New York State Department of Health

Performance audit of Managed Care Organizations (MCO) Encounter data submissions for calendar year 2019

Final Report
As of March 1, 2024

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March 1, 2024

Ms. Susan Montgomery
Director, Division of Health Plan Contracting & Oversight Office of Health Insurance Plans
New York State Department of Health One Commerce Plaza
Albany, NY 12210

Dear Ms. Montgomery:

This report presents the results of KPMG LLP's (KPMG) performance audit of the Managed Care Organizations (MCO) Encounter Data submissions for calendar year 2019, conducted on behalf of the State of New York (the State) Department of Health (the Department or DOH). Our substantive 2019 fieldwork began May 15, 2023. The results, reported herein, are presented as of the completion of testwork in November 2023.

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 2019.

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' 2019 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 16 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 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 (e.g., 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 2019.

Scope

This report presents the audits' results of calendar year 2019. For audit year 2019, 18 MCOs were selected by DOH. The 18 MCOs capture 32 distinct Lines of Business (LOBs). LOBs covered in the 2019 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), HIV Special Needs Plan (HIV-SNP), 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 18 auditees, 15 underwent desk procedures and three underwent field procedures.

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.

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 of non-compliance or specific instances of non-compliance.

The following procedures were conducted for desk audits:

- **Test procedures** automated through the KPMG Encounter Validation and Analytics (KVAL) tool to **test compliance with specific Federal and State requirements**. Results vetted with the Department as clear instances of non-compliance were noted as findings within this report.
- **Test procedures** automated through KVAL to **test for potential risks of non-compliance related to completeness, accuracy, and timeliness indicators**. Results vetted with the Department as posing risks of non-compliance were noted as observations within this report.
- **Benchmark analytics** automated through KVAL conducted **across all MCOs to help identify potential outlier results in comparison to the other MCOs.** Results vetted with the Department as potential outliers were noted as observations within this report.
- **Auditee encounter and process 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.
- **Data reconciliations** were reviewed to **test the completeness of the encounter data** submitted to DOH compared to the MCO claims systems. Results which exceeded a DOH-defined threshold for 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. Failed samples were noted as findings within this report.

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

- **Reconciliation of encounter data metrics to the MCOs' claim systems' data metrics for completeness testing**. Results which exceeded a DOH-defined threshold for variances were noted as observations within this report.
- **Medical record reviews to validate the accuracy of submitted encounter information against medical chart information** that MCOs' requested from the providers as well as additional claims system support. Items of non-compliance, including instances where data elements did not tie to supporting documentation, are noted as findings 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: Audit Planning and Project Management
- Phase 2: Audit kick-off
- Phase 3: Fieldwork
- Phase 4: Validation, Reporting, and Close Out

Each section below describes the key steps taken to complete the 2019 audit in greater detail.

Phase 1: Audit planning and project management

- Conducted auditee selection analysis in support of DOH determinations.
- Preparation of audit kick-off documentation, e.g., notification letters, documentation requests.
- Reviewed and confirmed the Audit Program Guide (APG) with DOH (see **APG Background** below for more details).
- Executed audit data set preparation and netting (see **Data Preparation** below for more details).
- Executed automated testwork via KVAL and prepared initial results packets (see **KVAL Testwork** below for more details).
- Assisted DOH with recording an instructional presentation for all auditees that outlined the audit processes, steps, expectations.

APG Background

KPMG reviewed the prior year APG to assess the need to make testwork changes for the 2019 audit year. A summary of APG review steps is included below:

- Researched the MCO regulations, including Federal and State guidance.
- Reviewed 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.

- Reviewed the Department's data procedures, including the Encounter Intake System (EIS) and acceptance/rejection data.
- Reviewed 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.
- Validated with DOH the approach for selecting auditees.
- Updated the audit testing approach, held ongoing discussions, and reviewed detailed documentation (e.g., the Audit Test Matrix, questionnaire, reconciliation, etc.). Once these steps were completed KPMG documented the approach within the APG for DOH approval. To create the APG, KPMG and DOH reviewed State requirements related to the collection and submission of encounter data and identified DOH approved 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 Ill)
    - Dictionary, which is elaborated in section 18.5(a)(iv) of the Model Contract
    - Validation requirements for encounters by encounter 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.

Data Preparation

KPMG leveraged the previously approved process and logic to build an encounter audit dataset using the DOH PACDR as the primary data source related to MCO submissions. The data preparation process included:

- Reconciling the full universe of encounter records (including original submissions, resubmissions, etc.) to the population of final encounters.
- Reconciling final encounters to the DOH MDW as a reasonableness benchmark to confirm completeness of dataset used for audit purposes.

— Presenting results for DOH approval as the 2019 audit data set.

KVAL Testwork

As the majority of encounter testwork is automated through KVAL, KPMG executed testwork and prepared results workbooks for each MCO, identifying preliminary findings and observations which would be sent with the notification packages to the MCOs, thus driving efficiencies in the process by giving this data to MCOs on Day 1.

Upon finalizing the preparation of audit letters, communications with DOH, and anticipated steps to prepare for audit launch, the audit moved into Phase 2.

Phase 2: Audit kick-off

— Onboarded the KPMG audit team and conducted detailed trainings.

— 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, a link to the pre-recorded instructional presentation, and Encounter Audit Tool (Tool) credentials and instructions.

— The ANP also included the details of 2018 findings and observations for MCOs' to review and respond to as part of the initial data request.

— Conducted an entrance conference with each MCO (field audits only).

— Walked each MCO through the detailed test results packet and documentation requests (field audits only).

— 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 responses to findings and observations, engaged in follow-up discussions as needed, and document auditees formal responses for use in review with DOH and documentation in Exit Dashboards.

— 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.

— Reviewed the comparison results of the data metrics testing, provided additional ICN detail to the MCOs for further variance analysis, and documented outcomes in the Tool (field audits only).

— 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 (where applicable).

— Held detailed findings walkthrough sessions with DOH and received final confirmation regarding the presentation of findings and observations not previously discussed with DOH.

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.
- Held Exit Conferences (field audit only) with field auditees 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 as needed 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 2019.

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
	Audit team kick-off calls with MCOs (field only)	5
	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, 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
	QC Review – Finalize potential findings and observations and prepare for Exit Dashboard	55 / 60
	DOH approval of Exit Dashboards	60/65
	Release Exit Dashboards	60/65
	MCO submits Exit Dashboards	65/70

Advanced data & analytics enablement

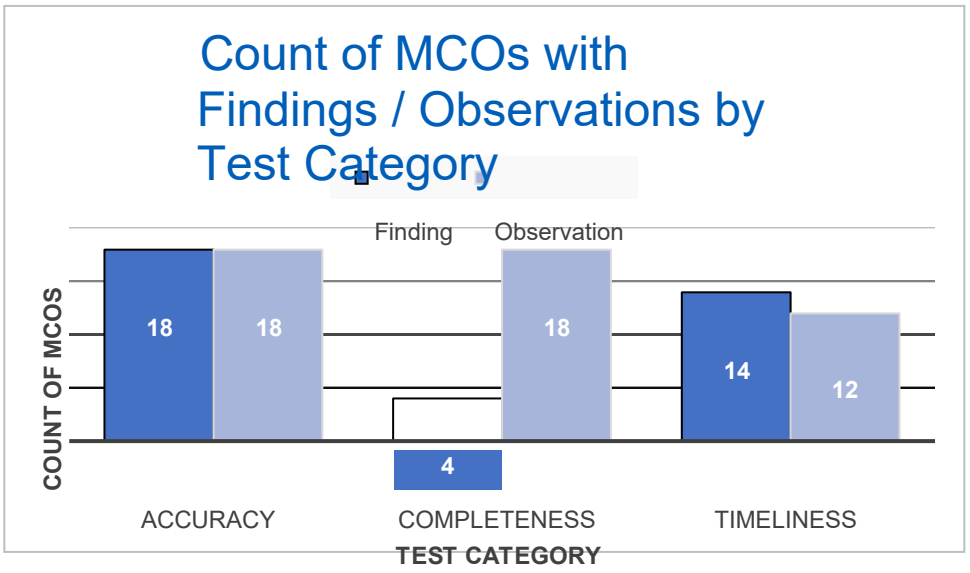
Upon executing DOH's data use agreement and gaining access to the data within DOH systems, KVAL was the enabling basis for the following key engagement activities:

- 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 2019 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 2019 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 the number of MCOs in the 2019 audit year that 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 the number of total tests which 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/ Instances	# of findings	# of observations	Report findings	Report observations
Desk	Test procedures automated through KVAL*	15 (Per MCO & LOB)	6	7	6	7
Desk	Benchmark analytics automated through KVAL (per MCO & LOB)	6 (Per MCO & LOB)	0	6	0	6
Desk	Sample testing**	18 (Total # of MCOs)	7	1	2	1
Desk	Auditee questionnaire	18 (Total # of MCOs)	0	0	0	0
Desk	Data reconciliation^	18 (Total # of MCOs)	0	5	0	1
Field	Medical chart review	3 (Total Field Auditees)	3	0	8	0
Field	Data Metrics comparisons+	3 (Total Field Auditees)	0	3	0	1
	Total	**81**	**16**	**22**	**16**	**16**

*Some tests resulted in both findings and observations approved by DOH at an individual auditee level, thus the number of report findings
**The seven instances of sample findings across MCOs are consolidated into two formal findings and one observation for this report
^The five data reconciliation observations are consolidated into one formal observation for this report.
+The three data metrics comparison observations are consolidated into one formal observation for this report.

As noted in the table above there are 16 findings which are further elaborated in the following pages. Based on the footnotes of the table, the three distinct observations noted for sample selection, reconciliation and data metrics have been consolidated into three 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. Multiple conditions may be reported within a single finding.
- **Cause**: An assessment of the underlying cause of the identified condition(s).
- **Effect**: Potential impact of the finding.
- **Recommendation:** A short discussion on what may be done to improve, resolve, or avoid the identified condition.
- Findings 1-6 are related to the desk audit test procedures automated through KVAL not including benchmarks analytics.
- Findings 7-8 are related to sample testing.
- Findings 9-19 are related to the medical chart reviews conducted during the field audits.

Findings and recommendations

Finding 1: MCO submitted encounters in which a CARC code was missing 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: Five MCOs, spanning seven 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 code 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 submitted encounters in which the COS codes 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: Six MCOs, spanning four unique lines of business, had a percentage of submitted encounters in which the COS codes do 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 that exceeded model contract terms between adjudication date and submission date.

Criteria: The NYS DOH Model Contracts with the MCOs stipulate plans must submit encounter data on a bimonthly (twice a month) basis, as specified by the Department and encounter data shall not be submitted to the DOH or its designated fiscal agent more than fifteen (15) calendar days from the date of adjudication of the corresponding claim.

Condition: 18 MCOs, spanning seven unique lines of business, had a percentage of encounters that were submitted beyond the model contract submission date terms.

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

Effect: Failure to properly submit encounters in a timely manner may impact the Department's ability to rely on the data for rate setting and other analytical purposes.

Recommendation: MCOs should update their encounter submissions policies to ensure their encounters are submitted within the terms of the Model Contracts.

Finding 4: 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: One MCOs, spanning two unique lines of business, had a percentage of 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.

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 5: MCO submitted encounters that have lag time greater than 180 days between the last day of the month of the paid date to the submission date of the original encounter.

Criteria: The All-Payer Database Guidance Manual provides guidance on submitting encounters within 180 days from the end of the month of the paid date to ensure timely submissions of encounters.

Condition: Fourteen MCOs, spanning seven unique lines of business, had a percentage of submitted encounters that have lag time greater than 180 days between the last day of the month of the paid date to the submission date of the original encounter.

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

Effect: Failure to properly submit encounters in a timely manner could impact the Department's ability to rely on the data for rate setting and other analytical purposes.

Recommendation: MCOs should follow DOH guidelines and All Payer Database Guidance Manual to minimize submissions of encounters over 180 days.

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. NYS DOH defines the provider specialty type code “999” as Other and should only be used in cases when no other code can be applied to describe the encounter.

Condition: One MCO, spanning one unique line of business, had a percentage of submitted encounters in which the Provider Specialty Type field has a value of “999”, for which the auditee indicated the encounters were for durable medical equipment (DME) and the DME Provider specialty code “307” should have been used.

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

Effect: Submission of encounters in which the Provider Specialty Type field has a value of “999” 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 New York State Medicaid Encounter Data Reporting for APD and MMCOR Category of Service – Service Utilization Guide to ensure the Provider Specialty Type does not include a value of “999”.

Finding 7: MCO was not able to obtain support from the third-party to validate encounter details.

Criteria: The NYS DOH Model Contracts require the MCOs to preserve and retain all records relating to the Contract and require its' Subcontractors to do same in accordance with the terms of the Contract for a period of ten (10) years. In addition, the Model contract states all provisions of the agreement relating to Contractor and subcontractor record maintenance and audit access shall survive the termination of the Agreement for up to ten (10) years, or when an audit is completed.

Condition: Two MCOs were not able to obtain support from their third-party administrator from 2019.

Cause: The third-party administrator (TPA) closed in 2020 and provided an Excel "database" that included encounter information that was submitted to DOH. The TPA did not provide the original encounters that were submitted to the Department on behalf of the MCOs.

Effect: Inability to reconcile encounters to supporting documentation in sample testing may indicate risks of inaccurate 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 Model Contract terms to ensure complete and accurate records are obtained prior to the closure of subcontractors.

Finding 8: MCO provided support that did not tie to the submitted encounter data.

Criteria: The NYS DOH Model Contracts require the MCOs to preserve and retain all records relating to the Contract and require its' Subcontractors to do same in accordance with the terms of the Contract for a period of ten (10) years.

Condition: Five MCOs provided support (claims screenshots and/or claim forms) in which one or more data elements did not tie to the submitted encounter data. Below are where support did not tie to the encounter data:

1. For one MCO: the units on the encounter did not tie to the support.
2. For one MCO: the header level charge amount and paid amounts on the encounter did not tie to the support.
3. For one MCO: the auditee indicated that the DRG code was submitted on the encounter in error.
4. For one MCO: the member ID on encounter did not tie to the support.
5. For one MCO:
   - Header level charge amount and paid amounts on the encounter did not tie to the support.
   - Line level paid amounts on the encounter did not tie to the support.
   - Place of service code on the encounter was not included on the support.

Cause: The auditees noted various reasons for the mismatch of the fields, notably, items 1, 3, and 5 the auditees indicated there were submission errors that impacted several encounters. Item 2 was due to a coordination of benefit issue on the sample selection, and item 4 was due to the auditee being unable to provide a sufficient crosswalk to tie the MCOs' internal member ID to the Medicaid ID on the encounter.

Effect: Inability to reconcile encounters to supporting documentation may indicate risks of inaccurate encounter submissions which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

Recommendation: The MCOs with noted errors were directed to contact the Managed Care Encounter Compliance team at DOH to discuss the impact of the errors on previous encounter submission and how to correct the error through the resubmission process. MCOs should implement a review process that ensure the information of the encounters prior to submission to DOH is accurate.

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, and in the case of a minor, for six (6) years after majority. In addition, CMS ICD-10-CM Official Guidelines for Coding and Reporting require that the CPT codes billed by the provider are accurately represented on the claim form, and furthermore represent actual services provided as evidenced by medical records.

For the four CPT codes relevant to this finding:

- AMA provides guidelines for billing radiology procedures, these include documenting the need for the procedures by a physician, the tests to be performed or supervised by a radiologist, the interpretation of the images, and a written report.
- AMA defines CPT code 99401 as preventative medicine counseling and/or risk factor reduction interventions provided to an individual; approximately 15 minutes.

Conditions: Three MCOs' medical chart supporting documentation did not include any information to validate the CPT codes on the claim form and encounters.

1. Two MCOs' Medical Chart samples tested included diagnostic CPT codes in which the documentation provided did not include any support that the diagnostic services were performed.
2. For one MCO, the documentation provided did not include any time in the progress note for CPT 99401, which is time based.

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 reconcile encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

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 communicated communication protocols:

- 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 2019 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 Department recommends that the MCO report the Provider to the Department as well as other appropriate channels such as Office of Medical Inspector General (OMIG).

Finding 10: Supporting documentation did not support the CPT billed.

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, and in the case of a minor, for six (6) years after majority. CMS ICD-10-CM Official Guidelines for Coding and Reporting require that the CPT codes and service modifiers billed by the provider are accurately represented on the claim form, and furthermore represent actual services provided as evidenced by medical records.

Condition: One MCOs' Medical Chart sample supporting documentation did not evidence all service lines billed, the documentation indicated 60 minutes of psychotherapy services were provided; however, only 45 minutes were billed.

Cause: The claims were not appropriately billed by the provider to accurately reflect the services provided.

Effect: Inability to reconcile encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions, which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

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

Finding 11: Services rendered per supporting documentation do not support the accuracy of the CPT codes billed.

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, and in the case of a minor, for six (6) years after majority. CMS ICD-10-CM Official Guidelines for Coding and Reporting require that the CPT codes and service modifiers billed by the provider are accurately represented on the claim form, and furthermore represent actual services provided as evidenced by medical records. Per AMA, for a provider to bill a second evaluation and management (E/M) CPT on the same encounter, the following criteria must be met: significant, separately identifiable E/M service by the same physician or other qualified healthcare professional on the same day of a procedure or other service. (As defined by the service modifier code.)

For the four CPT codes relevant to this finding:

- AMA defines CPT code 99393 as periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient.
- AMA defines CPT 99213 Office or other outpatient visit for the E/M of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
- AMA defines CPT code 99401 as preventative medicine counseling and/or risk factor reduction interventions provided to an individual; approximately 15 minutes.

Condition: One MCOs' Medical Chart sample documentation did not support the billing of three separate, identifiable E/M CPT codes (99213, 99393, and 99401) of an established patient visit as indicated on the encounter and claim form.

Cause: There documentation provide did not support a significant, separately identifiable E/M service by the same physician or other qualified healthcare professional on the same day of a procedure or other service.

Effect: Multiple E/M services on the same day may indicate risks of inaccurate encounter submissions, which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

Recommendation: MCOs should improve their oversight of providers to better confirm the accuracy of E/M CPT code usage on the same encounters

Finding 12: Supporting documentation does not support the accuracy of the service modifier code billed.

Criteria: The Model Contract Section 19.4 states that MCOs are required to make reasonable efforts to assure that Enrollees' medical records, inclusive of service modifier 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. In addition, CMS ICD-10-CM Official Guidelines for Coding and Reporting require that the CPT codes and service modifiers billed by the provider are accurately represented on the claim form, and furthermore represent actual services provided as evidenced by medical records. AMA defines service modifier code 25 as a significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of a procedure or other service.

Condition: One MCOs' Medical Chart sample's documentation provided did not support the billing of three E/M CPT codes and appending modifier 25.

Cause: There was not a significant, separately identifiable E/M service by the same physician or other qualified healthcare professional on the same day of a procedure or other service.

Effect: Inability to tie encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions, which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

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

Finding 13: Lack of supporting documentation resulted in the inability to validate diagnosis codes.

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 documentation describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter.

Condition: One MCOs' 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 reconcile encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions, which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

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 communicated communication protocols:

- 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 2019 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 has reported the Provider to the Department as well as other appropriate channels such as Office of Medical Inspector General (OMIG).

Finding 14: Supporting documentation did not support the diagnosis codes billed.

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. The CMS ICD-10-CM Official Guidelines for Coding and Reporting Section IV. Part C. requires that the documentation describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter.

Condition: One MCOs' Medical Chart sample's supporting documentation did not support the billing of diagnosis code.

Cause: The claims were not appropriately billed by the provider to accurately reflect the services provided.

Effect: Inability to tie encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

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

Finding 15: Supporting documentation did not support the units of service billed.

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 service line information, 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. CMS ICD-10-CM Official Guidelines for Coding and Reporting require the units of service billed by the provider are accurately represented on the claim form, and furthermore represent actual service units provided as evidenced by medical records. AMA defines HCPCS T1019 as 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: For one MCO, T1019 could not be validated because the units of service billed did not tie to the supporting documentation.

Cause: The auditee indicated that there was programming logic which inaccurately divided the units by 4 identified by their third-party vendor. The MCO indicated the error has been corrected.

Effect: Inability to tie encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

Recommendation: MCOs should improve their oversight of third-party vendors to ensure adequate controls are in place to validate the encounter programming logic.

Finding 16: Lack of supporting documentation resulted in the inability to validate the provider's signature.

Criteria: Per CMS Guidance, for a signature to be valid, the following criteria must be met: 1) services that are provided or ordered must be authenticated (signature with credentials) by the ordering practitioner; 2) signatures are written or electronic. Stamped signatures are not acceptable; 3) signatures are legible or can be confirmed by comparing it to a signature log or attestation statement.

Condition: For one MCO, signature validation was not clearly executed, as there were no credentials included with the signature provided on the medical chart.

Cause: The auditee was unable to obtain the appropriate credentials from the provider to adequately support the medical chart.

Effect: Inability to tie encounters to supporting documentation in a Medical Chart Review may indicate risks of inaccurate encounter submissions which effects the Department's ability to rely on the data for rate setting and other analytical purposes.

Recommendation: MCOs should improve their oversight of providers on the criteria for a valid signature and the impact of unauthenticated medical record documentation.

Observations

The following section presents test procedures which resulted in observations. These items may present 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 confirm if a finding or observation was relevant. As such, the following observations were documented for each of the related test procedures noted.

- Observations 1-6 are related to the desk audit benchmark analytics automated through KVAL.
- Observations 7-11 are related to two desk audit test procedures automated through KVAL. They are reported as observations because the results did not indicate an instance of non-compliance.
- Observation 12-13 are related to two desk audit test procedures automated through KVAL that DOH requested KPMG to run. These tests relate to guidance/regulations which were not yet applicable for the 2019 audit period but would provide potential insights and/or corrective actions for MCOs to consider for future periods for which the guidance/regulations were applicable.
- Observation 14 is related to the Sample Selection testwork.
- Observation 15 is related to the Data Reconciliation test procedures.
- Observation 16 is related to the Data Metrics comparisons between the encounter data and claims systems for the field audits.

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	Audit Result	# Of MCOs	# Of LOBs
1	MCO percentage of final inpatient encounters that are institutional is 1.5 deviations or more above or below the benchmark which could indicate that not all encounters are complete.	6	5
2	MCO percentage of substance use or abuse diagnosis codes is 1.5 deviations or more above or below the benchmark which could indicate inaccurate use of diagnosis codes.	8	7
3	MCO utilization rate is 1.5 deviations or more above or below the benchmark which could indicate that not all encounter submissions are complete.	14	7
4	MCO ratio of residential care facility encounters to home health encounters is 1.5 deviations or more above the benchmark which could indicate that not all encounter submissions are complete or coded correctly.	11	6
5	MCO median lag time between service data and encounter submission date per encounter is 1.5 deviations or more above the benchmark which could indicate that not all encounter submissions are timely.	11	4
6	MCO has at least one month where the median monthly submissions are 1.5 deviations or more above or below their own benchmark which could indicate that not all encounter submissions are complete.	18	7

Observation	Audit Result	# Of MCOs	# Of LOBs
7	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.	15	7
8	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.	14	6
9	MCO submitted encounters in which the Provider Specialty Type field has a value of "999".	7	5
10	MCO submitted inpatient encounters that have a length of stay equal to 1 day.	9	5
11	MCO submitted replacements and voids greater than 2 years from the date of service.	10	6
12	MCO submitted Inpatient encounters in which the Present on Admission (POA) code is null.	10	7
13	MCO submitted encounters that do not include the allowed amount or paid amount as required per the 2020 CMS final rule.	18	7
14	MCO sample support provided did not tie to the encounter data.	1	2
15	MCO submitted the reconciliation with a variance greater than 3%.	5	All
17	(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. Differences between the two metrices 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: — 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 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.	3	All

Summary

Based upon the procedures performed and documented within this report, we have met the 2019 audit objective. As of the completion of fieldwork, KPMG will no longer communicate with the MCOs or their representatives regarding the 2019 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.

Department of Health Management Response

KPMG,

As part of the Centers for Medicare and Medicaid Services (CMS) final regulations that revise existing Medicaid managed care rules, 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.

KPMG LLP (KPMG) was engaged by the New York State (NYS) Department of Health (DOH or the Department) to conduct performance audits of the accuracy, completeness, and timeliness of calendar years 2019 (CY2019) encounter data submitted by Managed Care Organizations (MCOs).

Many areas within the Department rely on encounter data reported by MCOs to the Department's encounter data intake system. Encounter data is utilized for a multitude of purposes including Medicaid rate setting, policy compliance monitoring, as well as numerous other analyses. This data is used by various bureaus and divisions within the Department and provided to numerous outside governmental and private organizations that also rely on this data for their work or research.

The audit process for CY2019 was designed by KPMG to improve the integrity of the encounter data submitted to the Department, and the audit findings are used to further educate MCOs on DOH data submission expectations and requirements.

Following a comprehensive review, the Department accepts KPMG's draft 2019 Encounter Data Audit Reports and approves of them becoming the final completed versions.

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