TransUnion Healthcare Insight Guide

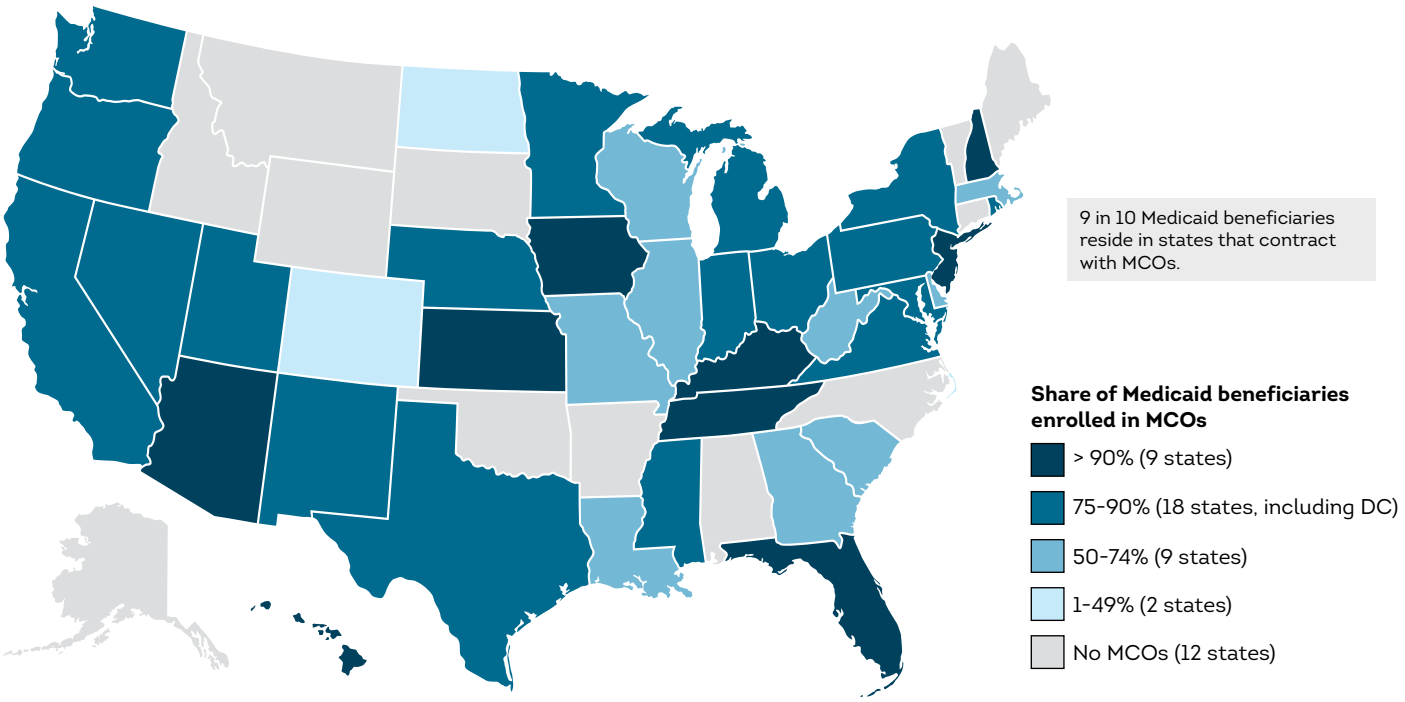
Best Practices for Collecting and Reporting Encounter Data

As the healthcare industry moves toward value-based care, there's been an increase nationally in both managed care enrollment and the number of providers embracing value-based or alternative payment models, rather than traditional fee-for-service.

In managed care, regulatory agencies, such as Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies, require contracted managed care organizations (MCOs) to report encounter data as an obligation to receive their capitated (per member, per month) payments. Regulatory agencies use this data for a number of purposes, including budget forecasting, capitation rate setting, program integrity, contract monitoring and measuring the quality of care delivered.

Figure 1

A large share of all Medicaid beneficiaries are enrolled in risk-based MCOs.



Source: "Data Note: Medicaid Managed Care Growth and Implications of the Medicaid Expansion." Henry J. Kaiser Family Foundation. April 24, 2017.

TransUnion

Intended audience

The issues explored in this insight guide will be of interest to any managed care organization, referred to throughout as the "MCO," which includes health plans, accountable care organizations, coordinated care organizations, IPAs, health systems and medical groups that assume risk and are responsible for reporting encounter data collected from their contracted provider network.

Healthcare professionals need to familiarize themselves with encounter data and understand some of the data quality challenges that exist in managed care that might not arise under traditional payment models, such as fee-for-service (FFS). This paper will showcase the common data quality trials faced by MCOs and outline best practices to address the issues.

What is encounter data?

CMS defines encounter data as "detailed data about individual services provided by a capitated managed care entity." CMS also notes that "the level of detail about each service reported is similar to that of a standard claim form."

Collecting and reporting complete and timely encounter data is crucial for financial reimbursement and population health management.

However, anyone with operational experience understands that fee-for-service claims and encounter data need to be treated differently. Although both are reported in the ANSI 837 format, for claims these data requirements are fairly standardized. For encounter data, there are increased complexities and variations in the outbound data required by regulatory agencies.

Why is encounter data so important?

There are four key areas where the quality of reported encounter data has a significant impact for MCOs, both financially and operationally.

Capitation rate setting: Regulatory agencies use historical encounter data for setting and adjusting capitation payment rates. Missing or incomplete data impacts the actuarial calculation of future payments. It's in everyone's interest to submit complete data that ensures reimbursements are not negatively impacted.

Quality and performance metrics: Quality measures, similar to those assessed for (HEDIS) Healthcare Effectiveness Data and Information Set, rely on the information contained in accurately coded encounter data. Organizations with data gaps will not be credited for the full scope of services provided to members. This has implications because individuals, employers and regulatory agencies consider quality metrics when selecting their members' coverage.

Risk adjustment: Encounter data contains information about members, including their health status and diagnosis codes, required by state and government agencies to calculate risk-adjusted payments. Organizations with poor data quality will lose out as risk-adjusted payments are distributed based on the health of their data, rather than the true health of their population.

Report cards: Regulatory agencies are now starting to audit encounter data quality through report cards. Organizations are being monitored and graded on the completeness, accuracy and timeliness of their data. Those with poor data quality are at risk of receiving hefty noncompliance penalties.

Organizations with poor data quality will lose out as risk-adjusted payments are distributed based on the health of their data, rather than the true health of their population.

The new regulations in summary

With the release of the Final Managed Care Rule in April 2016, CMS is holding each State Medicaid Agency accountable for the quality and timeliness of the encounter data received from MCOs. Here's what you must know about the new regulatory requirements:

- → State agencies that fail to meet the new standards – by submitting inaccurate, incomplete, untimely or inconsistent data – risk losing Federal Financial Participation (FFP) or matching funds
- → States will establish a monitoring system for all managed care programs, including encounter data quality and performance on quality metrics
- → All MCOs must comply with the new regulations and encounter data associated with sub-capitated providers is not excluded
- → MCOs must possess an IT system capable of meeting requirements and ensure that data received by providers is accurate and complete

TransUnion

Challenges collecting and reporting encounter data

Clearly, reporting correct and timely encounter data is important for all MCOs. However, listed below are common obstacles that have the potential to impact data quality.

Lack of data standardization: Despite standardization attempts across the industry, MCO encounter data requirements vary based on their own internal IT system requirements and interpretation of the requirements of the regulatory agencies' companion guides – which are often very general in nature.

With the ANSI 837 format comprising hundreds of required and optional data fields, not having a universally defined format creates an (EDI) electronic data interchange burden for providers. They're often left confused and frustrated as they receive conflicting rejection messages from different MCOs.

Finally, MCOs operating in multiple states also face the added challenge of having to report in alignment with the state-specific submission requirements. Most IT systems aren't configured to output files for different states, and this lack of standardization causes unnecessary costs and technical difficulties for these MCOs.

Legacy technology limitations: Often, MCOs operate in multiple lines of business and are typically using legacy technology systems that cannot reject invalid inbound data based off these different requirements. Consequently, MCOs need to loosen their up-front edits so data can be received into their systems. This is problematic because it will often be rejected when reported upstream. This not only impacts timeliness, but also reduces the chances that a provider will correct the data, as in their eyes the data was originally "valid." Some systems are even unable to generate a response file that can be easily digested back into the provider's system for resolution. The provider has no insight into the status of their sent transactions.

Technology limitations are also a major factor impacting providers' ability to generate accurate ANSI 837 encounter files. Often providers' legacy electronic health record (EHR) and practice management systems are restrictive and limit their ability to output data specifically for encounters and fee-for-service claims. This is an issue when data requirements change, as making the necessary upgrades can be costly and time-consuming, which leads to data being rejected in the interim.

Provider incentives and coding confusion: Fee-for-service models build in data submission incentives, as it's essential to submit a timely and accurate claim, or else you do not get paid. However, under value-based or alternate-payment models, such as capitation, the provider is typically paid prospectively, whether or not they submit accurate data. Consequently, sending suitable data and correcting errors becomes less of a priority for busy providers already faced with the time constraints of caring for patients.

The challenge is further exasperated by providers receiving limited training on how to code accurate encounter data. For example, codes are frequently sent that are valid in fee-for-service but cannot be submitted as an encounter to the regulatory agency. This is due to the difference in encounter and FFS, which causes data to be rejected. With limited understanding about the importance of accurate coding, and with reimbursement not being tied to specific codes, it's easy to see how data quality and timeliness can be compromised.

Losing insight and fixing rejections: When engaging in prospective payment models with providers, MCOs will often lose insight as to whether complete and timely data is being submitted and then corrected by their provider network. When payments aren't tied to submitting and correcting data, monitoring submissions and rejections becomes extremely important for organizations.

MCOs also struggle with inefficient processes to fix encounter data that's initially rejected by regulatory agencies. Organizations are challenged when they don't have the functionality to map the regulatory agency rejection back to the original encounter, and then effectively communicate the issue that requires resolution back to the correct provider.

Best practices for healthy data

The potential data quality issues described here are not inevitable. They can be combated – and were even prevented – when organizations embraced some of the best practices outlined below.

1. CONFRONT THE CHALLENGES POSED BY STANDARDIZATION

Our best practice advice is to work with a partner vendor that can address the problems caused by a lack of industry standardization. The partner will be able to apply business rules and edits to inbound provider data to ensure it reaches MCOs in their desired format. This reduces the burden to the provider data, ensuring the inbound data contains the required information needed for it to be reported to regulatory agencies.

For MCOs operating in multiple states, TransUnion Healthcare can also help combat some of the challenges faced when reporting data to regulatory agencies in multiple formats. TransUnion Healthcare can modify outbound encounter data by inserting rules specific to the needs of different state agencies, saving MCOs significant costs of operating multiple systems programmed for the requirements of each individual state.

2. EVALUATE THE EFFECTIVENESS OF YOUR CURRENT TECHNOLOGY

Arguably the most important best practice for MCOs is to ensure they've invested in the right technology that enables them to collect, validate, track and report complete and timely encounter data.

TransUnion

TransUnion Healthcare helps MCOs enhance processes so that strong, front-end edits and data quality validation are built up front, preventing inaccurate data from being ingested into their systems. Channeling the data through one gateway reduces the EDI burden of managing multiple, inbound sources and enables consistent validations and edits to be configured, which improves data accuracy.

Any data subsequently rejected by regulatory agencies can be returned to the providers for resolution, and MCOs are then able to monitor whether rejected data is actually being fixed by their contracted providers.

3. ADDRESS THE ISSUES CAUSED BY PROBLEMATIC PROVIDERS

MCOs can implement a number of best practices to improve the quality of data received by their provider networks.

Firstly, MCOs should ensure they establish a consistent point of contact for providers to reach their encounter data team. This team should oversee a coordinated provider education program, while also assisting with error support and communicating changing data requirements or upcoming submission deadlines. Proactive organizations will schedule training sessions via webinars to explain the causes of data quality problems or help resolve problematic issues. TransUnion Healthcare performs these functions for many of our MCO clients.

Secondly, MCOs should reach out to underperforming providers to understand their IT resources and EDI capabilities. Effective organizations will listen to this feedback and evaluate whether their current processes are making it easy or difficult for providers to send and correct encounter data. Finally, to address provider incentives, organizations can either put in place a financial incentive program to improve submissions, or alternatively, penalize individuals who aren't submitting encounters accurately by withholding a percentage of payment until their data quality improves.

4. ACTIONABLE REPORTING TO MONITOR DATA QUALITY

In managed care, there's a greater need for MCOs to have complete insight over data submissions so they can proactively monitor throughput, rejections and timeliness. Highly effective organizations employ a dedicated encounter team that uses internal reports to identify and resolve instances where data-quality bottlenecks exist.

Benchmarking is also critical in managed care because MCOs need to compare actual monthly encounter volumes to expected levels. Astute organizations will benchmark data throughput between similar sized providers or even against historical fee-for-service claim data.

By channeling inbound encounter data via TransUnion Healthcare, MCOs and providers benefit from enhanced reporting that enables them to easily monitor submissions and identify where rejections require resolution. Providers gain access to a web-based portal designed to help them fix their rejections, whilst MCOs benefit from crucial insight as to whether their encounter rejections are being addressed.

Summary

By adhering to the best practices outlined in this insight guide, MCOs should see the throughput of encounter data collected and reported improve over time. If your organization faces barriers to making these internal operational changes, then consider the cost-effectiveness of partnering with an experienced vendor.

We can help

The encounter data experts at TransUnion Healthcare specialize in helping organizations maximize the quality and quantity of encounter data reported – at a price possibly lower than the cost of handling it internally.

For more information, contact TransUnion Healthcare's Stephen Harrop, who will address any data quality concerns.

Stephen Harrop, Business Analyst

TransUnion Healthcare

310-337-8517

stephen.harrop@transunion.com

linkedin.com/company/transunion

@TransUnionB2B

About TransUnion Healthcare

TransUnion Healthcare, a wholly owned subsidiary of credit and information management company TransUnion, is a trusted provider of Revenue ProtectionTM solutions that help providers collect more cash up front and throughout the revenue cycle, and identify and maximize reimbursement opportunities to reduce bad debt. By leveraging our data assets, market-leading revenue cycle management technologies, and deep insights into consumer financial behavior, our customers are better enabled to reduce uncompensated care, engage patients early and improve cash flow.
www.transunionhealthcare.com

TransUnion