Rhode Island Medicaid Managed Care Encounter Data Quality Measurement, Thresholds and Penalties for Non-Compliance

Rhode Island Executive Office of Health and Human Services

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1. Introduction

The Rhode Island Executive Office of Health and Human Services (EOHHS) collects and uses medical, behavioral health, and pharmacy service encounter data for many purposes including, but not limited to, federal reporting, drug rebates, budgeting, rate setting, capitation payments and risk adjustment, qualified directed payments, services verification, Medicaid Managed Care quality improvement activity, fraud/waste/abuse monitoring, measurement of utilization patterns and access to care, and research studies. Contracted Medicaid managed care organizations (MCOs) are required to comply with all reporting requirements for encounter data established by EOHHS. This document sets forth the procedures, requirements for reporting and data submission, and penalties for non-compliance. Requirements described in this document are subject to the *EOHHS Medicaid Managed Care Organization (MCO) Requirements for Reporting and Non-Compliance* document and should be submitted in the timeframes described here and in the *MCO Reporting Calendar.*

2. Coordination Between EOHHS and MCOs

To facilitate and ensure effective communication and coordination among EOHHS, the Medicaid Fiscal Agent/ MMIS vendor, and MCOs, EOHHS will convene routine conferences to discuss encounter claims submissions to identify and address outstanding or unresolved issues. These meetings may be specific to each MCO or for all the MCOs together. MCOs will participate reviewing the file submission reports, identifying root causes of encounter rejections, documentation of variances and comparisons of accepted encounters as reflected in the Medicaid Management Information System (MMIS) to incurred claims. These conferences will provide the venue for problem identification in the submission and validation processes and determination of appropriate resolutions.

EOHHS shall provide the MCO with the appropriate reporting formats, instructions, submission timetables and technical assistance, as required. EOHHS will develop and maintain the *MCO Reporting Calendar* to be used as a living document of the reporting requirements.

3. General Requirements

MCOs must submit to EOHHS complete, accurate, and timely data for all services for which the MCO has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with guidance provided in this document and the related business design documents issued on behalf of EOHHS by its contracted MMIS vendor. These business design documents are incorporated by reference herein and include the following guides:

Standard Companion Guides Transaction Information for Rhode Island Medicaid include:

1. Instructions related to Transactions based on ASC X12 Implementation Guides
2. Instructions related to NCPDP Post Adjudication Transactions based on NCPDP Post Adjudication Standard Implementation Guide Encounter Data

The MCO shall transmit to EOHHS or its designee, all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by EOHHS, so long as EOHHS direction does not conflict with the law.

Notice of changes to this guidance will be provided to the MCO by EOHHS or its designated agent. The MCO is expected to implement these changes within the timeframe specified by EOHHS. Failure to implement changes timely and to submit timely and accurate encounter data may result in financial sanctions on the MCO as set forth in the MCO contract and in this document. The MCO will provide EOHHS or its designated agent 45 calendar days advance notice of any changes to codes, data, and other values submitted within the encounters.

If the MCO delegates claims payment and encounter submission responsibility to a subcontractor, the MCO shall ensure the subcontracting relationship and subcontracting documentation comply with EOHHS reporting requirements.

DATA VALIDATION

The MCO will reconcile encounter data to provider payments and attest to its accuracy with each submission. The MCO agrees to assist EOHHS in its validation of encounter data by making available a sample of its claims data upon request and providing any requested documentation of claims payment and encounter submission processes. The MCO agrees to verify claims handled by vendors before submitting to the state. In addition, MCOs are required to perform due diligence so that submitted encounters will be accepted by EOHHS. MCOs will comply with requested data extracts to assist in EOHHS encounter error reporting, program integrity, and program monitoring.

TIMELINESS

Encounter data must be submitted to EOHHS at an agreed cadence. Encounters must be accepted into the MMIS no later than forty-five (45) calendar days from the date in which the MCO paid the financial liability.

The MCO must notify EOHHS ten (10) business days prior to the due date of submission files if the MCO anticipates a delay in submission/processing and request an extension. EOHHS has sole authority for approving or denying any extension request.

ACCURACY

The MCO is responsible for collecting, monitoring, submitting and ensuring the accuracy of all encounter submission transactions. Submitted encounters and encounter records must pass all EOHHS's designated MMIS vendor’s edits to be accepted into the MMIS.

Acceptance of an encounter into the MMIS does not represent an approval from EOHHS regarding the accuracy of the encounter. The MCO is ultimately responsible for ensuring the accuracy of the encounter and shall cooperate and assist EOHHS in validating the accuracy of the submitted encounters. If issues are identified during the validation process, the MCO may be subject to the corrective actions, penalties, and/or new or revised performance metrics as specified in the contract and this document.

Submitted encounters must meet all standards set forth in the MMIS Vendor’s Standard Companion guides referenced above and include all required data elements. These companion guides provide detailed guidance of required fields for each type of encounter and should be reviewed each time an update occurs to ensure compliance with requirements.

Encounter records must not be a duplicate of a previously submitted and accepted encounter unless submitted as an adjustment or void per HIPAA Transaction Standards.

Encounter rejections are encounters returned to the MCO due to incorrect or missing data, e.g., incorrect procedure code or blank value for diagnosis codes. Rejections will be transmitted to the MCO electronically for correction and resubmission on a 277CA report. The MCO must track all encounter rejections and provide a report detailing transmission reconciliation of each failed transaction or file.

COMPLETENESS

The MCO shall submit encounters for all services received by enrollees and for which the MCO has incurred a claim or any financial liability, whether directly or through subcontracts or other payment arrangements. The MCO’s electronic encounter data submission shall include all adjudicated (paid and denied) claims, corrected claims, and adjusted claims processed by the MCO. The MCO shall attest to the completeness of the encounter data each quarter.

The MCO shall complete a File Submission Report (FSR) template monthly to assist EOHHS in monitoring encounter data completeness. The FSR templates will be used in evaluation of MCO’s encounter data submissions. The FSR will include summarized file submission information status by vendor, line of business and fiscal year in a format defined by EOHHS.

MCO is required to reconcile the FSR with the Financial Data Cost Report (FDCR), defined in the contract, cost allocations on a quarterly basis.

4. Method for Calculating Compliance and Thresholds for Compliance

The EOHHS Data Quality team shall be responsible for assessing and determining compliance with the timeliness, accuracy and completeness benchmarks. The basis for calculation of compliance is described below.

To support the calculation of the benchmarks, the EOHHS Data Quality Team will:

- Develop and maintain standard set of reports (discussed below) that will be routinely produced to track utilization, spending, claims submission, error tracking and resolution and other key trends over time.
- The Data Quality Team will maintain an ongoing list of outstanding system issues resulting in inappropriate claim rejections or acceptances. System issue solutions and issue closure dates will be monitored. Once issues are closed, the MCO will be required to submit, or resubmit, all encounters held from submission, erroneously rejected, or erroneously accepted as a result of the noted gap in a timeframe established by EOHHS. These claims submissions will be withheld from the timeliness, accuracy and completeness measures until the issue is resolved, or a date determined by EOHHS.

TIMELINESS

Timely File Submission: The MCO is required to submit an encounter submission file for each type of encounter (institutional, professional, dental and pharmacy) at an agreed upon cadence. Timeliness of encounter submission files will be monitored monthly by the MMIS Vendor and EOHHS Data Quality Team. The MMIS Vendor will prepare a report that indicates the number of files submitted by each type. If the number of files submitted and accepted for each type in the agreed upon cadence is less than one (1), the MCO will be subject to penalties for non-compliance as outlined in Section 5 of this document.

Timely Encounter Submission: The MCO is required to submit and have encounters accepted into the MMIS for each claim paid by the MCO within forty-five (45) days from the date the MCO paid the claim. If an encounter is initially rejected, the MCO must correct and resubmit the claim within the forty-five (45) day timeframe.

Timeliness of initial encounter submissions will be monitored monthly by the MMIS Vendor and the EOHHS Data Quality Team. The MMIS Vendor will calculate the difference between the MCO's paid date to the date the encounter was accepted into the MMIS. The MMIS Vendor will prepare a report monthly to summarize the calculated number of days for between the claim paid date and encounter acceptance. If the percentage of encounters submitted with greater than a forty-five (45) calendar day gap between the submission date and the payment date for accepted encounters is greater than 2%, the MCO will be subject to penalties for non-compliance as outlined in Section 5 of this document.

ACCURACY

Acceptance Rate*:* The acceptance rate is defined as the percentage of encounters that are accepted upon initial submission for each month. The MCO's are required to ensure that ninety-eight percent (98%) of the submitted encounters are accepted upon initial submission. The MMIS Vendor will calculate the number of rejected encounters upon initial submission and the number of total encounters submitted for each encounter file submitted by the MCO. The MMIS Vendor will prepare a report monthly that summarizes the number of total encounters submitted and rejected for each MCO by type (institutional, professional, dental and pharmacy) in that month. The number of rejected encounters will be the numerator and the total number of submitted encounters will be the denominator of the calculation for accuracy. If the ratio of the rejected encounters for the month over the total number of encounters submitted for the month is greater than 2%, the MCO will be subject to the penalties for non-compliance as outlined in Section 5 of this document.

Diagnosis Code Accuracy: EOHHS will develop a diagnosis code distribution report by file type (institutional, professional, dental and pharmacy) and state fiscal year for accepted encounter data in the MMIS. The diagnosis code distribution will illustrate the percentage of claims with a given number of diagnoses (e.g., 40% of claims have one diagnosis, 20% have two diagnoses, etc.). The MCO must attest that the diagnosis code distribution for each file type matches the diagnosis codes on the paid claims associated with the accepted encounter data. Failure to be able to attest any state fiscal year and file type combination will result in penalties for non-compliance as outlined in Section 5 of this document.

Data Accuracy for Business Use: If EOHHS determines there are material errors in the accuracy of the submitted encounter data that interrupt EOHHS business operations (such as capitation rate development and risk adjustment, fiscal analyses, etc.), EOHHS may enforce the penalty for non-compliance in encounter data accuracy as outlined in Section 5 of this document.

Other Metrics: As mentioned in Section 3 of this document, additional accuracy measures may be established in response to identified encounter data issues.

COMPLETENESS

Completeness Variance: The FSR templates will be used in evaluation of MCO's encounter data submission completeness. The FSR will include summarized file submission information status by vendor, line of business and state fiscal year in a format specified by EOHHS. The ratio of encounter claims accepted into the MMIS over the claims incurred as reported in the FSR template must meet or exceed an accepted rate of ninety-eight percent (98%) and will be evaluated on a quarterly basis.

The following table illustrates the measurement parameters associated with this metric for the first five measurements.

Encounter Data Completeness Measurement Parameters			
Measured Time Period	**Paid through Date**	**Encounter Submission Date**	**Evaluation Date**
July 1, 2020 – September 30, 2022	October 31, 2022	December 15, 2022	January 3, 2023
July 1, 2020 – December 31, 2022	January 31, 2023	March 15, 2023	April 3, 2023
July 1, 2020 – March 31, 2023	April 30, 2023	June 15, 2023	July 3, 2023
July 1, 2020 – June 30, 2023	July 1, 2023	September 15, 2023	October 2, 2023
July 1, 2021 – September 30, 2023	October 31, 2023	December 15, 2023	January 2, 2024

Failure to meet the 98% threshold above for any state fiscal year (e.g., SFY 2021, SFY 2022, or SFY 2023 for the evaluation on January 1, 2023) within each submission will result in penalties for non-compliance as outlined in Section 5 of this document.

Completeness Attestation: The MCO will submit an attestation that the amounts reported in the FSR are an accurate representation of the claim payment financial liability and encounter submission activity of the MCO. Failure to provide attestation will result the penalties for non-compliance as outlined in Section 5 of this document.

Completeness Consistency: The reported incurred expenditures submitted in the FSR must align with the sum of the Direct Paid, Non-State Plan Paid, and Subcapitated Proxy Paid expenditures submitted in the FDCR for each state fiscal year within a 0.1% threshold for each quarter the FDCR is submitted. The File Submission Report and FDCR used for this comparison will include the same paid run-out period. The format of the reconciliation will be specified by EOHHS. Failure to meet threshold will result the penalties for non-compliance as outlined in Section 5 of this document.

Penalties for Non-Compliance

The contract between EOHHS and MCOs provides for penalties in the event of non-compliance with contractual requirements for complete, timely, accurate and resolved submissions of encounter data or reporting requirements. Penalties may be assessed at EOHHS' discretion in the areas described in the table below.

No.	Metric Deficiency	Penalty Amount
Timeliness		
1.	***Timely File Submission*** Failure of the MCO to submit at least one file for each file type in the agreed upon cadence with EOHHS.	$1,000 per calendar day late fee.
2.	***Timely Submission*** Failure to submit and have encounters accepted into the MMIS within 45 days of the claim payment date.	$15,000 per month where the timeliness submission rate is greater than 2%.
Accuracy		
3.	***Acceptance Rate*** Failure to maintain a rejection rate for encounter claim submission that is less than or equal to 2%.	$5,000.00 for each month the encounter rejection rate is above 2%.
4.	***Diagnosis Code Accuracy*** Failure to be able to attest that the diagnosis code distribution matches the diagnosis codes on the paid claims associated with the accepted encounter data for each state fiscal year and file type combination.	$100,000 for each quarter the attestation is not completed.
5.	***Data Accuracy for Business Use*** Failure to submit accurate encounter data resulting in interruptions to EOHHS business operations.	Up to $100,000 per occurrence.
Completeness		
6.	***Completeness Variance*** Failure of the MCO to reach 98% threshold for encounter completeness.	$100,000 for each quarter the encounter completeness ratio is below 98%.
7.	***Completeness Attestation*** Failure of the MCO attest the FSR is an accurate and complete representation of the claim payment financial liability and encounter submission activity of the MCO.	$10,000 for each quarter the attestation is not submitted with the FSR submission, or within the timeframe specified by EOHHS.
8.	***Completeness Consistency*** Failure of the MCO to report total incurred cost within the 0.1% threshold in the FSR and FDCR submissions.	$100,000 per quarter the FSR and FDCR are not reconciled within 0.1%.