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Encounter Data Improvement Program

Data Standardization Workgroup

Working Session #4

January 13, 2020 | 3:00 – 5:00 pm

Agenda & Meeting Objectives

- **Cross-Workgroup Takeaways**
- **Workgroup Timeline and Approach**
- **Address High Priority Issue Areas**
  - Review scope of issue areas
  - Confirm root causes of issues and errors
  - Identify and assess potential solutions
- **Next Steps**

Key Takeaways - Working Session #4

Governance

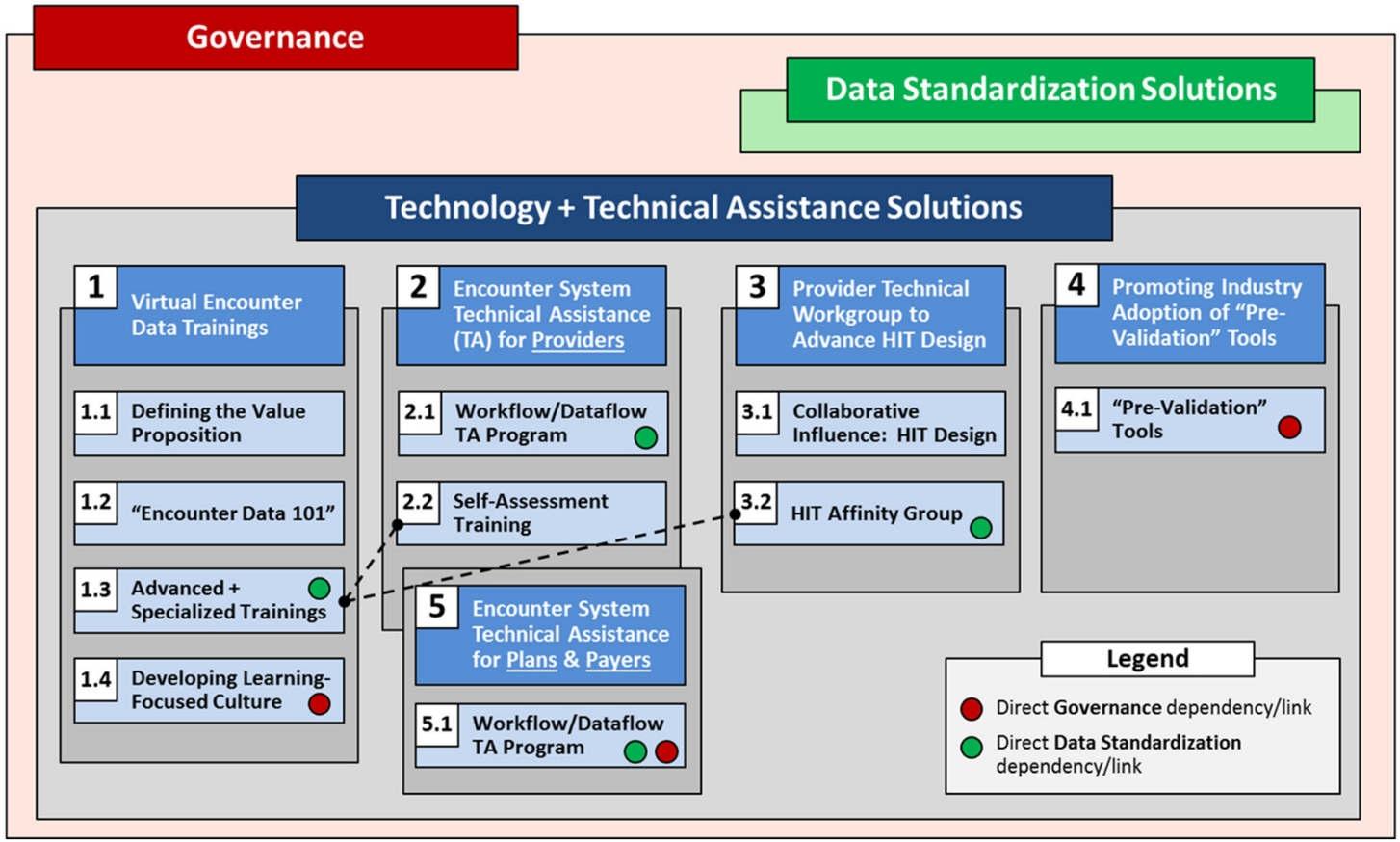
- **The Governance Workgroup meet on January 8th and reviewed the key takeaways from the Technology + Technical Assistance Workgroup and the Data Standardization Workgroup.**

- **The Governance Workgroup requested that a complete picture of functions, activities and oversight roles and responsibilities be developed and reviewed at the their next meeting.**

Technology + Technical Assistance

During its third working session on Tuesday, January 7th, the Tech + TA Workgroup focused on refining its first (virtual trainings), second (provider TA), and fifth (plan/payer TA) recommendations, assessing potential costs, owners and funders for each.

Tech + TA Recommendations (Developing)



Key Takeaways - Working Session #3

Data Standardization

The Workgroup met on December 5th and identified a preliminary list of the most impactful and prevalent issues, errors, and points of failure: (1) duplications; (2) local codes; (3) eligibility and enrollment; (4) newborn identification; (5) tracing errors; and (6) companion guide variation.

The Rapid Response Teams also identified the following issues for consideration:

- ***Implementation of New NDC Codes***: The NDC codes change on a quarterly basis, requiring considerable manual work to look up new codes. In addition, most plans are only checking to validate that the NDC code is present, not that the codes are accurate.
- ***Variable Void Replacement Logic***: Void replacement logic implementation differs from industry standard. Internal Control Number (ICN) returned vs ICN to be used for subsequent Void or Adjustment may not be the same thereby increasing the complexity.
- ***HCP Code Requirement***: DHCS has assigned a three digit HCP Code for each plan for each county. HCP number of the plan that the beneficiary was enrolled at the time of encounter must be used as first three characters of CLM01.
- ***CN Segment Requirement***: Segment is for non-HIPAA use as per the implementation guide. But DHCS requires this element to identify the paying contract for the claim/encounter.

The Rapid Response Teams also provided the following general observations:

- ***Nomenclature Variation***: Inconsistent use of terms to describe key points in the process flows stymies identification and correction of errors.
- ***Inadvertent Suppression of Valid Claims***: Workgroup participants warned that some screening algorithms may reject otherwise valid claims.
- ***Time Lags for Guidance Documents***: Time lags in the release of guidance, cross-walks, and coding updates impact the ability to mitigate and resolve errors.

Workgroup Timeline and Approach

#	Meeting Topics	Proposed Meeting Agenda
1	**Kick-off | Issue Confirmation** *October 25, 2019*	***Objectives**: Introductions, ratification of work group charter and charge; develop initial consensus around core issues for resolution* • Define key terms • Discuss critical issues and concerns to explore through working sessions • Identify important resources
2	**Issue Identification: Launch "Rapid-Response" Teams** *November 20, 2019*	***Objectives**: Launch "rapid response" teams to identify critical data standardization issues across the Medi-Cal encounter data ecosystem* • Assign "rapid response" teams to assess issue areas through three approaches: encounter data ecosystem mapping; reconciliation report reviews; and companion guide reviews • Set parameters for exercise
3	**Issue Identification: "Rapid Response" Team Report-outs** *December 5, 2019*	***Objectives**: Identify key challenges and discuss potential resolution strategies against key criteria* • "Rapid response" team report-outs with preliminary findings and facilitated discussion • Introduce "prioritization" framework/criteria • Inventory and prioritize data standardization issues for resolution
4	**Develop Draft Resolution Strategies** *January 13, 2020*	***Objectives**: Develop resolution strategies* ❑ Confirm list of priority issues ❑ Review root causes of priority issues ❑ Discuss proposed solutions ○ Assess impact and feasibility ○ Identify the relative level of effort to implement (i.e., easy, moderate, difficult) ○ Determine implementation timing (i.e., near term , mid term, long term)
5	**Test and Finalize Strategies** *January 27, 2020*	***Objectives**: Review recommendations, implementation and financial plan* ❑ Review revised draft tactics, strategies, and recommendations and draft implementation and financial plans

Encounter Data Standardization

"Highest Impact" Issues

To help prioritize the development of recommendations, the Workgroup identified the six most impactful and prevalent issues.*

Issue	Process Flow and Description of Failure/Errors
1. Duplications	Providers' creation of duplicate encounters and clearinghouses' and MCPs' varying logic and processes for identifying duplications has been identified by providers, MCPs, and Medi-Cal as the most prevalent encounter process error.
2. Use of Local Codes	Many providers use local codes for their managed care claims. Although Medi-Cal doesn't require clearinghouses and MCPs to do so, many MCPs and clearinghouses accept and cross-walk local codes to national codes using Medi-Cal's cross-walk tool. Medi-Cal rejects a number of cross-walked codes due to duplication issues or lack of an appropriate NDC code.
3. Newborn Identification	Newborns don't have a member ID and providers employ varied combinations of a mother's ID/CIN and modifier to indicate that the claim/encounter is for the newborn.
4. MCP Companion Guide Variation	MCP~~'s~~ companion guides have variable requirements; one assessment found that IEHP's and Molina's companion guides had a variance of 20%. Providers and clearinghouses must adapt their processes to accommodate variations in MCP's companion guides.
5. Visit/ Encounter Reconciliation	At various points in the process, the translation of visits to encounters is "lost" due to factors that include: (1) providers' Practice Management/Billing systems' failure to translate EHR-recorded visits into encounters; (2) providers relying on paper-based systems who don't submit all their encounters; (3) clearinghouse/IPA/MCP rejection of encounters that providers don't correct and re-submit.
6. Tracing Errors	At various points in the process, there are breakdowns in tracing rejected encounters and communicating the reasons for rejections to the responsible parties.

*Note: The Workgroup's assessment and rating of all issues are being maintained in a separate Excel file.

Overview and Primary Causes

Overview of Issue

Providers creation of duplicate encounters (and the propagation of the duplication through clearinghouses and payers), are a widespread problem.

At the payer level, Health Net reported duplicate records as the top error in 2017 and the third highest in 2018. At the Medicaid level, DHCS identified duplications as the most prevalent error for MCPs' submission of 837I, 837P (and #2 for NCPDP submissions) in Q3 2019.

Primary Causes*

1. ***Providers' Intentional Submission of Duplicates***. Providers may submit duplicate claims/encounter files in an attempt to expedite payments.

2. ***Stakeholders' Varying Logic for Identification of Duplications***. The logic used to identify and interpret duplications varies across providers, clearinghouses, MCPs, and Medi-Cal. In addition, many entities use a single algorithm and approach for their Medicaid, Medicare, and commercial businesses that fails to account for the nuances within business lines.

3. ***Variability in Providers' EHR & Billing Systems Approaches to De-duplication***. Many providers' EHRs and billing systems don't incorporate the appropriate de-duplication algorithms.

4. ***Varying Use of SNIP Level Edits***. SNIP level edits being applied in varying degrees due to insufficient staffing, processing of one error at a time, and some clearinghouses lack of portals.

*Additional reasons for creation of duplicate encounters are provided in the appendix

Potential Solutions

Solution #1: Identify Opportunities to Align De-Duplication Processes	**Solution #2:** Support Implementation of Standardized De-Duplication Processes	**Solution #3:** Enforce Alignment to the Standardized De-Duplication Process
Key Elements Convene DHCS, MCPs, clearinghouses, and providers to: (1) identify the types of duplicates and their causes; (2) compare the process to identify duplications; (3) assess underlying logic; and (4) identify opportunities for consistency and standardization. **Discussion Questions** 1. Should the assessment be facilitated by external third party?	**Key Elements** Support provider, MSO, clearinghouse, MCP, and technology vendors implementation of a standardized de-duplication process. **Discussion Questions** 1. What education/training should be offered to providers, MSOs, clearinghouses, and MCPs? 2. Should funds/resources be available to support provider implementation of the de-duplication approach? 3. What mechanisms should be used to support technology vendors' implementation?	**Key Elements** Develop processes and mechanisms to measure alignment with and conformance to the standardized process. **Discussion Questions** 1. Should DHCS contracts with MCPs include requirements for conformance with the de-duplication process? 2. Should conformance to the de-duplication algorithm be validated? 3. Should there be a certification process for vendors' conformance to the standard?
Roles/Responsibilities	**Roles/Responsibilities**	**Roles/Responsibilities**
TBD…	*TBD…*	*TBD…*
Anticipated Level of Effort to Implement	**Anticipated Level of Effort to Implement**	**Anticipated Level of Effort to Implement**
TBD…	*TBD…*	*TBD…*
Proposed Implementation Timing*	**Proposed Implementation Timing**	**Proposed Implementation Timing**
Nearterm? / *Midterm?* / *Longterm?*	*Nearterm?* / *Midterm?* / *Longterm?*	*Nearterm?* / *Midterm?* / *Longterm?*

*Proposed time frame for near term (<1 year), mid-term (1-2 years), long term (>2 years)

Overview and Primary Causes

Overview of Issue

Local codes are not accepted on managed care encounters by DHCS. However, many Medi-Cal providers continue to submit encounters with 'local codes', an artifact of the FFS environment where local codes are permitted and accepted by DHCS. DHCS offers a tool that allows MCPs to cross-walk local codes to national codes.

Primary Causes

1. ***Challenges cross-walking local codes to national codes.*** To avoid encounter data rejections, Medi-Cal plans, MSOs, and clearinghouses must either reject or attempt to translate local codes using a DHCS Local Code-to-HCPCS crosswalk. Attempting to translate codes using cross-walks tools, introduces additional opportunities for misinterpretation, omissions, or duplicate encounters.

2. ***Availability of updates to tools to cross-walk local codes to national codes.*** The periodicity of DHCS's release of local code cross-walks creates variability in interpretations.

Potential Solutions

Solution #1: Accelerate the Sun-Setting of Local Codes	**Solution #2:** Support Providers' Use of Allowable/Appropriate Codes
Key Elements • DHCS accelerate the sun setting of local codes in FFS environment. • Encourage MCPs to remove any existing contracting language that allows providers to use local codes. **Key Questions** 1. What are the barriers to sun setting local codes? What steps should be taken to discontinue their use in Medi-Cal? 2. To deter the continued use of local codes in the near term, should DHCS communicate (again) that MCPs are not required nor are the encouraged to accept local codes?	**Key Elements** • Train providers on the appropriate use of national codes. • In instances where there are options (e.g., if it is a J code), provide training on which code to use. **Key Questions** 1. What types of education/training would be most effective?
Roles/Responsibilities	**Roles/Responsibilities**
TBD…	*TBD…*
Anticipated Level of Effort to Implement	**Anticipated Level of Effort to Implement**
TBD…	*TBD…*
Proposed Implementation Timing*	**Proposed Implementation Timing**
Nearterm? / *Midterm?* / *Longterm?*	*Nearterm?* / *Midterm?* / *Longterm?*

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Overview, Primary Causes, and Potential Solutions

Overview of Issue

DHCS rejects encounters for newborns that fail to conform to the appropriate identification guidance.

Primary Causes

1. ***Providers' and clearinghouses' logic for addressing newborns' identification varies.*** Newborns do not immediately receive unique Medi-Cal member IDs; providers and MCPs may use mother's ID/CIN with or without a modifier to indicate that the claim/encounter is not for the mother, but for newborn.

Solution #1: Align Identification of Newborns to The Standard Practice

Overview

Review and revise as necessary Industry Collaborative Effort (ICE) and DHCS newborn coding guidance and promulgate a new standard/process to be adopted by DHCS, providers, MSOs, clearinghouses, and MCPs.

Key Questions

1. What education/training should be offered to providers?
2. Who should provide the training/education?

Roles/Responsibilities		
TBD…		
Anticipated Level of Effort to Implement		
TBD…		
Proposed Implementation Timing*		
Nearterm?	*Midterm?*	*Longterm?*

*Proposed time frame for near term (<1 year), mid-term (1-2 years), long term (>2 years)

Issue Overview, Primary Causes, and Potential Solutions

Overview of Issue

MCP's companion guides vary.

Primary Causes

1. MCPs' use of companion guides that don't conform to DHCS's companion guide.

Solution #1: MCPs Harmonize Companion Guides to DHCS			**Solution #2:** MCPs Adopt DHCS's Companion Guide		
Overview MCPs review differences across their Medi-Cal Companion Guides and identify and implement high-value opportunities for harmonization. **Key Questions** 1. At what frequency should the comparisons be conducted? 2. Should conformance be assessed and enforced?			**Overview** Create a single companion guide for all managed care plans to adopt to avoid variances. **Key Questions** 1. Should conformance be assessed and enforced?		
Roles/Responsibilities			**Roles/Responsibilities**		
TBD…			*TBD…*		
Anticipated Level of Effort to Implement			**Anticipated Level of Effort to Implement**		
TBD…			*TBD…*		
Proposed Implementation Timing			**Proposed Implementation Timing**		
Nearterm?	*Midterm?*	*Longterm?*	*Nearterm?*	*Midterm?*	*Longterm?*

Overview and Primary Causes

Overview of Issue

Previous assessments have found discrepancies in the expected volume of visits from a provider or MCP and the volume of encounters that DHCS receives. Gaps in expected and reported encounters have been identified in a number of ways, including:

1. Generation of estimates of expected volume of encounters based on the population characteristics (volume, geography, morbidity)
2. Audits of providers' EHRs
3. Comparison of the volume of encounters MCP routinely submit to DHCS vs. encounters submitted for rate setting

Primary Causes

1. ***Providers' Practice Management/Billing systems.*** In some instances, providers Practice Management or Billing Systems fail to translate EHR-recorded visits into encounters.

2. ***Providers who don't submit all their encounters.*** Some providers, particularly those who rely on paper-based systems,

3. ***Non-reconciliation of encounters rejected by clearinghouse/IPA/MCP.*** In some instances, providers that receive a rejected claim from a clearinghouse/IPA/MCP may choose not address the rejection even though the visit was valid and appropriate.

Potential Solutions

Solution #1: Assess the Extent to Which Encounters Fail to Move from Providers through Clearinghouses/MCPs to DHCS	**Solution #2**: Support Education, Training, and Incentives for Provider Submission of Encounters	**Solution #3:** Align MCPs' Claims and Encounter Submission Formats
Overview MCPs analyze their delegated and non-delegated encounters compared to DHCS's estimates. The analysis would provide a point-in-time spot check of missing data that would help target solutions to the appropriate areas. **Key Questions** 1. Who should facilitate the comparative assessment? 2. At what frequency should the comparisons be conducted?	**Overview** To improve POs' submission of encounter data: ❑ provide education to raise awareness of the issue ❑ offer training to support implementation ❑ expand incentives for submission of all encounter data in conformance with CART. **Key Questions** 1. Should incentives include penalties for failure to submit encounter data?	**Overview** Encourage MCPs to align their claims and encounter submission formats and the benchmarks that are used to compare expected vs. actual encounters. **Key Questions** 1. Should alignment be encouraged or required? 2. How will alignment be assessed?
Roles/Responsibilities	**Roles/Responsibilities**	**Roles/Responsibilities**
TBD…	*TBD…*	*TBD…*
Anticipated Level of Effort to Implement	**Anticipated Level of Effort to Implement**	**Anticipated Level of Effort to Implement**
TBD…	*TBD…*	*TBD…*
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*Proposed time frame for near term (<1 year), mid-term (1-2 years), long term (>2 years)

Overview and Primary Causes

Overview of Issue

At various points in the process, there are breakdowns in tracing rejected encounters and communicating the reasons for rejections to the responsible parties.

Primary Causes

1. In some complex delegation arrangements, it can be difficult to identify and track the originator of the encounter.

2. There is significant variability in MCPs' edit logic for encounters as illustrated in the assessment below.*

For edits: different processes and formats across plans create operational burden, data gets lost

Edit process grid by plan:

		Front End Edits		Back End Edits	Excel exporting Option
Payer	277 CA	Proprietary	Method of Receipt	Format	Yes
Plan 1	NO	YES	WEB	Combined	Yes
Plan 2	NO	YES	FTP and G-Drive	Combined	Yes
Plan 3	NO	YES	FTP and Email	Combined	Yes
Plan 4	NO	YES	WEB	Combined	No
Plan 5	NO	YES	FTP	Combined	Yes
Plan 6	YES	YES	Email	Proprietary edit Report	Yes
Plan 7	YES	YES	ENS	Separate but behind	Yes

3. DHCS and MCPs communicate rejections in differing methods.

*Source: Carol Wanke, Encounter Data Project Presentation, (March 2017).

Potential Solutions

Solution #1: Identify Key Fields To Maintain Throughout the Encounter Process	**Solution #2**: Enhance Communication and Clarification of Rejections and Remediation	**Solution #3:** MCPs Optimize Their Processes for Identifying Errors
Overview To enhance the traceability of errors, identify the key fields (e.g., submitting provider ID) that should be maintained throughout the entire encounter submission and reconciliation process. **Key Questions** 1. How does the degree of delegation impact potential solutions?	**Overview** The reasons for errors identified at the payer and Medicaid level and the steps for remediation should be clearly communicated back to the originators of the errors, including those that pass through IPAs and MSOs. **Key Questions** 1. A previous assessment for IHA recommended that MCPs' edit forms/reports be standardized. What is the status of that proposal?	**Overview** MCPs should create a seamless process that accurately identifies and appropriately routes rejected files to the provider in a timely manner for reconciliation. **Key Questions** 1. What are the barriers to MCPs' ability to align and optimize their processes?
Roles/Responsibilities	**Roles/Responsibilities**	**Roles/Responsibilities**
TBD…	*TBD…*	*TBD…*
Anticipated Level of Effort to Implement	**Anticipated Level of Effort to Implement**	**Anticipated Level of Effort to Implement**
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*Proposed time frame for near term (<1 year), mid-term (1-2 years), long term (>2 years)

Next Steps

- Provide additional feedback on proposed solutions
- Manatt to compile and synthesize feedback into draft recommendations

#	Meeting Topics	Proposed Meeting Agenda
5	**Test and Finalize Strategies** *January 27, 2020*	***Objectives**: Review recommendations, implementation and financial plan* ❑ Review revised draft tactics, strategies, and recommendations and related draft implementation and financial plans

Appendix

Reasons for Provider Creation of Duplicate Encounters

Duplicate Reason	Issue Remediation
A claim is charge corrected by provider and the claim status type 7 is not added with the original claim reference number	AR system has logic to ensure a corrected claim is sent out if the claim is corrected for a previously filed and accepted claim by the health plan. Work with software vendors.
A claim is resubmitted with a claim status type 7 but nothing on the claim changed	AR system logic in place to ensure a change in the previous filed claim before adding a 7
Claims are auto submitted by provider without checking claim status	Provider Education
Duplicate file transmissions create duplicates	Provider Education
Original encounter was denied submitted to health plan, subsequent claim is submitted and is denied as a duplicate at the plan because a claim status type of 7 was not submitted	Provider Education and AR system logic
Entire file was submitted because one claim was rejected within the file	Provider Education
DHCS criteria as a duplicate is insufficient (state logic 76 modifier to override duplicate)	DHCS to update duplicate logic in its system
Default in practice management systems set to (Yes) to generate a claim when any change is made	Eliminate default to yes for those systems with the default
Misdirected claims sent to group by the health plan and then provider received the CARC that states claim was misdirected and then provider sends another claim to the correct payer	Provider education. Provider does not need to submit a new claim, only change the payer category assignment that identifies correct payer.
End of the year AR clean if not paid, provider submits again	Provider education, use tools to look up claim status either electronically or on payer portal before resubmitting claims.
CMS sweeps to ensure all encounters are captured, providers resubmit everything and create massive duplicates encounters	Delegates have encounter reconciliation process in place to avoid mass resubmissions.
Groups are sending denials for encounter reporting and are not scrutinizing the denial reason and sending denials such duplicate or misrouted in their files to the plan	Payers agree on what denials they need to receive and inform providers

Workgroup Roster

#	First Name	Last Name	Job Title	Company	Industry
Co-Chair	**Eric**	**French**	**VP, Provider Performance & Analytics**	**Health Net**	**Managed Care Plan or Health Plan**
Co-Chair	**Carol**	**Wanke**	**VP Post Acute Revenue Cycle and Managed Care Operation**	**Sharp HealthCare**	**Independent Practice Association or Medical Group**
1	Michael	Arriaga	Encounter Manager	Molina Healthcare	Managed Care Plan or Health Plan
2	Terri	Bailey	Manager	Health Net	Managed Care Plan or Health Plan
3	Allyce	Barrios	Director Revenue Compliance	Hills Physicians Medical Group	Providers/IPAs/Health System
4	Laurie	Dean	Business Process Consultant	United Healthcare	Manager Care Plan or Health Plan
5	Genia	Fick	Sr. Director, Quality Systems	Inland Empire Health Plan (IEHP)	Managed Care Plan or Health Plan
6	Denise	Gionta-Del Rio	Encounter Manager, Medicaid Business	Aetna	Managed Care Plan or Health Plan
7	Starla	Ledbetter	Chief Data Officer, Branch Chief, Enterprise Data Operations	California Office of Statewide Health Planning and Development (OSHPD)	Government (State, County, Federal)
8	David	Lown	Chief Medical Officer	California Health Care Safety Net Institute (SNI)	Providers/IPAs/Health System
9	Larry	McIntosh	VP - Encounters and Capitation Ops	SBC Global (formerly United)	Managed Care Plan or Health Plan
10	John	Minot	Director of Policy	California Association of Public Hospitals and Health Systems (CAPH)	Providers/IPAs/Health System
11	Amber	Ott	Group Vice President, Data and Analytics	California Hospital Association (CHA)	Providers/IPAs/Health System
12	Thenn	Subramanian	Director of EDI Development	Partnership HealthPlan of California	Managed Care Plan or Health Plan
13	Aaron	Toyama	Chief, Data Analytics Branch	California Department of Health Care Services (DHCS)	Government (State, County, Federal)
14	Jennifer	Wei	Interim Chief, Financial Systems Support and Reporting	LA County Department of Health Services	Government (State, County, Federal)
15	Greg	White	Director, Encounters	L.A. Care Health Plan	Managed Care Plan or Health Plan
16	Mark	Yakimisky	Executive Director, Pricing Systems & Data Services	Kaiser Permanente	Managed Care Plan or Health Plan
HN	Stephanie	Landrum-Hall	Manager of Community Grants	Health Net	Project Leadership/Staff
Harder	Courtney	Huff	Research Consultant	Harder+Company Community Research	Project Leadership/Staff
Manatt	Jonah	Frohlich	Managing Director	Manatt Health Strategies, LLC	Project Leadership/Staff
Manatt	Lammot	duPont	Senior Advisor	Manatt Health Strategies, LLC	Project Leadership/Staff
PHCG	Tim	Reilly	Founder and Partner	Pacific Health Consulting Group	Project Leadership/Staff

Co-Chairs ***Workgroup members*** ***Health Net & Harder*** ***Manatt Health***