Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NOT ALL STATES REPORTED MEDICAID MANAGED CARE ENCOUNTER DATA AS REQUIRED

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EXECUTIVE SUMMARY: NOT ALL STATES REPORTED MEDICAID MANAGED CARE ENCOUNTER DATA AS REQUIRED
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WHY WE DID THIS STUDY

Approximately 70 percent of all Medicaid beneficiaries receive services through managed care. The high proportion of beneficiaries enrolled in managed care makes accurate "encounter data"—i.e., information about the services provided to Medicaid beneficiaries enrolled in managed care—essential for the oversight of Medicaid as well as prevention of fraud, waste, and abuse. State Medicaid programs are required to report encounter data to a national database, the Medicaid Statistical Information System (MSIS). However, previous Office of Inspector General (OIG) reviews have raised concerns about the completeness, timeliness, and accuracy of national Medicaid data. For example, in 2009 OIG found that the encounter data reported to MSIS were incomplete, and recommended that the Centers for Medicare & Medicaid Services (CMS) enforce Federal requirements for reporting encounter data. Another 2009 OIG report found that over one and a half years elapsed between when States submitted MSIS files and when CMS accepted them.

HOW WE DID THIS STUDY

We examined the third-quarter fiscal year 2011 MSIS claims files for the 38 States that had the types of managed care programs for which encounter data must be reported to MSIS. For each State we reviewed, we determined whether encounter data was present in MSIS for all of the managed care entities with which the State had contracts. For each State with missing encounter data, we contacted State Medicaid officials to determine why these data were missing. Finally, we conducted interviews with CMS and contractor staff regarding oversight of States' reporting to MSIS.

WHAT WE FOUND

States' reporting of encounter data to MSIS improved since our 2009 report, but some States are still not reporting data for all contracted managed care entities. In the 2009 report, OIG found that 15 States did not report encounter data to MSIS. In the current report, 8 of the 38 States we reviewed did not report encounter data from any managed care entities by the required deadline. An additional 11 States did not report encounter data for all managed care entities. Finally, because of issues with the data that seven States submitted, we could not assess whether those States reported encounter data for all of their managed care entities.

WHAT WE RECOMMEND

To ensure that all States comply with the requirement to submit encounter data, we recommend that CMS use its authority to withhold appropriate Federal funds from States that fail to submit encounter data to MSIS until those States report encounter data as required. We also recommend that CMS monitor encounter data to ensure they are reported for all managed care entities. CMS concurred with both recommendations.

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OBJECTIVES

1. To determine the extent to which States reported encounter data for all managed care entities to the Medicaid Statistical Information System (MSIS).
2. To identify factors that prevented States' reporting of MSIS encounter data.

BACKGROUND

Medicaid Managed Care

Medicaid managed care programs deliver health services through contracted arrangements between State Medicaid agencies and managed care entities. In 2013, approximately 70 percent of the 55 million Medicaid beneficiaries nationwide were enrolled in managed care programs.[1] The reimbursement methods and delivery systems of managed care programs vary depending on the type of program implemented. One reimbursement method is capitation. In capitated managed care programs, managed care entities receive a fixed monthly rate per enrolled Medicaid beneficiary in exchange for the provision of covered services.[2, 3]

Encounter Data

Encounter data are detailed information regarding the services provided to the individual beneficiaries enrolled in capitated managed care programs. Encounter data are the managed care counterpart of claims data from fee-for-service programs.

Accurate encounter data are essential for oversight of Medicaid. Encounter data are used for rate-setting, quality assurance, utilization review, and evaluation of how managed care entities performed. A 2009 OIG report found that despite the importance of encounter data to oversight of Medicaid, 15 of the 40 States reviewed were not reporting encounter data to MSIS. The report recommended that the Centers for Medicare & Medicaid Services (CMS) begin enforcing Federal requirements regarding the reporting of encounter data.[4] CMS concurred with this recommendation. In its comments on the 2009 report, CMS stated that it intended to increase its efforts to

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[1] Mathematica Policy Research, *Encounter Data Toolkit*, November 30, 2013.

[2] Managed care entities include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), primary care case managers (PCCMs), and health insurance organizations (HIOs). 42 CFR 455.101.

[3] Managed care entities receive a capitation payment for each beneficiary regardless of whether the beneficiary actually received services during the period covered by the payment. 42 CFR § 438.2.

[4] OIG, *Medicaid Managed Care Encounter Data: Collection and Use* (OEI-07-06-00540), May 2009.

consistently enforce all Federal requirements for the reporting of encounter data from Medicaid managed care programs.

The Medicaid Statistical Information System

MSIS is a national database of Medicaid fee-for-service claims, encounter data, and beneficiary eligibility information. CMS uses MSIS to produce, manage, and analyze information on Medicaid beneficiaries, services, and payments. MSIS data are also widely used for research and policy analysis by both public and private organizations, and may be used for detecting fraud, waste, and abuse.[5, 6]

Federal Authority to Require Encounter Data Reporting. Federal authority regarding submission of State Medicaid programs' encounter data stems from two laws. First, the Social Security Act requires States to submit data, including encounter data, to MSIS.[7, 8] Second, the passage of the Affordable Care Act (ACA) in 2010 gave CMS authority to withhold Federal Medicaid matching funds from States that do not include encounter data in their MSIS submissions.[9] However, rules for implementing the ACA provision have not been published, and as a result CMS has not yet exercised its authority to withhold funds for failure to submit encounter data.

MSIS Claims Files. States are required to submit files to MSIS quarterly. The *MSIS Data Dictionary* defines the data elements required for each type of MSIS file and establishes the dates by which the quarterly submissions must be received (6 weeks after the end of the reporting period).[10]

MSIS includes one eligibility data file and four claims data files for each State. The eligibility file contains one record for each person who was eligible for Medicaid for at least one day during the quarter, or for whom retroactive eligibility was established during the quarter. The four claims files are:

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[5] 53 Fed. Reg. 26674 (July 14, 1988).

[6] CMS, "MSIS Medicaid Statistical Information System." Accessed at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/msis/medicaid-statistical-information-system.html on October 20, 2014.

[7] Social Security Act § 1903(r)(1)(F).

[8] Encounter data must be reported to MSIS for only two types of managed care entities: MCOs and PIHPs. 42 CFR § 438.242. An MCO is a managed care entity that provides a comprehensive benefit package in exchange for capitated "risk-based" payments. (Under a risk-based contract, if the cost of the services exceeds the payments made to the managed care entity, the managed care entity incurs a loss.) A PIHP is a managed care entity that provides a limited benefit package including inpatient hospital or institutional services; payments to PIHPs may be risk-based or non-risk-based. CMS, *Managed Care*. Accessed at http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html on March 23, 2015. Definitions of these types of managed care entities can also be found in 42 CFR § 438.2.

[9] P.L. No. 111-148 § 6504.

[10] CMS, *MSIS Data Dictionary*, pp. 3, 18–63, 67–136.

1. The **inpatient claims file**, which contains records of inpatient hospital services.
2. The **long-term-care claims file**, which contains records of long-term-care services received in an institution, including nursing facilities, intermediate care facilities for the intellectually disabled, psychiatric hospitals, and independent psychiatric wings of acute-care hospitals.
3. The **prescription claims file**, which contains records of prescription drugs, including durable medical equipment and supplies provided by a pharmacist under a prescription.
4. The **other claims file**, which contains records of services that are not included in the inpatient, long-term-care, or prescription files—i.e., all noninstitutional services, institutional services that are not billed for as part of a long-term-care or inpatient claim, and services received under waivers—and records of capitated payments.

Each of the four claims files must contain one record for every claim that was paid and for every encounter that was processed during the reporting quarter.[11]

Each State reports the services covered by its managed care programs via the appropriate MSIS claims files, as described above. For example, if a State does not cover prescription drugs through managed care, it would report encounter data via only its inpatient, long-term-care, and other claims files. The State would not report any encounter data via its prescription claims file.[12]

MSIS File Review Process. We interviewed CMS officials regarding the process for reviewing MSIS files. Each file that a State submits to MSIS is reviewed twice before it is accepted. The first review is an automated review of the contents of each file that occurs at the time of submission. The second review is an indepth review conducted by staff of Mathematica Policy Research (hereinafter Mathematica). Mathematica staff review all of a State's files for a particular quarter. They review the files individually and collectively, to ensure consistency both within individual files and across files. For example, Mathematica staff determine whether every beneficiary for whom encounter data are reported in a claims file is also identified in the eligibility file as being enrolled in managed care. As Mathematica staff conduct these reviews, they contact the States to make followup inquiries and request corrections. State staff then respond to those inquiries and make the needed corrections before resubmitting their files.

After the files have passed all the levels of review and editing, Mathematica staff make a recommendation to CMS staff as to whether they should be

[11] CMS, *MSIS Data Dictionary*, p. 64.

[12] This example assumes that the State in question uses managed care to cover services of the types reported to the inpatient, long-term-care, and other claims files.

accepted. If CMS staff accept the files, they load the files into the MSIS database and make them available to MSIS users.

Transformed Medicaid Statistical Information System

Recognizing the need for a more comprehensive information management strategy for Medicaid, CMS began implementation of a new national Medicaid dataset called the Transformed Medicaid Statistical Information System (T-MSIS) in 2011.[13] With T-MSIS, CMS hopes to improve the completeness and timeliness of national Medicaid data.[14] The target date for States to start reporting to T-MSIS was July 1, 2014;[15] however, CMS officials told us that the agency actually expects most States to start reporting to T-MSIS in 2015.

T-MSIS will replace MSIS and other data reports that States are currently required to submit to CMS. The requirement for States to report encounter data—and CMS's authority to withhold funds from States that do not report these data—will apply to T-MSIS as they did to MSIS.

Related Reports

In addition to conducting this review—which focuses on data related to Medicaid managed care services—OIG has conducted other reviews that raised concerns about the completeness, timeliness, and accuracy of national Medicaid data. In 2009, OIG published two separate reports on MSIS. One review found—as mentioned earlier—that 15 States did not report encounter data to MSIS. The other review found that over one and a half years elapsed between States' submission and CMS's acceptance of MSIS files.[16] In addition to conducting these studies, OIG performed an early implementation review of T-MSIS in 2013 that also raised concerns about the completeness and accuracy of future T-MSIS data.[17]

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[13] Testimony of Peter J. Budetti, Deputy Administrator and Director of the Center for Program Integrity, CMS, on *Assessing Medicare and Medicaid Program Integrity* before the United States House Committee on Oversight and Government Reform, Subcommittee on Government Organization, Efficiency, and Financial Management, June 7, 2012. Accessed at http://oversight.house.gov/wp-content/uploads/2013/02/2012-06-07-Ser.-No.-112-176-SC-Govt-Orgs-on-Medicaid-Medicare.pdf on May 18, 2015.

[14] CMS, *T-MSIS Implementation Toolkit*, June 21, 2013.

[15] CMS staff will work with States to end their MSIS submissions when States are ready to submit files to T-MSIS on a monthly basis. CMS, *SMD#* [State Medicaid Director Letter] *13-004, RE: Transformed Medicaid Statistical Information System (T-MSIS) Data*, August 23, 2013.

[16] OIG, *MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse* (OEI-04-07-00240), August 2009.

[17] OIG, *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System* (OIG-05-12-00610), September 2013.

METHODOLOGY

This study assessed the extent to which States reported encounter data for all managed care entities to MSIS for the third quarter of fiscal year (FY) 2011 and identified factors that prevented States from reporting encounter data to MSIS. When we began this study, the most recent edition of the *National Summary of Managed Care Programs* available was for 2011. Therefore, we reviewed the 2011 MSIS files that were present in MSIS as of September 2013.[18]

To identify which States had programs for which encounter data should have been reported to MSIS, we reviewed the Medicaid managed care programs that were in operation during the review period in all 50 States and the District of Columbia. Thirteen States did not use MCOs or PIHPs to deliver Medicaid managed care services and were therefore excluded from the evaluation. These exclusions brought the total States reviewed to 38.[19]

In each of the 38 States that had the types of managed care programs for which encounter data must be reported to MSIS, we identified the services covered by each managed care program, the managed care entities participating in each managed care program, and plan IDs for those managed care entities. We used the unique plan ID for each managed care entity to determine if the entity had at least one encounter in the MSIS claims file(s) containing data on services of the types the entity provided. We assigned each State to a category indicating the status of its reporting of encounter data for contracted managed care entities: all data reported, some data reported, no data reported, or unknown. Table 1 shows the criteria for each category.

[18] We used information from the *National Summary* to identify which managed care programs each managed care entity was participating in, and to identify the MSIS claims files to which States should have reported encounter data for each managed care entity.

[19] The 2009 OIG evaluation reviewed 40 States. The 2009 evaluation excluded Mississippi, which was included in this evaluation. The 2009 evaluation also included three States—Alabama, North Dakota, and Vermont—that were excluded from the current evaluation because in 2011 they did not operate managed care programs of the types for which encounter data must be reported to MSIS.

Table 1: Criteria for Categories Indicating Status of States' Reporting of Encounter Data for Contracted Managed Care Entities

Status of States' Encounter Data	Description of Status
All data reported	At least one encounter showing the plan ID of every contracted managed care entity was reported in each of the four MSIS claim files containing services of the type(s) the managed care entity covered.
Some data reported	At least one encounter showing the plan ID of some, but not all, contracted managed care entities was reported in each of the four MSIS claims files containing services of the type(s) the managed care entity covered.
No data reported	No encounters showing any plan ID were reported to any of the four MSIS claim files by the required deadline
Unknown	The status of the encounter data reported could not be determined.

Source: OIG analysis of MSIS claims files from the third quarter FY 2011, 2015.

We corresponded with Medicaid officials in each reviewed State to ensure that our understanding of their managed care programs and contracted managed care entities was correct. In States with missing encounter data, we also asked Medicaid officials to identify factors that affected their reporting of encounter data. We interviewed CMS and Mathematica staff regarding their roles in MSIS submissions. Finally, we reviewed correspondence among CMS, Mathematica, and State Medicaid staff regarding the submission of MSIS files. See Appendix A for further details on our methodology.

Scope

While States are only required to report encounter data to MSIS for MCOs and PIHPs participating in capitated managed care programs, many States also report encounter data for other types of managed care entities. We reviewed the MSIS encounter data only for MCOs and PIHPs.

We reviewed only the MSIS claims files; we did not review the eligibility files because they do not contain encounter data.

Limitations

We did not review MSIS claims files to ensure that encounter data representing all services provided through MCOs and PIHPs were present. Our analysis determined whether at least one row of encounter data was present for each MCO and PIHP in each relevant MSIS file in each State.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Complete and accurate national data, including MSIS data, are essential for the oversight of Medicaid. However, previous OIG reviews have raised concerns about the completeness, timeliness and accuracy of national Medicaid data. For example, in 2009 OIG found that 15 States were not reporting any encounter data to MSIS, and recommended that CMS begin enforcing the requirement for such reporting. Our current review looked at 2011 MSIS data, finding that reporting of encounter data to MSIS has improved, but some States are still not reporting data for all managed care entities with which they have contracts. Eight of the thirty-eight States reviewed did not report any encounter data by the required deadline, and an additional 11 States did not report encounter data for all contracted managed care entities. Twelve States reported at least one encounter for every contracted managed care entity. We could not make determinations about the status of an additional seven States' encounter data reported to MSIS.

Eight States did not report any encounter data by the required deadline

The MSIS Data Dictionary establishes a deadline of 6 weeks after the end of the reporting period for receipt of quarterly MSIS files. However, eight States had not reported any encounter data from the third quarter of FY 2011 to MSIS by this deadline. CMS accepted MSIS claims files from six of these States knowing that the files did not contain any encounter data. The two remaining States submitted their MSIS claims files for the third quarter of FY 2011, including their encounter data, nearly 2 years after they were due. See Appendix B for a table showing the results of our assessment of each State's encounter data reported to MSIS.

CMS accepted MSIS claims files from six States knowing that required encounter data were not present

Email correspondence between CMS and Mathematica staff regarding the files submitted by the six States shows that CMS staff knew that the files did not contain encounter data.[20] Yet CMS still accepted those files. Because these six States enrolled between 50 and 100 percent of their Medicaid beneficiaries in managed care, services for at least half the Medicaid beneficiaries in each State were not reported to MSIS.[21]

Medicaid officials in all six States attributed the lack of encounter data in their MSIS claims files to limitations in their respective State data systems. These systems either did not collect encounter data from contracted managed care

[20] The six States were Massachusetts, Nevada, North Carolina, Pennsylvania, South Carolina, and West Virginia.

[21] CMS, *Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011*, p. 4.

entities, or did not report these data to MSIS. When we contacted officials from the six States in 2013, those from four of the six stated that they had already corrected the data system limitation(s) that prevented them from reporting encounter data to MSIS. Officials from the remaining two States stated that they were working to correct the limitations. CMS and Mathematica staff encouraged all six of these States to improve their reporting of encounter data and offered them technical assistance.

Two States' MSIS claims files were nearly 2 years overdue

MSIS claims files for the third quarter of FY 2011 were due on November 15, 2011. Two States first submitted their MSIS claims files for that quarter in September and October 2013, respectively, nearly 2 years after the deadline.[22] These States did not submit their files for the third quarter of FY 2011 until after the due date because they were correcting files submitted for previous quarters.

Data quality issues prevented the files submitted in 2013 from being accepted into MSIS at the time they were submitted. Only some of the rows of data in these files presented the problematic data issues. However, MSIS can only accept or reject *all* the data in a submitted file—there is no option for MSIS to accept only the rows of data that do *not* have quality issues and to reject the rows that do. Therefore, no data could be accepted into MSIS for these two States until the data issues were resolved and the entire files could be accepted. Despite frequent followup by CMS and Mathematica staff, the States did not resubmit acceptable files for the third quarter of FY 2011 until May and August 2014, respectively.[23] Officials from both States reported that the files accepted in 2014 did contain encounter data.

Eleven States did not report encounter data from all managed care entities

Eleven States did not report encounter data for all of their contracted managed care entities. Four of these eleven States were unable to collect required encounter data from all contracted managed care entities, despite the fact that State contracts with managed care entities require the reporting of these data. Another 2 of the 11 States were unable to report all required encounter data because of limitations in their State data systems. Another State cited both reasons—it was unable to collect encounter data from some managed care entities, and it also had limitations in its own data system. This State had five contracted managed care entities operating in the third quarter of FY 2011, but

[22] The two States were Kansas and Utah.

[23] The data quality issues that prevented these MSIS claims files from being accepted when they were first submitted were unrelated to the States' encounter data. We did not assess the encounter data in the files submitted in 2014.

two of the five did not start reporting encounter data until July 2012. In addition, in the third quarter of FY 2011, this State's data system did not yet have the ability to process encounter data representing long-term-care services.[24] The remaining four States did not identify the cause of their missing encounter data.

These 11 States varied as to their respective percentages of managed care entities for which encounter data were reported. Some States—such as Washington and Texas—were missing only a small percentage of managed care entities from one MSIS claims file. Other States—such as Colorado and Illinois—were missing a higher percentage of managed care entities from multiple files. Table 2 shows the percentage of managed care entities for which plan IDs were present among the encounter data in each MSIS claims file for each of these 11 States.

[24] This State was working on developing such capacity at the time of our review.

Table 2: Percent of Managed Care Entities for Which At Least One Encounter Was Reported to MSIS Among States Reporting Some Encounter Data

State	MSIS Claims Files Types			
	Inpatient	Long-term-care	Pharmacy	Other
California	◔	◔	◔	◔
Colorado	◖	◖	◖	◔
Delaware	◖	◖	NA	●
D.C.	◖	◖	◔	●
Illinois	◔	○	○	◔
Indiana	◖	◖	NA	◔
Iowa	●	○	NA	◖
New York	◔	◔	◔	●
Rhode Island	◖	●	●	●
Texas	●	◔	NA	●
Washington	◔	●	●	●

Legend	
○	0% of managed care entities reported
◖	1–50% of managed care entities reported
◔	51–99% of managed care entities reported
●	100% of managed care entities reported
NA	File type not applicable; State did not cover prescription drugs through managed care

Source: OIG analysis of MSIS claims files for the third quarter of FY 2011, 2015.

We could not determine whether seven States reported encounter data for all managed care entities

Seven States reported encounter data to MSIS with plan IDs that we could not use to determine the extent to which at least one encounter was reported for all managed care entities.[25] Five of these seven States had at least one MSIS claims file with encounter data that contained invalid, blank, or "dummy" values instead of plan IDs. Without accurate values for plan IDs, it is not possible to determine whether encounter data are present in a given MSIS claims file for all managed care entities; thus, we cannot make determinations about the status of the encounter data that

[25] The seven States were Florida, Missouri, New Mexico, Ohio, Oregon, Virginia, and Wisconsin.

these five States reported to MSIS. The remaining two States used multiple identifiers in the plan-ID field, rather than a single unique identifier corresponding to each managed care entity. We determined that for these two States, it would be prohibitively difficult to determine which of the multiple identifiers we should look for to confirm that the required encounter data were being reported for each managed care entity. Thus, we were unable to make determinations about the status of these two States' encounter data.

Invalid plan IDs. Two States included invalid values in the plan ID field in their encounter data. Both States reported health care provider IDs rather than the plan IDs of the managed care entities that paid for the services. Officials from one of these States explained that the data system it had in operation in 2011 did not have the ability to report plan IDs to MSIS. Officials from this State said that CMS staff directed them to report provider identification numbers in the plan ID field as a stopgap measure, and to develop the capacity to report plan IDs for when the State begins submitting files to T-MSIS. Medicaid officials from the other State explained that provider identification numbers were reported instead of plan IDs for services that beneficiaries received outside the provider networks of their respective managed care entities.

Blank plan IDs. Another two States reported encounter data with blank plan IDs in their prescription claims files. Officials from these States explained that problems in the process of creating the files for submission to MSIS resulted in the blank plan IDs. Officials from both of these States also stated that the problems had been corrected in subsequent MSIS claims file submissions.

"Dummy" plan IDs. Review of the fifth State's inpatient claims file showed that only the "dummy" plan ID—888888888888—was present. When we contacted officials in this State, they stated that the inpatient file they submitted had a valid plan ID on every row of encounter data. However, the file that was loaded into MSIS, after review and acceptance by CMS, contained only the "dummy" value in the plan ID field. We were unable to identify the source or cause of the discrepancy between what the State reported and the accepted MSIS inpatient claims file.

Multiple plan IDs. The remaining two States assigned multiple plan IDs to managed care entities. The first State assigned plan IDs to managed care entities based on the region(s) they served, the program(s) they participated in, and the type(s) of beneficiaries they covered. The second

State assigned each of its managed care entities a different plan ID for each county that the entity operated in.

States have flexibility in how they assign plan IDs to managed care entities; it is not incorrect for States to assign regional or county-specific plan IDs to each contracted managed care entity. However, we determined that it was prohibitively difficult to define which of the multiple identifiers for each managed care entity should be present in each MSIS claims file.[26] Just as it was for us, it would be difficult for CMS to obtain the information needed to ensure encounter data for every contracted managed care entity are present in the MSIS claims files of States that assign regional or county-specific plan IDs to their managed care entities.

[26] Defining which of the multiple plan IDs for each managed care entity should be present in a given MSIS file is difficult because there are legitimate reasons why no encounter data should be reported for a particular plan ID. For example, in a county with low Medicaid enrollment, it could be that no beneficiaries enrolled in a particular managed care entity in that county needed long-term care during the quarter.

CONCLUSION AND RECOMMENDATIONS

Previous OIG reviews have raised concerns about the completeness, timeliness, and accuracy of national Medicaid data. OIG's early implementation review of T-MSIS, published in 2013, raised concerns about the completeness and accuracy of future T-MSIS data. Other OIG work found that over one and a half years elapsed between States' submission of MSIS files and CMS's acceptance of them. A 2009 OIG report found that CMS did not enforce the required reporting of encounter data to MSIS, and recommended that CMS begin enforcing Federal requirements regarding such reporting. CMS concurred with that recommendation and said it would increase its efforts to consistently enforce all Federal requirements for Medicaid encounter data reporting. However, we found that—for data from the third quarter of FY 2011—CMS was still not enforcing the requirement for States to report encounter data to MSIS. Of the 38 States we reviewed, 8 States had not reported any encounter data by the required deadline. An additional 11 States did not report encounter data for all contracted managed care entities. Finally, we could not determine whether seven States reported encounter data for all managed care entities.

The passage of the Affordable Care Act in 2010 gave CMS new authority to withhold Federal funds from States that do not comply with requirements to report encounter data. In the past, CMS has accepted MSIS files that do not contain the required encounter data. CMS should change its practices for overseeing States' submissions to ensure full compliance with the requirement for States to report encounter data.

To ensure that all States comply with this requirement, we recommend that CMS:

Use its authority to withhold appropriate Federal funds from States

If States fail to submit encounter data within a reasonable timeframe after being notified of issues with their MSIS submissions, CMS should use its authority to withhold appropriate Federal funds, to an extent commensurate with the State's level of noncompliance, from those States until encounter data are reported as required.

Monitor encounter data to ensure States report data for all managed care entities

To accomplish this, CMS should monitor the submission of encounter data to ensure that:

- all States with capitated managed care programs using MCOs and PIHPs submit encounter data;

- submitted encounter data include all contracted managed care entities; and
- submitted encounter data include valid plan IDs.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with both of our recommendations.

In responding to our first recommendation, CMS noted that it has issued a notice of proposed rulemaking that would authorize the withholding of Federal funds from States until encounter data are reported as required and information systems meet established standards.

In responding to our second recommendation, CMS stated that it will continue to work with States to ensure that managed care programs submit encounter data to States, that encounter data submitted to MSIS by States include all managed care entities, and that the submitted encounter data include valid plan IDs. CMS stated that it takes a number of steps to ensure that States submit encounter data—specifically, it approves each new managed care program that a State implements, and as part of that approval process, the State attests that it will be able to report quality data for that managed care program. Once the new managed care program is operating, CMS monitors the quality and completeness of encounter data that the State submits to MSIS regarding the program. Finally, CMS said that it provides feedback to States to improve the quality of their encounter data.

We support CMS's efforts to ensure that encounter data are reported to MSIS as required, and to monitor and improve the encounter data that States submit to MSIS. However, the issues we identified in this report occurred despite CMS's current monitoring practices. We suggest that CMS either increase its monitoring of encounter data that States submit to MSIS, or expand its efforts to assist States to correct deficiencies identified through that monitoring. For the full text of CMS's comments, see Appendix C.

APPENDIX A

Detailed Methodology

Collection of MSIS Files

We obtained copies of the MSIS claims files for the third quarter of FY 2011 for each of the 38 States included in this evaluation. Within each MSIS claims file, we limited the data used in our analysis to those rows with value "3" in the "type of claim" field; this value indicates that the row of data represents an encounter provided through a capitated managed care program.

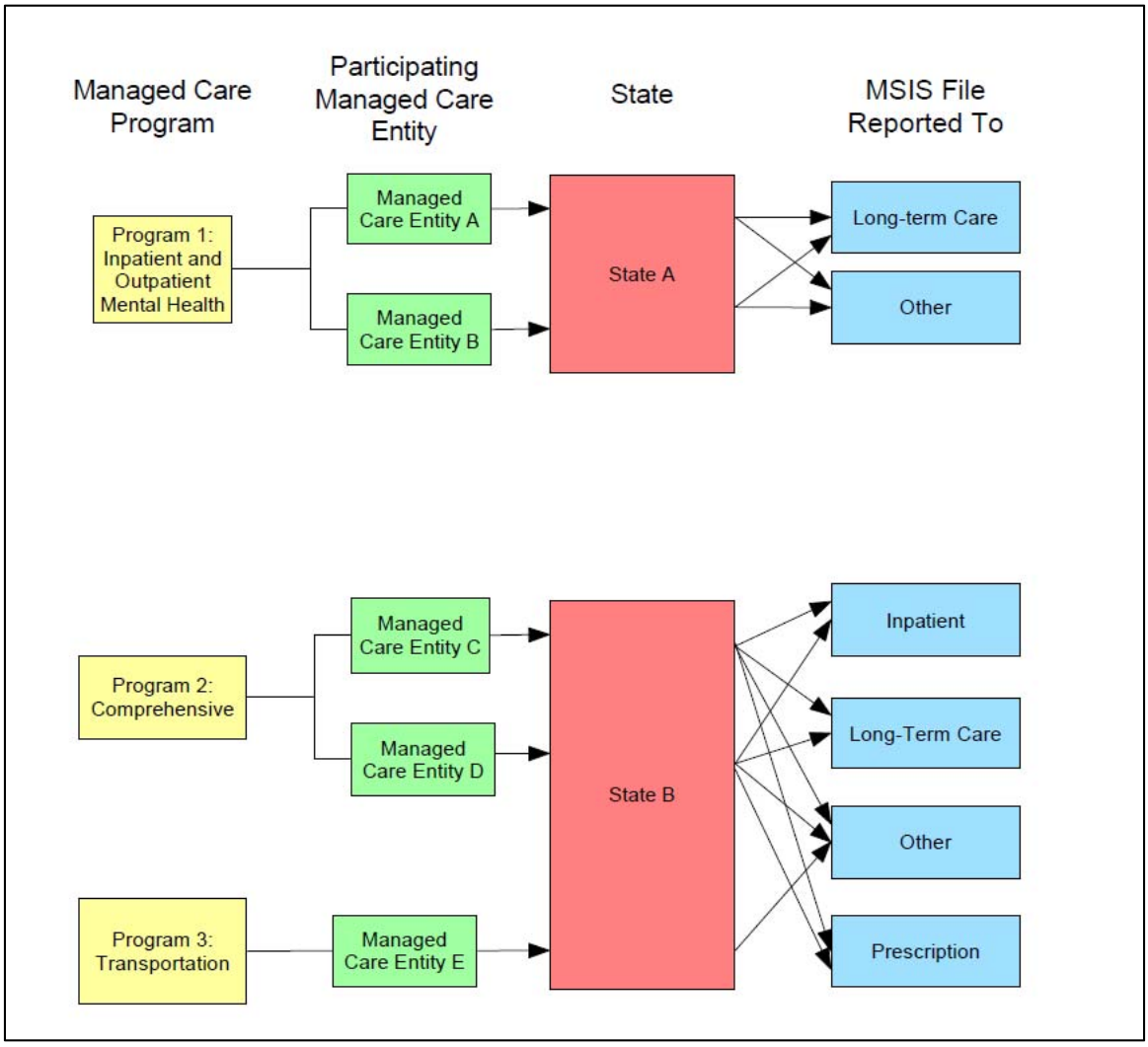
Identification of Managed Care Programs, Contracted Managed Care Entities, and Plan IDs

Each managed care entity has an identification number known as a plan ID, which is reported in the "plan ID" field in MSIS. CMS staff provided us with a list of managed care entities that were participating in managed care programs in each State in 2011, and the plan IDs for those managed care entities. CMS staff explained that the information in this list was reported by States and had not been validated. When the list provided by CMS proved inaccurate for a particular State, we collected correct information on contracted managed care entities and their plan IDs from State Medicaid staff.[27]

Using the plan ID list(s) and information in the 2011 *National Summary of Managed Care Programs*, we created a database showing the managed care programs through which each managed care entity was providing services, and the MSIS claims files to which the services provided should have been reported. Thus, we developed a table showing to which of the four MSIS claims files each State should have reported encounters for each managed care entity. Chart A.1 illustrates the flow of encounter data from managed care entities participating in managed care programs to States to MSIS claims files.

[27] We considered the plan ID information provided by CMS inaccurate if (1) the plan IDs in the MSIS claims files were of a different format or type than the plan IDs in the CMS information (i.e., "204776597032" vs "026"); (2) the number of plan IDs in a State's MSIS claims files greatly exceeded the number of plan IDs for that State in CMS's information; or (3) when CMS's information contained internal discrepancies, such as listing multiple plan IDs for one managed care entity, assigning the same plan ID to multiple managed care entities, or having missing plan IDs.

Chart A-1: Flow of Encounter Data to MSIS Claims Files



Assessment of Encounter Data in MSIS Claims Files

For each State we reviewed, we compared the plan IDs for contracted managed care entities to the plan IDs that were present among the encounter data in the MSIS claims files. We identified which, if any, managed care entities did not have any encounters present in a given file.

Prior to publication of the report, we shared with officials in each reviewed State the categorization of the State's encounter data, and gave them an opportunity to provide further information regarding the reasons for any missing encounter data.

CMS and Contractor Data Collection

We conducted three interviews spaced throughout the data collection period with CMS staff responsible for oversight of MSIS, regarding the

MSIS reporting requirements and file submission process. We also conducted a similar interview with staff from Mathematica.

Finally, we requested and reviewed correspondence among CMS, Mathematica, and State Medicaid staff regarding the submission of files for the third quarter of FY 2011, followup questions about those files, and resubmission of those files. We limited this correspondence review to the States that were placed in the "no data reported" category.

APPENDIX B

Status of Encounter Data Reported to MSIS by States for Third Quarter FY 2011

Status of Encounter Data	Description of Status	Number of States
All data reported	At least one encounter showing the plan ID of every contracted managed care entity was reported in each of the four MSIS claims files containing services of the type(s) the managed care entity covered.	12 (Arizona, Connecticut, Georgia, Hawaii, Kentucky, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New Jersey, Tennessee)
Some data reported	At least one encounter showing the plan ID of some, but not all, contracted managed care entities was reported in each of the four MSIS claims files containing services of the type(s) the managed care entity covered.	11 (California, Colorado, Delaware, the District of Columbia, Illinois, Indiana, Iowa, New York, Rhode Island, Texas, Washington)
No data reported	No encounters showing any plan ID were reported to any of the four MSIS claim files by the required deadline.	8 (Kansas, Massachusetts, Nevada, North Carolina, Pennsylvania, South Carolina, Utah, West Virginia)
Unknown	The status of the encounter data reported cannot be determined because of blank, invalid, or "dummy" plan IDs.	5 (Missouri, New Mexico, Oregon, Virginia, Wisconsin)
	These States assigned multiple plan IDs to their managed care entities; it was not possible to define which plan IDs should be present in each MSIS claims file.	2 (Florida, Ohio)
Excluded	These States did not use managed care of the types for which encounter data is required to be reported to MSIS during the review period.	13 (Alabama, Alaska, Arkansas, Idaho, Louisiana, Maine, Montana, New Hampshire, North Dakota, Oklahoma, South Dakota, Vermont, Wyoming)
Total		**51**

Source: OIG analysis of MSIS claims files for the third quarter of FY 2011, 2014.

APPENDIX C

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

MAY 19 2015

To: Daniel R. Levinson
Inspector General
Office of the Inspector General

From: /S/
Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services

Subject: Not All States Reported Medicaid Managed Care Encounter Data as Required (OEI-07-13-00120)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of the Inspector General's (OIG) draft report. CMS is committed to ensuring States report accurate and timely Medicaid encounter data.

Medicaid managed care programs deliver health services through contracted arrangements between State Medicaid agencies and managed care entities. For capitated managed care programs, encounter data are detailed information regarding the services provided to individual beneficiaries, the equivalent of claims data for fee-for-service arrangements. CMS works with states in a variety of ways to help them collect and report Medicaid encounter data. For example, CMS has issued an encounter data toolkit to States which contains best practices, sample processes and contact information for technical assistance and additional printed publications.

CMS has been also working with states to implement changes to the way in which data is collected by moving from the Medicaid Statistical Information System (MSIS) to the Transformed-MSIS or T-MSIS. T-MSIS will use data provided by states to embed front end data quality edits which provide greater transparency to a state's data quality and will have a robust business intelligence/data analytics front end interface which will allow states and other key stakeholders to analyze nationwide data, including encounter, claims, and enrollment data. T-MSIS will also help streamline the reporting process by reducing the number of reports and data requests CMS requires of states. The enhanced data available from T-MSIS will support improved program and financial management and more robust evaluations of demonstration programs. It will also enhance the ability to identify potential fraud and improve program efficiency.

OIG Recommendation

The OIG recommends that CMS use its authority to withhold appropriate Federal funds from States.

CMS Response

CMS concurs with this recommendation. CMS has issued a notice of proposed rulemaking (NPRM) that would authorize withholding Federal funds from states, under sections 1903(i)(25) and (m)(2)(A)(xi), until encounter data are reported as required and information systems meet established operability standards. This proposed rule, if finalized, would also extend federal funding for information systems at a 90/10 matched rate. The enhanced Federal funds can be used to build systems that produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability. These updated data systems would be able to collect and report encounter, enrollment, claims, and expenditure data. CMS verifies that states are able to meet certain criteria prior to being able to access the funds intended to improve their information systems including reporting of encounter data.

OIG Recommendation

The OIG recommends that CMS monitor encounter data to ensure states report all managed care entities.

CMS Response

CMS concurs with this recommendation. CMS currently works with states to ensure capitated managed care programs submit encounter data; that submitted encounter data includes all contracted managed care entities; and submitted encounter data includes valid plan IDs. CMS works with states in both the program approval phases (e.g. waiver, state plan amendment) to assure that states attest to their data quality and reporting capabilities as well as the post-approval program implementation and data reporting phase currently done through MSIS to monitor the quality and completeness of a states' managed care encounter data submission. CMS analyzes this data quality and provides feedback to states so that action plans can be developed to improve quarter over quarter quality of a state's managed care data. CMS will continue to work with States to ensure they submit accurate and timely data.

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This report was prepared under the direction of Brian T. Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Michala Walker served as the team leader for this study. Other Office of Evaluation and Inspections staff from the Kansas City regional office who conducted the study include Michael Barrett, Teresa Dailey, and Conswelia McCourt. Central office staff who provided support include Eddie Baker, Berivan Demir Neubert, Althea Hosein, Kevin Manley, and Christine Moritz.

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