1	0	0	0	0	0	0
WA	86.64%	7	1	1	1	1	1	0	0
WI	46.73%	34	3	2	0	1	0	0	0
WV	46.31%	3	0	0	0	0	1	0	0
WY	0.00%	0	0	0	0	0	0	0	0
Total	**65.34%**	**162**	**133**	**107**	**43**	**35**	**33**	**4**	**11**

Source: CMS, "2006 Medicaid Managed Care Enrollment Report."

*Alaska offers nonemergency medical transportation through a managed care waiver authority but uses a fee-for-service transportation broker.

States' Reporting Requirements for Medicaid Managed Care Encounter Data[21]

States With Capitated Medicaid Managed Care	Reporting Requirements			
	Format	Frequency	CEO/CFO Attestation	Data Must Pass Edit Checks
AL	X	X		X
AZ	X	X	X	X
CA	X	X		X
CO	X	X	X	
CT	X	X	X	X
DC	X	X	X	
DE	X	X		
FL	X	X	X	X
GA	X	X	X	
HI	X	X		X
IA	X	X	X	
IL	X	X	X	
IN	X			
KS	X	X	X	
KY	X	X	X	
MA	X	X	X	
MD	X	X	X	X
MI	X	X	X	X
MN	X	X	X	
MO	X	X	X	X

[21] See Glossary on page 28 for terms and abbreviations used in Appendix B.

States' Reporting Requirements for Medicaid Managed Care Encounter Data (Continued)

States With Capitated Medicaid Managed Care	Reporting Requirements			
	Format	Frequency	CEO/CFO Attestation	Data Must Pass Edit Checks
NC	X			
ND	X	X		
NE	X	X		
NJ	X	X	X	
NM	X	X	X	
NV	X	X	X	
NY	X	X	X	
OH	X	X	X	
OR	X	X	X	X
PA	X	X	X	
RI	X	X		
SC	X	X	X	
TN	X	X	X	X
TX	X	X	X	
UT	X	X	X	
VA	X	X	X	
VT	X	X		X
WA	X	X	X	
WI	X	X		
WV	X	X	X	
Total	**40**	**38**	**29**	**12**

Source: Office of Inspector General analysis of interview responses, 2008.

A blank field indicates that the State did not have the requirement or did not specifically indicate it in the interview.

APPENDIX ~ C

States' Established Incentives and/or Sanctions for Medicaid Managed Care Encounter Data[22]

States With Capitated Medicaid Managed Care	Incentives and/or Sanctions						
	Financial Inducements and/or Penalties	Rate Setting	Automatic Enrollment/ Assignment	Performance Measures	MFCU Referral	Suspension or Termination of Contract	Other Nonspecific
AL							
AZ	X	X	X	X			
CA						X	
CO							
CT	X	X					
DC	X						
DE							
FL							
GA	X						
HI*							X
IA		X			X		
IL	X						
IN		X					
KS	X						
KY	X						
MA	X		X	X			
MD	X	X		X			
MI	X	X	X	X			
MN	X	X					
MO	X				X		

[22] See Glossary on page 28 for terms and abbreviations used in Appendix C.

States' Established Incentives and/or Sanctions for Medicaid Managed Care Encounter Data (Continued)

States With Capitated Medicaid Managed Care	Incentives and/or Sanctions						
	Financial Inducements and/or Penalties	Rate Setting	Automatic Enrollment/ Assignment	Performance Measures	MFCU Referral	Suspension or Termination of Contract	Other Nonspecific
NC							
ND							X
NE*							X
NJ	X			X			
NM	X						
NV		X					
NY	X	X					
OH	X		X		X	X	
OR	X		X				
PA	X	X					
RI	X	X	X	X			
SC	X						
TN	X						
TX	X	X		X			
UT	X						
VA							
VT		X			X	X	
WA	X						
WI	X						
WV	X		X				
Total	**26**	**13**	**7**	**7**	**4**	**3**	**3**

Source: Office of Inspector General analysis of interview responses, 2008.
A blank field indicates that the State did not have the incentive and/or sanction or did not specifically indicate it in the interview.
*State has incentives and/or sanctions outlined in contractual agreement but does not currently implement them.

APPENDIX ~ D

States' Most Common Uses of Medicaid Managed Care Encounter Data[23]

States With Capitated Medicaid Managed Care	Uses of Encounter Data							
	Rate Setting	Quality Assurance	Service Utilization	EPSDT Reporting	Program Trending	HEDIS Measures	Monitoring Immunizations	Monitoring Program Expenditures
AL	X	X	X		X			
AZ*	X	X	X		X			
CA	X	X	X	X	X	X	X	
CO	X	X	X		X	X		X
CT	X		X	X		X		X
DC*	X	X	X		X	X		X
DE	X	X	X	X	X	X		
FL	X	X	X					X
GA	X	X	X	X	X	X	X	X
HI	X					X		
IA	X	X	X	X		X	X	
IL		X	X	X	X	X	X	
IN		X	X	X	X	X	X	X
KS		X	X	X			X	X
KY	X	X	X	X	X		X	X
MA	X	X	X	X	X	X		
MD	X	X	X	X	X		X	X
MI	X	X	X	X	X		X	X
MN	X	X	X	X	X	X	X	
MO		X		X		X		

[23] See Glossary on page 28 for terms and abbreviations used in Appendix D.

States' Most Common Uses of Medicaid Managed Care Encounter Data (Continued)

States With Capitated Medicaid Managed Care	Uses of Encounter Data							
	Rate Setting	Quality Assurance	Service Utilization	EPSDT Reporting	Program Trending	HEDIS Measures	Monitoring Immunizations	Monitoring Program Expenditures
NC	X							
ND	X							
NE				X				
NJ	X	X	X	X	X	X	X	
NM	X	X	X	X	X		X	X
NV	X	X	X	X	X	X	X	X
NY	X	X			X	X		
OH	X	X	X	X	X	X	X	
OR*	X	X	X	X	X		X	X
PA	X	X	X			X		
RI	X	X	X	X	X	X		X
SC								
TN	X	X	X	X		X	X	
TX*	X	X	X	X	X	X		X
UT*	X	X	X	X	X			
VA*		X	X	X		X	X	
VT	X	X	X	X		X		
WA*	X	X	X	X				
WI*	X	X	X	X	X		X	X
WV	X	X	X	X	X			
Total	**33**	**34**	**33**	**29**	**25**	**23**	**18**	**16**

Source: Office of Inspector General analysis of interview responses, 2008.

*State also uses encounter data for establishing DME payments and/or determining DSH payments.

A blank field indicates "not applicable."

APPENDIX ~ E

States' MSIS Submissions of Medicaid Managed Care Encounter Data[24]

States With Capitated Medicaid Managed Care	Most Recent MSIS Quarterly Submission Month/Year at the Time of Our Review	Encounter Data Included in Most Recent MSIS Submission	Application Indicates State Will Include Encounter Data in the MSIS	MSIS Files Containing Encounter Data				
				Inpatient	Other	Pharmacy	Long-Term Care	Eligibility
AL	04/2005	X	X	X				X
AZ	02/2007	X	X	X	X	X	X	X
CA	01/2007	X	X	X	X	X	X	
CO	01/2006							
CT	04/2006							
DC	02/2007							
DE	01/2007							
FL	02/2007							
GA	01/2007	X	X		X			X
HI	02/2007	X	X	X	X	X	X	X
IA	03/2006	X	X	X	X			
IL	01/2007	X	X	X	X			
IN	02/2007	X	X	X	X	X		
KS	02/2006	X	X	X	X	X		
KY	04/2006	X	X	X	X	X		X
MA	04/2004							
MD	01/2005	X	X	X	X	X		
MI	04/2005							
MN	04/2006	X	X	X	X	X	X	
MO	02/2007	X	X	X	X	X		

[24] See Glossary on page 28 for terms and abbreviations used in Appendix E.

States' MSIS Submissions of Medicaid Managed Care Encounter Data (Continued)

States With Capitated Medicaid Managed Care	The Most Recent MSIS Quarterly Submission Month/Year at the Time of Our Review	Encounter Data Included in Most Recent MSIS Submission	Application Indicates State Will Include Encounter Data in the MSIS	MSIS Files Containing Encounter Data				
				Inpatient	Other	Pharmacy	Long-Term Care	Eligibility
NC	04/2006	X	X	X				X
ND	01/2005	X	X	X	X			
NE	01/2007	X	X	X	X			
NJ	04/2005	X	X		X	X		
NM	01/2007	X	X	X	X		X	
NV	04/2005	X	X	X	X		X	
NY	02/2007	X	X	X	X	X	X	
OH	04/2005							
OR	01/2006	X	X	X	X			
PA	02/2005							
RI	03/2005	X	X	X	X	X		
SC	02/2007							
TN	04/2006							
TX	04/2006							
UT	04/2005							
VA	04/2006	X	X	X	X	X	X	X
VT	04/2005							
WA	02/2007	X		X		X	X	
WI	01/2007	X		X	X	X	X	
WV	03/2006							
Total		**25**	**23**	**23**	**22**	**15**	**10**	**7**

Source: Office of Inspector General analysis of the most recent and complete quarter of the State MSIS data submitted to the Centers for Medicare & Medicaid Services, 2008.

A blank field indicates "not applicable."

APPENDIX ~ F

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: APR 14 2009

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera
Acting Administrator

RECEIVED
2009 APR 16 PM 12:18
OFFICE OF INSPECTOR GENERAL

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Managed Care Encounter Data: Collection and Use" (OEI-07-06-00540)

Thank you for the opportunity to review and comment on the subject OIG Draft Report. The purpose of this report was to determine the extent to which States and the Centers for Medicare & Medicaid Services (CMS) are collecting and using Medicaid managed care encounter data.

As of 2006, 65 percent of the 45.6 million Medicaid beneficiaries were receiving all or part of their health care services through a Medicaid managed care program. Encounter data are the primary records of Medicaid services provided to beneficiaries enrolled in capitated managed care. Unlike claims data from fee-for-service providers, which is reported directly from the States to CMS, encounter data concerning managed care enrollees flows from the provider to the provider's group practice or other entity, to the managed care organization, to the State, and then finally from the State to CMS.

Section 4753(a)(1) of the Balanced Budget Act of 1997 (BBA), P.L. 105-33, amended section 1903(r) of the Social Security Act (the Act) to require, "effective for claims filed on or after January 1, 1999," that States "provide for electronic transmission of claims data in the format specified by the Secretary of Health and Human Services and consistent with the Medicaid Statistical Information System (MSIS), including detailed individual enrollee encounter data and other information that the Secretary may find necessary." While the term "encounter data" is most commonly used to refer to managed care settings in which an individual claim for payment may not be submitted, neither section 4753(a)(1), nor any other provisions of the BBA, amended the statutory provisions governing Medicaid managed care contracts to reference this new requirement. Moreover, the referencing of encounter data modifies a reference to "transmission of claims data," suggesting that "claims data" is to include encounter data.

Nonetheless, of the 40 States providing Medicaid services through capitated managed care programs, all 40 collect some encounter data from the managed care organizations and use it to manage their Medicaid managed care programs. We note MSIS data are used by CMS and other public and private organizations for research and policy analysis.

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CMS accepted the most recent MSIS submissions from 15 of the 40 States with managed care programs without encounter data being included. The absence of these encounter data from States with Medicaid managed care programs limits the usefulness of the MSIS.

After reviewing this report, CMS has the following comments in response to the report's recommendations:

OIG Recommendation

Clarify existing Federal requirements that States include encounter data in MSIS submissions.

CMS Response

The CMS concurs with this recommendation and intends to do the following: (1) issue a State Medicaid Director letter to all States that use managed care entities to provide services to their Medicaid beneficiaries that clarifies CMS' interpretation of section 1903(r) of the Act as requiring that managed care encounter data be submitted as part of MSIS claims data submissions, and indicate that central office and regional office staff will be available to provide technical assistance to assist the States in submitting such data; (2) utilize the various State Technical Advisory Groups (TAGs) to bring together appropriate State and CMS staff to collaborate on the best practices that States employ to collect, use, and submit encounter data and to determine what other types of technical guidance or clarifications are needed by the States and managed care entities; and (3) establish an Encounter Data Workgroup comprised of Central Office staff, Regional Office staff, and staff from States who are most closely involved in submitting encounter data to address issues related to the requirements for the ongoing submission, accuracy, completeness and uses of encounter data.

OIG Recommendation

Enforce existing Federal requirements that States include encounter data in MSIS submissions.

CMS Response

The CMS concurs that efforts should be made to ensure that States submit managed care encounter data to CMS and intends to increase our efforts to consistently enforce all current statutory, regulatory, and policy guidelines in this area. These enforcement efforts would include reminding States of their obligations as part of the State single-audit process, CMS oversight reviews, and through ongoing discussions with the State officials, State staff, and managed care entities during meetings, conferences, and other forums that take place on an ongoing basis. Additionally, we are going to review our current managed care and MSIS data statutory and regulatory authorities to determine

Agency Comments

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what changes may be needed and where we can strengthen current authorities to improve the collection, submission, use, of managed care encounter data

OIG Recommendation

Seek legislative authority to impose sanctions against States that fail to meet the MSIS reporting requirements for encounter data.

CMS Response

We do not concur with this recommendation at this time. Rather than pursuing legislative authority to impose sanctions we want to begin to more actively pursue the specific items we have outlined above to work with the States and managed care organizations collaboratively to improve the collection, submission, and use of managed care encounter data. We believe that by clarifying the existing requirements, sharing best practices, working together with the States and our managed care partners, and using our current authorities to improve this process needs to be done before considering an option to get sanction authority.

The CMS thanks the OIG for the opportunity to review and comment on this draft report.

GLOSSARY

Centers for Medicare & Medicaid Services (CMS)	The Federal agency responsible for administering Medicare, Medicaid, the State Children's Health Insurance Program, Health Insurance Portability and Accountability Act, Clinical Laboratory Improvement Amendments, and several other health-related programs. CMS was formerly known as the Health Care Financing Administration (HCFA).
Chief Executive Officer (CEO)	In an organization that has a board of directors, the CEO is (usually) the singular organizational position that is primarily responsible for carrying out the strategic plans and policies as established by the board of directors. In this case, the CEO reports to the board of directors. In a form of business that is usually without a board of directors (sole proprietorship, partnership, etc.), the CEO is (usually) the singular organizational position (other than partnerships, etc.) that sets the direction and oversees the operations of an organization.
Chief Financial Officer (CFO)	CFOs direct the organization's financial goals, objectives, and budgets. They oversee the investment of funds and manage associated risks, supervise cash management activities, execute capital-raising strategies to support a firm's expansion, and deal with mergers and acquisitions.
Disproportionate Share Hospital (DSH)	A hospital with a disproportionately large share of low-income patients. Under Medicaid, States may augment payment to these hospitals.
Durable Medical Equipment (DME)	Medical equipment ordered by a doctor or other authorized medical professional for use in the home. DME includes reusable items, such as walkers, wheelchairs, and hospital beds.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program	The child health component of the Medicaid program. It is required in every State and is designed to improve the health of low-income individuals under age 21 by financing appropriate and necessary pediatric services.

Healthcare Effectiveness Data and Information Set (HEDIS)	A set of standard performance indicators used to compare the quality of care, access, and cost of health care services provided through managed care plans.
Health Insuring Organization (HIO)	An entity that provides or arranges for the provision of care and that contracts on a prepaid capitated risk basis to provide a comprehensive set of services.
Managed Care Organization (MCO)	An entity that serves beneficiaries on a risk basis through a network of employed or affiliated providers.
Medicaid Fraud Control Unit (MFCU)	The mission of MFCUs is to investigate and prosecute Medicaid provider fraud and incidences of patient abuse and neglect. Currently, 49 States and the District of Columbia have MFCUs, most of which are located within the Offices of State Attorneys General.
Medicaid Statistical Information System (MSIS)	The electronic system through which States submit all of their Medicaid eligibility and claims data to CMS on a quarterly basis. The purpose of MSIS is to collect, manage, analyze, and disseminate information on Medicaid-eligible beneficiaries, Medicaid utilization, and payments for services covered by State Medicaid programs.
Prepaid Ambulatory Health Plan (PAHP)	An entity that provides ambulatory medical services to beneficiaries under contract with the State agency on the basis of prepaid capitation payments or other payment arrangements that do not use State plan payment rates. The entity does not provide, arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services for its beneficiaries.

Prepaid Inpatient Health Plan (PIHP)	An entity that provides, arranges for, or otherwise has responsibility for the provision of inpatient medical services to beneficiaries under contract with the State agency on the basis of prepaid capitation payments or other payment arrangements that do not use State plan payment rates.
Primary Care Case Management (PCCM)	An entity or a provider that contracts with the State to furnish case management services (e.g., locating, coordinating, and monitoring covered primary care services) to Medicaid beneficiaries.
Program of All-inclusive Care for the Elderly (PACE)	A comprehensive program that combines medical, social, and long term care services that enable elderly beneficiaries to remain independent and live in their communities.

A C K N O W L E D G M E N T S

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Deborah Walden served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Kansas City regional office who contributed to the report include Michael Barrett, Megan Buck, Lt. Mike Garner, and Amber Meurs; other central office staff who contributed include Jennifer Jones and Kevin Manley.