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Community HealthChoices Managed Care Program
Calendar Year 2020 Encounter and Financial Data Triennial Audit

Summary of Results

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Department of Human Services

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Introduction

The 2016 Medicaid and Children's Health Insurance Program Managed Care Final Rule (42 Code of Federal Regulation [CFR] § 438.602[e]) requires state Medicaid programs to conduct an encounter and financial data audit no less frequently than once every three years. The purpose of this audit is to confirm the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each managed care organization (MCO).

In order to comply with this requirement, the Department of Human Services (DHS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to conduct an audit to verify the accuracy, truthfulness, and completeness of the encounter and financial data submitted by each MCO to the Community HealthChoices (CHC) program for Calendar Year (CY) 2020. Mercer worked with DHS' Office of Long-Term Living (OLTL) staff to perform the audit. An overview of the encounter data and financial audit approach and results are provided below.

Approach

Mercer's approach to this audit was based on Centers for Medicare & Medicaid Services' (CMS') External Quality Review (EQR) Protocol 5 for encounter data validation (EDV).[1] The CMS EDV protocol includes five activities, which guided Mercer's methodology and audit procedures. Specific tasks conducted under these activities are listed below, along with the financial audit activities conducted.

CMS EDV Protocol Activity	Mercer Tasks
Activity 1: Review State Encounter Data Requirements	Review the Commonwealth's encounter data regulations, CHC-MCO encounter data contractual requirements, DHS' encounter data specifications, DHS' request for information (RFI) responses, and conduct interviews for further clarification.
Activity 2: Audit CHC-MCO Encounter Data Capability	Review CHC-MCO's completed RFI responses, supporting information, and conduct virtual on-site meetings.
Financial Audit Incorporated Into Activity 2	Review CHC-MCO Independent Audit Reports and compare Financial Reporting Requirement (FRR) paid amounts against Provider Reimbursement and Operations Management Information System (PROMISe™) encounter extract paid amounts.
Activity 3: Analyze Electronic Encounter Data	Conduct analyses of encounter data extract using the 2020 encounter files from DHS PROMISe system and the CHC-MCO's claims extracts with 2020 dates of service provided in accordance with Mercer's data request.
Activity 4: Medical Record Review (at State's discretion)	Not applicable for this audit.
Activity 5: Submit Findings	Draft report to outline audit methodology, summarize observations, and make recommendations.

[1] https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

Audit Observations

A summary of the overall observations by audit activity is contained in the table below.

Activity	Overall Observations
Activity 1: Review State Encounter Data Requirements	The systems capabilities and day-to-day encounter data oversight and monitoring DHS performs on behalf of the CHC program aligns with, and in some cases exceeds, the standards currently outlined in federal regulations and related CMS guidance, including: the CMS EDV Toolkit[2], 42 CFR § 438.242[b][2], 42 CFR § 438.242[b][3][iii], 42 CFR § 242[c][1-4], 42 CFR § 438.242[d], 42 CFR § 438.604[a][1], 42 CFR § 438.606[a], and 42 CFR § 438.818[a][1]. It is recommended that OLTL commence audit activities contained within the CHC-MCO contracts to identify additional opportunities to enhance encounter data quality.
Activity 2: Audit CHC-MCO Encounter Data Capability	All CHC-MCOs have sufficient systems, processes, policies, and personnel to successfully monitor encounter data submission and ensure accurate and timely encounter data are available to the Commonwealth to use for capitation rates, quality measurement, program integrity, and policy development. However, several opportunities for improvement were identified that could strengthen individual CHC-MCO practices. • While the audit identified one instance where a CHC-MCO was deemed to have Not Met a review criteria, this instance did not reveal any underlying systems nor process issues with the CHC-MCOs. • In a handful of cases, CHC-MCOs were deemed to have partially met one of the review criteria. Recommendations were provided to DHS for sharing with the CHC-MCOs. Financial Audit Incorporated Into Activity 2: Variances and inconsistencies in financial schedules identified as part of this audit activity were within tolerable ranges.

[2] State Toolkit for Validating Medicaid Managed Care Encounter Data. August 2019. Available at: State Toolkit for Validating Medicaid Managed Care Encounter Data. Last accessed on September 2, 2021.

Activity	Overall Observations
Activity 3: Analyze Electronic Encounter Data	Overall, the program displays an expected degree of encounter data quality given that CY 2020 represents the first year of statewide managed care program implementation. While Mercer's quantitative analysis of PROMISe encounter paid amounts against FRR paid amounts did not identify any material variances, the analytics processes, which compare PROMISe encounter extracts against the CHC-MCO claims extracts provided as part of this audit, did identify areas where PROMISe data as provided to Mercer by DHS did not uniformly agree to the CHC-MCO claims system extracts obtained. There are a variety of reasons this could occur, and the audit did identify one instance where the limitations of one CHC-MCO's claim extract submission compromised the audit's ability to produce meaningful conclusions about certain categories of service. Should DHS and/or the CHC-MCOs desire deeper understanding of these differences, a focused examination of impacted claims and encounters could be conducted to determine whether any of these discrepancies have a material impact on DHS processes reliant on PROMISe encounter data. It should be noted that while this audit included an examination of the degree to which the DHS-provided PROMISe encounter data extract files agree with the CHC-MCO-provided claims data extracts, the fact that this audit did not actually compare the two source systems should not be understated. The logistical impossibilities associated with independently auditing three unique and independent claims systems is likely recognized by CMS, as EQR Protocol 5 assumes the use of extract files in the performance of this activity. It should be noted that any findings, observations, or recommendations arising from Activity 3 represent the results of comparing two snapshots of underlying data sources, and could result from issues in the snapshots rather than the systems themselves.
Activity 4: Medical Record Review (at State's discretion)	Not applicable for this audit. The inclusion of medical record review activities in future triennial encounter data and financial audits would likely enhance the degree to which more substantive conclusions can be reached as a result of preliminary observations made in Activity 3.
Activity 5: Submit Findings	This report represents DHS' satisfactory completion of Activity 5.

Conclusion

Mercer's qualitative findings from the CHC encounter and financial data audit suggest that the CHC program displays an expected degree of encounter data quality given that CY 2020 represents the first year of statewide managed care program implementation. In most cases, the CHC encounter data display levels of accuracy, completeness, and truthfulness, which align with, and in some cases exceed, the standards currently outlined in federal regulations and related CMS guidance, including: the CMS EDV Toolkit[3], 42 CFR § 438.242[b][2], 42 CFR § 438.242[b][3][iii], 42 CFR § 242[c][1-4], 42 CFR § 438.242[d], 42 CFR § 438.604[a][1], 42 CFR § 438.606[a], and 42 CFR § 438.818[a][1]. That said, there remain areas for improvement, as DHS and the CHC-MCOs continue to develop their processes to ensure continued compliance with federal regulations and any subsequent federal guidance. Additionally, while quantitative analysis of PROMISe encounter paid amounts against FRR paid amounts did not identify any material variances, the analytics processes, which compare PROMISe encounter extracts against the CHC-MCO claims extracts, did identify areas where PROMISe data do not uniformly agree to the CHC-MCO claims system extracts obtained. There are a variety of reasons this could occur, such as unfamiliarity with the new process on the CHC-MCOs' part, extracts being pulled from disparate data systems, and possible misunderstandings by staff pulling the claims data. Should DHS and/or the CHC-MCOs desire deeper understanding of these differences, a focused examination of impacted claims and encounters could be conducted.

This report is prepared on behalf of DHS and is intended to be relied upon by DHS. To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

The suppliers of data are solely responsible for its validity and completeness. Mercer has reviewed the data and information for internal consistency and reasonableness utilizing CMS EDV protocols and guidance, but validation of each encounter and data element against source systems and medical records was not within the scope and timing of the audit objectives. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

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[3] State Toolkit for Validating Medicaid Managed Care Encounter Data. August 2019. Available at: State Toolkit for Validating Medicaid Managed Care Encounter Data. Last accessed on September 2, 2021.