

**Collecting, Using, and Reporting
Medicaid Encounter Data:
A Primer for States**

Final Report

October 19, 2011

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James Verdier



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I. INTRODUCTION

Federal law called for the submission of Medicaid eligibility and claims data as early as 1999 to the Medicaid Statistical Information System (MSIS).¹ While states have routinely submitted eligibility and fee-for-service (FFS) claims data through MSIS, the Centers for Medicare and Medicaid Services (CMS) has not strictly enforced this requirement for encounter data—the claims records of health care services for which managed care organizations (MCOs) pay. Most states that have relied heavily on MCOs to provide Medicaid services have been collecting, using, and reporting encounter data in MSIS for many years. With many states planning to increase their reliance on Medicaid managed care, however, there are likely to be several states whose experience with MCOs and encounter data is somewhat limited.² CMS has therefore contracted with Mathematica Policy Research (Mathematica) to provide technical assistance to states that would benefit from assistance in submitting Medicaid encounter data through MSIS. For some states, the need for encounter data assistance occurs before the point at which they are ready to begin submitting encounter data through MSIS. They need help in working with MCOs to obtain the encounter data that the state then reports to CMS. This primer is aimed at helping states that are in this earlier stage of collecting, using, and reporting encounter data. It also provides some basic guidance regarding the submission of encounter data into MSIS. Chapter II provides a general background of encounter data uses and reporting. Chapter III summarizes what we have learned across interviews with states, actuaries, and multi-state health plans; including some basic guidance

¹ Balanced Budget Act of 1997, H.R. 2015, 105th Congress, Section 4753(a)(1); Social Security Act, Section 1903(r)(1)(F).

² Medicaid and CHIP Payment and Access Commission (MACPAC). “The Evolution of Managed Care in Medicaid.” Report to the Congress, June 2011, pp. 19-21. Available at: <http://www.macpac.gov/reports>. See also Kathleen Gifford, et al. “A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey.” Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2011. Available at: <http://www.kff.org/medicaid/upload/8220.pdf>.

regarding the submission of encounter data into MSIS. In Chapter IV we lay out guidelines for collecting complete and reliable encounter data that states emphasized throughout our conversations. State-by-state profiles for each state that we spoke with appear in Appendix A, and Appendix B compiles links to resources on encounter data and examples of documents we mention in this primer. We are providing more detailed guidance on MSIS encounter data submission issues primarily through site visits to individual states.

II. BACKGROUND ON ENCOUNTER DATA

A. Encounter Data

Encounter data are records of the health care services for which MCOs pay and—in many states—the amounts MCOs pay to providers of those services. Encounter data are conceptually equivalent to the paid claims records that state Medicaid agencies create when they pay providers on a FFS basis. States that contract with MCOs to deliver Medicaid services typically require those MCOs to report encounter data to the state so that the state has a full record of all the services for which the state is paying, either directly through the FFS system or indirectly through MCOs.

Collecting and reporting encounter data at the state level is considerably more complicated than MSIS reporting of FFS data by state Medicaid agencies because of the numerous entities involved in the collection, production, and use of encounter data, including MCOs, outside contractors, and other state agencies. Further complicating encounter data collection and reporting at the federal level is that the entities involved and their relationships vary substantially from state to state. Although FFS Medicaid programs have many providers rendering services, there is usually just one payer for those services—the state.

State Medicaid managed care programs include a number of different MCO payers, each with a network of health care providers, with providers often participating in several MCO networks. Each MCO may have different requirements for filing claims, including variations in the level of detail providers are required to submit to receive reimbursement for services they render. They may also pay their providers differently; some may pay providers on a FFS basis according to a set fee schedule, or they may pay providers on a capitation basis. Many states, especially those that rely heavily on MCOs to provide Medicaid services, have been collecting

encounter data for more than a decade and have achieved a degree of standardization among their MCO providers, but state-by-state variations remain.

B. How States Work with Encounter Data

States use the data for a variety of purposes, including setting MCO rates, evaluating MCO performance, and providing detailed reports to governors, state budget agencies, legislatures, and the public on Medicaid services provided through MCOs and their costs. Without encounter data, much of what goes on inside MCOs is essentially a “black box,” so state Medicaid agencies that want to act as responsible and accountable purchasers view encounter data as an important resource.

States review encounter data quality and completeness in a variety of ways, using a combination of in-house staff, actuaries (external and in-house), fiscal agents, and external quality review organizations (EQROs).³ States may also use EQROs to collect and report encounter-based performance measures, such as Healthcare Effectiveness Data and Information Set (HEDIS) measures.⁴

Within state Medicaid agencies, various parts of the agency are typically involved in collecting, processing, and reporting Medicaid claims data, including information technology staff, managed care operations and policy staff, staff actuaries, and the state’s fiscal agent or claims processing staff. Good communication and coordination among these parties is needed to collect and report reliable encounter data. In some states, agencies outside the Medicaid agency

³ For a good example of an EQRO encounter data validation report, see Institute for Child Health Policy. “Validating Encounter Data: Texas Medicaid Managed Care and Children’s Health Insurance Program Managed Care Organization Medical Record Review, Fiscal Year 2006,” January 4, 2008. Available at [http://www.hhsc.state.tx.us/reports/FY2006_EncounterDataValidation.pdf]. Accessed January 17, 2011.

⁴ See, for example, Institute for Child Health Policy. “Texas Medicaid Managed Care STAR+PLUS Quality of Care Measures, Fiscal Year 2007.” May 27, 2009. Available at [<http://www.hhsc.state.tx.us/reports/STARPLUSAnnualQOCReportFY2007.pdf>]. Accessed January 25, 2011.

may also be involved, especially when there are separate managed care programs for behavioral health services or Children's Health Insurance Programs. These other agencies may have competing demands and constrained resources and may not have easy channels of communication with the Medicaid agency. This can add to the challenge of collecting complete and reliable Medicaid encounter data and submitting the data into MSIS.

C. Federal Reporting Requirements

Federal law has required states to submit their Medicaid eligibility and claims data electronically to CMS through MSIS since 1999 according to specifications outlined by CMS.⁵ These specifications, in the form of the MSIS Data Dictionary, provide guidance to states in transmitting data from their Medicaid programs into five file types every federal fiscal quarter, which are combined to create a single Medicaid data warehouse. According to the Federal requirement, states must submit both FFS and encounter data to CMS through MSIS to represent the full breadth of Medicaid utilization paid for by federal dollars, and most do.

Medicaid managed care has had a varied history across states and over time, however.⁶ Many states have not always received usable encounter data from MCOs, especially in the early years of their managed care programs, and have only reported to MSIS the amounts they pay to MCOs in the form of capitated payments for each enrollee, not the amounts MCOs pay to providers. Because of this history, CMS has not run encounter data through the same validation and distributional quality checks that are applied to FFS data. Rejection of submitted files for major data quality errors found through these validation and quality checks are the only opportunity CMS uses to communicate about the files, and as a result, encounter data have been

⁵ Balanced Budget Act of 1997, H.R. 2015, 105th Congress, Section 4753(a)(1); Social Security Act, Section 1903(r)(1)(F).

⁶ MACPAC. "The Evolution of Managed Care in Medicaid." June 2011.

perceived as not required in MSIS or as having been largely overlooked. There has been very little analysis of the encounter data's quality and completeness.

More recently, the Patient Protection and Accountable Care Act of 2010 (Public Law 111-148) included provisions requiring Medicaid MCOs to provide encounter data to states [Section 6504(b)] and requiring CMS to withhold federal Medicaid matching payments to states for any individuals enrolled in MCOs for whom the state does not report enrollee encounter data through MSIS [Section 6402(c)]. These Accountable Care Act provisions will take effect at a time and in a manner to be specified by the Secretary of the Department of Health & Human Services. Based on a Mathematica analysis of encounter data submitted by states through the MSIS, 29 of the 36 states that report enrollment of some of their Medicaid population in a fully capitated managed care plan submitted encounter data in their most recent submission to MSIS.⁷

D. Potential for Data Uniformity

Most states contract with an outside organization [Hewlett Packard (HP), ACS, Molina, CNSI, or others] to serve as the state fiscal agent to collect and process Medicaid claims and to report that data into MSIS, although 15 states currently perform this function in-house with state staff.⁸ State encounter data reporting requirements for MCOs usually lead to a substantial degree of uniformity within individual states on these claim payment features, since the encounter data the MCOs must collect are specified by the state and must be fed into a single state system, but these encounter data reporting requirements vary considerably across states. As a result, Medicaid MCOs that operate in multiple states (AMERIGROUP, Aetna/Schaller

⁷ We analyzed the most recent quarter submitted for each of 50 states (varying from FY 2009 Quarter 4 to FY 2011 Quarter 2) of both eligibility and claims files submitted to CMS and passed through Mathematica's validation review. We counted states that reported enrollment in a comprehensive managed care plan in the last month of the respective quarter.

⁸ CMS. "MMIS Fiscal Agent Contract Status Report." September 19, 2011. Available at [<http://www.cms.gov/MMIS/Downloads/MMISFAQR.pdf>]. Accessed September 26, 2011.

Anderson, Centene, Molina, United Healthcare, WellCare, WellPoint, and others) and that could potentially develop uniform encounter data collection and reporting systems are unable to do so.

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III. SUMMARY OF STATE CASE STUDIES

The guidelines and themes outlined in this primer are based primarily on discussions held between November 2010 and April 2011 with nine states with extensive experience collecting and using encounter data (Arizona, Delaware, Michigan, Minnesota, New Jersey, Oregon, Pennsylvania, Texas, and Washington). All but one of the states (Pennsylvania) have been submitting encounter data through MSIS for a number of years. We supplemented these state discussions with discussions in June and July 2011 with Medicaid health plans and actuaries who have had experience working with encounter data in a wide range of states. Our discussions covered the history of their collection efforts, the evolution of their processes, relevant state requirements for health plans, challenges they have faced, and details specific to implementation. Appendix A is a state by state summary of our discussions with the nine states. Table III.1 summarizes each state's experience with encounter data. In this section we provide an overview of the main themes and issues that emerged from these discussions that may be most relevant to states working to improve their encounter data and submit it to MSIS.

A. State Encounter Data Reporting Requirements and Resources

All states we talked with have provisions in their contracts with MCOs that spell out encounter data reporting requirements, including specifications requiring the type of data to be reported, and a predetermined reporting schedule. For example, in Delaware, contracted MCOs are responsible for submitting encounters for all covered services delivered under the state's basic benefit package. This includes behavioral health data even when the MCO has a subcontracted behavioral health program. Encounter data must be submitted monthly and within 240 days of the date of service. Arizona, Minnesota, and New Jersey have detailed sections on their websites that provide a wealth of encounter data guidelines and tools for plans, and Texas makes similar resources available to plans. Appendix B includes links to these resources.

Table III.1. Selected States' Experience Collecting, Using, and Reporting Medicaid Encounter Data

	When managed care and encounter data collection began	State uses of encounter data	Encounter data validation	State requires health plans to report amounts paid to providers	Submission of encounter data to MSIS	Percentage of Medicaid enrollees in any Managed Care	Number of Managed Care Entities ^a
Arizona	AHCCCS (1982) ALTCS (1989) Encounter data required from the outset	Rate setting, performance and quality measurement and reporting	State staff including actuary	Yes	Yes	90.5	30
Delaware	Mandatory managed care since 1996; data collected since 2004/2005	Rate setting, performance and quality measurement and reporting	EQRO (Mercer) and actuary (Mercer)	Yes	Yes	77.4	3
Michigan	Managed care since 1982; data collected since 1997 dates of service	Rate setting, performance and quality measurement and reporting	State staff	Yes	Yes	86.2	36
Minnesota	Managed care since 1985; data collected since mid-to late 1990s	Rate setting, performance and quality measurement and reporting	State staff	No	Yes	63.8	8
New Jersey	Managed care since 1995; data collected since 1995	Performance and quality measurement and reporting	State staff	Yes	Yes	76.8	7
Oregon	Managed care since 1994/1995; data collected since 1995/1996	Rate setting, performance and quality measurement and reporting	Actuary on staff	Yes	Yes	86.7	32
Pennsylvania	Mandatory managed care since 1986; encounter data collected since 1997	Rate setting, performance and quality measurement and reporting	EQRO (IPRO) and actuary (Mercer)	Yes	No	81.7	67
Texas	Mandatory managed care began in 1993; data collected since late 1990s	Rate setting, performance and quality measurement and reporting	EQRO (Florida Institute for Child Health Policy)	Yes	Yes	66.9	25
Washington	Managed care began in 1994; mandatory data reporting began in the late 1990s	Rate setting, beginning to use for reporting	State staff including actuary	Yes	Yes	86.7	13

^a CMS. "2010 Medicaid Managed Care Enrollment Report: Medicaid Managed Care Enrollment as of July 1, 2010 and Number of Managed Care Entities By State as of July 1, 2010."

B. Encounter Data Uses

Each of the nine states we talked with uses encounter data to set capitated MCO rates and seven use it to report HEDIS and other managed care performance measures. Additionally, most of the states with which we spoke use their encounter data for a variety of ad hoc reports and analyses for state budget agencies, other state agencies, the legislature, and external constituencies. The need for reliable data for these various uses provides a continuing quality check on the data at the state level, as well as an incentive for MCOs to submit good encounter data. MCOs that do not submit good data may not receive appropriate rates, meet quality benchmarks, or be portrayed fully or well in state-level reports. These uses of encounter data are all important elements in an encounter data program, since data that are not used tend not to improve.

C. Encounter Data Validation

In states we spoke with, the most important use of encounter data is for capitated MCO rate setting; therefore, much of the encounter data validation that occurs takes place in connection with this function and is performed by the states' in-house or contracted actuaries. Actuaries check to make sure that the encounter data submitted by type of service and type of beneficiary are consistent with their expectations, which in turn are based on a combination of past experience in that and other states, comparisons of MCOs in the state to each other, and comparisons to FFS experience in the state.⁹

Actuaries told us that one of the most important validation checks involves a comparison of the amounts paid to providers by MCOs as shown on the encounter records to the expenditures

⁹ For a detailed description of one actuarial firm's approach to encounter data validation, see Mercer Government Human Services Consulting. "Capitation Rate Development Base Data Review and Assessment." Prepared for the California Department of Health Services, September 2006.

for provider payment reported in the financial reports that MCOs are required to submit to the state. For this comparison to be possible, the state must require MCOs to report the amounts paid to providers on the encounter records, and also require the MCOs to submit financial reports that separate their Medicaid business from commercial, Medicare, and other business they may be doing in the state. Further complications may arise in states where MCOs pay physicians and other providers on a capitated, rather than FFS, basis. In those cases, the state, its actuaries, or the MCOs may need to create “shadow” FFS-type payment amounts on the encounter records for the services included in these “subcapitation” arrangements.

We found some variability in state requirements regarding whether MCOs report the amounts they pay to providers in their networks. Arizona, Delaware, and Michigan have always required that these payment amounts be submitted with the encounter data. New Jersey, Pennsylvania, Texas, and Washington currently require submission of payment amounts, Oregon is just beginning to implement this requirement, and Minnesota does not currently require it. Both Oregon and Minnesota told us that MCOs considered this information to be proprietary. A newly enacted state law in Minnesota requires some reporting of payment information by MCOs, but in relatively aggregated form and not in MCO encounter data submissions.¹⁰

The actuaries we spoke with said that in the states with which they were familiar, health plans had no reluctance to submit these paid amounts (subject to the problem with subcapitated provider payment amounts noted above), and the multi-state health plans we spoke with agreed. If the state required encounters to include payment information, the plans complied.

Another potential resource for encounter data validation is EQROs. All states with capitated Medicaid managed care programs are required to contract with EQROs to assist with MCO

¹⁰ Minnesota Statute 256B.69, Subd. 9b. Available at [<https://www.revisor.mn.gov/statutes/?id=256B.69>]. Accessed January 25, 2011.

monitoring. States receive 75 percent federal matching payments for these EQRO activities rather than the 50 percent match that is common for most other Medicaid administrative functions. Encounter data validation is one of the optional activities that EQROs may perform for states¹¹; several of the states we spoke with have used their EQRO for this purpose, including Pennsylvania and Texas.

D. Differences Between Fee-For-Service and Encounter Data Processes

Eight of the states we spoke with reported that they include encounter data in their Medicaid Management Information Systems (MMIS) in approximately the same way as they do FFS claims data. One significant difference is that not all of the edits states use to screen claims for payment in the MMIS are relevant for encounter data. For example, some of the documentation needed for payment purposes, such as compliance with a fee schedule, may not be needed in order to record whether a service was provided.¹² In addition, claims that are initially denied for payment and then resubmitted may be difficult to track in encounter data systems, depending on how those systems are set up.

Among the states we spoke with, Minnesota appeared to have the most systematic and fully developed approach to dealing with these issues in what they call their “True Denial” project.¹³ This project focuses on the encounter data elements that are most needed for purposes of data analysis and reporting, and denies or rejects the encounters that do not include those elements. As an incentive for accurate encounter data reporting, encounters that are denied and not

¹¹ See 42 CFR Section 438.358(c).

¹² If a state requires MCOs to report the amount paid to providers on the encounters, however, encounter data edits would need to be applied to this element of the encounter.

¹³ More information about the True Denial Project can be found at [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dDocName=dhs16_145907&RevisionSelectionMethod=LatestReleased].

properly resubmitted are not included in calculating capitated payments to MCOs or in performance reporting.

The actuaries and multi-state health plans we spoke with indicated that the issue of how to handle encounters for claims that the MCO initially denies and subsequently pays arose consistently, and was handled differently in different states, with some states requiring submission of the subsequent paid encounter and voiding of the earlier denied one, and some requiring less systematic adjustments or none at all.¹⁴

Another issue multi-state health plans mentioned was that many providers still file paper claims.¹⁵ Several states, however, require MCOs to submit all encounter records to the state electronically in ANSI X12 N 837 claim format (837 format).¹⁶ In order to fulfill this requirement, the health plans must create an electronic 837 record from the paper record they have received. This is a time-consuming process, which can be further complicated by incomplete claims, but health plans have agreed to these requirements in their contracts with states.

E. Submission of Encounter Data to MSIS

In general, states that we spoke with did not find reporting encounter data into MSIS much more difficult than reporting FFS data, but did have to make some accommodations for the differences between the types of data. Because encounter data submitted to MSIS currently does not undergo a full editing or data quality validation process at the federal level, it is difficult to determine with certainty whether the data are in fact being reported consistently across states.

¹⁴ Release 3.1 of the MSIS File Specifications and Data Dictionary notes that IP, LT, OT, and RX “production files must contain one record for every adjustment to a prior quarter claim/encounter that was adjudicated during the reporting quarter.”

¹⁵ Most states still accept these paper claims from providers in a direct Medicaid FFS relationship.

¹⁶ The ANSI X12 N 837 format is the HIPAA-compliant file format used for electronic billing of professional medical services.

Several states mentioned that they had minor difficulties understanding MSIS Data Dictionary guidelines for submitting encounter data because the current guidelines for encounter data submission are the same as or modeled after FFS data submission guidelines, causing some confusion. Most have taken their best guess and proceeded. One example is interpreting the current MSIS reporting rules for amounts MCOs pay to providers. The data dictionary requires states to report this data in the “amount charged” field, rather than in an “amount paid” field. The “amount paid” field in MSIS is currently used for states to report what they have paid to FFS providers and for the capitated payments states make to the MCOs. States reported that they felt uncomfortable with this guidance and would find it more useful to structure the MSIS reporting system and the instructions in a way that distinguishes more clearly between the payments the state makes to FFS providers and the amounts MCOs pay to the providers in their networks. At least one state interprets “amount charged” to mean the amounts providers charge to MCOs, not the amounts MCOs pay to providers.

States also vary on whether they receive and report encounters for services that MCOs initially deny payment for, but ultimately pay after the claim is resubmitted. Such retrospective adjustment information is currently required according to the CMS Data Elements Dictionary, but CMS is aware this might cause difficulty for states that do not require MCOs to make these kinds of adjustments in the encounter data they submit to the state.

Another challenge states mentioned is the uniform coding of their data into MSIS from several different individual MCOs. Data elements such as type of service or provider taxonomy can be reported very differently across plans, making their mapping to MSIS time-consuming and often complex. States that have been collecting data longer have worked to receive the data in a more consistent manner, or have created coding to first map individual MCO data to uniform state standards, and then take the uniform state data and map it into the MSIS fields. While time-

intensive, these detailed processes provide a “paper trail” that states can use if problems arise in MSIS validation procedures. Either method requires a good deal of investment in the quality of the encounter data and the resources to do additional mapping into MSIS fields.

Health plan ID numbers also appear to pose a challenge for reporting encounter data through MSIS. Using the same plan ID on capitation, encounter, and enrollment files is important for MSIS data validation. Providing assistance in pinpointing errors in MSIS submissions is made much easier if the state reports plan IDs uniformly. States assign plan IDs with a logic that meets their requirements, and do not always provide crosswalks that link plan IDs across the MSIS enrollment and claims files. CMS requests these types of crosswalks, but discrepancies in the plan ID reporting to MSIS has not traditionally been a focus of data quality reviews and many of the crosswalks are out of date. Since MCOs in individual states often vary in both the quality and completeness of the encounter data they submit, and in terms of their underlying performance, MCO-specific encounter data with correct plan IDs is important for a number of state and federal performance measurement purposes.

IV. SOME GUIDELINES FOR STATES

We hope that the information and resources compiled here will be helpful to states at varying stages of collecting and using encounters, especially those at earlier stages. In order to collect complete and reliable encounter data from MCOs, state Medicaid agencies must have specific collection strategies that require uniform data. Based on our discussions with states, actuaries, and health plans, here are some guidelines that had widespread support:

- Have continuing and consistent agency leadership support and resources for encounter data collection and use
- Make submission of the data a contractual requirement for MCOs
- Provide detailed specifications and ongoing technical assistance to MCOs
- Carefully review and validate the encounter data submitted by MCOs, using state staff, actuaries, EQROs, or other contractors
- Compare the encounter data from each MCO to external benchmarks, such as MCO financial reports, FFS, and other MCOs
- Work collaboratively with the MCOs over time to improve the completeness and reliability of the encounter data
- Impose meaningful sanctions for failure to report adequate encounter data

Encounter data will also never be complete and reliable unless they are used for important state purposes to ensure that they accurately reflect the use of and expenses for the state Medicaid program, including: setting capitated payment rates for MCOs; reporting publicly on service use, expenditures, and quality in MCOs, with comparisons of MCOs to each other and to FFS Medicaid; using the encounter data to support performance-related MCO payments or penalties.

Our team plans to use the information gathered for this primer to enhance the value of our technical assistance work to states. Appendix B includes a full listing of the publicly available resources we have drawn from for readers interested in learning more detailed information about individual state encounter data histories, processes, and tools states have created for health plans.

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APPENDIX A
STATE PROFILES

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ARIZONA

A. History of Data Collection

Arizona was the first state to implement its Medicaid program as a managed care program in 1982, and it has never had a stand-alone FFS program. From the outset, the state has collected encounter data, although the collection and format have evolved over the years. The state has gathered service utilization data as well as data on what plans pay to providers for at least 25 years, including FFS rates, capitated rates (when plans subcapitate providers), approved amounts, and paid amounts.

B. Requirements and Resources

State staff members characterize their contracts with MCOs as “very sophisticated.” Contracts include the encounter data reporting requirements, and MCOs must conduct three different reviews and report the results to the state to ensure accuracy and to validate the data.

Arizona has two units dedicated to encounter data—a policy and data unit that work together to provide assistance to plans and validate the data.

C. Collection Processes

All Medicaid claims processed in the state are processed through its Pre-Paid Medicaid Management Information System (PMMIS), including denials and claims with no payments if another insurer covered the entire cost (because Arizona analyzes utilization, and not just costs). Arizona currently uses the 837 format to receive encounter records because they reported that plans receive claims in this format from providers.

D. Data Validation

State staff perform encounter data validation that they describe as rigorous and detailed, largely because the processes were prescribed as part of the original Section 1115 demonstration waiver agreement with CMS. The state is planning to streamline their validation process to allow more flexibility.

Arizona validates encounter data in a variety of ways. Their in-house actuary analyzes three to five years of encounter data at a time to compare trends across contractors and geography as part of the capitated rate-setting process, looking specifically at data elements such as month of service, contractor, geographical service area, number of encounters, total paid, amount paid per member per month, and form type. The actuary's review helps identify any gaps that may have been missed through other encounter review processes, and the columnar display of data that the actuary produces makes it easy to identify potential gaps in encounter reporting or in completion of paid values.

Contractors must submit unaudited financial statements either on a quarterly basis or on a monthly basis, and are required to submit audited financial statements annually. *Arizona's finance staff review all submitted financial reports, including an assessment of compliance with Arizona's financial standards, trend identification, review of accruals and prior period adjustments, medical claims liability run-out analysis, and a variance analysis of quarter-to-quarter reporting. Their actuary compares the encounter data to contractors' financial reports in order to ensure the completeness of encounter data.* Additionally, the ratio of payments reported on encounters to payments recorded on financial statements is compared across health plans to ensure consistent reporting.

E. Data Challenges

MCOs new to the state have always struggled with submitting encounter data to some degree and have had varying levels of success in getting up to speed. Issues arise around claims rather than around eligibility or enrollment.

DELAWARE

A. History of Data Collection and State Resources

Delaware began operating a managed care program in 1996 with four MCOs, and the receipt of encounter data followed several years later. While the data sets were stored in the MMIS and accessible, several factors made meaningful analysis on the data difficult. These included the differences between the fiscal agent's and the MCO's claims processing systems, MCO sub-capitation of some physician services, and that the state used the provider tax ID as a unique identifier, which did not always allow differentiation of service types because often the tax ID represents broad corporations instead of individual providers. The state made some improvements, such as creating a logic for how to assign the correct type of service, with technical assistance from CMS in 1999 (via MEDSTAT), and they subsequently began submitting encounter data on MSIS files.

At the same time, the state started working with the MCOs to correct data reporting issues, such as miscoding of provider type and specialties. Implementation of a new MMIS on July 2002 using the HIPAA-compliant 837 standard transactions facilitated many improvements to encounter data reporting, including use of the Medicaid fee-for-service provider ID and later the National Provider Identifier (NPI) number, as well as the use of standard taxonomies which fed into efforts to identify provider service types. Despite these improvements, the encounter data was generally not considered to be of good quality until 2004 when Aetna (Schaller Anderson at the time) began participating in the state's Medicaid managed care program. The Aetna capitation rates were set up as partial risk payments with a stop loss arrangement for outliers. Aetna, therefore, had a strong incentive to submit complete encounter data in order to maximize their stop loss payments which were based on their encounter claim payments. When

United Health Care (Unison Health Care at its inception with Delaware managed care) began participating as a Medicaid plan in 2007, they submitted encounter data from the start.

B. Data Requirements, Collection Processes, and Validation

Delaware's MCOs are required to submit encounter data within 240 days of the date of service and no later than 75 calendar days after the encounters are processed. They must use the 837 electronic formats to submit their encounter data, the same format that is used for FFS data. The MCOs may submit encounter data as frequently as weekly. The data must be for all services that are rendered under the Medicaid Benefit Package which the MCO is contracted to provide. MCOs must submit the amounts they pay to providers on encounter claims.

Delaware currently uses Mercer Government Consulting (Mercer) as both their actuary and EQRO. Mercer has in the past used encounter data to develop actuarially sound rate ranges that the state uses as part of the rate negotiation process with the MCOs. Beginning with the State Fiscal Year (SFY) 2010 rates, the actuary financial data submitted by the MCOs has been of sufficient quality to be used as part of the rate process in concert with encounter data. This comparison framework has been developed over the past two years, and Mercer and the state continue to improve their methods.

In addition to the capitated rates that are negotiated with the MCOs, beginning with the SFY2007 MCO contract cycle, the state has contracted with Mercer to apply a risk adjustment methodology to MCO claims to count the potential impact of adverse selection of members between plans. The current methodology employed is the CDPS+Rx model developed by the University of San Diego.

C. Challenges

Delaware reported that much of the encounter data submitted does not pass the state's edits, even though they represent claims that the MCOs have paid. This means that encounter

records in the MMIS sometimes have a claim status of “denied.” While all encounters processed in the MMIS are assigned an internal control number, sometimes the MCOs will submit a new claim to correct a previously submitted claim rather than submitting an adjustment to the original claim. This means that there are duplicate encounter records in the MMIS, and Delaware has difficulty determining which of the encounters is the “correct” one, although the assumption is often made that the most recently submitted claim that appears to be a duplicate is the correct version.

The institutional encounter claims that Delaware receives from MCOs also present challenges because the MCOs do not always report their billing providers in the correct field, causing the MMIS to assign them to an “Unknown” category of service. Sometimes the MCOs do not use the fields the state has designated for the billing provider ID and taxonomy or they report only the attending physician or other individual instead of the facility.

The quality of inpatient data that Delaware receives from MCOs also presents challenges because MCOs currently do not report billing and referring providers in the correct fields and this impacts how the state identifies the claim type, and thus, in determining whether they are inpatient or outpatient claims, for instance. Regarding MSIS reporting, they recently discovered that their coding was erroneously categorizing claims paid to the state’s transportation broker as capitation payments to comprehensive managed care and they are fixing the associated coding.

MICHIGAN

A. History of Data Collection and State Resources

Michigan began operating managed care for Medicaid in 1982. The state began requiring encounter data from plans for 1997 dates of service, for claims submitted in 1998. It wasn't until 2007 that the state reported that all plans were submitting complete and reliable data to the state, although many plans were submitting it before then. State staff working with encounter data have resided in different departments, starting originally in what was a Medicaid data department and then moving to a division that works more closely with the health plans.

B. Data Requirements, Collection Processes, and Validation

Michigan requires plans to submit all of the information that resides on a typical 837 claim transaction on a monthly basis, including the amounts that plans pay to providers. Health plans send the information directly to the state. State staff monitor submissions for how reasonable the volume of claims is and to ensure that edits are set to reject encounter data that do not meet basic reporting requirements. The state contracts with an actuarial firm to review encounter data for reasonableness at the plan level and in the aggregate as part of the annual capitation rate setting process.

C. Data Uses

The state uses the encounter data for internal quality monitoring and to generate reports for the legislature to provide evidence that certain Medicaid requirements are being met. One example of this is how many Medicaid recipients are screened for lead exposure. The data are also used for HEDIS reporting and capitated rate setting. The state also provides data to academic researchers.

D. Challenges

In the first ten years of collection and reporting, some plans struggled to submit the required data. *One incentive that the health plans have responded to is the state structured auto-*

assignment process for beneficiaries who have not self-selected a plan. The auto-assignment process is based on data quality thresholds and rewards plans that submit good encounter data with more enrollees. The state also found that creating internal data quality reports to look for reasonableness prior to submitting the data to MSIS has helped point out flaws in the data. These types of reports also help the state when they have to respond to questions about the data from CMS. Staff also reported that more specific guidance on how to report sub-capitation arrangements through managed care would help ensure their reporting is accurate.

MINNESOTA

A. History of Data Collection and State Resources

Minnesota began formally collecting encounter data from MCOs in the mid to late 1990s. The state operates its own MMIS with in-house programming and has extensive experience with claims processing with both state and national MCOs. Minnesota is one of 15 states that does not contract out its claims processing to a fiscal agent but instead performs all of the processing in-house. Minnesota Medicaid contracts only with Minnesota-based health plans, which are required by state law to be not-for-profit.

B. Data Requirements and Collection Processes

By contractual obligation, Minnesota's MCOs submit data directly to the state each month in a uniform manner. The state then conducts edits on the encounter data based loosely on the edits it uses for FFS data, though they use fewer edits on encounter data than on FFS data. Minnesota told us that FFS edits are generally too restrictive to be applied to encounter claims.

When a service provider submits a FFS claim to the Department of Human Services (DHS), the claim is processed in MMIS to determine whether DHS should pay or deny the claim, and if it is paid, how much should be paid to the provider. Most of the FFS edits applied to the claim look for the requirements to determine payment, such as compliance with a fee schedule. When the FFS edit denies a claim, it is denying a payment to the service provider. This denial of payment to the provider is an obvious incentive to correct data that are in error and submit a corrected claim to DHS, since FFS payment is not made until the corrected claim is processed. Minnesota has sought to develop similar incentives for correcting encounter data as part of their "True Denial" project, which is described further below.

Minnesota currently has eight MCOs contracting with DHS. Each MCO has its own system for processing service-provider claims and individual agreements with the service providers

regarding claim submissions and pricing. Some of the MCOs contract with a third party administrator to manage their encounter data. When a service provider submits a claim to the MCO, the MCO processes the claim in its payment system. The MCO's system applies the necessary edits to determine whether the MCO should pay the service provider or deny the claim according to the MCO agreement with the provider.

Each MCO submits encounters to DHS for only the claims paid by the MCO. *The encounter data that DHS receives from the MCO are utilized for multiple purposes including risk-adjusted capitation payments, incentive payments to MCOs, and withholds to encourage quality encounter data submissions.* Minnesota does not receive information related to amounts that providers are paid. State staff told us that the MCOs consider this to be proprietary information. Legislation enacted last year may make some of this information available to the state in aggregated form, but not in Medicaid encounter data.¹⁷

C. Data Validation

On October 8, 2010, Minnesota began implementing what they term the “True Denial” project in phases, a system developed by the state that aims to improve the quality, completeness, and usability of encounter and MSIS data submissions. The project involves creating encounter-specific edits in MMIS that apply managed care business rules, along with creating related DHS policies and guidelines to analyze and correct encounter data errors for resubmission. (It is still too early to judge the impact of the True Denial system, state staff told us, but they expect that quality and completeness will improve starting in Federal Fiscal Year 2011 and improve over time.) Minnesota also runs internal ad hoc analyses to gauge data accuracy and completeness.

¹⁷ Minnesota Statute 256B.69, Subd 9b. Available at [<https://www.revisor.mn.gov/statutes/?id=256B.69>]. Accessed January 28, 2011.

According to the state Medicaid officials that we spoke with, encounter edits should be used to ensure that the MCOs' computer systems build the encounter data files correctly and should be more general than many of the fine-grained edits used for FFS claims processing, since the edits must be used to check the data of different MCO payers. *In Minnesota's "True Denial" project, denied encounters are not included in the capitation payment calculations or in plan performance measures, so the MCOs have incentives to correct the data.*

D. Challenges

There are occasional difficulties with plan submissions, but Minnesota does not characterize any plan as being better or worse regarding submission of encounter data.

NEW JERSEY

A. History of Data Collection and State Resources

New Jersey created a state-owned HMO in 1995 and has always required submission of encounter data. The state developed a proprietary format for data collection from the outset, prior to Health Insurance Portability and Accountability Act (HIPAA), that resembled FFS claim data in that it contained client and provider identifiers, service codes, diagnosis codes, and other such information. The state has always collected amounts that plans pay to providers, but the state found that the data were not uniform across the MCOs until 2005. With the institution of HIPAA requirements, the state began accepting transactions from plans in the 837 and National Council for Prescription Drug Program (NCPDP) formats in early 2004.

The state has an encounter data monitoring unit that started as a series of workgroups and ad hoc committees working over several years. At first the Medicaid agency found it was difficult to pull scarce staff who were experts at what they were already doing into a different or new full-time position. By 2008, the encounter data team became its own official unit of three full-time staff consisting of one programmer with experience providing technical assistance, an expert in contract language with experience working with contractors, and a data analyst/supervisor with detailed knowledge of claims and encounter data. *The state believes that by having staff that are dedicated to encounter data analysis, 2008 became a turning point in improving the quality of the data. The relationship between this unit and the plans has now reached a point where the state is providing regular technical assistance and has created good lines of communication to improve the quality of the data. The state continues to have workgroup meetings monthly with other agency staff; when extra hours are needed to deal with encounter data issues, other state staff occasionally dedicate their time as well.*

B. State Requirements, Collection Processes, and Data Validation

The managed care contracts that plans sign are very detailed regarding data error tolerances and thresholds the data must meet for plans to receive payment.¹⁸ The state uses encounter data for a variety of analyses, but they currently do not use them for rate setting. For data validation, New Jersey uses data editing processes to determine whether data meet contractually-specified benchmarks and conducts internal analysis to validate the quality of the data. The state previously used language about sanctions in their contracts with MCOs, but recently moved to withholding payment if plans do not submit complete data. The state also measures the rate of service use reported per thousand beneficiaries against 28 service category benchmarks (i.e. rate of inpatient hospitalizations per 1,000 MCO members), holding plans to a standard of front end accuracy. They believe this system encourages plans to report higher quality data and correct errors rapidly to receive the withheld payments. Each month, the team presents MCOs with reports about denial rates, duplication rates, and each plan's ability to achieve the benchmarks for that month and compares performance to historical rates. The state has also shared among plans the plans' data quality performance against the contractual benchmarks for the past six years. The state has seen noticeable improvement in the approval rate on encounter submissions as a result of their processes. In the last two years, the state developed a process in which its actuary uses encounter provider payment data to reconcile the financial data that MCOs submit. According to a new standard adopted for fiscal year 2011, the numbers cannot differ by more than 2%. Prior to this standard, the state said it had been warning plans that one day CMS would require encounter data for rate setting. The plans did not respond by making their data better, so the state had to impose its own quality processes.

¹⁸ An example of the contract can be found at: <http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-vol1.pdf>

C. Challenges

The state told us that there was a lot of pushback early on regarding encounter data, both internally in the state and externally with the MCOs. In the early days, there were misconceptions about the data and whether they were even useful. The issue of providing data on amounts paid was a particular challenge because they had not previously been required; there was further misunderstanding about whether amount charged or amount paid should be reported, and how to report it.

In terms of technical challenges, the state said that difficulties tend to arise whenever switching systems of data collection, specifically in reference to the switch to the HIPAA formats. Technical understanding of HIPAA and encounter data claims is sometimes lacking among the various parties involved. The state has experienced varying levels of successful encounter reporting across the MCOs, with each organization experiencing challenges submitting complete and accurate data at one time or another. According to the state, “this comes with the territory,” and is not unique to one type or size of MCO. A specific example was that at one point the state was seeing an extreme number of duplicate encounters.

Another challenge they discovered when they first began validating the financial data is that plans were submitting paid amounts in very disparate ways. To arrive at uniform data from plans, they had to make sure the individual data fields were being reported accurately and in a uniform manner.

Generally, the state has found that certain areas tend to present more challenges in reporting, including when categories of service are subcontracted to another vendor or if there is a sub-capitated arrangement with some providers. New Jersey’s plans are moving away from sub-capitated arrangements because they have found they do not receive complete encounters under these arrangements. Claims processing systems can also vary greatly by plan, and as systems

change and new off-the-shelf products are available, these elements can introduce new issues with the data.

OREGON

A. History of Data Collection and State Resources

Oregon has been accepting encounter data since 1995 and works mostly with local plans that have “grown up” with the Medicaid program. In 1998 the state introduced a proprietary electronic format for encounter submissions. The state legislature required measurement of key performance indicators using encounter data to track how well the health plans fulfilled contract requirements, including measures of preventable inpatient admissions quality indicators, ER use, prenatal care, and Early Periodic Screening, Detection, and Treatment for children. The state currently employs five full-time research analysts for the encounter data team and an actuary who performs analysis on both FFS and encounter data. A contractor runs the MMIS system and the data warehouse.

B. Data Requirements, Collection Processes

The state’s detailed contractual requirements with the health plans include data submission practices. Oregon collects the same level of detail for encounter data as they do for FFS data and as of March 2010, plans are required to report what they pay their providers. Oregon had previously received the billing amounts but not the paid amounts from MCOs.

Internal staff work closely to monitor the data and collaborate with MCOs to correct any anomalous reporting. Encounter data are run through data edits in the MMIS with fewer edits than FFS data. Several MCO contractors work with data clearinghouses or third-party administrators, and state staff works with a variety of these entities (including their fiscal agent, HP) in collecting and processing the data. They meet with plans monthly and conduct workgroups by type of service (such as dental and mental health) or discussion topic.

C. Data Validation

Formerly, the state contracted for actuarial services with PricewaterhouseCoopers, but now the in-house actuary takes data from the Oregon data warehouse and completes further analysis

and “cleaning” of the data for state use. Many of the internal edits applied through the MMIS check data elements like procedure code and diagnosis, but the state is currently working to analyze encounters on a more granular level by looking at service use per member per month to check completeness and accuracy of the data. The state also uses a subset of FFS data to run comparisons against its encounter data. Some of the measures the state uses include quality measures such as tracking emergency room visits, prenatal care service use, EPSDT events, and well-person visits. The state legislature requires some key performance measures from the plans, and the data are used to ensure that plans meet these measures. The state views the encounter data as useful for both monitoring the plans and as a training tool to show plans how they can improve.

D. Challenges

Oregon experienced some difficulties in their change to a new MMIS two years ago. They transferred FFS data to their new system first, and then encounter data. The state would like to receive third-party liability information in the encounter data, but their system is currently not set up to receive this information. In particular, MCOs often face challenges in becoming HIPAA-compliant with the 837 claim format. In general, plans have experienced varying difficulties over time in reporting data and the state is not convinced that current data represent all service use at the per-member-per-month level. Oregon’s planned analyses on the encounter data are intended to help them achieve more confidence in the data.

PENNSYLVANIA

A. History of Data Collection and State Resources

Pennsylvania's managed care consists of behavioral health and physical health, each with separate data collection efforts. Physical health MCOs contract with and are overseen by the Office of Medical Assistance Programs (OMAP), and that office's Bureau of Data and Claims Management manages their data. The Office of Mental Health and Substance Abuse Services (OMHSAS) oversees the behavioral health contracts and manages their data. Both offices fall under the Department of Public Welfare (DPW). In 43 counties, DPW contracts with counties or groups of counties to provide behavioral health services. The counties subcontract with Behavioral Health Managed Care Organizations (BH-MCOs). In the remaining 24 counties, county governments have opted out of managing the Medicaid behavioral health managed care for residents and DPW contracts directly with one of two BH-MCOs. Five BH-MCOs serve 67 counties, covering approximately 1.88 million of the 2.1 million Medicaid enrollees in the state. Eight physical health managed care organizations (PH-MCOs) contract with the state directly to cover physical health services for 1.2 million recipients.

The state began collecting encounter data from the BH- and PH-MCOs in 1997 with the implementation of Health Choices Managed Care. At that time, the data was stored in proprietary files. In 2004, Pennsylvania implemented Provider and Operations Management Information System in electronic format (PROMIS_e), which now stores both the physical and behavioral health data, as well as the FFS data.¹⁹

¹⁹ PROMIS_e started as a claims processing system; HIPAA and encounter processing were added later.

B. Data Requirements, Collection Processes, and Validation

Until 2004, the data from BH- and PH-MCOs were transmitted in proprietary files kept by DPW. The data were used to create utilization reports and to help contractors conduct evaluations. Very little editing was performed on the data before 2004, and the accuracy of the data was questionable. When the state implemented PROMIS_e, they decided to use it to process both FFS and encounter data, however FFS data was the main focus of the system in the first couple of years. Encounter data was converted to PROMIS_e, but little or no editing was performed on the converted data. In 2007, a PH-MCO data initiative helped to improve the quality and accuracy of the encounter data. The state put extensive edits in place beginning December 2007, and made significant efforts to educate and monitor the PH-MCOs as they submitted their encounter data.

Pennsylvania uses the BH- and PH-MCO data for various projects. The state's actuary, Mercer, uses the data as part of the annual capitation rate setting process and for the monthly risk adjusted rates process. Encounters are also used in the collection of federal drug rebates, for other routine reporting, budget cost analysis, and ad hoc reporting as requested by DPW. Pennsylvania's EQRO, IPRO, uses encounter data to construct HEDIS measures and other ad hoc analyses as requested. Both Mercer and IPRO provide DPW with feedback when they identify reporting issues. DPW staff work with BH- and PH_MCOs to correct reporting problems. If necessary, they develop corrective action plans. DPW staff also utilize the encounter data for internal projects.

DPW currently conducts encounter data validation for PH-MCOs and the EQRO performs encounter validation for the BH-MCOs. The BH-MCOs and EQRO are currently working together to develop management reports using the data.

C. Challenges

Implementation of PROMISe coincided with new transaction requirements from CMS, creating significant difficulties for data collection. Pennsylvania currently has 2003 encounter data through the current year stored in PROMISe. As mentioned above, the system did very little editing prior to December 2007, but the state has undertaken extensive efforts to improve the quality of the data since then.

While FFS and encounter data are stored in the PROMISe system, the data are housed in different locations in the claims processing system. Encounter data are identified by the first two digits of the internal control number (PROMISe claim identifier), and the behavioral and physical health data are identified by plan codes. Physical health data are identified by a numeric two digit plan code and behavioral health data are identified with an alpha-numeric two-digit county code. Currently there are no major issues with the submission of the physical health encounter data, but the BH-MCOs have had some difficulties with the PROMISe software requirements.

Pennsylvania does not currently submit encounter data to MSIS, but it is in the process of defining requirements for their fiscal agent to meet the CMS reporting requirements for the data. They plan to begin submitting encounter data in early 2012.

TEXAS

A. History of Data Collection and State Resources

The Texas Medicaid and Healthcare Partnership (TMHP) (a coalition of contractors headed by ACS) assumed administration of claims processing for the Texas Medicaid programs on January 1, 2004, including encounter data, but the state had been collecting encounter data since the late 1990s. TMHP acts as the interface between the Texas Health and Human Services Commission's (HHSC) Medicaid and CHIP unit and the MCOs to gather the required encounter data in a uniform fashion. ACS performs internal edits for quality and completeness in various units, including an actuarial unit, and contracts with an EQRO to review and validate the encounter data.

There is no single encounter data unit within HHSC, but various staff spend significant portions of their time analyzing the data. One set of team members focuses on the encounter data for utilization analysis and another on financial analysis of the MCOs. TMHP then prepares both FFS and encounter data for MSIS submission. When collection began, there was very narrow and limited use of the encounter data, but use has expanded over the years. *The state now sees the encounter data as helping to ensure that the MCOs are complying with state and federal requirements, and that the data are also used for in-depth analysis of service utilization. They have found it particularly useful recently for geographic utilization comparisons.*

B. State Requirements and Collection Process

Health plans all submit encounters electronically in the 837 format. The state created an encounter data submission guide for plans, including a state-specific 837 companion guide. These documents were created after realizing the nationally standard 837 companion guidance

was not always relevant to their Medicaid program. The state guides are continually reviewed and revised. Texas gathers data for both paid and denied claims.

C. Data Validation

When TMHP receives encounter data from the plans, they perform 65 automated edits on the submissions, although at first they ran only 10 edits. Texas's EQRO, the Institute for Child Health Policy at the University of Florida, is responsible for validating encounter data and has developed a very detailed process in their 10 years of performing this function.²⁰ Their process includes setting up specific metrics to calculate quality of care results and sharing those results with the health plans every year. A key reason this process has yielded better data is that plans see that the data are utilized. Additionally, high-level state staff made it clear to health plans early on that if the data were not meeting the outlined thresholds, the plans would have to resubmit the data. Texas has found that using the reports generated during validation as a tool to begin discussions between the state and the plans in a collaborative way has worked better over the years than using the reports as a punitive tool.

D. Challenges

Encounter data are complex, with 17 different MCOs submitting data that are supposed to be uniform. The EQRO reported that in the very beginning plans had to resubmit data as many as 15 to 16 times to get them into reasonable shape. Building good relationships with the plans has been integral to obtaining better data, we were told. The state also instituted a contractual requirement that if an MCO is planning to make a big change in their data systems, they must inform the state in advance so that the state can do a "readiness review" to ensure the new system will be in sync with reporting requirements. Switching to new systems is often a cause of

²⁰ Institute for Child Health Policy. "Validating Encounter Data." January 4, 2008. Available at http://www.hhsc.state.tx.us/reports/FY2006_EncounterDataValidation.pdf. Accessed on January 26, 2011.

problems with the data reporting by plans and this knowledge helps the state to keep track of all the plans.

Texas has also come up with its own system of cross-walking services from each of the plans into a standardized classification that translates into Type of Service mapping for MSIS reporting. Type of Service is not something that exists on the 837 billing forms; figuring out how each plan describes and bills services is a major challenge the state feels it has overcome.

WASHINGTON

A. History of Data Collection and State Resources

Washington implemented managed care in 1994 and has been collecting encounter data for over 10 years. Starting in 2000, data were collected in a state-developed proprietary format; in 2005, the state began requiring plans to submit claims in the 837 HIPAA electronic transaction format. This format brought better standardization to encounter data reporting, making it more complete and easier to identify errors.

B. Data Requirements and Collection

Contractual mandates from the state were one of the most useful ways to ensure what Washington considers to be complete and reliable encounter data from MCOs. In the past, auto-assignment of beneficiaries that do not self-select to plans was based in part on a scoring method related to the accuracy of encounter data submissions. The state plans to re-institute this method at some point in the future. Another incentive for MCOs to provide good data is use of the data to determine capitation rate payments and risk adjustments. *The state uses service-based enhancement payments to plans, that are extra payments triggered by meeting thresholds for the submission of certain encounter data records. This provides additional incentive for MCOs to report data to the state in a timely fashion.*

Washington requires MCOs to report amounts they pay to providers unless the servicing provider was paid under a capitation agreement. Their newly-implemented MMIS system also shadow-prices encounter data according to FFS rules.

MCOs are required to report their data monthly, and some choose to report more frequently. When the state first started requiring encounter data collection, some plans proved more successful than others in submitting the data. Not all MCOs maintained the required data in their own systems and so some had to create a claim-like transaction in-house before they submitted

the data to the state. In general, the differences in MCOs were due to internal technical capabilities and to variation in data collection and in-house support. Some of the differences were due to the individual plan's ability to maintain the state-required format; this tended to vary based on whether a plan was commercial or Medicaid-only, with the Medicaid-only plans better able to comply with Medicaid requirements. In particular, Pharmacy NCPDP encounter submissions seem to be the most problematic for MCOs in Washington.

C. Data Validation

At this time the state does not use an EQRO to validate their data, but uses automated edits and quality check processes. The data pass through edits at submission, as mentioned above. In addition, the state's actuaries receive utilization data from MCOs and compare them to the encounter data to complete analysis of data in-house. The state currently requires submission of encounter data for all services with the same level of detail as is required for FFS claims and in the same electronic format. Encounters go through the HIPAA validation edits at submission and are subject to the same system edits as FFS data.

D. Challenges

Washington's managed care arrangements for Medicaid beneficiaries have not all been coordinated from within the same agency and this can pose challenges in gathering comprehensive data and for reporting the data uniformly to MSIS. For example, the behavioral health benefits that all Medicaid recipients receive are administered through a separate agency than traditional managed care and that data set was not reported to the state's MMIS. As a result, enrollment for the population was reported, but not capitation payments or encounters. With the state's new MMIS system, all the information is reported to the same place, making it possible to compare enrollment to utilization.

APPENDIX B
INTERNET RESOURCES FOR STATES

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Table B.1. State Internet Resources

State	Internet Pages
Arizona	Encounter Data Validation Technical Document: http://www.azahcccs.gov/commercial/Downloads/Encounters/CompanionTechnical/EncounterValidationTechnicalDocument.pdf AHCCS Encounter Data Resources: http://www.azahcccs.gov/commercial/ContractorResources/encounters/encounters.aspx
Michigan	Michigan Encounter Data Website: http://www.michigan.gov/mdch/0,4612,7-132-2945_24020-36737--,00.html
Minnesota	Minnesota Encounter Data Website: http://www.health.state.mn.us/healthreform/encounterdata/index.html Managed Care Encounter Submission Guidance: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_139822# True Denial Project: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dDocName=dhs16_145907&RevisionSelectionMethod=LatestReleased
New Jersey	New Jersey Medicaid Resources: http://www.njmms.com/ New Jersey HMO Contract Example: http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-vol1.pdf
Oregon	Oregon Encounter Data Minimum Data Set Requirements and Corrective Action: http://www.oregon.gov/OHA/healthplan/data_pubs/contracts/pco/2007/exhibit_d_fchpco07.pdf?ga=t Oregon Companion Guide for Pharmacy Encounter Submissions: http://www.oregon.gov/OHA/edi/docs/ncpdp-enc.pdf?ga=t
Texas	Texas Medicaid Program -Related Links & Reports: http://www.hhsc.state.tx.us/medicaid/other.asp#content EQRO Encounter Data Validation Report: http://www.hhsc.state.tx.us/reports/FY2006_EncounterDataValidation.pdf
Washington	Washington 837 Encounter Data Companion Guide: http://hrsa.dshs.wa.gov/DSHSHIPAA/attachments/pdf/837EncounterCG04012010.pdf Washington Encounter Data Reporting Guide: http://hrsa.dshs.wa.gov/ProviderOne/documentation/P1%20ED%20Reporting%20Guide.pdf
Other	Office of the Inspector General Presentation: http://www.mmisconference.org/MMIS2010_Agenda/Presentations/100818_1600_02/Wednesday_Encounter_Data_Walden_Meurs.pdf New York Encounter Data Reporting Requirements: http://www.health.state.ny.us/health_care/managed_care/partner/operatio/docs/chapter_22.pdf Thomson Reuters Report on Improving Encounter Data Quality and Completeness: http://mmisconference.org/MMIS2010_Agenda/Presentations/100818_1600_02/Wednesday_Encounter_Data_Schneider.pdf

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