



ISSUE BRIEF

Texas Health and Human Services Office of Inspector General

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Objective

Encounter data is the primary record of services provided to Medicaid managed care members. This data is used to determine capitation rates and allows the OIG to monitor and detect fraud, waste and abuse (FWA) from a systemic level.

Key Facts

- In state fiscal year 2017, the majority of Medicaid clients, 92 percent, were enrolled in Medicaid managed care.
- An external quality review organization performs a yearly data certification and produces a certified data set for HHSC Actuarial Services to use with other data to develop capitation rates

Key References

42 CFR 438.602(e)

42 CFR 438.818

Uniform Managed Care Contract Version 2.25 Section 8.1.18.5

Uniform Managed Care Manual Version 2.6 Chapter 2.0 Claims Manual

ENCOUNTER DATA

OVERVIEW

Encounter data is a record of paid claims by Medicaid managed care organizations (MCOs) and dental maintenance organizations (DMOs) for services provided to persons with Medicaid. Texas Medicaid shifted from operating a primarily fee-for-service (FFS) payment system that pays providers directly, to a managed care model that uses a capitated payment system to reimburse providers for their services. In a managed care system, the Health and Human Services Commission (HHSC) pays MCOs and DMOs a monthly amount called a capitation payment based on the number of persons enrolled in their health plan. Health care providers submit their claims to MCOs/DMOs to receive payment for covered services.

ENCOUNTER DATA IS USED IN OIG WORK

Encounter data allows the OIG to monitor and detect FWA across all MCOs/DMOs as well as a specific provider. Accurate encounter data is important for quality analysis. OIG auditors, investigators, reviewers, and inspectors use encounter data to identify irregular billing behaviors and patterns that may be indicators of FWA. Encounter data gives OIG staff a complete view of a provider's billing behavior across 18 MCOs and two DMOs contracted to provide medical and dental services in Texas Medicaid.

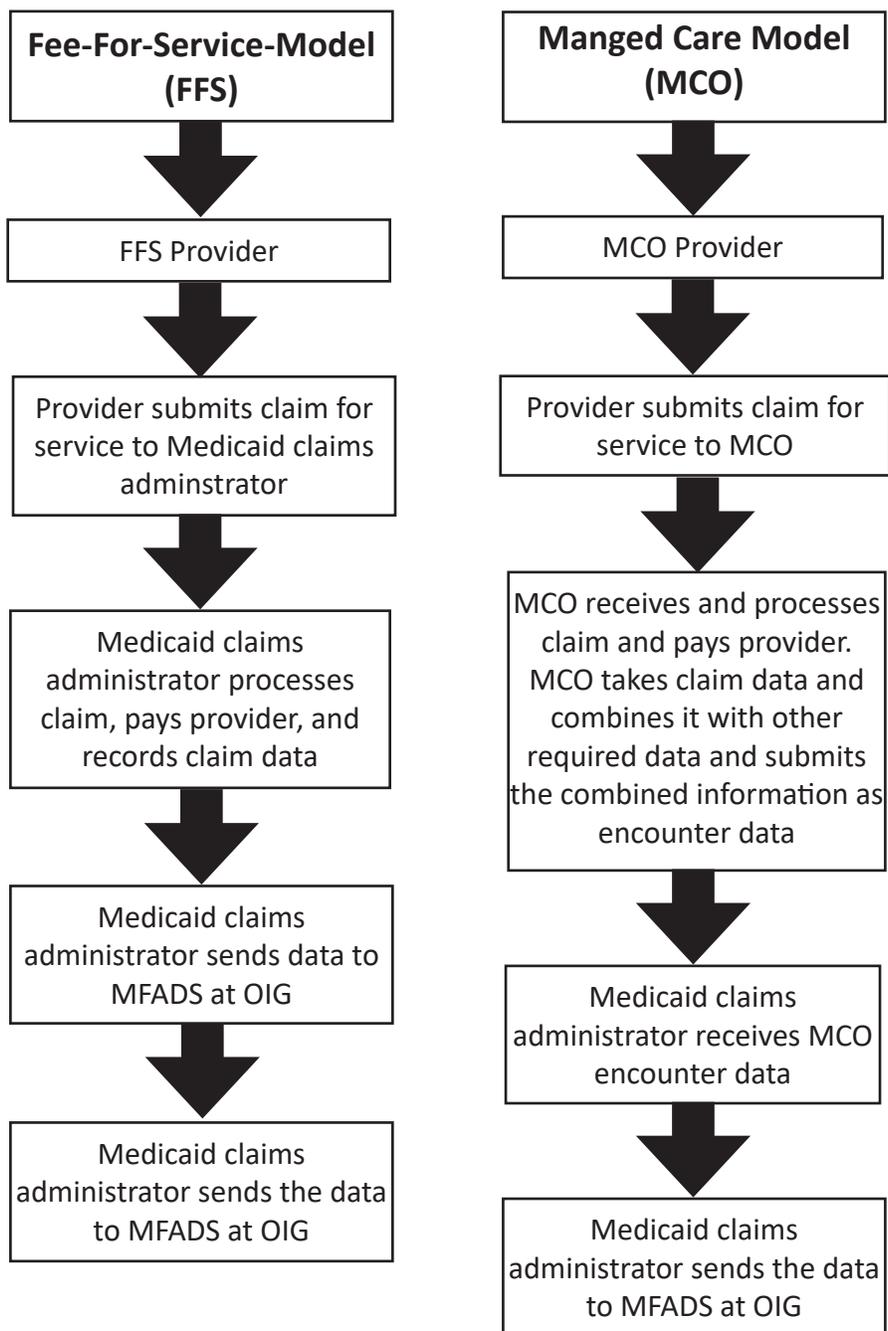
WHY IS ENCOUNTER DATA IMPORTANT?

Both encounter data and FFS claim data have detailed information about the services Medicaid clients received from a health care professional. Examples of information in a FFS or managed care claim include: the diagnosis and procedure information, date of service, and provider information. However, requirements for the data fields that need to be populated may vary among MCOs/DMOs.

The creation of encounter data begins when Medicaid managed care providers submit their claims to an MCO/DMO. The MCO/DMO processes the claim and enters the information into its claim system and then pays the providers for the item or service delivered. MCOs/DMOs process and compile the paid claim data and the data required by HHSC to create the encounter data. Encounter data is submitted to Texas' Medicaid claims administrator. The Medicaid claims administrator sends the information to the OIG's Medicaid Fraud and Abuse Detection System (MFADS). Figure 1 shows the basic steps how claim and encounter data are created and made available to the OIG in the FFS and managed care models.

Issue Brief: Encounter Data

Figure 1: Medicaid Payment Models and Claims Processing, 2018



HOW THE OIG USES ENCOUNTER DATA

Examining Covered Services

OIG staff use encounter data as a basis to determine whether any program violations occurred related to FWA. For example, investigators can determine if claims sent to the MCOs by a provider match the information that was sent to the state by the MCO in their encounter data. Analysis of encounter data may reveal a provider billing beyond what is allowable. For example, a therapy provider that contracts with four MCOs may bill each MCO for eight hours of therapy services for the same day, thereby resulting in the total hours billed to be 32 hours in one day. Events like these would go undetected by MCOs because each MCO only knows what the provider billed to them and not to other MCOs.

Issue Brief: Encounter Data

Tracking Payments

Encounter data allows the OIG to see a representation of a claim event. Texas added a data field to provide information about the payment arrangement between the provider and the MCO. A variety of payment arrangements exist between MCOs and providers ranging from a fee-for-service model based on a set fee schedule to a sub-capitation arrangement. Knowledge of the payment arrangement provides OIG staff clarity about the flow of payments when investigating providers suspected of FWA.

Analyzing the Use of Services and Medical Record Reviews

Encounter data is used to understand utilization patterns and to monitor the use and cost of services. For example, the OIG Data and Technology division analyzes the volume of certain services provided and their cost. Outliers for utilization and cost can be identified and may lead to further investigation about why these providers stand out from their peers. Investigators can conduct a thorough investigation of these providers' billing history and identify patterns of overutilization that may have resulted in overpayments and build a case for their recovery.

Review of encounter data can determine whether the correct provider type, place of service and units of service were delivered and allowed. The OIG uses encounter data to pull a sample of medical records to review. Medical record reviews are conducted to determine if the encounter data is substantiated within the medical record. An analysis may determine if the services provided aligned with what is allowed per the individual MCO's policies and procedures.

FUTURE ISSUES: ENCOUNTER DATA AND HEALTH CARE REFORM INITIATIVES

In May 2016, CMS released the Medicaid Managed Care Rule. The rule requires states to enforce encounter data collection and reporting identified by federal regulations, CMS, and the state. Additionally, states are required to: (1) monitor MCOs' compliance with the new regulations and (2) verify the accuracy, truthfulness, and completeness of encounter and financial data submitted by each MCO. States that fail to perform these audits or fail to meet encounter data submission and review requirements may be subject to federal match withholdings or deferment.

Health care reform initiatives designed to improve patient outcomes and reduce the cost of care are changing how health care providers are paid. Some of these arrangements like value-based contracting will require new methods and strategies, in addition to using encounter data to determine if fraud, waste, or abuse has occurred. Value based contracting (VBC) is a term used to describe healthcare payment arrangements that link a portion or all of the payment to measures of quality, access, value, or other patient outcomes. In Texas, VBC describes other types of payment reform such as, pay-for-performance, pay for quality, alternate payment models, and value-based purchasing. As these payment arrangements continue to expand within Texas, reporting tools may need to be evaluated to determine how information will be captured for these different payment methods. This tool could provide clarity for the flow of payments while investigating providers suspected of FWA.

DISCLAIMER

"This document is part of an ongoing discussion of an important health care issue. It is provided for general informational purposes only, and is not intended to present an official position of the State of Texas, HHSC, or the Office of Inspector General. This document does not constitute an official interpretation of the HHSC Managed Care Contract (Contract), or state or federal law. Specific questions concerning the appropriate interpretation of the Contract or state or federal law are dependent upon the precise facts and circumstances then existing. Any particular question should be evaluated independently."