Audit of the Medicaid Encounter Data Quality Assurance

Report Number 2018-01

August 24, 2019

Utah Office of
Inspector General

Gene Cottrell
Inspector General

October 24, 2019

To: Utah Department of Health

Please see the attached report, **Audit of the Medicaid Encounter Data Quality Assurance,** Report 2018-01. An Executive Summary is included at the inception of this report. The objectives and scope of the audit are explained on page 11 of this report.

Sincerely,

Gene Cottrell
Inspector General
Utah Office of Inspector General

cc: Justin Harding, Chief of Staff, Office of Governor Gary R. Herbert
J. Stuart Adams, President of the Utah Senate
Brad Wilson, Speaker of the Utah House of Representatives
Joseph Miner, MD, Executive Director, Utah Department of Health
Nathan Checketts, Deputy Director, Utah Department of Health, Division Director, Medicaid & Health Financing
Emma Chacon, Utah Medicaid Division Operations Director
Shari Watkins, Chief Administrative Operations Director, Utah Department of Health
Eric Grant, Assistant Division Director, Utah Department of Health
Tonya Hales, Assistant Division Director, Utah Department of Health
Aaron Eliason, Audit Liaison, Utah Department of Health
Melanie Henderson, Internal Audit Director, Utah Department of Health

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EXECUTIVE SUMMARY

Utah Office of Inspector General (OIG) initiated this audit in response to Centers for Medicare and Medicaid Services (CMS) Program Integrity audit titled "Utah Focused Program Integrity Review," issued June 2017 (CMS Audit). Recommendation One of the CMS Audit states:

"The OIG should continue their program integrity efforts to increase their managed care oversight of administrative and management procedures. Specifically, the OIG should access ACO [Accountable Care Organization] encounter data and ensure that it is sufficient, timely, accurate, and complete, and utilized to improve its program integrity oversight of its managed care program"

The Utah OIG reviewed the ACO encounter data as well as encounter data received from all the managed care entities (MCE). The MCE's for Utah include the following:

Health Medicaid Type	Operating Authority
Four Medicaid ACOs	1915(b) Choice of Health Care Delivery (CHCD) waiver
One Medicaid Mental and Physical Health MCO (HOME)	1915(a) contracting authority
Eleven Prepaid Mental Health Plans (PMHPs), 10 of which are Prepaid Inpatient Health Plans (PIHPs) and one which is a SUD PAHP	1915(b) Prepaid Mental Health Plan (PMHP) waiver
Two CHIP MCOs	CHIP authority
Two Medicaid Dental PAHPs	1915(b) Choice of Dental Care Delivery waiver
Two CHIP Dental PAHPs	CHIP authority

Audit Objectives:

- Determine if the current control structure, governing encounter data submissions follows CMS Standards;
- Determine whether encounter data submitted through Utah Health Information Network (UHIN) and processed by the Utah Medicaid Managed Care System (MMCS) achieve completeness and accuracy requirements;
- Determine the sufficiency of data elements processed by MMCS for program integrity purposes.

Audit Scope:

- The audit specifically reviewed encounter records in Utah Medicaid's Data Warehouse (DW) having a "ClaimPdDate" in September 2017.[1]
- DOH-contracts with managed care entities effective 2012 through 2017 including revisions;
- Systems documentation of data structures, flow documents and standards;

[1] ClaimPdData is the date the MCE paid the provider or made adjustments for services rendered. Appendix 1 reports encounter records in the DW with ClaimPdData in September 2017 include dates of service extending back to 2010.

Audit Findings:

Finding 1: Controls are not adequate to identify all incomplete or inaccurate encounter records, to ensure completeness and accuracy within Utah Medicaid computer systems.

Utah Medicaid computer systems receive encounter records through UHIN compliant syntactically with the X12 format required by CMS but not verified for completeness and accuracy.

The audit finding recommends adding standard compliance verification controls and modification of the MCE contracts to include measures of completeness or accuracy to enable the current financial penalties to become actionable.

Finding 2: Delayed adjudication negatively affects program integrity, rate capitation and potentially, federal match.

Claims paid or processed by the MCEs during September 2017 total 374,780 include 10,194 encounter records with end dates of service prior to 2017 extending back to 2013, with one end date of service in 2010. Utah Medicaid accepts encounter records despite the length of time lapse between the end date of service and the date submitted to Utah Medicaid.

Starting in the fall of 2017 Utah Medicaid initiated a quarterly monitoring process providing feedback to MCEs using a timeliness measure of 45 days following the adjudication date. Using 45 days as the timeliness measure is not consistent with all the current MCE contract terms and conditions.

The audit finding recommends Utah Medicaid:

- modify the MCE contracts submission date requirement to all agree with Utah Medicaid's expected timeliness measure of 45 days or less, referenced in the Utah Medicaid quarterly monitoring and
- monitor MCE compliance with the timely payment requirements stipulated in 42 CFR 447.45(d)(2) and (d)(3) of ninety percent of clean claims from practitioners must be paid within thirty days of date of receipt, and ninety-nine percent within ninety days.

Finding 3: Utah Medicaid did not implement the CMS requirement for MCE certification of data accuracy and completeness concurrent with data submission.

Federal law requires the State to require the MCE to certify *concurrent with the encounter data submission* that the encounter data is complete, accurate and truthful based on the best information, knowledge and belief of the chief executive officer (CEO) or chief financial officer (CFO) or one delegated authority by the CEO or CFO.[2]

During the course of the audit, a provision was added to the 2018 ACO contracts requiring certification of completeness, accuracy and truthfulness *concurrent with the submission of encounter data*, and specifically holding the CEO or CFO ultimately responsible.

MCE contracts, except the ACO contracts, do not include "concurrent with encounter data submission", and specifically holding the CEO or CFO ultimately responsible.

[2] https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8#se42.4.438_150. See Section 438.606

The audit finding recommends revision of contracts not currently requiring certification of completeness, accuracy and truthfulness *concurrent with the submission of encounter data*, and specifically holding the CEO or CFO ultimately responsible as soon as practically possible as required by federal law.

Finding 4: Companion Guides, key to specifying Utah Medicaid's data requirements, are not current.

The contracts specify the 837 standard format, documented and explained in the national Implementation Guides (Guides) and supplemented by Utah Medicaid Companion Guides (Companion Guides), as the authority for data requirements for transmitting healthcare claims.

The Companion Guides, last updated effective October 1, 2014, do not contain all data practices currently required or allowed (if different or not specified in the Guides) by Utah Medicaid.

MCEs may not be reporting data correctly due to confusion caused by outdated Companion Guides.

The audit finding recommends updating the Companion Guides to include all data requirements and as changes occur, using only the Companion Guides to implement changes as described in the MCE contracts.

Finding 5: Encounter data not defined, not mapped, missing data elements, and contain multiple unique element types in the same data warehouse field.

The Program Integrity (PI) function must evaluate various trends or conditions of patient care statewide using Utah Medicaid's encounter records and FFS claims data. To properly analyze PI situations encounter records must be complete, accurate and user discernable. Mapping including links, definitions and acceptable code values must be documented and available to data scientists.

Utah Medicaid did not publish a Data Warehouse (DW) dictionary to define and map encounter tables or fields, or field values for data analysts. Utah Medicaid made available a user controlled application called the "Wiki" by which users can add information similar to a data dictionary.

The audit finding recommends for Utah Medicaid to:

- develop an authoritative, centrally controlled data dictionary defining all encounter tables, fields and field values including information for mapping and linking fields,
- minimize or eliminate the use of narrative in the encounter data by developing codes and code values; define or specify precise codes for MCE denial of payment to providers and
- include all fields in the data warehouse views.

The recommendations in the report require urgency to facilitate improved program integrity evaluations and investigations and to comply with CMS PI audit recommendations. The audit does not recommend at this time any resubmission of encounter data.

INTRODUCTION

BACKGROUND

The Utah OIG initiated this audit in response to a CMS Utah Focused Program Integrity Review audit titled "Utah Focused Program Integrity Review," issued June 2017 (CMS Audit).[3] Recommendation One of the CMS Audit states:

The OIG should continue their program integrity efforts to increase their managed care oversight of administrative and management procedures. Specifically, the OIG should access ACO encounter data and ensure that it is sufficient, timely, accurate, and complete, and utilized to improve its program integrity oversight of its managed care program.

The Utah OIG reviewed the ACO encounter data as well as encounter data received from all the managed care entities (MCE). The MCE's for Utah include the following:

Health Medicaid Type	Operating Authority
Four Medicaid ACOs	1915(b) Choice of Health Care Delivery (CHCD) waiver
One Medicaid Mental and Physical Health MCO (HOME)	1915(a) contracting authority
Eleven Prepaid Mental Health Plans (PMHPs), 10 of which are Prepaid Inpatient Health Plans (PIHPs) and one which is a SUD PAHP	1915(b) Prepaid Mental Health Plan (PMHP) waiver
Two CHIP MCOs	CHIP authority
Two Medicaid Dental PAHPs	1915(b) Choice of Dental Care Delivery waiver
Two CHIP Dental PAHPs	CHIP authority

MCEs must report to Utah Medicaid all services, medications, supplies and equipment delivered to Medicaid recipients through the submission of complete and accurate encounter records.

During SFY 2017 MCEs delivered services to approximately 90% of all Utah Medicaid recipients with responsibility to manage approximately 46% of total Utah Medicaid spend.[4]

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA required the US Department of Health and Human Services (HHS) to establish national standards for electronic transactions to improve the efficiency and effectiveness of the nation's health care system.

Prior to HIPAA the healthcare insurance industry had already adopted the American National Standards Institute (ANSI), Accredited Standards Committee (ASC) X12 837 Electronic Data Interchange (EDI) format for the interchange of healthcare data for encounter records and FFS.

[3] See complete CMS Utah Focused Program Integrity Review Final Report at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/UTfy16.pdf
[4] SFY 2017 Utah Medicaid & CHIP Annual Report, page 1, issued December 29, 2017.

HHS, and hence CMS to comply with HIPAA, adopted the X12 Standard version 4010 in August 2000.[5] The 4010 revised to the 5010 in 2009 and CMS required full compliance to the 5010 by January of 2012.[6] Utah Medicaid became compliant with the 5010 with the implementation of the Oracle software, EDIFECS in August 2015.

X12 837 EDI Industry Standard – Adopted by CMS

The X12 837 standard is primarily syntactical, specifying the formatting of healthcare claims data submission.

The Washington Publishing Company (WPC) holds the rights for publishing the X12 format for healthcare claims known as the 837 Implementation Guides (Guides). WPC publishes the Guides separately for Institutions, Professionals and Dentistry referenced as types 837I, 837P and 837D. The Guides do not distinguish between FFS and encounter records and all specifications apply equally to both encounters and FFS claims except for one additional segment for encounters, the CN1.[7] The CN1 segment contains six unique data elements of which several are situational based on payment terms. The CN1 data elements provide encounter payment information such as the payment basis, or payment methodology of the MCE to the provider for each encounter.[8] The X12 837 Standard specifies the CN1 segment as required "only if contractually required" and Utah Medicaid does not require all six data elements. Utah Medicaid Companion Guide requires one of the six but the SOA blocks the whole CN1 segment and the one data element is not collected. See Appendix 11 for the complete CN1 segment X12 837 Guide specification.

The X12 Standard primarily prescribes the syntax / formatting lists the required standard code sets and classifies the data elements:

- Basic fields required for every record (Required),
- Situational fields required depending on the service provided (Situationally Required), and
- Contractually obligated fields required if contracted between trading partners.

The Guides, prescribe for both FFS and encounters the same Basic fields (Required) and Situational fields (Situationally Required) plus six payment fields for encounters if contractually obligated.

The Guides prescribe the use of external code sources such as the National Uniform Billing Committee (NUBC), National Drug, National Health Care Claim Payment, and other code sets including syntax for code sets agreed between trading partners. The NUBC publish billing manuals specifying the correct code set or value for each situation, service or product type. The Guides discourage (but permit) the use of claim notes, instead recommending that all values be codified.

Utah Medicaid publishes 837 Companion Guides that are supplemental to the Guides. The Guides specify syntax and apply equally to encounters and FFS. The Utah Companion Guides, supplemental to the Guides publish separately for FFS versus encounter data submissions.

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[5] Title 45 → Subtitle A → Subchapter C → Part 162 → Subpart K §162.1101 Health care claims or equivalent encounter information transaction. §162.1102 Standards for health care claims or equivalent encounter information transaction. https://ecfr.io/Title-45/sp45.1.162.k

[6] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2009-Fact-sheets-items/2009-01-153.html and https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0 /Version _5010.html

[7] The X12 837 Guides refer to encounter records as "post-adjudicated" records and as such are not healthcare claims. Prior to adjudication, encounter records were healthcare claims.

[8] The X12 Guide lists seven different values to accommodate the various types of provider payment. The seventh type is "other." Utah Medicaid companion guides may describe and explain proper usage of the values available.

A Utah Department of Technology Services (DTS) software installed in 2015 referred to as the Service Organization Architecture (SOA), no longer allowed the CN1 segment data fields containing the encounter payment terms into the DTS production systems.[9]

Some states requiring use of the CN1 segment include Wisconsin, New Jersey and Florida.

CMS requires completeness, accuracy and timeliness

In April 2016, CMS issued new requirements referred to as the "MCO Final Rule" to strengthen encounter data quality assurance. Effective for rating periods or contracts starting on or after July 1, 2018 the Final Rule states that CMS may defer or disallow federal match if encounter data is incomplete, inaccurate or untimely.[10]

The MCO Final Rule states, "The State must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP"[11] effective June 30, 2017. Utah Medicaid has until June 30, 2020 to fulfill the requirement.

Federal law also states that submission of enrollee encounter records to the State by contractors must be at a level of detail specified by not just CMS, but also the State for program integrity needs and administration purposes."[12]

The X12 Standard does not include guidance to develop edits facilitating complete and accurate

The X12, as a standard does not specify or provide guidance to develop completeness and accuracy edits at either an individual or summary level, or edits to verify the validity of reported codes or code values, or math edits, or edits to ensure all fields are included for each type of service or situation. Completeness and accuracy of record fields is not assured in the absence of fully developed specification and verification. It is incumbent on the MCE or Utah Medicaid to ensure all encounter records and fields are complete and accurate

Qualities of Complete and Accurate

Encounter records, for Utah Medicaid eligible recipients are complete and accurate when fully compliant with the X12 Standard including accuracy of reporting:

- balanced financial detail and summaries,
- balanced detail record counts with summary counts,

[9] The DTS Service Organization Architecture (SOA) gateway blocks the CN1 segment, which is the X12 segment for reporting the encounter claim payment type information. DTS implemented the SOA, an EDIFECS software in August 2015 and the CN1 segment no longer reported. The X12 specifies the CN1 segment as required only if Utah Medicaid contractually requires the CN1 segment. The X12 Guide lists seven different values to accommodate various compensation methods or provider payment types. The seventh type is "other." If necessary for proper usage, Utah Medicaid companion guides may describe and explain proper usage of the values.
[10] https://www.gpo.gov/fdsys/pkg/CFR-2016-title42-vol4/pdf/CFR-2016-title42-vol4-sec438-818.pdf
[11] https://www.gpo.gov/fdsys/pkg/CFR-2016-title42-vol4/pdf/CFR-2016-title42-vol4-sec438-602.pdf
[12] 42 eCFR section 438.242(c); Contracts between a State and a MCO, PIHP, or PAHP must provide for: (2) *Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs.*

- all applicable data segments and elements (situational completeness and accuracy) for each service type, medical supply or equipment,
- the CN1 payment elements (if required by contract provision),
- using only current authorized codes and values as specified by CMS and Utah Medicaid:
    - for administration, and
    - program integrity needs.[13]

Utah Medicaid's actuary, Milliman, Inc. estimates that data files submitted in the 837 format on average contain approximately 1000 fields.[14]

Levels of "Complete and Accurate" – Purpose Driven

The auditors observe three meanings for what constitutes "complete and accurate."

- Level One All Claims: The data set must include all encounter claims for all medical services, supplies and equipment rendered to an eligible Utah Medicaid recipient, even if no payment made.
- Level Two Capitation Rate Methodology: The data set must include all encounter claims along with the minimum X12 required data elements necessary to comply with CMS approved capitation rate determination methodology. This may not include all situationally required or trading partner specific data elements necessary for program integrity.
- Level Three Program Integrity: The data set must include all encounter claims, data elements required for calculation of future capitation rates using CMS approved methodology, plus all situationally required and contractually obligated data elements specified for and by program integrity. This requires the most complete, most accurate data set. Utah Medicaid information systems do not provide full assurance of the qualities described in S.N.I.P. test levels 3 to 7 below.

Accuracy requires completeness and, reporting correctly authorized or prescribed codes and values for each encounter. It is the responsibility of Utah Medicaid to specify or prescribe codes and values or, how MCEs are to report various sets of codes and values where more than one set of codes and values are allowable. Clear reporting instructions and directions improve program integrity capabilities to extract meaning from the X12 data submissions.

S.N.I.P. Test Levels for Completeness and Accuracy

The 1996 Health Information Portability and Accountability Act (HIPAA) specified the Workgroup for Electronic Data Interchange (WEDI) as an advisory group to HHS.[15]

The WEDI / S.N.I.P. (Strategic National Implementation Process) recommends seven types or levels of claim data validation to assure HIPAA compliance for the CMS required X12 transmission.

[13] Contracts between a State and a MCO, PIHP, or PAHP must provide for: 2) Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs. https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8#se42.4.438_1242

[14] http://www.milliman.com/uploadedFiles/insight/2017/medicaid-encounter-data.pdf.

[15] https://www.wedi.org/about-us

Utah Medicaid accepts claim data in compliance with only the basic S.N.I.P. Level type 1 and 2 as required by UHIN and does not require compliance with levels 3 through 7:

Utah Medicaid requires S.N.I.P. Level 1 and 2 only, as follows:
1. Integrity Testing - This kind of testing validates the basic syntactical integrity of the provider's EDI file.
2. Implementation Guide - Requirements Testing - This kind of testing involves requirements imposed by the transaction's HIPAA Implementation Guide, including validation of data elements specified in the Guide.

Utah Medicaid does not require MCEs comply with S.N.I.P. levels 3 to 7:
3. Balancing Testing - This kind of testing validates for balanced field totals, record or segment counts, financial balancing of claims, and balancing of summary fields.
4. Inter-Segment Situation Testing - Situation testing validates inter-segment situations specified in the Implementation Guide (e.g., accident claims must include an accident date).
5. External Code Set Testing - This kind of testing validates code set values for HIPAA mandated codes defined and maintained outside of Implementation Guides. HCPCS Procedure Codes and NDC Drug Codes are examples.
6. Product Type or Line of Service Testing - This kind of testing validates specific requirements deemed in the Implementation Guide for specialized services such as durable medical equipment (DME), chiropractic, ambulance, etc.
7. Trading Partner-Specific Testing - Testing of trading partner requirements involves Implementation Guide requirements for transactions to or from Medicare, Utah Medicaid and Indian Health Services. Trading partner requirement testing includes testing of the approaches that Utah Medicaid has taken to accommodate necessary data within HIPAA compliant transactions and code sets.

Medicaid partially offsets the lack of requiring S.N.I.P. levels 3 to 7 compliance and testing by installing some select edits (see Appendix 9) during MMCS processing.

Utah Medicaid contracts with Health Services Advisory Group (HSAG) to perform external quality review (EQR) for services mandated by CMS. CMS makes validation of encounter data an optional EQR activity and Medicaid did not include this activity in the HSAG contract.[16]

Data Flows and Edits

Utah Medicaid's actuary, Milliman, Inc. estimates that data files submitted in the 837 format on average contain approximately 1000 fields.[17] The X12 837 Guides specify the same data fields for both FFS and encounter records plus six additional data fields for encounter payment information contained in the CN1 data segment.

Files submitted by MCEs in the 837 format include Institutional, Professional and Dental services. The MCEs submit the encounter records in the 837 format through UHIN, to the DTS SOA gateway and to the "staging tables." The staging tables capture approximately 500 fields. Fields not captured in the staging tables do not flow downstream to the Utah Medicaid systems but are retrievable by DTS for up to two years from the EDI 5010 server prior to migration to long-term storage.

[16] https://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol4/xml/CFR-2012-title42-vol4-part438-subpartE.xml
[17] http://www.milliman.com/uploadedFiles/insight/2017/medicaid-encounter-data.pdf.

The SOA verifies syntactical compliance (S.N.I.P. levels 1 and 2) to the 5010 Standard, not completeness and accuracy of the values reported.

Following the SOA gateway and the subsequent translator programs, encounter records flow to the MMCS application system for additional processing and edits. MMCS, a commercial off-the-shelf product from Maximus, Inc. went live in 2005. Following "Go Live" MMCS has not had a significant revision.

Encounter records flow to the DW following MMCS processing and application of the edits listed in Appendix 9. The MMCS list of edits includes verification of ICD-10 or ICD-9 codes (before 10-1-2015), diagnosis codes, procedure codes, and a number of other tests. However, other codes and code values needed for program integrity, for example the Claim Adjustment Reason Code (X12 837 Data Element 1034) are not verified; or, verification that the Accident Date is present for all accident claims. Other controls needing further development are testing for balanced field totals, record or segment counts, financial balancing of claims, and balancing of summary fields.

Uses of Encounter Data

Utah Medicaid reports encounter records to CMS and Milliman, Inc., Utah Medicaid's actuary for determination of capitation payment rates. Utah Medicaid includes encounter data stored in the Data Warehouse and other databases for reporting purposes.

Utah Medicaid did not provide program data to CMS for reporting periods October 2015 through December 2017. Utah Medicaid became current in the program data submission during May of 2018. Utah Medicaid advised CMS of 78 program data fields requested in the T-MSIS that Utah Medicaid is not able to provide until implementation of the new MMIS in January 2020. The new MMIS, called Provider Reimbursement Information System for Medicaid (PRISM) is now under redevelopment with a newly projected "go live" in 2022, one of several times the projected "go live" date moved out. Of the 78 data elements not presently available for the CMS T-MSIS data submission, 56 (see Appendix 10) are missing from the X12 837 claims data for both encounter records and FFS. CMS accepted the T-MSIS data submissions and the delay of missing data elements Utah committed to with the implementation of PRISM. A CMS letter issued April 8, 2019 reports Utah Medicaid data submissions are current, but have issues in five of the CMS 12 Top Priority Items. See Appendix 12 for additional information.

The Utah Medicaid Fraud Control Unit (MFCU) performs queries of DW encounter records in support of cases for investigation and prosecution. The Utah OIG performs queries of the DW for program integrity analyses, evaluation and investigations of Fraud, Waste and Abuse.

The Utah OIG enabling legislation, "USC 63A-13-202, Duties and Powers of Inspector General" lists "discovering and eliminating fraud, waste, and abuse of Medicaid funds" as a primary responsibility. Program Integrity (PI) includes all aspects of fraud, waste and abuse. PI activities include the "In Patient Payer Review" (IPPR), analytics evaluating proper utilization, economy and efficiency relative to quality care, and capitations and are highly dependent on complete and accurate encounter data.

Federal law states that submission of enrollee encounter records to the State by contractors must be at a level of detail specified by not just CMS, but also the State for program integrity needs and administration purposes."[18]

[18] 42 eCFR section 438.242(c)(2); https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8#se42.4.438_150

Utah Medicaid reported to the UOIG auditor the following monitoring activities for data at rest in the Data Warehouse

Utah Medicaid reported to UOIG the following monitoring activities. The below is based on UOIG discussion with Medicaid and actual performance of the process described below by Utah Medicaid was not verified or validated by UOIG.

Utah Medicaid indicates that, in approximately the fall of 2017, Utah Medicaid started a process that provides additional opportunity for MCEs to review submitted encounter records. Utah Medicaid states that regular encounter validation processes are mainly created/driven by known issues. As the issues change, so do the monitoring activities. These activities currently include reconciling the files received and accepted by SOA to the files loaded into MMCS. Validating that encounters submitted are loaded into MMCS (multi ST segments), watching for MMCS duplicate load issues, addressing MCE inquiries regarding file status and response file timing, and regular bimonthly coordination meetings with the Bureau of Coverage and Reimbursement Policy (BCRP) actuarial specialist regarding more specific data concerns or issues.

Utah Medicaid indicates the quarterly encounter review process includes:

- A letter and data file to verify with MCEs that the data available (for the specified quarter) is complete from their perspective. The data represents what Milliman uses for rate setting purposes and allows the MCE and the state, an opportunity to reconcile any discrepancies prior to the rate setting data book review that is generally done yearly.
- The data file includes all the encounters with an accepted status in the Utah Medicaid system that an MCE submitted within a specified state fiscal quarter. The file includes encounters replaced as of the data pull, encounters submitted as a void, but rejected encounters are not included in the file.
- MCE responses are collected and compared against other internal data validations
  - The MCE's 'Completeness' response evaluates against the 'Timeliness' measure as well as additional internal "smell test" measures.
  - The internal measures include ’Fail Rate', 'Rejection Reason' and 'Encounter Volume'. While the measures do not necessarily directly relate to one another, they provide a view of the overall status of a plans encounter experience.
  - Anomalies or blips trigger further questioning of known issues.

<u>Utah OIG Comments of Medicaid’s Reported Monitoring (Above)</u>
Utah Medicaid indicates their normal monitoring derives mainly from known issues and, as the issues change so does the monitoring activity, i.e. watching for MMCS duplicate load issues, addressing MCE inquiries, and coordinating with Utah Medicaid internal actuaries regarding specific concerns.

Utah Medicaid’s monitoring of encounter data is an undocumented informal process. The UOIG acknowledged that Utah Medicaid began a process of monitoring the data but due to inconsistency in data and reporting requirements the UOIG did not validate or audit the process.

OBJECTIVES AND SCOPE

The audit objectives are:

- Determine if the current control structure governing encounter data submissions follows CMS Standards;

- Determine whether encounter data submitted through Utah Health Information Network (UHIN) and processed by MMCS achieve completeness and accuracy requirements;
- Determine the sufficiency of data elements processed by MMCS for program integrity purposes.

Audit Scope:

- The audit specifically reviewed encounter records in the DW having a ClaimPdDate in September 2017;[19]
- DOH full risk contracts with managed care entities effective 2012 through December 2017 including revisions;
- System documentation of data structures, flow documents and standards.

METHODOLOGY

To fulfill the audit objectives the Utah OIG:

1. Reviewed the CMS MCO Final Rule updated April 21,2016:
   a. 42 CFR Part 438 – Managed Care;
   b. CMS publications: CMS 2390-F;
   c. Implementation timeline schedule;
2. Reviewed analyses of the MCO Final Rule by Utah Medicaid's actuary, Milliman, Inc. and the Kaiser foundation;
3. Reviewed UHIN.org reference materials explaining processes and procedures
4. Reviewed the data structures, standards and policies:
   a. The 837 X12 national Implementation Guides for Institutions, Professionals and Dental;
   b. The 837 X12 Utah Medicaid Companion Guides for encounter records;
   c. DTS record layouts for the 837 X12 for institutions, professionals and dentists (staging tables);
   d. MMCS encounter records layout;
   e. The CMS Transformed - Medicaid Statistics Information System (T-MSIS) record submission detail mapping and planning documents being implemented for CMS program data submission;
   f. The DW Production Tables: encounter record layout;
   g. The DW Views: encounter record layout;
   h. The DW Views: FFS record layout for DW tables in the Claim Header and Claim Detail Views;
5. Summarized, analyzed and compared record layouts for:
   a. Encounter records available in views to production tables not available for views;
   b. FFS records in views to encounter record layouts
6. Obtained from the DW views, encounter records with claim paid dates during September 2017, and analyzed data for:
   a. Uniformity and understandability
   b. Usability and reliability for data query design.

[19] ClaimPdData is the date the MCE paid the provider or made adjustments for services rendered. Appendix 1 reports encounter records in the DW with ClaimPdData in September 2017 include dates of service extending back to 2010.

7. Researched code definitions in the Utah Medicaid user maintained sharing site called the "WIKI."
8. Researched healthcare industry code definitions not contained in the WIKI to discern meaning of codes used.
9. Joint-consult with US GAO Auditors regarding audit methodology;
10. Performed numerous inquiries of Utah Medicaid and DTS in person, email, phone, and reviewed data inconsistencies or anomalies with Medicaid;
11. Consulted with DTS regarding current control structure relative to data structures;
12. Reviewed MCE contract provisions including revisions pertaining to encounter data for scope period;
13. Obtained and reviewed other States MCE Contracts and Companion Guides.
14. Researched other states Medicaid required S.N.I.P. levels.

PRIOR AUDITS

The Utah OIG has not previously audited the controls governing the X12 837 encounter data processing, or the DW file and field structures. Utah OIG has not previously requested changes to the encounter data to the DW.

ANALYSES OF ISSUES AND OPPORTUNITIES

Utah Medicaid implemented the basic, minimal requirements for X12 837 for encounter data submission, but to achieve the completeness and accuracy requirements of program integrity, investigation and prosecution, requires more than the minimum X12 837 requirements.

Program integrity requires completeness and accuracy of many data elements not just the qualities achieved with the minimum S.N.I.P. levels 1 and 2 currently required along with the current MMCS edits.

Program integrity requires encounter records to be timely, complete and accurate to achieve the necessary quality.

Federal law states Contracts between a State and a MCO, PIHP, or PAHP must provide for: "Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs."[20]

MACPAC states:[21]

"When designed and implemented well, program integrity initiatives help to ensure that:

- eligibility decisions are made correctly;
- prospective and enrolled providers meet federal and state participation requirements;

[20] 42 eCFR section 438.242(c)(2); https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8#se42.4.438_150
[21] https://www.macpac.gov/subtopic/program-integrity/ The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP. MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, 42 U.S.C. 1396

- services provided to enrollees are medically necessary and appropriate; and
- provider payments are made in the correct amount and for appropriate services."

The recommendations in this report will improve the quality of data completeness, accuracy, reliability, timeliness and usability on a go-forward basis and do not include retroactive data collection changes.

The Utah MCE contracts now commit billions of dollars of taxpayer funding for Utah Medicaid services and the recommendations should not be delayed to the new Provider Reimbursement Information System for Medicaid (PRISM) projected for 2022, a date with a history of changing. All or nearly all of the recommendations will carry over to PRISM and the greater benefits in the near term for investigations and program integrity require urgency.

FINDING 1	Controls are not adequate to identify all incomplete or inaccurate encounter records, to ensure completeness and accuracy within Utah Medicaid computer systems.

A. Utah Medicaid computer systems receiving encounter data submissions do not identify all incomplete or inaccurate encounter records.

Utah Medicaid computer systems receive encounter records through UHIN compliant syntactically with the X12 format required by CMS.

The X12 National Standard format required by CMS does not include guidance for developing edits to ensure completeness and accuracy of encounter data. During processing, the Utah Medicaid Managed Care System (MMCS) applies a selection of edits. However, Utah Medicaid computer systems do not verify balanced record or segment counts, field totals, and financial balances. Additionally Utah Medicaid computer systems do not verify that fields situationally required for the type of medical service, supply item and equipment were included in the encounter data submission, and loaded properly to MMCS. [22] Utah Medicaid does not require the MCEs to submit their encounter data in conformance with S.N.I.P. levels 3 through 7 that verifies completeness and accuracy. The S.N.I.P. test levels are explained in detail in the background section of this report and Appendices 7 and 8 list examples of two states, Arizona and Tennessee that reference all 7 S.N.I.P. levels.

Utah Medicaid does not yet provide CMS with 56 data elements (DE) of the 837 (Appendix 10) requested by CMS (T-MSIS). Utah Medicaid informed CMS of 56 data elements (DE) representing both encounter records and FFS claims Utah cannot provide at this time. Utah Medicaid committed to provide the 56 data elements in 2020 with PRISM "Go Live", now projected for 2022. CMS currently accepts the claims without the 56 data elements. A CMS letter issued April 8, 2019 reports Utah Medicaid data submissions are current, but have issues in five of the CMS 12 Top Priority Items. See Appendix 12 for additional information.

MMCS applies other edits, called "soft edits" during processing that do not reject the encounter but label the encounter with a code. Utah Medicaid states that the original purpose of "soft edits" was to facilitate management information for noncritical items in the encounter records data. However, many of the "soft edit" descriptions indicate missing information that may be key to program integrity.

The audit reviewed DW encounter records with MCE claim paid dates during September 2017. Of the 374,780 claims, 52,471 or 14% accepted with errors (AE) noted by the soft edits. Further, the audit tallied the accepted encounter records by soft edit description for claim paid dates during CY 2017.[23] See Appendix 2 for a list of soft edit descriptions and counts.

See Appendices 7 and 8 for examples of two states, Arizona and Tennessee, referencing all seven S.N.I.P. levels. These benchmark states establish a standard or point of reference to compare encounter processing controls.

[22] See Appendix 9 for a list of all MMCS edits.
[23] CY 2017 refers to encounter records having a Claim Paid Date during the January 01 – December 31, 2017.

B. MCE contracts do not include specification or measures of completeness and accuracy

Federal law states Contracts between a State and a MCO, PIHP, or PAHP must provide for: "Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs."[24]

The MCE contracts do not include specification or measures of completeness and accuracy. The MCE contracts require the MCE to submit encounter records consistent with the X12 Guide and the Utah Medicaid Companion Guide Standards that specify primarily, syntax. The MCE contracts do not specifically require the MCEs to meet the attributes listed in S.N.I.P. levels 3 through 7 before encounter submission.

Nearly all[25] the MCE contracts include damages (penalties) for incomplete or inaccurate encounter records, but do not state a specific quantity (i.e. one record, all records, or percentage) or other measurement point at which penalties will charge. [26] For example, the ACO contracts include a fixed dollar penalty but do not include a measurable point at which penalties will charge:

- $1,000 per calendar day the Contractor fails to submit Encounter Data;
- $1,000 per calendar day the Contractor fails to submit accurate or complete Encounter Data.

The MCE contracts state damages may be incapable or very difficult of accurate estimation.[27] In the absence of measureable pass – fail rates, damages for incomplete or inaccurate encounter records are difficult to impossible to calculate or estimate.

As a result, the MCE contracts minimize the motivating aspects that the potential for damage assessment, to become due and payable, would otherwise represent if measures of completeness and accuracy were included.

The MCO final rule allows for positive and negative incentives based on measurable performance determined and specified by the state in the MCE contracts. The MCO final rule allows for positive incentives up to 5% of the approved capitation payments and negative incentives by withholding up to 1% of capitation payments.[28] The states award the incentive funds annually according to performance metrics specified in the MCE contracts.

Other states include measures of completeness, accuracy and timeliness and connect the measures to financial consequences. The State of Michigan regularly withholds 1.00% of the approved Capitation Payment from each Contractor and then based on performance throughout the year the

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[24] §438.242 Health information systems (c) *Enrollee encounter data.*(2)
[25] The PMHP contracts do not contain damage provisions pertaining to "incomplete or inaccurate" encounter records.
[26] For example: Health Choice Trad Amd and Molina-Trad-Amd 13 BCF eff Jan_17, Attachment B, 15.3.2 Liquidated Damages, Per Day Amounts: (A) "(3) $1,000 per calendar day the Contractor fails to submit Encounter Data (as required by Article 13.3)or the Post Adjudication Pharmacy file (as required by Article 4.14.8); (4) $1,000 per calendar day the Contractor fails to submit accurate or complete Encounter Data (as required by Article 13.3) or Post Adjudication History file (as required under Article 4.14.8);"
[27] For example: Health Choice Trad Amd and Molina-Trad-Amd 13 BCF eff Jan_17, Attachment B, 15.3.1 Liquidated Damages, Generally, "(A) If the Contractor fails to perform or does not perform in a timely manner provisions under this Contract, damages to the Department may result. The Parties agree that the damages from breach of this Contract may be incapable or very difficult of accurate estimation."
[28] https://ecfr.io/Title-42/pt42.4.438#se42.4.438_16 Section 438.6 Special contract provisions related to payment.

1% withheld is awarded to MCE Contractors.[29] The State of New Jersey measures encounter record denial rates, duplicate resubmission rates, and completeness benchmarks by category of service.[30]

CMS assessments also provide examples of specific measures (CMS Specific Measures) for encounter data completeness and accuracy:[31]

1. Percentage of OT (outpatient services) encounter records with a:
   a. procedure code in CPT-4 or HCPCS format,
   b. primary diagnosis code
   c. primary diagnosis code length greater than three characters
2. Percentage of RX records with a:
   a. date prescribed
   b. quantity
3. Percentage of Inpatient Hospital encounter records with a:
   a. diagnosis code

Additionally, the MCE contracts glossary adds confusion by stating a "Clean Claim means a claim that can be processed without obtaining any additional information from the Provider of the service or from a third party. It includes a claim with errors originating from the Contractor's claims system. It does not include a claim from a Provider who is under investigation for Fraud or Abuse or a claim under review for medical necessity."[32] Specifying a "claim with errors originating from the Contractor's claims system" as a part of the definition of "clean claim" makes it acceptable for encounter claims submitted to Utah Medicaid to contain errors originating from the contractors system.

Controls to identify inaccurate or incomplete encounter records will enable measures or percentage of completeness and accuracy to become actionable, and the potential for specific, calculable damages will likely increase the level of completeness and accuracy.

C. CMS Requires Completeness and Accuracy for Encounter Data

The "MCO Final Rule" makes it clear that CMS requires complete and accurate encounter data, Single State Medicaid Agencies must verify and ensure completeness and accuracy and CMS may deny or delay the federal match for capitation payments relative to the encounter records found incomplete or inaccurate,[33] effective for rating periods for contracts starting on or after July 1, 2018.

The MCO Final Rule states, "The State must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP"[34] effective June 30, 2017; hence no later than June 30, 2020.

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[29] https://www.michigan.gov/documents/contract_7696_7.pdf

[30] https://www.nj.gov/humanservices/dmahs/info/d-snp_contract.pdf

[31] www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo /Downloads/ MAX_IB_15_AssessingUsability.pdf

[32] Molina, Health Choice, Healthy U Contract Amendment #13, Select Health Amendment #12 Attachment B – Traditional, Effective January 1, 2017, Article 2. The wording comes from Title 42 § 447.45 Timely claims payment however, the context is that the MCE must not withhold payment to the provider for errors not originating from the provider and for which the provider has supplied all information required for payment.

[33] https://www.gpo.gov/fdsys/pkg/CFR-2016-title42-vol4/pdf/CFR-2016-title42-vol4-sec438-818.pdf

[34] https://www.gpo.gov/fdsys/pkg/CFR-2016-title42-vol4/pdf/CFR-2016-title42-vol4-sec438-602.pdf

Requiring MCEs by contract to comply with measures of completeness and accuracy of encounter data upon submission will add assurance for the fulfillment of federal match funds and Program Integrity evaluations and investigations requirements.

Recommendations

We recommend Utah Medicaid:

1.1 Modify the MCE contracts to define a clean claim to mean a complete and accurate claim submitted timely that complies with both the National Guide and Utah Companion Guides. In addition, MCE contracts should include data specifications adequate to enable MCEs to achieve compliance with all seven S.N.I.P. X12 WEDI HIPAA Compliance Levels prior to submission of 837 data on a progressive or benchmark basis. Benchmark with other States requiring level 5 or higher and progressively increase to all seven levels of compliance over time. Each level enhances the completeness and accuracy prior to submission for program integrity purposes.

1.2 Modify the MCE contracts to include specific measures of completeness, accuracy and timeliness (see "CMS Specific Measures") for determining when financial incentive, or penalties are incurred. Specify in the MCE contracts a progressive benchmark approach that requires increasing levels over time for completeness, accuracy, and timeliness using specific measures.

1.3 Review the "soft edits" and if the edit applies to encounter record accuracy and completeness for program integrity, adjust the edit to reject the encounter. If the soft edit serves no reasonable, regular and continuous purpose then inactivate the edit.

FINDING 2	Delayed adjudication negatively affects program integrity, rate capitation and potentially, federal match.

Claims paid or processed by the MCEs during September 2017 (see Appendix 1) include 10,194 encounter records with end dates of service prior to 2017 extending back to 2013, with one having end date of service in 2010. Utah Medicaid accepts encounter records despite the time elapsed between the end date of service and the date submitted to Utah Medicaid.

Accepting encounter records without regard to time elapsed following the end date of service diminishes incentive for timely submission, or for encounter records to be complete and accurate on first filing.

Delayed payment of provider claims by the MCE impacts:

- Federal funding – CMS may deny or delay federal match for capitations based on submission of encounter data;
- Program integrity - evaluations and assessments lack completeness and accuracy during the period encounter claims data is delayed;
- Capitation Rate Determinations – incomplete datasets for encounters not yet submitted diminishes accuracy of rate determination.

The original, traditional coverage for the calendar period 2013 – 2017 for Molina, Select Health, and Healthy U signed and executed in 2012 required all initial filings be within 180 days of dates of service with potential for corrective action if more than 10% of initial submissions exceed 180 days, or submission duplicates exceed 10% per month.[35] CMS allows up to one year from data of service for the provider to submit a claim. CMS also allows a shorter required period when stipulated in the MCE contracts. The contract revisions effective 2014 and later do not contain dates of services deadlines for submission of paid provider claims encounter data to Utah Medicaid. A contract clause was added in the 2014 revisions requiring data be submitted at least monthly for both medical and institutional claim types but does not specify applicability to each individual claim.

The ACO and Dental MCE contracts require adjudicated encounter records be submitted to Utah Medicaid on a monthly basis.

The PMHP MCE contracts allow, depending on the contract either quarterly or every four months from the date of adjudication or service to submit encounter records to Utah Medicaid.

The MCE contract provisions include the requirements of 42 CFR 447.45(d) (2) and (d) (3) which state:

- Ninety percent of clean claims from practitioners must be paid within thirty days of date of receipt, and ninety-nine percent within ninety days. And,
- Any alternative schedule must be stipulated in the contract.[36]

[35] The original 2013-2017 ACO Contract, Traditional Coverage: Article 13.3.1 Encounter Data (Select Health, Molina, Healthy U):
The Contractor shall submit all initial and unduplicated Encounter Data to the Department within 180 days of the date of service. The Department may require corrective action if more that 10% of the Encounter Claims submitted are over 180 days after the date of service or known exact duplicate claims exceed 10% per month.
[36] § 447.46 "Timely claims payment by MCOs. (d)(3) Alternative schedule. Any alternative schedule must be stipulated in the contract."

Starting in the fall of 2017 Utah Medicaid initiated a quarterly monitoring process providing feedback to MCEs using a timeliness measure of 45 days following the adjudication date for all MCEs. Using 45 days as the timeliness measure is not consistent with all the current MCE contract terms and conditions. For example, the PMHP MCE contracts allow 90 days or four months from either, the date of adjudication or service, to submit encounter records to Utah Medicaid.

Utah Medicaid indicates having encounter data submission deadlines based on dates of service less than 12 months is problematic since CMS allows for a maximum of 12 months. Utah Medicaid does not include dates of service deadlines in the MCE contract provisions, but instead the MCE contracts provide deadlines based on the number of days from claim adjudication to submission date.

Utah Medicaid indicates that receiving an updated encounter record regardless of length of time following the date of service will improve data quality. Utah OIG agrees that increased accuracy and completeness may result when MCEs submit encounter records regardless of the timeliness since the date of service, however, the Program Integrity function works with inaccurate and incomplete information prior to timely submission.

Recommendations

We recommend Utah Medicaid:

2.1 Modify the MCE contracts requirement for data submission to Medicaid so all agree with Utah Medicaid's expected timeliness measure referenced in the Utah Medicaid's Bureau of Managed Health Care (BMHC) quarterly monitoring, 45 days or less from date of adjudication not to exceed 180 days from date of service. Require submission of all complete and accurate encounter healthcare records as identified throughout this report.

2.2 Monitor and provide performance statistics of MCE compliance with the timely payment requirements stipulated in 42 CFR 447.45(d)(2) and (d)(3) of ninety percent of clean claims from practitioners must be paid within thirty days of date of receipt, and ninety-nine percent within ninety days.

FINDING 3 — Utah Medicaid did not implement the CMS requirement for MCE certification of data accuracy and completeness concurrent with data submission.

Federal law requires the State to require the MCE to certify, *concurrent with the encounter data submission* that the encounter data is complete, accurate and truthful based on best information, knowledge and belief of the chief executive officer (CEO) or chief financial officer (CFO) or one delegated authority by the CEO or CFO.[37]

Utah Medicaid relied on a provision in all the MCE contracts titled Encounter Data Certification, which states that by electronically submitting the Encounter Data to the Department, the Contractor ensures that the person certifying the encounter data attests to the completeness and truthfulness of the data and documents based on the person's best knowledge, information, and belief.

Federal law states that the MCE must submit the certification of accuracy and completeness concurrently with the certified data. [38] See Appendix 6 for examples of other state contracts specifying submission of the certification with the data.

As a result, the absence of concurrent data certification:

- may not fully comply with 42 CFR 438.606 and
- may contribute to the lack of accuracy in the 14% accepted with errors described in Appendix 1.

Note:
During the course of the audit Utah Medicaid included in the ACO contracts effective January 1, 2018 certification of completeness, accuracy and truthfulness holding the CEO or CFO ultimately responsible, concurrent with the submission of encounter data.

Recommendation

We recommend Utah Medicaid:

3.1 Modify all the MCE contracts, not just the ACO, to require certification of completeness, accuracy and truthfulness holding the CEO or CFO ultimately responsible, concurrent with the submission of encounter data.

[37] https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8#se42.4.438_150. See Section 438.606
[38] https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8#se42.4.438_150. See Section 438.606

FINDING 4 Companion Guides, key to specifying Utah Medicaid's data requirements, are not current.

The Utah Medicaid Companion Guides to the 837 supplement the national X12 Guides. Utah Medicaid issues Companion Guides separately for FFS and Encounter Records and separately for institutions, professionals, and dentistry for data submission.

The Guides specify syntactical requirements, and the Companion Guides specify Utah Medicaid data element usage and content requirements not specified in the Guides. The contracts require encounter records comply with the national Guide and Companion Guide data requirements. The contracts only specify the Guides, and the Companion Guides for communication or documentation of data methodology requirements.

The Companion Guides, last updated by Utah Medicaid effective October 1, 2014 do not contain all data practices currently required or permitted by Utah Medicaid. The 837 Institutional Companion Guide incorrectly refers to Version 4010 as the standard of compliance and refers to Utah Medicaid's intent to convert to Version 5010. Utah Medicaid converted to Version 5010 in 2015 and data syntax and content requirements changed. The Companion Guides do not reflect Version 5010 changes.

After publication of the Companion Guides in October 2014, Utah Medicaid communicated changes to data practices by email. Utah Medicaid issued instructions by email to selected MCEs to report Usual & Customary Charges (UCC) in the "MCOPdAmt" field on the encounter record submission as payment to providers on sub-capitation. Entering the UCC in the "MCOPdAmt" field, as Utah Medicaid instructed by email causes incorrect information reporting since the UCC was not paid for a sub-capitation encounter.

Utah Medicaid does not require the CLIA (clinical laboratory improvement amendment) number for encounter records even though the X12 Guide requires it (X12 Data Element R0203), and CMS states that all clinical laboratories must be properly CLIA certified to receive Medicaid payments.[39] The Companion Guide does not document Utah Medicaid approval for ACOs not to submit the CLIA.

As a result, Companion Guides do not report all practices currently accepted by Utah Medicaid despite the MCE contracts specifying Companion Guides as the media for requirements documentation.

Providing instruction and direction by email or any means other than the Companion Guides is inconsistent with the contractually obligated method – Companion Guides.

Federal law states that submission of enrollee encounter records to the State by contractors must be at a level of detail specified by not just CMS, but also the State for program integrity needs and administrative purposes.[40] The Companion Guides, as specified in the MCE contracts are the publication to specify and include data elements required by the state for program integrity and administration purposes.

[39] www.cms.gov/regulations-and-guidance/legislation/clia/index.html "all clinical laboratories must be properly certified to receive Medicare or Medicaid payments.

[40] 42 eCFR section 438.242(c)(2); https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8#se42.4.438_150

Recommendations

We recommend Utah Medicaid:

4.1 Update the Companion Guides to include all data requirements not already specified or supplemental to, the Guides adequate to ensure complete, accurate and consistent reporting of encounter claims, codes and values by all MCEs. Include:

- State specific program integrity and administration data elements or values, and include full and complete directions, explanations and descriptions to ensure clear understanding;
- Code sets or values supplemental to the Guide;
- Add the X12 CN1 segment data elements for payment type information.

4.2 Maintain the Companion Guides to include all data practices and requirements on an on-going basis.

FINDING 5 — Encounter data not defined, not mapped, missing data elements, and multiple unique element types in the same data warehouse field.

The Program Integrity (PI) function must evaluate various trends or conditions of patient care statewide using Utah Medicaid's encounter records and FFS claims data using many of the same data elements for both. For example, an allegation that hospitals are abusing a particular area of patient care in a rural region of the state also raises the question of whether the same alleged condition occurs statewide. To analyze PI situations encounter records must be situationally complete and accurate for all service types, supplies, and equipment rendered to Utah Medicaid recipients in multiple settings. Mapping including links, definitions and acceptable code set values must be documented and available to data scientists to disseminate stored data into accurate information. Reliable data is crucial to identifying key evidence for subsequent investigation.

The Utah OIG Program Integrity did not take initiative previously to request encounter data corrections. The Utah OIG PI accepted Utah Medicaid's assertion that the MCE contracts requiring MCEs be responsible for PI as adequate. Nonetheless, encounter records are the State's primary means of evaluating quality of care and other program issues provided through managed care. Utah OIG now evaluates encounter records with progressively more scrutiny and professional skepticism.

CMS specifies the same national X12 Standards for both FFS claims and encounter records and both types flow through UHIN to Utah Medicaid. The X12 prescribes the same data elements for FFS claims and encounter records, except for an additional six post payment elements for encounters. If the Utah Medicaid DW mapped the same data structures for both encounter records and FFS then the process of detecting fraud, waste and abuse could apply to both.

Utah Medicaid implemented the SOA gateway software, EDIFECS in 2015. DTS states that the particular version of EDIFECS does not allow six post payment elements described in the X12 Guide (segment CN1) through the gateway (see Appendix 11). The post payment elements include the MCE contracted payment plan arrangement and payment amount to providers and hence, the program integrity function lacks this information for evaluation.

Utah Medicaid does not capture all data elements submitted by MCEs. For example, MMCS does not process and the DW does not report the provider taxonomy code for encounter records. DTS captures the taxonomy code in the DTS staging table but does not deliver the element to MMCS or the DW.

Utah Medicaid did not publish a data dictionary to define encounter record fields or field values and did not map or crosswalk the fields to other tables. Utah Medicaid made available a user application called the "MHF Media Wiki," "Medi-Wiki," or "Medicaid Wiki" (Wiki) by which users can add information similar to a data dictionary. The Wiki provides a template format for entering specific information. However, Utah Medicaid did not take "ownership" of the Wiki since edit control is dispersed to the user community. Appendix 3 lists select encounter tables and fields that remain undefined and unmapped for encounter records found in the DW.

The following lists seven-issue types (see Appendix 3 for more examples summarized in the issues):

1. <u>Encounter MMCS process codes – not defined; what do they mean?</u>
   The DW reports the results of MMCS processing using codes that without documentation may be misinterpreted. For example: "DupInd" is a MMCS derived field containing a "Y" for yes or "N" for no. WIKI (an informal, incomplete information tool) does not define whether "Y" means, "yes it is a duplicate submission" or "yes the duplicate test was performed." See Appendix 3 for more examples.

2. <u>Encounter fields sometimes comingle codes and narrative</u>: The "ClmNote" field in the table "Encounters" contains both codes (undefined) and narrative. The Guides discourage use of narrative in data submissions,[41] although it is allowed and available. The examples of "ClmNote" values reported in the DW in the September 2017 (claim paid dates) data include: single numbers and number-sets (triplets), codes, and narrative comments; the codes and numbers are undefined and lack meaning to DW users.

3. <u>Encounter name convention not intuitive for all fields - causes inefficiency for users.</u>
   The DW name conventions for encounter records are not always clear. For example, Encounter Table "EnctrServLines" contains a field labeled "RclkCd." This is the Revenue Code. Other encounter tables, fields, labeled "MOLPCd" are modifier codes; a field labeled "HOCCCd" refers to Occurrence Code; a field labeled "IPCLCd" refers to Utah "ProcCode." See Appendix 3 for more examples.

4. <u>Encounter views in DW do not contain all fields</u>
   A. Not all DW fields are available in Views for query purposes. For example, Tooth Number, and Tooth Surfaces 1 – 5. Tooth Number and Tooth Surface are *key to program integrity assessment of dental encounters but are not in the DW View.*
   B. Not all MMCS fields load to the DW and significance is not always documented in the absence of a data dictionary; for example:

Ref	MMCS Table	MMCS Field Name not in DW	Comments
1	HLMC ENCOUNTER	COPAY_UPDATED	Was a co-pay collected?
2	HLMC ENCR. EDITS	CREATED_BY	Which organization, department, or process created or edited the record?
3	HLMC ENCOUNTER	DATA_UPDT_IND	Was the record updated?
4	10 Tables	DW_SOURCE	Unknown significance
5	HLMC_EN_SL_ TPL	PROC_CODE_QUALIFIER	Indicates the type of code sent
6	HLMC_EN_ BATCHES	RECEIVE_ID_TYPE	X12 Standard for indicating the type of receiver id sent
7	HLMC_EN _BATCHES	SEND_**X** (ADDR, CD, FName, ID, IDCode, LName, TypeCd;	8 fields of information pertaining to the plan sending the 837 file

[41] "The developers of this implementation guide discourage using narrative information within the 837. Trading partners who use narrative information with claims are strongly encouraged to codify that information within the X12 environment." Page 209 of the 837P NTE Claim Note #2.

5. Encounter data split to multiple tables and users lack mapping information to link the fields together for data mining.
   Encounter information segments into multiple tables and without documented mapping needed to link each record, program integrity is not able to achieve their PI function. For example: CPT Code Modifiers at the service line level separate to a table labeled "EnctrSLModCds." The record containing the modifier code contains field "SLModCdId" must link to other records in other tables to obtain a flat record representing the claim.

   Data scientists must then reassemble the encounter record for program integrity evaluations and in the absence of documentation mapping the relationships, and in some cases absence of established links, data scientists lack confidence in the data results. Queries with complex links to data spread across various tables sometimes lack data integrity. See Appendix 4.

   Effect: To assess information successfully for encounter records analysts must identify the relationships between multiple tables, using identifiers unique to encounter fields. Without an official data dictionary and documented mapping, program integrity results are inconclusive.

6. Encounter Claim Note field (Table: "EnctrServLines") lack explanations for items denied payment
   The "EnctrServLines" table for the line items the MCE denied payment to the provider should contain the reason for denial. Of the total line items denied, 94% did not provide reasons for the denial, but merely "Line Item Denied."[42] Knowing the reasons for claim denial, for tracing claim history, are key for measuring potential waste, abuse or fraud.

7. Encounter fields received in the same X12 837 location are not always separated in the DW field – causes inefficiency for users.
   The DW encounter tables have fields sharing different types of key information.
   For example: Diagnosis Related Group (DRG) Codes and Diagnosis Codes (DC) both map to the "DiagnosisCd" field in the "EnctrDiagnoses" table despite being different codes with different meaning. To illustrate, many hospitals pay based on DRG Codes, but no hospital pays based on DC despite the importance of both.

Utah Medicaid's interest in the encounter data was primarily for capitation rate setting. The Utah OIG performs significant portions of the Utah Medicaid Program Integrity functions required by CMS. Program Integrity functions require complete and accurate data in order to properly assess and evaluate the various aspects of quality of care given to Utah Medicaid recipients. The Utah OIG must have complete and accurate encounter records to properly assess, analyze and correct any fraud, waste or abuse of Utah Medicaid funds especially as it affects quality and cost of care. Mapping including links, definitions and acceptable code set values must be documented and available to PI data scientists.

[42] 94% is based on total line items of 899,228 (Total paid claim line items in Sept. 2017), of which 128,955 were denied for payment by the MCO. Of the 128,955 denied, 121,042 had no explanation. 121,042 / 128,955 = 94%

Recommendations

We recommend Utah Medicaid:

5.1 Actively seek recommendations for data elements from MFCU, Utah OIG Program Integrity, Milliman, Inc., other DOH divisions and primary stakeholders dependent on encounter data quality and usability. In addition, provide planned, structured, formalized training to stakeholders for analyzing encounter data per stakeholder recommendations. For example, training on different data fields that contain multiple data types, and linking of fields contained in different tables.

5.2 Develop a centrally controlled data dictionary containing definitions of *all* acceptable encounter fields and values, and include mapping to other encounter fields and tables contained in the Medicaid Data Warehouse.

5.3 Define or specify precise codes for MCE denial of payment to providers. PI and other stakeholders can then use the codes to identify the reason for denial of payment and its claim history.

5.4 Add encounter fields to Views not already available in the Views, for example the dental services data elements.

5.5 Program the S.O.A. gateway to allow all 837 syntactically valid data elements defined in the Guides and Companion Guides, and code sets including the CN1 segment, through to downstream systems. Identify a method to capture and report the X12 specified CN1 segment of the six, post payment fields and make the CN1 segment contractually obligated.

Appendix 1
Encounter records of provider claims paid or processed during September 2017

The table below summarizes encounter provider claims paid by MCEs during September 2017. The table summarizes the encounter claims by the calendar year date of service and the Utah Medicaid Status Code following MMCS processing. See legend below table for meaning of the Status Codes.

Data Summary: MCEs during September 2017 paid or processed provider claims with ending dates of service extending back to 2010. The encounter records with dates of service preceding the audit scope are included since Utah Medicaid accepted the encounter records during the audit scope. Utah OIG data scientist queries of DW were performed February 6-8, 2018.

Ending DOS*	Provider Claims Paid by MCOs during Sept. 2017 MMCS StatusCd (Count)						Total
	AC	**AE**	**AN**	**AW**	**RJ**	**VD**	
(blank)					49		49
2010		1				1	2
2013	15	53		3	1	73	145
2014	20	110		27	5	155	317
2015	113	113		182	8	265	681
2016	6,532	3,237		2,671	182	3,128	15,750
2017	236,035	48,957	1	17,929	45,947	8,967	357,836
Total	242,715	52,471	1	20,812	46,192	12,589	374,780

LEGEND:

1. DOS = Date of Service

2. MMCS StatusCd

   AC = Accepted
   AE = Accept With Errors
   AN = Accept Plan Negative, (Voids for claim that is not in the system.)
   AW = Accept Without Edits Applied (for records indicated by MCE as payment denied)
   RJ = Rejected
   VD = Void

3. [blank] = no date of service indicated on submitted record. All were rejected

See Findings 1, 2, and 3.

Appendix 2
Soft edit counts and descriptions for encounter records with ClaimPdDates during calendar year 2017

The summary below represents encounter records accepted and not rejected by soft edit description. The information, summarized by the soft edit description, listed across columns by MCO Type for encounter records with ClaimPdDates during calendar year 2017. Some TCNs include more than one soft edit.

Utah Medicaid states that the original purpose of "soft edits" was to facilitate management information for noncritical items in the encounter records data. However, many of the "soft edit" descriptions indicate issues key to accuracy and completeness necessary for program integrity analyses. The encounter is accepted and processed by Utah Medicaid and reported as having accepted with errors, or StatusCd of "AE." A legend for MCOTypeCD follows the table.

Audit Finding 1 recommends Utah Medicaid review the soft edit settings and adjust items relevant to "completeness and accuracy" for program integrity purposes, or remove the edit.

Edit Description	**MCOTypeCd** (Not in WIKI)							Total
	CDEN	CHIP	DDD	DEN	HMO	PMHP	SUD	
Admit type missing/invalid		9			171			180
Client has Foster Care Eligibility		12						12
Condition code invalid		2	18		2,655			2,675
Diagnosis to sex mismatch					621			621
DRG code invalid					1			1
Encounter is greater than 12 months From End Date Of Service.	629	386	372	1,325	30,217			32,929
From-through service dates cannot span more than one month		5	3		358			366
Invalid/Missing State Assigned Medicaid ID	2,003							2,003
MCO paid amount equal TPL amount					2			2
Missing SPMI indicator						670,803	75,156	745,959
No match found on history for replacement - Replacement Claim TCN not included.	14			526				540
Occurrence code missing		565	135		19,413	2,275	170	22,558
Procedure Code for Non Traditional is Not Covered - Inst					38			38

Edit Description	MCOTypeCd (Not in WIKI)							Total
	CDEN	CHIP	DDD	DEN	HMO	PMHP	SUD	
Procedure Code for Non Traditional is Not Covered - Prof					569			569
Procedure to sex mismatch					60	42,850	564	43,474
Recipient enrolled with another plan during service Period						5,675	1,459	7,134
Recipient enrolled with another plan on admission date						3		3
Recipient enrollment not reflected on system						1,230	155	1,385
Revenue Code Not Covered for Non Traditional Client					33			33
Too Many Proc Code T1015 for Non Traditional Client For Year					262			262
Tooth surface missing	4,383			34,523				38,906
Value amount invalid		36	139		6,710			6,885
Grand Total	**7,029**	**1,015**	**667**	**36,374**	**61,110**	**722,836**	**77,504**	**906,535**

CDEN = CHIP Dental
CHIP = CHIP ACO
DDD = H.O.M.E. Program
HMO = ACO
PMHP = Prepaid Mental Health Plan
SUD = Substance Use Disorder

See Findings 1.

Appendix 3
Examples of DW encounter fields and values undefined and not mapped

The table below illustrates the need for an official data dictionary. Data analysts do not know how to use the field, or the meaning of the values in the field causing incomplete program integrity analyses, or misinterpreted results. Field names and the values reported in the fields need definition to be useful for analyzing fraud, waste and abuse.

The table below represents the summary results of encounter records paid or processed by the MCE during September 2017 submitted to Utah Medicaid as reported in the Utah Medicaid DW. Records in the DW display in tables containing fields displayed in values or codes not defined, or that contradict the unedited WIKI.

The below list contains examples of field values in the Data Values column, of which the meaning is not documented or explained for data analysts to use for program integrity purposes. The percentages next to a value report the proportion of records with the value. The "Issue" column lists the particular item not defined, or contradicts the unedited WIKI information. This list is not all-inclusive. See Finding 5.

Ref	Table	Field	Data Values	Observation	Issue
1	Encounters	DWStInd	12.3% **N**, 87.7% **Y**	WIKI says, "Not currently used" but it is populated.	What exactly is the meaning of "N," "Y"?
2	Encounters EnctrEditDisp	PlanRespInd	88% N 12% Y	In WIKI but not defined	What exactly is the meaning of "N," "Y"?
3	Encounters	HistRejectCd	100% N	In WIKI but not defined	What is the meaning of this field? "N"?
4	Encounters	ProcessedInd	100% Y	Wiki no meaning to end user	What is the meaning of the ProcessedInd?
5	Encounters	RepStInd	12.3% N, 87.7% Y	WIKI says "Not currently used," but it is.	What is the meaning of RepStInd? N or Y?
6	EnctrBatches	ReportsSent	Y	Not in WIKI. What reports?	What is the meaning of "Y"? What reports?
7	EnctrBatches	TrnsDate	9/1/17 to 2/1/18	Not in WIKI	What is the meaning of TrnsDate?
8	EnctrBatches	TrnsSetID	Inconsistent	Not in WIKI	What is the meaning of TrnsSetID?
9	EnctrBatches	HTNo	Usually systemic	Not in WIKI	What is the meaning?
10	EnctrDiagnoses	DiagnosisType	53% ABF, 45%ABK, ABJ,ABN,BF, BJ, BK, BN,BP, **DR**	WIKI not updated to include 3 character DiagnosisType	What do the 3 character codes mean
11	EnctrDiagnoses	DiagnosisCode	2-6 Digits, Alpha Numeric	Not in WIKI as to format for ICD-9 or 10, **or DRG**	DRG and DCs in shared field. More efficient to analysts to make unique fields (especially DR)

Ref	Table	Field	Data Values	Observation	Issue
12	EnctrEdit, EnctrEditCds	EditCdId	3 Digit	Not in WIKI	How should EditCdId be used?
13	EnctrEditDisp	DWDisp	98% Y 2% N	Not in WIKI	What is the meaning of DWDisp? N or Y?
14	EnctrEditDisp	RPTDisp	98% Y 2% N	Not in WIKI	What is the meaning of RPTDisp? N or Y?
15	EnctrEditDisp EcntrEditResults	EditDispID	4 Digit Seq	Not in WIKI	What is the meaning of EditDispID? What should the ID link to?
16	EnctrEditDisp	EncEditID	3 Digit	Not in WIKI	What is the meaning of EncEditID? What should the ID link to?
17	EnctrEditDisp	ResubmitInd	75% Y 25% N	WIKI says, “Yes=Critical, No =NotCritical.”	*What* is critical?
18	EnctrEditDisp	StatCatCd	A1 0.3% A2 20.3% A3 21.9% A6 25.2% A7 32.3%	Not in WIKI	What is the meaning of StatCatCd? What is A1-A7 mean?
19	EnctrEditResults	EditId	9 digits	Not in WIKI	What is meaning of the “EditID”? What should it link to?
20	EnctrEditResults	RecordId	Appears as TCN	Not in WIKI	What is the meaning of RecordId?
21	EnctrProviders	Verified	76% Y 24% N	WIKI says, “Used in the edit of the provider No Reporting Value.”	Meaning? (Verified what? Why N)
22	EnctrProviders	ProviderId EnctrProvID	Mixed Values for each field: dates & Numbers	WIKI: Primary Indicator. MMCS Derived	How to use? Why mixed dates with numbers in same field?
23	EnctrProvInt	ProvIntID	Systemic 8 digit	In Wiki, MMCS Derived.	How to use?
24	EnctrProvSLInt	ProvSLIntId	Systemic Seql All SLs	Not in WIKI. All 9/26/17 ClaimPdDate	How to use?
25	EnctrServLines	LineReviewed	99% N 1% Y	Not in WIKI	What is the meaning?
26	EnctrServLines	ProvCntlNum	Multiple Sequences	Not in WIKI About Half are blank	What is a ProvCntlNum? Meaning?
27	EnctrServLines	ZeroPriceInd	14% -0- 86% Blank	Not in WIKI	What is a ZeroPriceInd? Meaning? Why 14%

Ref	Table	Field	Data Values	Observation	Issue
28	EnctrServLines	ZeroPriceAmt	68% -0- 32% Blank	Not in WIKI	What is a ZeroPriceAmt? Meaning?
29	EnctrServLines	LinePRCalc	All -0-	Not in WIKI	What is LinePRCalc? Meaning?
30	EnctrServLine	NCLPCd		Wiki – No reporting value. Loop 2400 Segment SV101-2-Procedure Code where SV101 = N4	Why not in use? Companion Guide includes this element
31	EnctrSLModCds	SLModCdId	Seq 8 digit	Not in WIKI	What should SLModCdId link to?
32	EnctrSpanOccur	SpanOccurId	Seql 5 digit	Not in WIKI	What should SpanOccurId link to?
33	EnctrSpanOccur	HOCCCd	70-72,78	Not in WIKI	What is HOCCCd? Values legend?
34	EnctrSrvLnDrugs	ServLnDrugsId	Seql 7 digit	Not in WIKI	How to use?
35	EnctrSrvLnDrugs	ServLineId	Seql 8-9 digit	MMCS Derived Primary Key for table	What should ServLineId link to?
36	EnctrSrvLnDrugs	DrugCd	Multi Seqs: 7, 8,11 digits	Not in WIKI	What is DrugCd? Why different seq's?
37	EnctrTPLAmts	PayerType	11,BL,CI, HM, M MB,MC,OF P,T,ZZ	Only 2 (M, MB) labeled in WIKI. No definition	What is meaning of PayerType codes, values?
38	EnctrTPLAmts	PayerIDType	PI	Not in WIKI	What is meaning of PayerIDType codes, PI? Blank?
39	EnctrTPLAmts	PayerRespCd	A,B,P,S,T	Not in WIKI	What is meaning of PayerRespCd? Meaning of A,B,P,S,T?
40	EnctrTPLAmts	AmtPd	Various Amt	Not in WIKI.	Who Paid?
41	EnctrTPLAmts	TPLAmtId	Seq 7 digit	Not in WIKI	What should TPLAmtId link to?
42	EnctrTPLDetail	TPLDetailId AdjGroupCd	Seq 7 digit CO, PR	Not in WIKI	What should TPLDetailId link to? What is AdjGroupCd? CO, PR Meaning?
43	EnctrValues	ValuesId	Seq 7 digit	Not in WIKI	What should ValuesId link to?
44	EnctrValues	EnvcCd	1 or 2 digit or alpha (36 unique)	Not in WIKI	What is EnvcCd? Meaning of the values entered (36)?

Appendix 4
DW encounter claim tables and field counts

Encounter information segments into multiple tables. Data scientists must reassemble the encounter record for program integrity evaluations and in the absence of documented mapping the relationships, data scientists lack confidence in the data results. For example: CPT Code Modifiers at the service line level separate to a table labeled "EnctrSLModCds." The record containing the modifier code contains field "SLModCdId" must link to other records in other tables to obtain a flat record representing the claim. Not all tables are listed below.

Effect: To assess information successfully for encounter records analysts must identify the relationships between multiple tables, using identifiers unique to encounter fields. Without an official data dictionary and documented mapping, program integrity results are inconclusive.

Ref	Encounter Claim Tables	Info Type	Field Count
1	Encounters		105
2	EnctrDiagnoses	Diag	5
3	EnctrProcCds	Proc	6
4	EnctrProvTPLInt	TPL	5
5	EnctrServLines	Line	52
6	EnctrSLModCds	Line	5
7	EnctrSLTPL	TPL	13
8	EnctrSLTPLDetail	TPL	6
9	EnctrSplitTCN		5
10	EnctrSrvLnDrugs	Drug	8
11	EnctrTPLAmts	TPL	18
12	EnctrTPLDetail	TPL	6
	Encounter Fields		**234**

See Finding 5.

Appendix 5
42 CFR 438 and 447: Key citations.

Summary: The citations below report CMS requirements for States Medicaid to ensure through contracts, MCE information systems collect and report complete and accurate enrollee and provider information and to verify completeness, accuracy and consistency at a frequency and level of detail to specified by CMS and the State, based on program administration, oversight, and program integrity needs. **(§438.242).** The State must audit at least every 3 years (starting July 1, 2017), the accuracy, truthfulness, and completeness of the encounter and financial data submitted **(§438.602)**. The MCE must submit certification of the accuracy, completeness and truthfulness of the data or documents *concurrently with the certified data* **(§438.606)**. MCEs must pay practitioners 90 percent of all clean claims within 30 days of receipt and 99 percent within 90 days or have alternative provisions stipulated in the contract **(§447.45 and 447.46)**. States must fully cooperate with CMS. CMS will assess a State's submission to determine if it complies with current criteria for accuracy and completeness. If, after being notified of compliance issues the State is unable to make a data submission compliant, CMS will take appropriate steps to defer and/or disallow FFP on all or part of an MCE contract in a manner based on the enrollee and specific service type of the noncompliant data (**§438.818**).

Specific citations follow:

§ 438.242 Health information systems.
(a) General rule. The State must ensure, through its contracts that each MCO and PIHP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and dis-enrollments for other than loss of Medicaid eligibility. (b) Basic elements of a health information system. The State must require, at a minimum, that each MCO and PIHP comply with the following: (1) Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State. (2) Ensure that data received from providers is accurate and complete by— (i) Verifying the accuracy and timeliness of reported data; (ii) Screening the data for completeness, logic, and consistency; and (iii) Collecting service information in standardized formats to the extent feasible and appropriate. (3) Make all collected data available to the State and upon request to CMS, as required in this subpart. (c) *Enrollee encounter data.* Contracts between a State and a MCO, PIHP, or PAHP must provide for:(1) Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.(2) Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs.

§ 438.602 State Responsibilities
(e) Periodic audits. The State must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP.

§ 438.606 Source, content, and timing of certification.
(a) Source of certification. For the data specified in § 438.604, the data the MCO or PIHP submits to the State must be certified by one of the following:
(1) The MCO’s or PIHP’s Chief Executive Officer.

(2) The MCO's or PIHP's Chief Financial Officer.
(3) An individual who has delegated authority to sign for, and who reports directly to, the MCO's or PIHP's Chief Executive Officer or Chief Financial Officer.
(b) Content of certification. The certification must attest, based on best knowledge, information, and belief, as follows:
(1) To the accuracy, completeness and truthfulness of the data.
(2) To the accuracy, completeness and truthfulness of the documents specified by the State.
(c) Timing of certification. The MCO or PIHP must submit the certification concurrently with the certified data.

§438.818 Enrollee encounter data.
(a) FFP is available for expenditures under an MCO, PIHP, or PAHP contract only if the State meets the following conditions for providing enrollee encounter data to CMS:
(1) …
(2) States must ensure that enrollee encounter data is validated for accuracy and completeness as required under §438.242 before submitting data to CMS. States must also validate that the data submitted to CMS is a complete and accurate representation of the information submitted to the State by the MCOs, PIHPs, and PAHPs.
(3) States must cooperate with CMS to fully comply with all encounter data reporting requirements of the Medicaid Statistical Information System or any successor system.(b) CMS will assess a State's submission to determine if it complies with current criteria for accuracy and completeness.
(c) If, after being notified of compliance issues under paragraph (b) of this section the State is unable to make a data submission compliant, CMS will take appropriate steps to defer and/or disallow FFP on all or part of an MCO, PIHP, or PAHP contract in a manner based on the enrollee and specific service type of the noncompliant data. Any deferral and/or disallowance of FFP will be effectuated utilizing the processes specified in §§430.40 and 430.42 of this chapter

§ 447.45 Timely claims payment
(d) *Timely processing of claims.*
(2) The agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt.
(3) The agency must pay 99 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt.

§ 447.46 Timely claims payment by MCOs.
(c) *Contract requirements*—
(1) *Basic rule.* A contract with an MCO must provide that the organization will meet the requirements of §§ 447.45(d)(2) and (d)(3), and abide by the specifications of §§ 447.45(d)(5) and (d)(6).
(2) *Exception.* The MCO and its providers may, by mutual agreement, establish an alternative payment schedule.
(3) *Alternative schedule.* Any alternative schedule must be stipulated in the contract.

Appendix 6
Example contracts with *concurrent* data submission certification required by 42 CFR 438.666

Concurrent Data Submission Certification:

1. Arizona Medicaid MCO Contract Section E, paragraph 18 page 149 of 198:
   "The Contractor shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful [42 CFR 438.604; 42 CFR 438.606(b)]. Certification of financial and encounter data must be submitted concurrently with the data [42 CFR 438.606(c); 42 CFR 438.604(a) - (b)]. Certification may be provided by the Contractor's Director, Deputy Director of the Division, CFO or an individual who is delegated authority to sign for, and who reports directly to the Director, Deputy Director or CFO [42 CFR 438.604; 42 CFR 438.606(a)]."

2. Tennessee Medicaid MCO Statewide Contract, Section E.24.1
   "In accordance with 42 CFR 438.604 and 438.606, when State payments to the CONTRACTOR are based on data submitted by the CONTRACTOR, the CONTRACTOR shall certify the data. The data that shall be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals and related documents including the medical loss ratio (MLR) report. The data shall be certified by one of the following: the CONTRACTOR's Chief Executive Officer, the CONTRACTOR's Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to the CONTRACTOR's Chief Executive Officer or Chief Financial Officer. The certification shall attest, based on best knowledge, information, and belief, as follows:

   E.24.1.1 To the accuracy, completeness and truthfulness of the data; and
   E.24.1.2 To the accuracy, completeness and truthfulness of the documents specified by the State.
   E.24.2 The CONTRACTOR shall submit the certification concurrently with the certified data."

See Finding 3.

Appendix 7
Arizona Medicaid requires all seven S.N.I.P. Compliance Levels

The below material is an excerpt from the Arizona Medicaid website:
https://www.azahcccs.gov/Resources/EDI/EDItesting.html

“Each AHCCCS trading partner is responsible for ensuring that its transactions are compliant with HIPAA mandates based on the types of testing described below.

AHCCCS encourages providers and other entities to use either a third party tool or AHCCCS’ Community Manager tool to certify that the entity can produce and accept HIPAA compliant transactions. Success is determined by the ability to pass the seven types of compliance tests listed below. The initial four of the seven types of testing are also used as categories for edits performed by the AHCCCS translator.

The testing types have been developed by the Workgroup for Electronic Data Interchange (WEDI), a private sector organization concerned with implementation of electronic transactions. They are:

1. Integrity Testing - This kind of testing validates the basic syntactical integrity of the provider’s EDI file.
2. Implementation Guide - Requirements Testing - This kind of testing involves requirements imposed by the transaction’s HIPAA Implementation Guide, including validation of data element values specified in the Guide.
3. Balancing Testing - Balancing verification requires that summary-level data be numerically consistent with corresponding detail level data, as defined in the transaction’s Implementation Guide.
4. Inter-Segment Situation Testing - Situation testing validates inter-segment situations specified in the Implementation Guide (e.g., for accident claims, an Accident Date must present).
5. External Code Set Testing - This kind of testing validates code set values for HIPAA mandated codes defined and maintained outside of Implementation Guides. HCPCS Procedure Codes and NDC Drug Codes are examples.
6. Product Type or Line of Service Testing - This kind of testing validates specific requirements deemed in the Implementation Guide for specialized services such as durable medical equipment (DME).
7. Trading Partner-Specific Testing - Testing of trading partner requirements involves Implementation Guide requirements for transactions to or from Medicare, Medicaid and Indian Health Services. For AHCCCS trading partners, trading partner requirement testing includes testing of the approaches that AHCCCS has taken to accommodate necessary data within HIPAA compliant transactions and code sets.

Arizona Medicaid verified by reply email on November 21, 2018 all 7 S.N.I.P. levels are required and validated:

AHCCCS does require that encounter data pass the seven (7) types of Strategic National Implementation Process (S.N.I.P.) compliance tests. When encounter files are received, they are first translated and then validated.

See Finding 1.

Appendix 8
Tennessee Medicaid Seven S.N.I.P. Compliance Levels and Test Process

Tennessee Medicaid (TennCare) requires each submitter to be tested and approved before HIPAA transactions will be processed in production. TennCare refers to the Strategic National Implementation Process (S.N.I.P) seven types of transaction testing. TennCare has custom S.N.I.P. 7 edits in place for enforcement of balancing requirements where standard S.N.I.P. 1-7 edits do not exist. A listing of custom S.N.I.P. 7 edits is provided to an approved trading partner for any impacted transaction. These and other requirements are specified online at:
https://www.tn.gov/content/dam/tn/tenncare/documents/HCFATennCareEDIFrontMatter.pdf
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Section 4.07 Strategic National Implementation Process (S.N.I.P.) Test Types

TennCare requires each prospective electronic data interchange (EDI) submitter to be tested and approved before HIPAA transactions will be processed in production. TennCare will conduct the required testing with a submitter via test file(s) from the submitter to TennCare in one of our test environments. The Workgroup for Electronic Data Interchange (WEDI), through a collaborative healthcare industry effort called the Strategic National Implementation Process (S.N.I.P.), developed seven types of transaction testing:

1) Integrity Test: Testing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 syntax, and compliance with X12 rules. This will validate the basic level integrity of the EDI submission.

2) Requirement Test: Testing for TR3 specific syntax requirements, such as repeat counts, used and not used codes, elements and segments, required or intra-segment situational data elements. Testing for non-medical code sets as laid out in the TR3. Values noted in the TR3 via an X12 code list or table.

3) Balance Test: Testing the transaction for balanced field totals, financial balancing of claims or remittance advice, and balancing of summary fields, if appropriate.

4) Situational Test: Testing of specific inter-segment situations described in the TR3, including the validation of situational fields based on rules present in the TR3 for loops, segments, and data elements.

5) External Code Set Test: Testing for valid TR3 specific code set values. This type will not only validate the code sets but also make sure the usage is appropriate for any particular transaction.

6) Specialty of Line of Business Test: Testing to ensure that the segments and data elements required for certain healthcare services are present and correctly formatted according to the TR3.

7) Trading Partner Requirements Test: Testing to ensure that trading partner specific requirements are implemented. TennCare does enforce multiple S.N.I.P. 7 edits for most claims and select other transactions.

Separate testing as appropriate will be required for each transaction type. Once testing is validated, the submitter is placed into production for the approved transaction.

See Finding 1.

Appendix 9
Edits applied during MMCS programming that reject the encounter record.

Utah Medicaid indicates the 93 edits listed below apply to encounter records, applicable claim types during MMCS processing. If the encounter record fails the edit, the encounter reports to the MCE as rejected. See Finding 1.

Ref	Description
1	Admit date after statement covers begin date
2	Admit date missing
3	Admit hour missing/invalid
4	Admit source missing
5	Admitting diagnosis code invalid
6	Admitting diagnosis code missing
7	Attending physician ID missing or invalid
8	Charges missing/invalid
9	Client has Foster Care Eligibility
10	Covered days missing/invalid
11	Diagnosis code not on file
12	Diagnosis code x-ref Invalid
13	Diagnosis code x-ref Missing
14	Diagnosis to sex mismatch
15	Discharge Hour Invalid
16	Discharge Hour Missing
17	Discharge status invalid
18	Discharge status missing
19	DRG code invalid
20	Drug Procedure Code must have a valid NDC Code
21	Drug Procedure Code must have a valid NDC Code In Crosswalk
22	Duplicate encounter.
23	E-code is invalid
24	From date after submit date
25	From date of service missing
26	Group Billing Provider has Invalid Rendering Provider
27	Healthy U: submit date > 2012 & service was 2012 or before, or new amount > original paid
28	ICD9 on/after 10/1/2015 or ICD10 before 10/1/2015
29	Invalid claim frequency code
30	Invalid/Missing Quadrant Arch
31	Invalid/Missing State Assigned Medicaid ID
32	Max units exceeded
33	MCO paid amount equal TPL amount
34	MCO's Entry Date Missing
35	MCO's Paid Date Missing
36	MCO's Paid Date Missing - HMO With MCO Paid Amount <> 0
37	Missing claim frequency code
38	Modifier invalid
39	Modifier invalid for procedure code
40	Must contain at least one service line not plan denied.
41	No match found on history for replacement - Replacement Claim TCN not included.
42	No match found on history for replacement - Replacement Claim TCN not included.
43	No match found on history for void

44	Original TCN being voided Was Rejected
45	Original TCN was rejected
46	Other payer amount missing
47	Other procedure code not on file
48	Patient account number is missing
49	Payer ID invalid
50	Place of service invalid
51	Place of service missing
52	Plan Paid Amount missing
53	Previous TCN not present for void code
54	Primary Diagnosis Code for Substance Abuse
55	Primary Diagnosis code Invalid
56	Primary Diagnosis code Missing
57	Principle procedure code missing
58	Principle procedure code not on file
59	Procedure code invalid
60	Procedure code missing
61	Procedure code must exist for this Revenue Code
62	Procedure date not between admit date and statement through date
63	Procedure date of service missing
64	Procedure to sex mismatch
65	Rate Invalid
66	Rate Missing
67	Recipient DOB missing
68	Recipient DOB Month and year does not match file month and year
69	Recipient enrolled with another plan during service Period
70	Recipient enrolled with another plan on admission date
71	Recipient enrollment not reflected on system
72	Recipient ID missing from encounter
73	Recipient ID not on file
74	Recipient ineligible during service period
75	Recipient ineligible on admission date and the first capitation payment was not made during hospital stay
76	Recipient name does not match file name
77	Recipient name missing
78	Rendering Provider ID Missing
79	Rendering Provider Medicaid ID Missing/Invalid
80	Replacement/void code not present for previous TCN
81	Revenue code invalid
82	Revenue code missing
83	Service through date after submit date
84	Service through date prior to service from date
85	TCN has already been replaced
86	TCN has already been voided
87	Through date after submit date
88	Through date prior to from date
89	Tooth number invalid (must be a number 1 to 32 OR Letter between A to T)
90	Tooth number missing
91	Tooth surface invalid
92	Total charge missing/invalid
93	Units missing

Appendix 10
Claims data elements missing on T-MSIS and promised CMS

The data elements listed below, that Utah Medicaid is not currently providing to CMS, are part of the 837 X12 encounter data submissions for both encounter and FFS claims. Utah Medicaid informed CMS that these will be provided with the implementation of PRISM in January, 2020.

Ref	T-MSIS DE NO	DATA ELEMENT NAME
1	CIP170	BIRTH-WEIGHT-GRAMS
2	CIP184	ADMITTING-PROV-NPI-NUM
3	CIP185	ADMITTING-PROV-NUM
4	CIP186	ADMITTING-PROV-SPECIALTY
5	CIP187	ADMITTING-PROV-TAXONOMY
6	CIP188	ADMITTING-PROV-TYPE
7	CIP198	OUTLIER-DAYS
8	CIP213	COPAY-WAIVED-IND
9	CIP220	MEDICAID-AMOUNT-PAID-DSH
10	CIP226	UNDER-SUPERVISION-OF-PROV-NPI
11	CIP227	UNDER-SUPERVISION-OF-PROV-TAXONOMY
12	CIP250	IP-LT-QUANTITY-OF-SERVICE-ALLOWED
13	CLT128	WAIVER-TYPE
14	CLT129	WAIVER-ID
15	CLT135	REFERRING-PROV-NUM
16	CLT136	REFERRING-PROV-NPI-NUM
17	CLT137	REFERRING-PROV-TAXONOMY
18	CLT138	REFERRING-PROV-TYPE
19	CLT139	REFERRING-PROV-SPECIALTY
20	CLT160	COPAY-WAIVED-IND
21	CLT171	UNDER-SUPERVISION-OF-PROV-NPI
22	CLT172	UNDER-SUPERVISION-OF-PROV-TAXONOMY
23	CLT174	ADMITTING-PROV-NPI-NUM
24	CLT175	ADMITTING-PROV-NUM
25	CLT176	ADMITTING-PROV-SPECIALTY
26	CLT177	ADMITTING-PROV-TAXONOMY
27	CLT178	ADMITTING-PROV-TYPE
28	CLT203	IP-LT-QUANTITY-OF-SERVICE-ALLOWED
29	CLT231	HCPCS-RATE
30	COT058	OTHER-TPL-COLLECTION
31	COT127	DAILY-RATE
32	COT150	UNDER-SUPERVISION-OF-PROV-NPI
33	COT151	UNDER-SUPERVISION-OF-PROV-TAXONOMY
34	COT176	COPAY-AMT
35	COT184	OT-RX-CLAIM-QUANTITY-ALLOWED
36	COT188	HCBS-TAXONOMY

37	COT197	TOOTH-QUAD-CODE
38	CRX035	CLAIM-PYMT-REM-CODE-1
39	CRX036	CLAIM-PYMT-REM-CODE-2
40	CRX037	CLAIM-PYMT-REM-CODE-3
41	CRX038	CLAIM-PYMT-REM-CODE-4
42	CRX049	OTHER-TPL-COLLECTION
43	CRX059	MEDICARE-REIM-TYPE
44	CRX079	MEDICARE-HIC-NUM
45	CRX095	COPAY-WAIVED-IND
46	CRX099	THIRD-PARTY-COINSURANCE-DATE-PAID
47	CRX101	THIRD-PARTY-COPAYMENT-DATE-PAID
48	CRX123	COPAY-AMT
49	CRX124	TPL-AMT
50	CRX127	MEDICARE-DEDUCTIBLE-AMT
51	CRX128	MEDICARE-COINS-AMT
52	CRX129	MEDICARE-PAID-AMT
53	CRX131	OT-RX-CLAIM-QUANTITY-ALLOWED
54	CRX137	OTHER-TPL-COLLECTION
55	CRX146	REBATE-ELIGIBLE-INDICATOR
56	CRX152	OTHER-INSURANCE-AMT

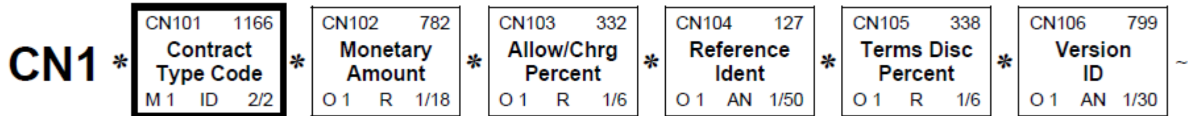
See Finding 1.

Appendix 11
X12 837 CN1 Segment: Payment Terms Data Elements

The CN1 segment of the X12 837 Standard contains the six data elements (DE) CN101 – CN106. The below describes the X12 requirements for each DE.

- CN101 Contract Type Code: reports the payment type agreed between the MCE and the provider for the encounter, for example flat fee, capitated, other.
- CN102 Monetary Amount: provides the payment amount.
- CN103 Percent, decimal format: is the allowance or charge percent for the applicable payment type.
- CN104 Reference Identification: is the contract code or reference identification qualifier.
- CN105 Terms Discount Percent: is the terms discount, expressed as a percent, available to the purchaser if an invoice is paid on or before the terms discount due date.
- CN106 Version Identifier: is the revision level of the particular format, program, technique or algorithm.

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CN101**	**1166**	**Contract Type Code** Code identifying a contract type	**M 1 ID 2/2**

CODE	DEFINITION
01	Diagnosis Related Group (DRG)
02	Per Diem
03	Variable Per Diem
04	Flat
05	Capitated
06	Percent
09	Other

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**CN102**	**782**	**Monetary Amount** Monetary amount	**O 1 R 1/18**

SEMANTIC: CN102 is the contract amount.

SITUATIONAL RULE: ***Required when the provider is required by contract to supply this information on the claim. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Contract Amount**

SITUATIONAL	CN103	332	**Percent, Decimal Format** Percent given in decimal format (e.g., 0.0 through 100.0 represents 0% through 100%) SEMANTIC: CN103 is the allowance or charge percent. SITUATIONAL RULE: ***Required when the provider is required by contract to supply this information on the claim. If not required by this implementation guide, do not send.*** IMPLEMENTATION NAME: **Contract Percentage**	O 1	R	1/6
SITUATIONAL	CN104	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: CN104 is the contract code. SITUATIONAL RULE: ***Required when the provider is required by contract to supply this information on the claim. If not required by this implementation guide, do not send.*** IMPLEMENTATION NAME: **Contract Code**	O 1	AN	1/50
SITUATIONAL	CN105	338	**Terms Discount Percent** Terms discount percentage, expressed as a percent, available to the purchaser if an invoice is paid on or before the Terms Discount Due Date SITUATIONAL RULE: ***Required when the provider is required by contract to supply this information on the claim. If not required by this implementation guide, do not send.*** IMPLEMENTATION NAME: **Terms Discount Percentage**	O 1	R	1/6
SITUATIONAL	CN106	799	**Version Identifier** Revision level of a particular format, program, technique or algorithm SEMANTIC: CN106 is an additional identifying number for the contract. SITUATIONAL RULE: ***Required when the provider is required by contract to supply this information on the claim. If not required by this implementation guide, do not send.*** IMPLEMENTATION NAME: **Contract Version Identifier**	O 1	AN	1/30

See Finding 4 and 5.

Appendix 12
CMS Assessment of Utah Medicaid T-MSIS data submission

In April 2019 CMS issued the following assessment of the Utah Medicaid T-MSIS monthly submission. The assessment states that Utah Medicaid is current, but with issues in five of the 12 Top Priority Items (TPI). Two of the five are not associated with the claims data flow.

Current T-MSIS Assessment for Utah

1. Ensuring T-MSIS files are submitted monthly and remain current at all times

As of March 20, 2019 Utah has submitted T-MSIS files for February 2019. This means the state is Current.

2. Resolving data issues associated with CMS' 12 Top Priority Items (TPIs)

Utah has 5 of the 12 Top Priority Items with Open data issues:

TPI 4	Reasonableness of CHIP eligible counts using CHIP Code
TPI 6	Completeness and robustness of eligibility group
TPI 8	Consistency of managed care plan reporting and cross-file consistency
TPI 9	Capitation payment volume
TPI 12	Linking providers from claims to provider files

Notes: Based on state's December, 2018 T-MSIS Submissions.
This assessment excludes data quality findings that may be impacted by errors resulting from overlapping record segments in your non-claims files. After April 19, 2019, CMS expects states to be compliant with the non-claims guidance for your selected submission method(s). Thus, CMS will no longer exclude these data quality findings from your TPI assessment.

3. Resolving data element missingness: key data elements must be populated and where appropriate, must link across files. *CMS will work individually with each state in the identification, prioritization and resolution of key data elements relevant to your state.*

See Finding 1.

GLOSSARY OF TERMS

Term	Description
837	The standard format for transmitting health care claims electronically. The full description is the ANSI ASC X12N 837
4010	Prior version of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards for health care professionals and suppliers. In effect from 200 to 2012. Utah Medicaid edits remained at the 4010 level until the SOA EDIFECS was implemented in 2015.
5010	Current version of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards for health care professionals and suppliers. CMS required Version 5010 effective January 2012. Utah did not implement 5010 until 2015.
ACO	Accountable Care Organization – A type of MCO
AE	Encounter was accepted with errors.
AHCCCS	The Arizona Health Care Cost Containment System is the name of the Medicaid program in the state of Arizona.
ANSI	American National Standards Institute
ASC	Accredited Standards Committee
ASCA	The Administrative Simplification Compliance Act (H.R.3323: 12/27/2001), prohibits payment of initial health care claims not sent electronically as of October 16, 2003, except in limited situations
AW	Encounter record was accepted by Utah Medicaid without edits applied.
BCRP	Bureau of Coverage and Reimbursement Policy
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations (CFR) is the codification of the general and permanent rules and regulations (sometimes called administrative law) published in the Federal Register
Companion Guides	Utah Medicaid Companion Guides document the data requirements for MCE encounter claims. The CGs supplement the Guides. The Guides and CGs are the only two media specified in the contracts for communicating and documenting data requirements for encounter records.

CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology (CPT) code set is a medical code set maintained by the American Medical Association. CPT is Level I of the Healthcare Common Procedure Coding System (HCPCS) code system and accompanied by the HCPCS Level II supply and service codes.[43]
CY	Calendar Year (CY) of January 1 through December 31.
DTS	Utah Department of Technology Services
DW	Data Warehouse, Utah Medicaid's centrally controlled data repository.
EDI	Electronic data interchange is the concept of businesses electronically communicating information that was traditionally communicated on paper.
EQR	External Quality Review
FFS	Fee For Service is the model used by payers of health care claims to pay providers directly for services provided.
Guides	National Implementation Guides, published and copyrighted by the WPC documenting the 837 standards requirements.
HHS	US Department of Health and Human Services
HIPAA	The Health Insurance Portability and Accountability Act of 1996 was enacted by the United States Congress and signed by President Bill Clinton in 1996.
HCPCS	The Healthcare Common Procedural Coding System (HCPCS). The HCPCS is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.[44]
HSAG	Health Services Advisory Group. Medicaid contracts with HSAG to perform the external quality review (EQR) for services mandated by CMS.
ID	Identification Number
IPPR	In-Patient Payer Review

[43] https://www.aapc.com/resources/medical-coding/cpt.aspx
[44] https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Transactions/TransactionFAQs.html#q4 https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html https://www.aapc.com/resources/medical-coding/cpt.aspx

MACPAC	The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan federal legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states. The U.S. Comptroller General appoints MACPAC's 17 commissioners.
MCE	Managed Care Entities
MCO	Managed Care Organization, includes ACO and PIHP
MFCU	Utah Medical Fraud Control Unit
MIB	Utah Medicaid Information Bulletin published by Utah Medicaid.
MMCS	Utah Medicaid Managed Care System
MMIS	Utah Medicaid Management Information System
MSIS	See T-MSIS
NUBC	National Uniform Billing Committee. The NUBC was formed in 1975 to develop and maintain a single billing form and standard data set to be used nationwide by institutional, private and public providers and payers for handling health care claims. The 837 requires the use of codes maintained by the NUBC.
PAHP	Prepaid Ambulatory Health Plan
PI	Program Integrity
PIHP	Prepaid Inpatient Health Plan
PRISM	Provider Reimbursement Information System for Medicaid
SFY	Utah State Fiscal Year beginning July 1 and ending June 30.
S.N.I.P.	**S**trategic **N**ational **I**mplementation **P**rocess of the WEDI. Developed and recommended by the WEDI, seven levels to achieve HIPAA compliance certification.
SOA	Service Oriented Architecture: A software, EDIFECS, implemented by Utah DTS Medicaid in SFY 2015 quarter one as part of a gateway for claims to enforce the 5010 standard.
TCN	Transaction Control Number (TCN). The Health Care Provider Taxonomy code is a unique alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Grouping, Classification, and Area of Specialization. The National Uniform Claim is presently maintaining the code set.
TennCare	Tennessee Medicaid Managed Care Plan

T-MSIS	The Transformed Medicaid Statistical Information System is the CMS system that all state Medicaid program data is uploaded for both FFS and managed care.
TR3	Type 3 Technical Reports (TR3) define explicit data requirements for a specific business purpose. Trading partners define their specific transport requirements separately. Neither ASC X12 standards nor TR3s define transport requirement. http://www.wpc-edi.com/reference/repository/006020CC.PDF
UHIN	Utah Health Insurance Network is the clearinghouse through which nearly all encounter records and claims are submitted to Utah Medicaid.
OIG	Utah Office of Inspector General
WEDI	Workgroup for Electronic Data Interchange. Formed in 1991 by the Secretary of Health and Human Services (HHS), WEDI was named in the 1996 HIPAA legislation as an advisor to HHS and continues to fulfill that role today.
WIKI	The Main Page States: "Medi-Wiki, Medicaid-Wiki, of MHFWiki. This site is intended to promote information flow by and for the Division of Medicaid and Health Financing. All logged in users may perform edits." http://hcfnet.health.utah.gov/wiki/index.php/Main_Page
WPC	Washington Publishing Company. WPC has publishing rights for X12 standards.
X12	The X12 is an organization chartered by the American National Standards Institute develops and maintains EDI standards and schemas that drive business processes globally.

MANAGEMENT RESPONSE

State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

JOSEPH K. MINER, MD, MSPH, FACPM
Executive Director

Division of Medicaid and Health Financing

NATE CHECKETTS
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

~~August 25~~ September 27, 2019

Gene Cottrell
Inspector General
Office of the Inspector General of Medicaid Services
P.O. Box 14103
Salt Lake City, Utah 84114

Dear Mr. Cottrell:

Thank you for the opportunity to respond to the audit titled *Audit of the Medicaid Encounter Data Quality Assurance* (Report 2018-01). We appreciate the effort and professionalism of you and your staff in this review. Likewise, our staff spent time collecting information for your review, answering questions, and planning changes to improve the program. We believe that the results of our combined efforts will make a better, more efficient program.

We concur and partially concur with the recommendations in this report with the exception of recommendation 1.2. The Department of Health is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need improvement.

Sincerely,

Nate Checketts

Nate Checketts
Deputy Director, Department of Health
Division Director, Medicaid and Health Financing

288 North 1460 West • Salt Lake City, UT
Mailing Address: P.O. Box 143101 • Salt Lake City, UT 84114-3101
Telephone (801) 538-6689 • Facsimile (801) 538-6478 • www.health.utah.gov

Response to Recommendations

Recommendation 1.1

We recommend Utah Medicaid modify the MCE contracts to define a clean claim to mean a complete and accurate claim submitted timely that complies with both the National Guide and Utah Companion Guides. In addition, MCE contracts should include data specifications adequate to enable MCEs to achieve compliance with all seven S.N.I.P. X12 WEDI HIPAA Compliance Levels prior to submission of 837 data on a progressive or benchmark basis. Benchmark with other States requiring level 5 or higher and progressively increase to all seven levels of compliance over time. Each level enhances the completeness and accuracy prior to submission for program integrity purposes.

Department Response:

The Department partially concurs with this recommendation

42 CFR 447.45 (b) includes the following definition, which is the definition used in the Department's MCE contracts. The Department believes the current language regarding clean claims is sufficient:

42 CFR 447.45 (b) Definitions.

"Clean claim" means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity."

The Department currently validates incoming claim and encounter submissions using SNIP levels 1 and 2. These validate basic syntactical structure and HIPAA Implementation Guide Requirements within the submitted file (837). Once the file passes this initial validation each encounter is processed into the state system and internal edits are applied and must be passed before being accepted. The internal edits address key elements that also occur in SNIP levels 3-7.

Not all components validated in SNIP editing are of substantial value to the quality of the encounter. For example, a 9 digit zip code of the provider is required in some instances. If the plus-four segment is invalid the encounter will be rejected. Applying all 7 SNIP level edits to encounter file submissions may result in unnecessarily rejected encounters.

Encounters are generally submitted in large batches. A single 837 file will contain up to 5,000 individual encounters. Because of the way encounter files are submitted, SNIP validations are applied to the file as a whole. If even one encounter fails the zip code validation mentioned above, the other 4,999 encounters will also be rejected.

The Department will explore the possibility of working with UHIN to apply appropriate levels of SNIP edit to claims and encounters before they are submitted to the Department by UHIN. UHIN provides this service for commercial payers. UHIN also reports that most

commercial payers are applying SNP level 4 or 5 to their claims. The Department will determine if additional SNIP levels or additional internal edits will improve the quality of submitted encounters without placing undue burden on providers.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: June 30, 2020

Recommendation 1.2

We recommend Utah Medicaid modify the MCE contracts to include specific measures of completeness, accuracy and timeliness (see "CMS Specific Measures") for determining when financial incentive, or penalties are incurred. Specify in the MCE contracts a progressive benchmark approach that requires increasing levels over time for completeness, accuracy, and timeliness using specific measures.

Department Response:

The Department does not concur with this recommendation. MCE contracts include language regarding requirements for encounters in Section 12.3. In addition, the Department conducts quarterly reviews with each plan addressing the completeness, accuracy, and timeliness of their encounter data. Specific language addressing this process has already been added to contracts. In addition, MCE contracts include specific language regarding liquidated damages for failure to comply with the provisions of Section 12.3. for non-compliance.

MCE's have an incentive to submit as many valid encounters as possible as only accepted encounters are included in evaluation for rate setting.

Finally, the measures mentioned in the "CMS Specific Measures" relate to a third party review of nationwide TMSIS encounter data from 2007-2009. These measures provide a reasonableness check by comparing FFS and TMSIS data submitted during the same timeframe. Determination of "completeness" is based on high level measures such as average number of encounter claims per enrollee. Determination of "quality" is based on measures such as average number of claims with a primary diagnosis code.

While these measures are interesting and can be, and occasionally are, used as a reasonableness check, they are very high level and don't provide additional value to the already existing quarterly encounter review process.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: Not applicable

Recommendation 1.3

We recommend Utah Medicaid review the "soft edits" and if the edit applies to encounter record accuracy and completeness for program integrity, adjust the edit to reject the encounter. If the soft edit serves no reasonable, regular and continuous purpose then inactivate the edit.

Department Response:

The Department concurs with this recommendation. The Department will review its "soft edits" and determine if current edits should continue or be modified.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: June 30, 2020

Recommendation 2.1

We recommend Utah Medicaid modify the MCE contracts requirement for data submission to Medicaid so all agree with Utah Medicaid's expected timeliness measure referenced in the Utah Medicaid's Bureau of Managed Health Care (BMHC) quarterly monitoring, 45 days or less from date of adjudication.

Department Response:

The Department concurs with this recommendation. This change was made in contracts effective January 1, 2019.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: January 1, 2019

Recommendation 3.1

We recommend Utah Medicaid modify all the MCE contracts, not just the ACO, to require certification of completeness, accuracy and truthfulness holding the CEO or CFO ultimately responsible, concurrent with the submission of encounter data.

Department Response:

The Department concurs with this recommendation. The Department will add this requirement to all contracts no later than July 1, 2020 as contracts come up for amendment or renewal.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: July 1, 2020

Recommendation 4.1

We recommend Utah Medicaid update the Companion Guides to include all data requirements not already specified or supplemental to, the Guides adequate to ensure complete, accurate and consistent reporting of encounter claims, codes and values by all MCEs. Include:
- *State specific program integrity and administration data elements or values, and include full and complete directions, explanations and descriptions to ensure clear understanding;*
- *Code sets or values supplemental to the Guide;*

• *Add the X12 CN1 segment data elements for payment type information.*

Department Response:

The Department partially concurs with this recommendation. The State Companion Guide is intended to be used in conjunction with HIPAA X12 Implementation Guide and provides State specific instructions regarding certain elements within the X12 Implementation Guide.

The State Companion Guide is not intended to be a source of complete element or code set. For example, ICD 10 Diagnosis Codes could not possibly be included in the State Companion Guide.

The X12 Implementation Guide does not maintain all code sets and cites external code sources as applicable.

The Department will review and update the Companion Guide with current State expectations and practices along with including the same external code sources as applicable and appropriate.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: March 31, 2020

Recommendation 4.2

We recommend Utah Medicaid Maintain the Companion Guides to include all data practices and requirements on an on-going basis.

Department Response:

The Department concurs with this recommendation. The Department will review the State Companion Guides on an annual basis and also update them as needed.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: March 31, 2020 and ongoing

Recommendation 5.1

We recommend Utah Medicaid actively seek recommendations for data elements from MFCU, Utah OIG Program Integrity, Milliman, Inc., and other stakeholders dependent on encounter data quality and usability. In addition, discuss training needed for stakeholders to understand and analyze encounter data.

Department Response:

The Department concurs with this recommendation. The Department communicates with Milliman on a regular basis. The Department has on several occasions specifically asked the Utah OIG for their feedback regarding additional data or changes to data they may need in MCE encounter data and the Department has not received recommendations or requests to date. The

Department has not deterred or refused to provide assistance on understanding encounter data and has encouraged stakeholders, Utah OIG specifically, to ask questions so they can better understand encounter data.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: Ongoing

Recommendation 5.2

We recommend Utah Medicaid develop a centrally controlled data dictionary containing definitions of all acceptable encounter fields and values, and include mapping to other encounter fields and tables contained in the Medicaid Data Warehouse..

Department Response:

The Department partially concurs with this recommendation. Please see the Department's response to Recommendation 4.1 with regards to encounter fields and values. With regards to creating a data dictionary for the Medicaid Data Warehouse, this would be primarily the responsibility of the Department of Technology Services (DTS) with the assistance of the Department. The Department will work with DTS to determine the feasibility of creating a data dictionary and the date by which this project can be completed given all other IT priorities in support of Medicaid and CHIP.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: The Department will meet with DTS on this recommendation by November 30, 2019.

Recommendation 5.3

We recommend Utah Medicaid define or specify precise codes for MCE denial of payment to providers. PI and other stakeholders can then use the codes to identify the reason for denial of payment and its claim history.

Department Response:

The Department concurs with this recommendation. The Department will review how other states have standardized this and determine what Utah can adopt in the current legacy system. In the PRISM system, industry standard denial reasons will be captured.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: June 30, 2020

Recommendation 5.4

We recommend Utah Medicaid add encounter fields to Views not already available in the Views, for example the dental services data elements.

Department Response:

The Department concurs with this recommendation. A change request (DOT 94083) was submitted to create data warehouse views of all production tables.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: September 30, 2020

Recommendation 5.5

We recommend Utah Medicaid program the S.O.A. gateway to allow all 837 syntactically valid data elements defined in the Guides and Companion Guides, and code sets including the CN1 segment, through to downstream systems. Identify a method to capture and report the X12 specified CN1 segment of the six, post payment fields and make the CN1 segment contractually obligated.

Department Response:

The Department partially concurs with this recommendation. The Department will investigate the feasibility of this recommendation in its legacy system. The current SOA gateway does not currently allow for non-HIPAA segments and will reject the file submission if present. The Department will revisit the issue with DTS and determine if these elements can be included without causing file rejection.

The Department will have this capability in the new PRISM system.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: January 1, 2022

EVALUATION OF MANAGEMENT RESPONSE

Utah Medicaid, as the Single State Agency, is responsible for the integrity of its programs. Utah Medicaid looks to the Utah OIG to fulfill many program integrity functions while also acknowledging that the encounter data, adequate for capitation rate determination according to Utah Medicaid, is not adequate for program integrity purposes.

Utah OIG and other users cannot rely on the X12 837 encounter data submissions. Two specific examples follow:

A. Federal regulations prohibit Medicaid payments for "provider-preventable conditions", or PPCs. Utah Medicaid does not collect the X12 field required for all inpatient encounter claims, to verify if the MCEs pay PPCs. The field not collected by Utah Medicaid is the "Present on Admission" (POA) indicator. If Utah OIG submits a programming request to Utah DTS to collect the POA field it would be several years after date of implementation before PPCs could be audited. The US HHS OIG conducts audits of PPCs and in August 2019 identified $43 Million in payments to the State of Pennsylvania for encounter claims containing PPCs.

   Utah OIG could request the information directly from the ACOs, but this would bypass the X12 data submissions process controls. Utah Medicaid presently receives quarterly reports from the MCEs however, the report information is not mapped and not verifiable.

B. Federal regulations prohibit Medicaid payments to laboratories that are not CLIA (or equivalent state certification) certified. *Utah Medicaid does not collect the CLIA in the encounter data submission, even though the CLIA is a required field in the X12 837 Guide.*

The implication to not collecting all situationally (inpatient, DME …) required fields (vs. the minimum HIPAA required fields) is that alleged program integrity issues come to Utah Medicaid and OIG attention that cannot be researched in the absence of key fields and then the only option is to obtain the information by special request directly from the MCEs absent the X12 controls including unmitigated, potential conflicts of interest.

Milliman, Inc. estimates there are approximately 1000 data fields in the typical X12 837 encounter data submission. Utah Medicaid collects approximately half this total. Most fields not collected by Utah Medicaid are designated in X12 837 Guide as situationally required fields.
Utah Medicaid did not implement the X12 required encounter data submission process adequate to perform its program integrity duties and responsibilities and the recommendations made in this report, if fully implemented would correct many of the deficiencies.
The Utah Medicaid response to the audit recommendation is deficient in the following specific areas.

Recommendation 1.1

We recommend Utah Medicaid modify the MCE contracts to define a clean claim to mean a complete and accurate claim submitted timely that complies with both the National Guide and Utah

Companion Guides. In addition, MCE contracts should include data specifications adequate to enable MCEs to achieve compliance with all seven S.N.I.P. X12 WEDI HIPAA Compliance Levels prior to submission of 837 data on a progressive or benchmark basis. Benchmark with other States requiring level 5 or higher and progressively increase to all seven levels of compliance over time. Each level enhances the completeness and accuracy prior to submission for program integrity purposes.

Utah Medicaid's response partially concurs.

Utah OIG Evaluation of Medicaid's Response:

Utah Medicaid's response refers to 42 CFR 447.45 which references MCE paying of providers for the definition of a clean claim, not MCE submitting of encounter claims data to the Single State Agency which should be, truly clean claims.

Utah Medicaid's response acknowledges that incoming claims validate to only SNIP Levels 1 and 2, and acknowledges that most Utah commercial payers currently apply through SNIP Level 4 or 5. Other States, including Arizona Medicaid, apply through level 7 (See Appendix 7). Utah Medicaid's response indicates "Once the file passes this initial validation [SNIP Levels 1 and 2] each encounter is processed into the state system and internal edits are applied and must be passed before being accepted. The internal edits address key elements that also occur in SNIP levels 3-7."

Finding one makes it clear the internal edits being few in number are not comparable to the benefits derived from SNIP Levels 3-7 implementation.

Utah Medicaid's response refers to SNIP Level 7 as rejecting an entire batch of encounter data submission if just one encounter fails a zip code test. Medicaid misunderstands the recommendation: the recommendation is that *providers* should submit the data compliant to SNIP Compliance Levels 5 or higher on a benchmark or progressive basis and to increase to all 7 over time *prior* to submitting the data to Medicaid. The SNIP allow for programming adjustments and rejecting a whole batch based on the failure of one minor error in SNIP level 7 is unnecessary.

Again, Utah Medicaid presently accepts encounter claims at SNIP level 1 and 2.
Utah OIG recommends Utah Medicaid require providers to submit the encounter claim data compliant to SNIP level 5 or higher on a progressive basis, increasing to all 7 over time will enable a higher quality data stream, rejecting fewer encounters - all benefits that are transferable to PRISM.

Utah Medicaid needs to map and collect the situationally required data fields for program integrity purposes.

Recommendation 1.2

We recommend Utah Medicaid modify the MCE contracts to include specific measures of completeness, accuracy and timeliness (see "CMS Specific Measures") for determining when financial incentive, or penalties are incurred. Specify in the MCE contracts a progressive benchmark approach that requires increasing levels over time for completeness, accuracy, and timeliness using specific measures.

Utah Medicaid did not concur.

Utah OIG Evaluation of Utah Medicaid's Response:

Utah Medicaid's response rejects the development of specific measurement of completeness, accuracy, and timeliness *despite acknowledging explicitly in the contracts that the damages from breach of this Contract may be incapable or very difficult of accurate estimation*. Audit recommendation 1.2 recommends Medicaid develop measures so damages will be "capable of accurate estimation."

Utah Medicaid does not define, or measure, completeness (includes all fields) and accuracy (valid field values) of *an encounter healthcare claim*.

Utah Medicaid recently implemented an informal and undocumented process review of encounter records by periodically emailing a list of encounter records to the MCEs for post-processing review. Utah OIG acknowledges this review as beneficial to identifying missing encounters, but not for completeness (includes all fields) and accuracy (valid field values) of individual encounter data fields.

Since Utah Medicaid only requires compliance with SNIP Levels 1 and 2, completeness (includes all fields) and accuracy (validity of field values) of individual encounter claims cannot be assured or measured. SNIP Levels 3 -7 verify completeness (includes all fields) and accuracy (valid field values) of individual encounter records. MMCS processing edits only partially offset the absence of SNIP levels. See Appendices 7 and 8 for a description of the SNIP Levels.

The MCE contracts do not require the encounter data submissions to comply with SNIP Levels 3-7.

The MCE contracts include damages for (a) lack of data submission and for (b) incomplete or inaccurate encounter data. However, the MCE contracts do not contain a definition or measurement for what constitutes complete and accurate, or incomplete and inaccurate. For example, does "lack of data submission" only occur when no encounter records were submitted, or also when significant amounts of encounter records, or few were not submitted? Does failure to submit just one encounter record constitute incomplete? Does not submitting a particular required field constitute incomplete? How many? (The MCE contracts contain no measure or specification of what constitutes "failure to submit encounter data" or, what constitutes "incomplete and inaccurate"). The audit report page 15 provides examples of specific measures used by the States of New Jersey and Michigan Medicaid.

As a result of not having measures by which damages could be calculated, the State of Utah MCE (ACO/MCO) contracts state: "The Parties agree that the damages from breach of this Contract may be incapable or very difficult of accurate estimation."

Again, Utah Medicaid did not concur with recommendation 1.2 and the MCE contracts remain without measures of completeness and accuracy.

See Finding One pages 14-16 above.

Recommendation 4.1

We recommend Utah Medicaid update the Companion Guides to include all data requirements not already specified or supplemental to, the Guides adequate to ensure complete, accurate and consistent reporting of encounter claims, codes and values by all MCEs. Include:

- *State specific program integrity and administration data elements or values, and include full and complete directions, explanations and descriptions to ensure clear understanding;*
- *Code sets or values supplemental to the Guide;*
- *Add the X12 CN1 segment data elements for payment type information.*

Utah Medicaid only partially concurs.

Utah OIG Evaluation of Utah Medicaid's Response:

Other States, for example Arizona, publish complete encounter manuals in addition to the Arizona X12 837 Companion Guide. The Arizona Encounter Manual includes 7 chapters containing explanations, directions, and "how to" information. Utah Medicaid should consider publishing more complete guidance to the MCEs.

The intent of recommendation 4.1 is to encourage Utah Medicaid to specify codes and values not already specified in the Guide or an external source; the publishing of helpful information, helpful to ensure understanding toward the achievement of completeness and accuracy at the individual encounter claim level.

Codes and values already described in the Guide may need no further explanation, but other fields may need specification or helpful instruction, direction. For example, if there is more than one industry practice for reporting the field then Utah Medicaid must clarify which industry practice to use in the data submission.

ICD-10 code values are of course, specified externally and should not be repeated in the Companion Guide.

Recommendation 5.2

We recommend Utah Medicaid develop a centrally controlled data dictionary containing definitions of all acceptable encounter fields and values, and include mapping to other encounter fields and tables contained in the Medicaid Data Warehouse.

Utah Medicaid only partially concurs.

Utah OIG Evaluation of Utah Medicaid's Response:

It is unclear as to the reason Utah Medicaid only partially concurs.

All encounter tables, data fields, and field values contained or reported in the Utah Medicaid Data Warehouse should include direction for data scientists on how to use. If field values are explained or defined in an external source then the external source should be referenced and the content does not need to be repeated.

MMCS processing codes, for example that link two tables together also need "how to link" information for users to join fields for the same encounter. Data fields for encounter records process to multiple tables in the Medicaid Data Warehouse and in the absence of "how to link" information query results lack integrity. This should also be expedited and should include directions for all MMCS processing codes.

The specification of codes and field values, or reference to outside sources should not be delayed since these will likely carry over to the new PRISM.

Recommendation 5.5

Program the S.O.A. gateway to allow all 837 syntactically valid data elements defined in the Guides and Companion Guides, and code sets including the CN1 segment, through to downstream systems. Identify a method to capture and report the X12 specified CN1 segment of the six, post payment fields and make the CN1 segment contractually obligated.

Utah Medicaid partially concurs.

Utah OIG Evaluation of Utah Medicaid's Response:

Utah Medicaid states, "The Department will have this capability in the new PRISM system." However, the PRISM system must still undergo significant development and testing before CMS approves the system.

Presently, Utah Medicaid collects only about half of the total data fields contained in the average X12 837 data submission as estimated by Milliman, Inc. the firm Utah Medicaid contracts to perform actuary services.

Utah Medicaid is not collecting multiple fields key to program integrity and key to the Utah OIG mission of preventing fraudulent, abusive, and wasteful practices within the Medicaid program. Utah Medicaid indicates January 1, 2022 as the implementation date; however, the implementation date is uncertain.

Conclusion:

The lack of adequate encounter data prior to PRISM implementation causes significant risk to the Medicaid program resulting in waste of taxpayer dollars.

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

UTAH OIG CONTACT

Ron Sufficool
Lead Auditor

Neil Erickson
Audit Manager

UTAH OIG MISSION STATEMENT

The Utah Office of Inspector General will enhance the integrity of the Utah State Medicaid program by preventing fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting a high quality of patient care.

ADDRESS

Utah Office of Inspector General
Martha Hughes Cannon Health Building
288 N 1460 W
Salt Lake City, Utah 84116

OTHER

Website: http://www.oig.utah.gov/
Hotline: 855.403.7283