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Managed Care Encounter Data

Recording:
https://safetynetinstitute.webex.com/safetynetinstitute/lsr.php?RCID=9645aac3fc3649f290aeb798a1f78539

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Two Major Goals

I. **SHORT TERM**: Resolve with health plans which encounter data is not making it up to DHCS - why is that occurring?

- Provide projections for amount of missing services so that it can be included in CAPH projections
- Equip members with tools in order to resolve discrepancies with health plans.

II. **LONG TERM**: Create regular process to resolve data submission issues and ensure sufficiently accurate actual data for 17-18 distribution.

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What is EPP/QIP?

- Both payment programs intended to replace SPD-IGT and MCE-to-cost
  - New managed care rule means these programs no longer work as payment mechanisms
- Enhanced Payment Program (EPP) additional payment pools for PHS managed care services
- Quality Incentive Program (QIP)
- Current proposal worth $2.2 billion gross (~$1.6b EPP, $640m QIP)
  - Net amount TBD, depending on FMAP

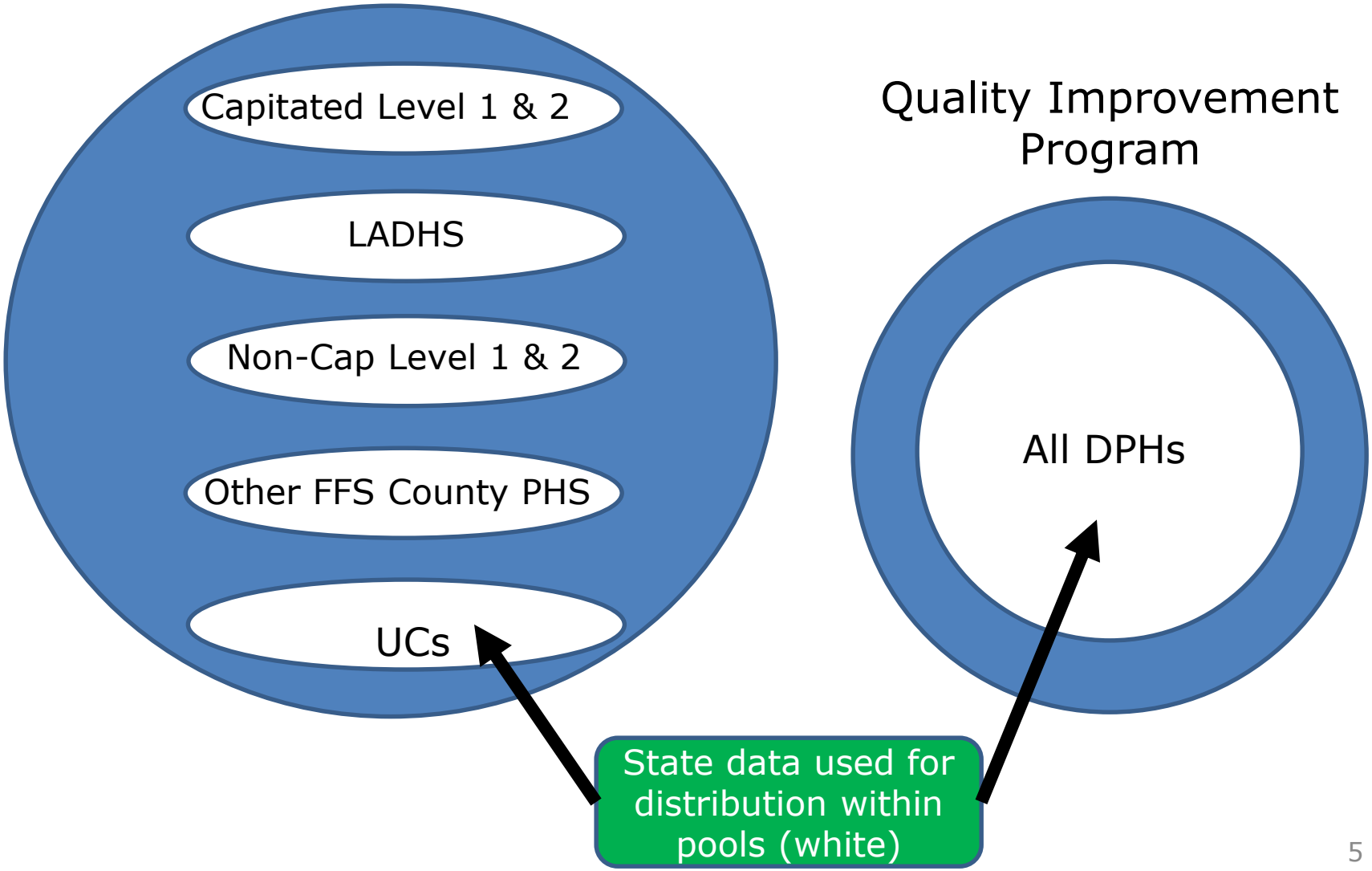
How does encounter data impact EPP/QIP distribution?

- EPP – Within class pools, distribution will likely be based on state's encounter data from plans.
  - Both IP and OP component
    - IP: Days paid
    - OP: Service count, by RDT category
  - Contracted plans only (in-county)

- QIP – Distribution will likely be based on a combination of unduplicated patient count (UDPC) and/or assigned lives.
  - UDPC component: from state's encounter data from plans

State's encounter data from health plans key for both programs

Enhanced Payment Program



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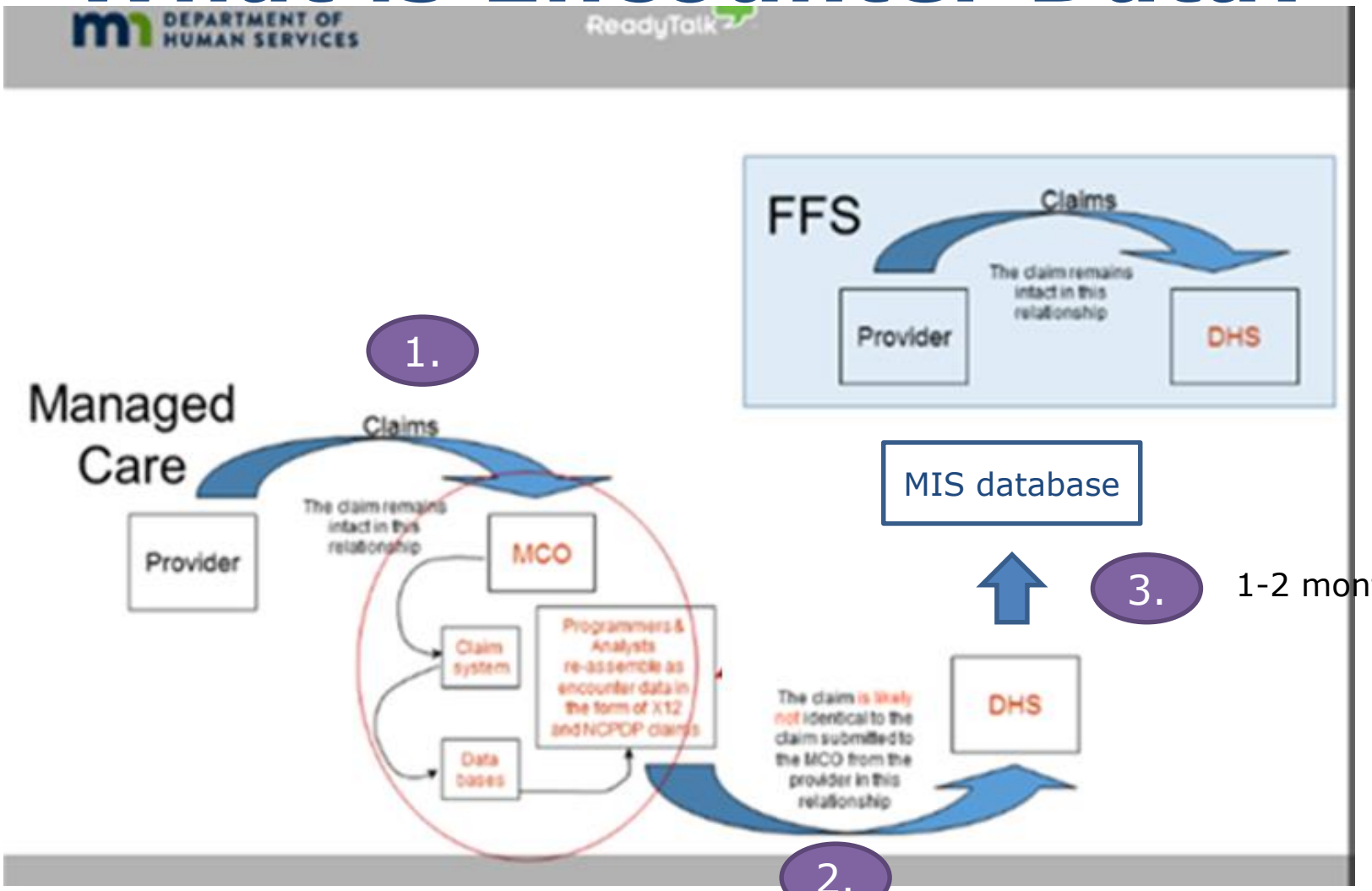
Current Status

- Imperative to resolve distribution by end of October to make "pre-print" documents for CMS submission
- Programs likely to be approved for 3-5 years

What is Encounter Data?



1. Provider => MCO

- Data usually claim data, sometimes encounter data
- Receiving payment ≠ clean claim
- HP payment file ≠ encounter file
  - Make sure you are comparing your data against the right file from the health plan.

Potential gap: What data might you, the provider, not have submitted?

How much? (days, OP services)

2. MCO=> DHCS

- Provider data moves across multiple systems within MCO and may be "transformed" in the process
- Encounters that have issues or cannot be matched may be withheld so the data can be fixed before submitted.
  - Sometimes this is low priority for health plans and data sits for >1year. This cannot be the case going forward if DHCS distributes on the encounter data.
- Once file is sent to DHCS, DHCS indicates "accepted" or "rejected" and provides a unique encounter ID (or "record ID")
  - Record ID is useful to allow health plans to match their data to DHCS's data.

Potential gap: How much data that the MCO holds might it not have sent to DHCS yet?

What were the reasons data was withheld (may be several reasons)?

Is there a certain type of encounter missing (i.e. professional claims, clinic xyz)?

How much? (days, OP services)

3. DHCS=> MIS database

- DHCS produces summary of services to CAPH, with filters:
  - CAPH-supplied NPIs
  - Exclusion of duals (crossovers)
  - Exclusion of denied, duplicates, and reversed claims.

Potential Gap: CAPH is working to see there are issues with their datapull logic. Please let CAPH know if you see anything.

Missing NPIs can significantly change the output.

- Can providers validate the HP submission to DHCS and what billing NPIs are on that list of encounters?
- Can HP look up hospital by tax ID and provide a list of billing NPIs used?

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Let's look at MIS data

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OP-specific examination

- Category of service grouping, not days, is key output
  - Must follow DHCS-provided logic
  - Reference: Supplemental Data Request
- How closely do billed charges match overall?
- Professional bill (PCP, SP, NPP) – included?

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Next steps

- Find right people at health plan to begin this comparison and reconciliation.
- Make sure you comparing the plan's encounter data, not paid claims report.
- Obtain plan's PHS service data compiled for state in its recent Supplemental Data Request (CY2015 and CY2016, due 10/6/2017), identify more variances.
- Identify reasons data is not being sent to health plans
- Provide CAPH improved estimates for EPP/QIP modeling purposes
- Begin conversation of monthly meeting and reconciliation process

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Appendix: Monthly Reconciliation Process

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Key Components

- Identify right people for the meeting
- Understand both provider and health plan's flow chart of data so we can identify potential bottlenecks:
  - Provider to health plan
  - Healthplan to DHCS
- Create Key Performance Indicator reports to review at monthly meeting
  - Quarterly claim submission, paid and denied
  - Quarterly % of claims sent to DHCS
  - Quarterly % of claims denied by DHCS
  - Report of reasons claim withheld
  - Report of reasons claim denied
- Discuss action plan to correct issues, with timing.
- Other suggestions?