



New York State Department of Health

**Performance audit of Managed Care Organizations (MCO)
Encounter data submissions for calendar year 2018**

Final Report
As of August 22, 2022

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August 22, 2022

Mr. Jonathan Bick
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Dear Mr. Bick:

This report presents the results of KPMG LLP's (KPMG) performance audit of the Managed Care Organizations (MCO) Encounter Data submissions for calendar year 2018, conducted on behalf of the State of New York (the State) Department of Health (the Department or DOH). Our substantive fieldwork began June 18, 2021, and the results, reported herein, are presented as of DOH's final approval on May 12, 2022.

KPMG conducted this performance audit in accordance with Generally Accepted Government Auditing Standards (GAGAS) issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and recommendations based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and recommendations based on our audit objectives.

We have evaluated GAGAS independence standards for performance audits and affirm that we are independent of the Department and the relevant subject matter at the MCO level to perform the performance audit of the Encounter Data submissions for submission Year 2018.

This audit did not constitute an audit of financial statements in accordance with GAGAS or U.S. Generally Accepted Auditing Standards. KPMG was not engaged to, and did not, render an opinion on the Department's and MCOs' internal controls over financial reporting or over financial management systems.

Based on the procedures performed and results obtained, we have met our performance audit objectives as agreed upon with the Department.

This report is intended solely for the information and use of management of the Department, and is not intended to be, and should not be, used by anyone other than this specified party.

Sincerely,

KPMG LLP

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Executive summary

KPMG LLP (KPMG) was engaged by the New York State (NYS) Department of Health (DOH or the Department) to conduct a performance audit of the accuracy, completeness, and timeliness of the encounter data submitted by Managed Care Organizations (MCOs).

This report is the final deliverable for the performance audit of selected auditees' 2018 encounter data, as defined by Contract #C033852 between KPMG and DOH.

The report includes the audit background, objective, scope, approach, and results, as well as details around the technology enablement and automation leveraged to enhance DOH's ability to analyze and audit encounters. Within the results section KPMG summarizes the findings and observations which resulted from the test procedures.

A **finding** is a noted issue of non-compliance with Federal or State guidance for which a recommendation was provided with the expectation that the auditee would provide a corrective action. An **observation** is a potential indicator of risk based on comparing test results across plans or DOH provided criteria, but not a specific instance of non-compliance.

KPMG noted a total of 15 audit findings related to one or more MCOs, which were summarized and presented to DOH, and subsequently presented to MCOs for formal response and comment. These findings are described within the Results section of the report.

Additionally, observations are included in the Results section to provide additional detail on analytical and benchmark test steps conducted across all MCOs. Each MCO benchmark test result was compared to the mean and median test results for all MCOs unless otherwise noted, and a DOH-defined deviation was used to flag outliers. KPMG shared these observations with the MCOs and submitted follow-up questions for further review. Observations are not instances of non-compliance. Observations can help MCOs further assess their own processes, controls, and data compliance, and employ performance improvement opportunities where relevant.

Background

On April 25, 2016, the Centers for Medicare and Medicaid Services (CMS) issued final regulations that revise existing Medicaid managed care rules. As part of the Final Rule, CMS provided requirements for program integrity which are detailed in *42 CFR § 438.242 – Health information systems*.

This includes encounter data submissions from MCOs to states and from states to CMS. For contracts starting on or after July 1, 2017, states require that managed care plans:

- Collect and submit encounter data sufficient to identify the provider rendering the service.
- Submit all encounter data necessary for the State to meet its reporting obligation to CMS.
- Submit encounter data in appropriate industry standard formats (i.e., X12).
 - The rule requires that all managed care plan contracts require complete, timely, and accurate encounter data.
 - Submit reports to the State in the level of detail and format required by CMS. The Federal government uses encounter data to measure state and plan performance, monitor compliance, and facilitate comparisons across states and between fee-for-service and managed care.
- Ensure the data is accurate and complete.

Furthermore, the MCO encounter data is heavily relied upon by the Department for key Medicaid Program functions, including oversight of MCOs, program analytics, rate setting, and policy and leadership decision making.

Objectives

As described within DOH's request for proposal and furthermore in engagement planning meetings, the Department identified two primary objectives for this audit:

1. Achieve compliance with the CMS's requirement for encounter data validation per 42 CFR § 438.242(d); and
2. Gain insights into the completeness, accuracy, and timeliness of encounter data to support the ability to place reliance on encounter data as a key basis for rate setting, analytics, and to support policy and leadership decision making.

Based on the DOH-approved scope and approach described in the following report sections, KPMG executed against the Department's objectives and documented the results within this report to satisfy the objectives and contract requirements for audit year 2018.

Scope

This report presents the audits' results of calendar year 2018 for eight MCOs selected by DOH. The eight plans capture 22 distinct Lines of Business (LOBs). LOBs covered in the 2018 scope include Medicaid Managed Care (MMC), Programs of All-Inclusive Care for the Elderly (PACE), Partial Managed Long-Term Care (MLTC), Health and Recovery Plans (HARP), and Fully Integrated Duals Advantage (FIDA), Medicaid Advantage, and Medicaid Advantage Plus (MAP).

Desk and field audits were conducted according to contract requirements with DOH determining which entities were subject to desk or field procedures. Definitions of desk and field audits are captured in the Approach section. Of the eight auditees, seven underwent desk procedures and one underwent field procedures. As agreed with the Department, two MCO desk audits were performed by a separate firm.

The following Approach section captures the key planning activities, desk and field procedures, and audit close-out activities. Subsequently, the findings, observations, and recommendations are captured within the Results section, which covers all audits executed by KPMG. The results reported herein are as of May 12, 2022.

Approach

KPMG performed calendar-year-specific procedures, as approved by the Department, to meet the audit objectives for both desk and field audits. As part of the process, KPMG provided the Department with a detailed Audit Program Guide (APG), which specified project procedures and test steps and was reviewed and approved by DOH.

This Approach section includes several key elements to the desk and field audits, and then summarizes the key steps taken across the four phases of the audits:

- Definition of desk and field audits
- Four-phased approach and detailed tasks
- Engagement milestones
- Summary of technology enablement

Definition of desk and field audits

The requirements to conduct both desk and field audits were defined by DOH within the RFP. The approved desk audit approach was focused on reasonableness of test outcomes compared to DOH expectations and risk-based test procedures designed to indicate the risk non-compliance or specific instances of non-compliance. While desk audits did not consist of substantive record sampling or on-site visits, the following procedures were conducted during these audits:

- **Test procedures automated through the KPMG Encounter Validation and Analytics (KVAL) tool**, which resulted in clear instances of non-compliance that are noted as findings within this report.
- **Benchmark analytics automated through KVAL**, conducted across all MCOs to help identify potential outlier results in comparison to the other MCOs that are noted as observations within this report.
- **Auditee questionnaire** responses were reviewed to help understand the MCO processes and procedures related to the MCO encounter submissions. No findings or observations were noted in this report in relation to the MCO questionnaire responses.
- **Data reconciliations** and supporting documentation was reviewed to test the completeness of the encounter data submitted to DOH compared to the MCO claims systems, significant variances were noted as observations within this report.
- Review of supporting documentation for a limited **sample selection** to validate the accuracy of submitted encounter information to the MCO claims system information. No findings or observations were noted in this report in relation to this test.

Field Audits included the same reasonableness and risk-based procedures as the desk audits and included both an increased number of test procedures and greater depth of substantive testing through:

- Additional **sampling selection** of encounters to validate the accuracy of submitted encounter information to the MCO claims system information. No findings or observations were noted in this report in relation to this test.
- **Medical record reviews** included the same level of testing of the sample selection review of comparing the submitted encounter information to the MCO claims system information as well as additional medical chart information from the Provider, items of non-compliance are noted as findings within this report.
- Reconciliation of **encounter data metrics** to the MCO's claim systems' data metrics for completeness testing; monthly and total variances were noted as an observation within this report.

The findings and observations that are documented in this report are categorized to the procedures outlined above.

Four phased approach and detailed tasks

KPMG proposed, and DOH approved, a four phased audit approach, which culminates with this final report. The specific phase and procedures executed during the Audit, as agreed to by the Department, are noted below:

- Phase 1: Engagement Planning and Project Management
- Phase 2: Pre-audit kick-off
- Phase 3: Fieldwork
- Phase 4: Validation, Reporting, and Close Out

Each section below describes the key steps taken to complete the 2018 audit in greater detail.

Phase 1: Engagement planning and project management

Being the first year of the engagement, the 2018 audit year factored in a period of engagement start-up, gaining access to and working with the data to validate an auditable dataset, and the development and approval of test procedures prior to engaging with the MCOs.

As part of the engagement start-up, KPMG:

- Researched the MCO regulatory environment, including Federal and State guidance
- Documented the State's encounter process flow from inception through the reporting and analysis of aggregated data by the Department
- Defined encounters in the context of the audit and outlined the encounter lifecycle from patient initial engagement (e.g., primary care appointment, lab work, outpatient, inpatient pre-admission, etc.) through fulfillment and discharge
- Documented the Department's data procedures, including the Encounter Intake System (EIS) and acceptance/rejection data
- Documented the process, flow, and storage of encounter data through the DataMart, Medicaid Analytical Extract for Encounters (MAEE), and the Medicaid Data Warehouse (MDW)
- Performed a reconciliation between each database and determined with DOH the database for conducting the audits – X12 Post Adjudicated Claims Data Reporting (PACDR)
- Summarized DOH's current utilization of data throughout the lifecycle and its relationship to analysis, reporting, and rate setting
- Identified an approach for selecting auditees that was reviewed and approved by the Department

- Developed a detailed audit testing approach, held ongoing discussions, and formal reviews of detailed documentation (e.g., the Audit Test Matrix, questionnaire, reconciliation, etc.), and ultimately documented the approach within the APG for DOH approval

As a result of identifying the PACDR as the primary data source related to MCO submissions, DOH and KPMG embarked on a process not originally envisioned within the RFP to generate an auditable dataset. This process included the conversion of X12 code into a structured database file, the netting of the full universe of encounter records (including original submissions, resubmissions, etc.) to the population of final encounters, and reconciling to Medicaid Managed Care Operating Reports (MMCOR) and MDW to confirm completeness of dataset used for audit purposes.

To create the APG, KPMG and DOH reviewed State requirements related to the collection and submission of encounter data and identified specific benchmarks of risk to be leveraged as the basis of all test procedures. KPMG worked with the Department to confirm/receive:

- The Department’s requirements related to the collection and submission of encounter data by MCOs as stipulated by Section 364-J of the New York State Social Services Law
- The Department’s requirements related to the collection and submission of encounter data by MCOs as stipulated by, but not limited to, the State’s Medicaid Managed Care Model Contract (Model Contract)
- The data submission format specified by Post Adjudication Implementation Guides and New York State Companion Guides (e.g., Trading Partner Information, Transaction Information, and other relevant data submission format guides)
- Data field definition requirements such as the Medicaid Encounter Data (MEDS III) Dictionary, which is elaborated in section 18.5(a)(iv) of the Model Contract
- Validation requirements for encounters by claim type (Professional, Institutional, Pharmacy, and Dental)
- Contracts between the Department and the MCOs subject to audit, as well as any supporting documentation submitted from the MCO to the Department that would relate to the integrity of data, apparent risks, or as otherwise deemed relevant
- Clear standards for encounter data completeness, accuracy, and timeliness for each data field submitted for each encounter type
- Performance measures based on the CMS recommendation that MCOs’ targeted error rates should be below five percent for each time period examined
- Documentation of the understanding of the State's data intake/export process controls that may impact data integrity through the transfer processes, such as data process maps

Phase 2: Pre-audit kick-off

- Onboarded the KPMG audit team and conducted detailed trainings
- Executed all automated test procedures within KVAL, generated results workbooks for each MCO, and prepared follow-up questions on all tests that met DOH’s approved criteria for audit follow-up with MCOs
- Engaged MCOs through emailing the Audit Notification Package (ANP) to the auditees. The ANP included an audit notification letter, kick-off guide, background, data requests, and Encounter Audit Tool (Tool) instructions
- Conducted an instructional webinar alongside DOH for all auditees
- Conducted an entrance conference with DOH and each MCO
- Walked each MCO through the detailed test results packet and documentation requests

- Followed up with each MCO as needed until all required elements of audit documentation were provided and noted instances of lateness or lack of sufficiency with DOH

Phase 3: Fieldwork

- Reviewed the questionnaires completed by auditees, engaged in follow-up questions and activities, and documented outcomes or instances of non-compliance within the tool
- Reviewed the reconciliations completed by MCOs, held follow-up discussions, and documented outcomes within the tool
- Reviewed the supporting documentation provided for samples
- Conducted medical chart reviews (field audit only)
- Held walkthrough sessions of auditee responses to inquiries and results with DOH to identify additional information required from auditees to finalize testwork
- Identified potential findings and observations and provided to DOH for review
- Held detailed findings walkthrough sessions with DOH and received final determinations around the presentation of findings and observations to each auditee

Phase 4: Validation, reporting, and closeout

KPMG consolidated audit results and initiated the validation, reporting, and closeout phase as follows:

- Provided a formal Exit Dashboard including findings and observations to each MCO, as well as instructions for providing a formal response, corrective action plan, and an invitation to an Exit Conference
- Held Exit Conferences with DOH and each auditee to review results, findings, observations and set parameters for auditees to provide a formal response and corrective action plan
- Received auditees formal responses and held further discussions with DOH and Auditees to close out open items
- Developed a draft report for review and comment by DOH
- Received DOH comments and processed edits
- Issued the Final Report Deliverable to DOH, completing the audit contract requirements for year 2018

Engagement milestones

All procedures were performed against standard milestone due dates defined by the Department for desk and field audits, as depicted in the table below. Please note that individual auditee extension requests were captured by KPMG and reported to DOH for review and approval.

| Phase | Milestone | Day (Desk / Field) |
|-------------------|--|-----------------------|
| Audit kick-off | Audit kick-off and notification | 1 |
| | Kick-off Webinar with DOH | 5 |
| | Audit team kick-off calls with MCOs | 10 |
| | Completion of Electronic Questionnaire, Reconciliation, submission of sample support, submission of medical charts (field only), and submission of data metrics (field only) | 20 / 25 |
| Audit testwork | Review MCO Questionnaire responses, Reconciliation and sample support, and comparison of metrics data (field only) and submit follow-up questions | 30 / 40 |
| | Complete and submit follow-up responses | 35 / 45 |
| | Resolution of Questionnaire, Reconciliation, and sample support issues. | 45 / 55 |
| | Compile findings and submit to DOH | 55 / 60 |
| | Review of findings with DOH | 65 / 70 |
| | MCO walkthrough of findings | 70 / 75 |
| | Auditee response to findings and exit dashboard | 80 / 85 |

Advanced data & analytics enablement

Upon executing DOH’s data use agreement and gaining access to the data within DOH systems, KVAL was the enabling basis for the following key engagement activities:

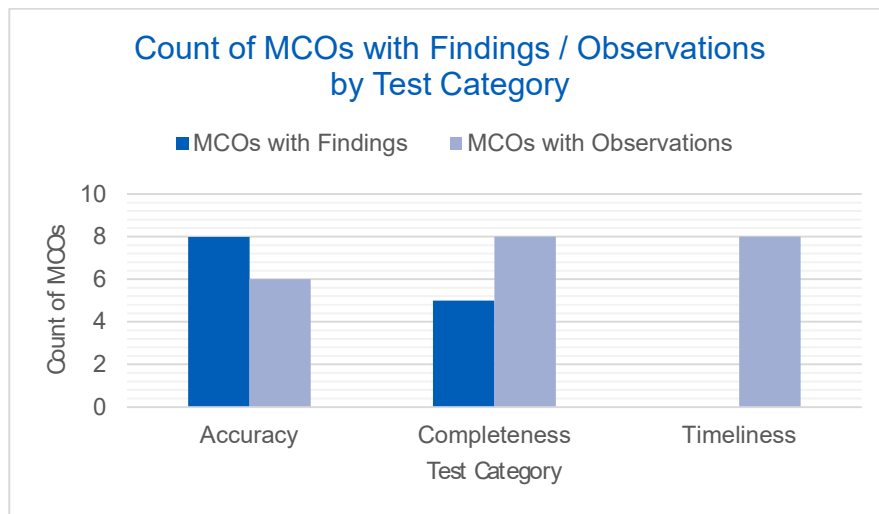
- Data preparation
 - Executed PACDR conversion from X12 code to a structured database
 - Executed data comparisons between PACDR and MDW for reconciliation purposes
 - Netted final encounter records for all 2018 MCO data
 - Finalized cleansing and preparation to achieve a DOH-approved audit database
- Audit procedures
 - Generated analysis of all MCOs and LOBs to support DOH 2018 auditee selection
 - Programmed and automated benchmark analyses across all MCOs to identify outliers related to identified risk areas
 - Programmed and automated test procedures to be applied to auditees across various levels of detail including MCO level, LOB level, encounter type, and various individual data elements
 - Organized over 10,000 distinct outputs throughout the aforementioned levels of data into reporting tables
 - Flagged test results which met DOH-approved criteria for follow-up with auditees

- Enabled auditee-to-auditee comparisons of test results to support the consistent findings and observations determinations
- Reporting results
 - Generated report-ready detailed results tables and summary dashboards and shared these items with DOH to review initial test results
 - Generated auditee results dashboards to facilitate follow-up procedures and questions with MCOs

Results – Findings and observations

The Results section presents the findings and observations reviewed and approved by DOH and presented to the MCOs for their response and corrective action. The findings and observations described in this section are directly correlated to the test procedures described in the “Definition of desk and field audits” section of this report. A **finding** is a noted issue of non-compliance with Federal or State guidance. An **observation** is a potential indicator of risk based on comparing test results across plans or DOH provided criteria, but not a specific instance of non-compliance.

As DOH’s primary objective related to compliance with CMS’s requirements for audit accuracy, completeness, and timeliness, the graphic below displays how many of the MCOs in the Year 1 audit scope had findings and/or observations within each respective test category.



The following table provides a summary of the types of test procedures approved by DOH that were executed for each MCO and LOB by test type. The table demonstrates how many of the total tests resulted in findings and observations. Please note that some observations, as defined in the table footnotes, were consolidated for report presentation purposes.

| | Test Type | Total Tests | Tests with no findings | Tests with findings | Tests with observations | Report findings | Report observations |
|--------------|--|-------------|------------------------|---------------------|-------------------------|-----------------|---------------------|
| Desk | Test procedures automated through KVAL | 10 | 2 | 8 | | 8 | |
| | Benchmark analytics automated through KVAL | 9 | | | 9 | | 9 |
| | Sample selection* | 22 | 22 | | | | |
| | Auditee questionnaire** | 8 | 8 | | | | |
| | Data reconciliation** | 8 | 6 | | 2 | | 1 |
| Field | Additional sampling selection* | 40 | 40 | | | | |
| | Medical chart review* | 10 | 3 | 7 | | 7 | |
| | Data Metrics comparisons*** | 4 | | | 4 | | 1 |
| Total | | 111 | 81 | 15 | 15 | 15 | 11 |

*Tests are equivalent to # of encounters selected for sample testing

**The two data reconciliation tests resulting in an observation are consolidated into one formal observation for this report.

***The four data metrics comparison tests resulting in an observation are consolidated into one formal observation for this report.

As noted in the table above there are 15 findings which are further elaborated in the following pages. Based on the footnotes of the table, the four distinct observations have been consolidated into two observations for reporting purposes.

Components of findings

The DOH approved findings are documented on the following pages. Each finding includes the follow elements:

- **Criteria:** An explanation of the requirements related to the identified condition.
 - **Condition:** Describes the issue observed as part of the audit. In many cases, there are multiple conditions reported within one finding.
 - **Cause:** An assessment of the underlying cause of the identified condition.
 - **Effect:** Potential result if condition continues.
 - **Recommendation:** A short discussion on what should be done to improve, resolve, or avoid the identified condition.
- Findings 1-8 are related to the desk audit test procedures automated through KVAL not including benchmarks analytics.
 - Findings 9-15 are related to the medical chart reviews conducted during the field audits

Findings and recommendations

Finding 1: MCO did not report CARC code when adjustment amount was indicated.

Criteria: The PACDR and National Council for Prescription Drug Programs (NCPDP) Post Adjudication Implementation Guides and the New York State Standard Companion Transaction Guide X12 provide guidance on how to properly report adjustment amount and the necessary inclusion of corresponding CARC. Encounter data is required to include a CARC where needed.

Condition: Two MCOs, spanning three unique lines of business, had a percentage of submitted encounters in which the adjustment amount was indicated, but was missing a CARC code.

Cause: The Auditees either misunderstood or misapplied the requirement of the Federal or State guidelines.

Effect: Failure to include a CARC may impact the completeness and accuracy of encounter submissions which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

Recommendation: MCOs should follow DOH guidelines and ensure the CARC code is included when an adjustment amount is indicated as instructed in the PACDR and NCPDP Post Adjudication Implementation Guides for adjustments.

Finding 2: MCO reported Category of Service (COS) codes that do not align with the expected encounter type.

Criteria: New York State Standard Companion Transaction Guide X12 and NCPDP Appendix A provides a table of COS codes and descriptions that the MCOs are instructed to include on each encounter submission. Each code correlates to a specific Encounter Type (Professional, Institutional, Dental or Pharmacy/Durable Medical Equipment (DME)).

Condition: Four MCOs, spanning five unique lines of business, had a percentage of submitted encounters in which the COS codes did not align with the expected encounter type.

Cause: The Auditees either misunderstood or misapplied the requirement of the Federal or State guidelines.

Effect: Failure to provide correct COS codes may impact the completeness and accuracy of encounter submissions which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

Recommendation: MCOs should review internal processes, including monitoring of their TPAs, and update their systems and processes to ensure correct data mapping and use of COS codes are in accordance with New York State Standard Companion Transaction Guide X12 and NCPDP Appendix A.

Finding 3: MCO submitted encounters in which the diagnosis code(s) did not match the demographic of the patient.

Criteria: According to CMS ICD-10-CM Official Guidelines for Coding and Reporting Section IV Part C diagnosis codes are required to be reported accurately by providers on Institutional, Professional, and Dental claims, and thus reported to DOH as an element of an encounter.

Condition: Two MCOs, spanning two unique lines of business, had a percentage of submitted encounters in which the diagnosis codes did not align to the age of the member at the time of the service.

Cause: The Auditees either misunderstood or misapplied the requirement of the Federal or State guidelines.

Effect: Failure to properly apply diagnosis codes may impact the completeness and accuracy of encounter submissions which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

Recommendation: MCOs should update their claims processing edits to consider children to be 17 years of age and less (under 18), which is in line with the ICD-10 diagnosis code definitions and to look at all diagnosis point positions in their claims adjudication systems.

Finding 4: MCO submitted encounters in which the Interchange Control Number (ICN) of the encounter is equal to the value of the previous ICN field identified on the same record.

Criteria: New York State Standard Companion Guide Trading Partner Information requires that "ISA13 Interchange Control Number is unique for all of an Issuer's submissions;" the Post Adjudication Implementation Guides (Institutional, Professional, Dental, & NCPDP) and the New York State Standard Companion Guides Transaction Information X12 and NCPDP provide the specific data elements and qualifier codes to use to reference the previous (adjusted/original) ICN number when submitting adjustments, voids, and replacements and voids of previously submitted encounters.

Condition: Four MCOs, spanning ten unique lines of business, had a percentage of submitted encounters in which the previous ICN field was equal to the ICN on the same record.

Cause: The Auditees either misunderstood or misapplied the requirements of the Federal or State guidelines.

Effect: Failure to utilize the previous ICN field when submitting adjustments, voids, and replacements may impact the completeness and accuracy of encounter submissions which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

Recommendation: MCOs should follow DOH guidelines and utilize the previous ICN field as instructed in the PACDR and NCPDP Post Adjudication Implementation Guides for adjustments, voids, and replacements.

Finding 5: MCO submitted encounters in which the ICN was reused on at least one other encounter by the same MCO with the same encounter type and member; however, none of the encounters were for the same record originally submitted.

Criteria: New York State Standard Companion Guide Trading Partner Information requires "ISA13 Interchange Control Number is unique for all of an Issuer's submissions." The Post Adjudication Implementation Guides (Institutional, Professional, Dental, & NCPDP) and the New York State Standard Companion Guides Transaction Information X12 and NCPDP further note the ICNs should not be reused in the combination of MCO, encounter type, and member.

Condition: Three MCOs, spanning nine unique lines of business, had a percentage of submitted encounters in which the ICN was incorrectly used on at least one other encounter.

Cause: The Auditees either misunderstood or misapplied the requirements of the Federal or State guidelines.

Effect: Failure to ensure the ICN is unique for all Issuer submissions within the combination of MCO, encounter type and member may impact the completeness and accuracy of encounter submissions which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

Recommendation: MCOs should follow DOH guidelines and ensure unique ICNs are created for encounters as instructed in the PACDR and NCPDP Post Adjudication Implementation Guides.

Finding 6: MCO submitted encounters in which the Provider Specialty Type field has a value of “999”.

Criteria: The New York State Medicaid Encounter Data Reporting for APD and MMCOR Category of Service – Service Utilization Guide specify logic on assigning Provider Specialty Type code at the encounter level.

Condition: Four MCOs, spanning 10 unique lines of business, had a percentage of submitted encounters in which the Provider Specialty Type field defaulted to “999”, which is defined as “other specialty” as opposed to an available code listed in the Utilization Guide.

Cause: The Auditees either misunderstood or misapplied the requirements of the Federal or State guidelines.

Effect: Failure by the auditee to properly assign the provider specialty type code could impact the accuracy encounter submissions which effects the Department’s ability to rely on the data for rate setting and other analytical purposes.

Recommendation: MCOs should update to their system logic to be in accordance with New York State Medicaid Encounter Data Reporting for APD and MMCOR Category of Service – Service Utilization Guide, which outlines specific logic on how to assign Provider Specialty Type code at the encounter level.

Finding 7: MCO submitted encounters in which the paid amount of final encounter at the header level does not equal the sum of the paid amount at the line level.

Criteria: The PACDR and NCPDP Post Adjudication Implementation Guides and the New York State Standard Companion Transaction Guide X12 provide guidance on how to submit encounters accurately to ensure the sum of the paid amount at the line level ties to the paid amount at the header level.

Condition: Four MCOs, spanning four unique lines of business, had a percentage of submitted encounters in which the paid amount at the header level does not equal the sum of the paid amount at the line level.

Cause: The Auditees either misunderstood or misapplied the requirements of the Federal or State guidelines.

Effect: Failure to properly submit accurate sum of the paid amounts could impact the completeness and accuracy encounter submissions which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

Recommendation: MCOs should follow the guidance outlined in the PACDR and NCPDP Post Adjudication Implementation Guides to ensure the amount at the header level ties to the sum of the amounts at the line level, as well as conduct internal reconciliations of the header and line level paid amounts.

Finding 8: MCO submitted Professional encounters with transportation (e.g., ambulette, taxi, livery, van) Healthcare Common Procedure Coding System (HCPCS) codes that do not have an appropriate service modifier code on the same service line.

Criteria: The New York State Medicaid Program Transportation Manual Policy Guidelines instructs MCOs to include service modifiers to transportation HCPCS codes.

Condition: Three MCOs, spanning three unique lines of business, had a percentage of submitted encounters in which service modifiers did not align to New York State Medicaid Program Transportation Manual Policy Guidelines.

Cause: The Auditees either misunderstood or misapplied the requirements of the Federal or State guidelines.

Effect: Failure to ensure service modifiers are accurate may impact the completeness and accuracy encounter submissions which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

Recommendation: The MCOs should update their processes to align with New York State Medicaid Program Transportation Manual Policy Guidelines so that when transportation HCPCS codes are used, the appropriate modifiers are assigned.

Finding 9: Lack of supporting documentation resulted in the inability to validate the CPT code

Criteria: The Model Contract section 19.4 states that MCOs are required to make reasonable efforts to assure that Enrollees’ medical records, inclusive of CPT codes, are retained by providers after the date of service rendered to the member. Per the AMA, there are five different levels of codes providers can choose to bill for Evaluation and Management (E/M) office or other outpatient visits. The level of service billed must be based on the intervention(s) that are performed in relationship to the medical care required by the presenting symptoms and resulting in diagnosis of the patient. Professional codes are based on complexity, performed work, which includes the “cognitive” effort (office or other outpatient visits CPT) and criteria for each level are described in the table below:

| Office or other outpatient visits CPT and criteria for each level | | | | |
|---|--|---|---|---|
| 99201 | 99202 | 99203 | 99204 | 99205 |
| Problem focused history | Expanded problem focused history | Expanded problem focused history | Detailed history | Comprehensive history |
| Problem focused examination | Expanded problem focused examination | Expanded problem focused examination | Detailed examination | Comprehensive examination |
| Straightforward medical decision making | Low complexity medical decision making | Moderate complexity medical decision making | Moderate complexity medical decision making | High complexity medical decision making |

Condition: One Medical Chart sample tested included a CPT code of 99203; however, results of testwork indicated that these three constraints were not supported by documentation provided.

Cause: The auditee was unable to obtain the entire medical record from the Provider to adequately support the use of 99203 of CPT code for an office visit.

Effect: Inability to tie encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions.

Recommendation: MCOs should improve their oversight of providers to better confirm the accuracy of CPT codes in context of the claim form. Based on the information provided for this encounter, a lower CPT code would have been more appropriate, 99201.

Finding 10: Lack of supporting documentation resulted in the inability to validate the HCPCS code.

Criteria: The Model Contract section 19.4 states that MCOs are required to make reasonable efforts to assure that Enrollees' medical records, inclusive of HCPCS codes, are retained by providers after the date of service rendered to the member, and in the case of a minor, for six (6) years after majority. HCPCS codes in the encounter data represent services billed on the claim form and are required to represent actual services provided as evidenced by medical records. In addition, the units of service in the encounter data must match the units of service billed on the claim form, and furthermore represent actual units as evidenced by medical records. CMS defines HCPCS T1019: "Personal care services, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant), per 15 minutes."

Condition: The HCPCS code T1019, could not be validated on several encounter sample selections. Below are the instances of lack of documentation:

1. The inability to confirm the services provided; therefore, HCPCS codes could not be validated.
2. The inability to confirm if the services are provided by the appropriate caregiver; therefore, HCPCS codes could not be validated.
3. The inability to validate the units of service billed because supporting documentation did not tie to the relevant sample records
4. The inability to validate the units of service billed because supporting documentation was not provided

Cause: The auditee was unable to obtain the entire medical record from the Provider to adequately support the HCPCS codes, or no support was provided at all.

Effect: Inability to tie encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions.

Recommendation: MCOs should improve their oversight of providers to better confirm the accuracy of HCPCS codes in context of the claim form.

Finding 11: Lack of supporting documentation resulted in the inability to validate the service line on an encounter and claim form

Criteria: The Model Contract section 19.4 states that MCOs are required to make reasonable efforts to assure that Enrollees' medical records, inclusive of claim forms, are retained by providers after the date of service rendered to the member, and in the case of a minor, for six (6) years after majority. Service lines within the encounter data are required to accurately represent services on the claim form, and furthermore represent actual services provided as evidenced by medical records.

Condition: Two Medical Chart samples' supporting documentation did not evidence all service lines billed.

Cause: The auditee was unable to obtain the entire medical record from the Provider to adequately support the service line data.

Effect: Inability to tie encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions.

Recommendation: MCOs should improve their oversight of providers to better confirm the accuracy of services lines in context of the claim form.

Finding 12: Lack of supporting documentation resulted in the inability to validate that the primary diagnosis code is related to the primary services provided.

Criteria: The Model Contract Section 19.4 states that MCOs are required to make reasonable efforts to assure that Enrollees' medical records, inclusive of primary diagnosis, are retained by providers after the date of service rendered to the member, and in the case of a minor, for six (6) years after majority. In addition, the CMS ICD-10-CM Official Guidelines for Coding and Reporting Section IV Part G requires that the first diagnosis code listed on the claim form (primary diagnosis code) represent the diagnosis, condition, problem, or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided. Instructions state that additional codes that describe any coexisting conditions should also be listed. In some cases, the first-listed diagnosis may be a symptom when a diagnosis has not been established or confirmed by the physician.

Condition: One Medical Chart sample supporting documentation does not include any reference to services related to the primary diagnosis on the claim form.

Cause: The auditee was unable to obtain the entire medical record from the Provider to adequately support the primary diagnosis code.

Effect: Inability to tie encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions.

Recommendation: MCOs should improve their oversight of providers to better confirm the accuracy of primary diagnosis codes in context of the claim form.

Finding 13: Lack of supporting documentation resulted in the inability to validate that the diagnosis code on the claim form and encounter.

Criteria: The Model Contract section 19.4 states that MCOs are required to make reasonable efforts to assure that Enrollees' medical records, inclusive of all relevant diagnoses, are retained by providers after the date of service rendered to the member, and in the case of a minor, for six (6) years after majority. In addition, the CMS ICD-10-CM Official Guidelines for Coding and Reporting Section IV Part C requires that the supporting documentation describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter.

Condition: Two Medical Chart samples' supporting documentation does not include any information to validate the diagnosis on the claim form and encounter.

Cause: The auditee was unable to obtain the entire medical record from the Provider to adequately support the diagnosis codes.

Effect: Inability to tie encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions.

Recommendation: MCOs should continue to work with the providers to communicate and address requests for supporting documentation. In addition, in cases that incomplete or no supporting documentation was received, KPMG recommends the MCO follow DOH's previously communicated guidance as outlined below:

- Send a formal letter reminding providers of contractual obligations for document retention (including specifics of the contract) and that a DOH audit finding for the 2018 Encounter Audit resulted for lack of supporting documentation from their organization.
- Notify providers that they are contractually required under the NYS Medicaid program to respond to such requests. As a result of the failure to communicate and address the request for supporting documentation for a State audit, the MCO will now be reporting the Provider to the Department as well as other appropriate channels such as Office of Medical Inspector General (OMIG).

Finding 14: Lack of supporting documentation resulted in the inability to validate the claim form and encounter.

Criteria: The Managed Long Term Care Partial Capitation Model Contract article V.K.4 states that the MCO is responsible for comprehensive assessment and development of a person-centered service plan for all MLTC services for Enrollees using Consumer Directed Personal Assistance Program (CDPAS). However, the Contractor must permit CDPAS Enrollees (or an Enrollee’s representative) to have decision making authority regarding CDPAS staff: (a) recruitment, (b) training, (c) scheduling, (d) evaluation, (e) time sheet verification and approval, (f) discharge.

Condition: One Medical Chart sample the documentation support provided by the MCO included a letter from the Fiscal Intermediary (FI) (billing provider) addressed to the MCO noting “as the member’s FI, we do not obtain or maintain records of the member’s physician orders, nursing notes, procedure reports, laboratory reports, advance benefit notices, and discharge summaries.”

Cause: The auditee was unable obtain the entire medical record from the Provider to adequately support the claim form and encounter data.

Effect: Inability to tie encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions.

Recommendation: MCOs should continue to work with the providers to communicate and address requests for supporting documentation. In addition, in cases that incomplete or no supporting documentation was received, KPMG recommends the MCO follow DOH’s previously communicated guidance as outlined below:

- Send a formal letter reminding providers of contractual obligations for document retention (including specifics of the contract) and that a DOH audit finding for the 2018 Encounter Audit resulted for lack of supporting documentation from their organization.
- Notify providers that they are contractually required under the NYS Medicaid program to respond to such requests. As a result of the failure to communicate and address the request for supporting documentation for a State audit, the MCO will now be reporting the Provider to the Department as well as other appropriate channels such as OMIG.

Finding 15: Lack of supporting documentation resulted in the inability to validate the claim form and encounter.

Criteria: The Model Contract section 19.4 states that MCOs are required to make reasonable efforts to assure that Enrollees' medical records, inclusive of claim forms, are retained by providers after the date of service rendered to the member, and in the case of a minor, for six (6) years after majority.

Condition: One Medical Chart sample the documentation provided by the MCO did not include requested information: physician orders, nursing notes, procedure reports, laboratory reports, advance benefit notices, or discharge summaries.

Cause: The auditee was unable to obtain the entire medical record from the Provider to adequately support the claim form and encounter data. In addition the provider terminated communications with the MCO after additional inquiries were made.

Effect: Inability to tie encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions.

Recommendation: KPMG recommends that the MCO continues to work with the providers to communicate and address requests for supporting documentation. In addition, in cases that incomplete or no supporting documentation was received, KPMG recommends the MCO follow DOH's previously communicated guidance as outlined below:

- Send a formal letter reminding providers of contractual obligations for document retention (including specifics of the contract) and that a DOH audit finding for the 2018 Encounter Audit resulted for lack of supporting documentation from their organization.
- Notify providers that they are contractually required under the NYS Medicaid program to respond to such requests. As a result of the failure to communicate and address the request for supporting documentation for a State audit, the MCO will now be reporting the Provider to the Department as well as other appropriate channels such as OMIG.

Observations

The following section presents test procedures which resulted in observations and potential performance improvement opportunities to be considered by the MCOs. These observations are based on risk areas or test procedures requested by DOH that included benchmark and threshold testing, but test results did not specifically indicate an instance of non-compliance. Inquiries were made with all MCOs who met the threshold criteria for follow-up per each test step, and responses were reviewed with DOH to determine if a finding or observation was relevant. As such, the following observations were documented for each of the related test procedures noted.

- Observations 1-7 are related to the desk audit benchmark analytics automated through KVAL
- Observations 8-9 are related to two desk audit test procedures automated through KVAL that DOH and KPMG agreed should be observations because the results did not indicate an instance of non-compliance, however, DOH wanted to formally document the information
- Observation 10 is related to the Data Reconciliation
- Observation 11 is related to the Data Metrics comparisons between the encounter data and claims systems

In general, KPMG recommends the MCOs perform monthly, quarterly, and annual trend analyses using internal metrics and reporting, as well as the utilization reports provided by DOH to monitor risks related to the completeness, accuracy, and timeliness of encounters submitted to DOH.

| Observation | Test Description | # Of MCOs | # Of LOBs |
|-------------|--|-----------|-----------|
| 1 | MCO had a ratio of inpatient to total institutional encounters that was 1.5 deviations or more below the benchmark median calculated for all MCOs, which could indicate that not all encounters are complete. | 1 | 2 |
| 2 | MCO had a percentage of encounters with substance use or abuse diagnosis codes that was 1.5 deviations or more above the benchmark median calculated for all MCOs, which could indicate inaccurate use of diagnosis codes. | 6 | 9 |
| 3 | MCO utilization rates of services (defined as eligible encounters by eligible members) was 1.5 deviations or more below the benchmark median calculated for all MCOs, which could indicate that not all encounter submissions are complete. Note, the following service types were tested: A. Inpatient hospital, B. Primary care, C. Outpatient hospital, D Pharmacy (non-DME dispensations), E. Personal care. | 3 | 4 |
| 4 | MCO ratio between residential care facility encounters to homecare encounters was 1.5 deviations or more above the benchmark median calculated for all MCOs, which could indicate that not all encounter submissions are complete or coded correctly. | 7 | 8 |
| 5 | MCO had a ratio of personal care and CDPAS encounters that was 1.5 deviations or more below the benchmark median calculated for all MCOs, which could indicate that not all encounter submissions are complete or coded correctly. | 3 | 5 |

| Observation | Test Description | # Of MCOs | # Of LOBs |
|-------------|---|-----------|-----------|
| 6 | MCO average lag time between service date and encounter submission date was 1.5 deviations or more above the benchmark median calculated for all MCOs, which could indicate that not all encounter submissions were submitted timely. | 6 | 10 |
| 7 | MCO monthly submissions are 1.5 deviations or more below the specific benchmark median calculated for all MCOs, which could indicate that not all encounter submissions are complete. Note: the benchmarking was conducted within an individual plan's month to month results, not comparing plan to plan. | 8 | 20 |
| 8 | MCO submissions include inpatient encounters identified by bill type code which have a length of stay equal to 1 day. | 4 | 6 |
| 9 | MCO submitted replacements and voids greater than 2 years from the date of service. | 6 | 15 |
| 10 | MCO had a reconciliation variance greater than 3 percent between submitted encounters and amount reported by the MCO. | 2 | All |
| 11 | <p>(Field audit only) Data metrics collection and comparison tests compared aggregated metrics calculated from encounters against metrics calculated by the MCO from their claims systems and/or data warehouses.</p> <p>Differences between the two metrics raise potential questions and/or risks of compliance related to completeness, accuracy, and timeliness of the MCOs encounter data. There were four sets of metrics for comparison:</p> <ul style="list-style-type: none"> — Total count of final encounters — Total paid amount of final encounters — Total count of members with at least one encounter — Total count of encounters with paid amount > \$0.00 <p>Overall, the MCO's claim reports reconcile within immaterial degrees of variance. While nuances exist within certain months, the volume of records and/or dollars driving variances was not considered to be high risk when assessing the completeness of the encounters.</p> | 1 | All |

Summary

Based upon the procedures performed and documented within this report, we have met the 2018 audit objective. As of the date of this report, KPMG will no longer communicate with the MCOs or their representatives regarding the 2018 encounter audit and DOH assumes responsibility for any further discussion related to corrective plans and ongoing monitoring that takes place outside of the context of a future audit.



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