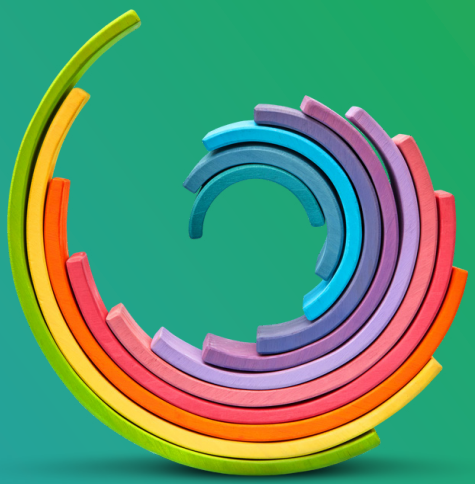
Mercer

welcome to brighter

Triennial audits

A comprehensive approach



Mercer Government
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Case study

Situation

The 2016 Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (42 § Code of Federal Regulation [CFR] 438.602[e]) requires state Medicaid programs to conduct an encounter and financial data audit of managed care organizations (MCOs) at least once every three years. The purpose of this regulation is to **ensure high quality encounter** and financial data for managed care capitation rate development, risk adjustment, program monitoring/oversight, and other data analytic needs.

Challenge

The Department of Health and Human Services, Office of Inspector General Data Brief from March 2021 stated that most states did not provide the Centers for Medicare and Medicaid (CMS) complete or accurate data on Medicaid managed care payments to providers, however, Mercer Government's extensive experience working with encounter data has shown that the completeness and accuracy of data is dependent on many variables. These variables include, but are not limited to, the state's encounter submission standards, the state's Medicaid Management Information System (MMIS) capabilities, the MCO's claims and encounter data management practices, as well as each stakeholder's understanding of the data. Therefore, the design of any encounter data audit/validation project should **identify and address those specific variables** in the audit findings.

Action

Mercer Government's comprehensive approach to conducting the required triennial audits aligns with the CMS External Quality Review (EQR) Protocol 5 for encounter data validation (EDV).

[1]https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

CMS EDV protocol

5 key activities

1. Review state encounter data requirements
2. Audit MCO encounter data capabilities
3. Analyze electronic encounter data
4. Perform medical record review (at state's discretion)
5. Submit findings

Because activity four – Medical Record Review – is both time and resource intensive, Mercer Government offers our clients enhanced encounter data analyses utilizing macro-analytics to assess data integrity, data completeness, and data accuracy to meet regulatory requirements.

Data integrity—evaluates the state's encounter extract records for population and reasonableness rates of key fields.

Data completeness—compares the state encounter records to the MCO submitted claims extracts to evaluate the percentage of records that match between the two data sources.

Data accuracy—measures the degree to which key fields are populated with identical values between the two data sources.

Mercer Government then seeks to understand **the root cause of any data discrepancies** recognizing that data quality is often not a function of the data itself, but rather the systems and processes related to the data.

Results

A recent state Medicaid agency encounter data validation project revealed that while the client had robust and mature encounter data management practices, the MCOs had varying degrees of knowledge, processes and systems related to their claims and encounter data management practices. These variances in capabilities impact the encounter data the state receives and submits to CMS.

Additionally, because of the state's MMIS processing logic and/or financial reporting requirements, the MCOs must adapt specific claims information in order to submit the corresponding encounter successfully. Identifying and documenting these particular data details is crucial to demonstrating that our state client's encounter data management practices are appropriate given the state's financial reporting needs and any inherent MMIS limitations. Mercer Government is committed to providing our state Medicaid clients with financial and encounter data audit solutions that **meet regulatory requirements** and provide **reliable, actionable insights** on servicing their managed Medicaid constituents.

Reach out to your client leader for more information specific to your state or email us at mercer.government@mercer.com.

For more information

Visit our website at www.mercer-government.mercer.com to view our experience, services, and client feedback.

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Action

Low acuity non-emergent (LANE) emergency room analysis

Emergency room visits are expensive, costing two to three times as much as visits in a physician's office. Research published by the Centers for Disease Control and Prevention indicates that approximately 31% of ER visits in the United States are for nonurgent events or visits requiring immediate service.[1] Mercer's LANE analysis employs a subset of ICD10 codes, which research indicates can be representative of instances in which an ER visit could have been avoided had effective outreach, care coordination, and access to preventive care been available. Based on industry best practices and supporting literature, Mercer developed a data-analytic procedure to identify low to moderate acuity diagnosis codes that could potentially be avoided. Some examples of conditions included in this type of analysis are fever, headache, cough, rash, and removal of sutures.

Potentially preventable admissions (PPA) inpatient analysis

Many hospitalizations represent ambulatory care failures. According to the Agency for Healthcare Research and Quality (AHRQ), one out of every 10 hospital stays was potentially preventable (based on 2008 data).[2] Mercer's PPA analysis identifies inpatient admissions that could have been avoided in the managed care programs through high-quality outpatient care and/or reflect conditions that could be less severe and not warrant an inpatient level of care if treated early and appropriately. These are identified through claims data using criteria from the AHRQ's Guide to Prevention Quality Indicators and Pediatric Data Indicators, with additional filters applied to better understand MCOs' ability to prevent the admissions in the Medicaid environment.

Results

As a result of these clinically informed, data-driven analyses, Mercer actuaries have incorporated medical efficiency adjustments into the development of actuarially sound capitation rate ranges. These adjustments, based on sound clinical input, have reduced the MCO capitation rates to reflect clinical medical efficiency targets, even after factoring in the offset of expected increases in physician and other outpatient costs. The results vary by state, but the following ranges should help inform the magnitude of each measure:

- LANE adjustments: typically 5%–10% of total ER costs
- PPA adjustments: typically 3%–5% of total inpatient hospital costs

1 Nawar EW, Niska RW, and Xu J. "National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary," Division of Health Care Statistics Advanced Data for Vital and Health Statistics, Number 386 (2007), available at www.cdc.gov/nchs/data/ad/ad386.pdf

2 Stranges E and Stocks C. "Potentially Avoidable Hospitalizations for Acute and Chronic Conditions, 2008," AHRQ's Healthcare Cost and Utilization Project (HCUP) Statistical Brief, Number 99 (2010), available at www.hcup-us.ahrq.gov/reports/statbriefs/sb99.pdf

For more information

Visit our website at www.mercer-government.mercer.com to view our experience, services, and client feedback.

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