New York State Department of Health

Performance audit of Managed Care Organizations (MCO) Encounter data submissions for calendar year 2021

Final Report
As of August 14, 2024

kpmg.com

KPMG LLP
515 Broadway
Albany, NY 12207-2974

Telephone +1 518 427 4600
kpmg.com

August 14, 2024

Ms. Susan Montgomery
Director, Division of Health Plan Contracting & Oversight
Office of Health Insurance Programs
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 2021, conducted on behalf of the State of New York (the State) Department of Health (the Department or DOH). Our substantive 2021 fieldwork began October 27, 2023. The results, reported herein, are presented as of the completion of testwork on April 18, 2024.

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 2021.

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

Table of contents

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' 2021 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 9 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 2021.

Scope

This report presents the audit results of calendar year 2021 for 12 MCOs selected by DOH. The 12 MCOs capture 25 distinct Lines of Business (LOBs). LOBs covered in the 2021 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, 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 12 auditees, 9 underwent desk procedures and 3 underwent field procedures. As agreed with the Department, two MCO desk audits were performed by a separate firm.

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 findings or 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, were noted as findings within this report. The findings and observations that were 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 2021 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 2021 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), Original Source Data Submitter (OSDS) and acceptance/rejection data.

— Reviewed the process, flow, and storage of encounter data through the DataMart, Medicaid Analytical Extract for Encounters (MAEE), Medicaid Encounter Data for Analytics (MEDA), 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 2021 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 2021 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 2021.

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 data comparisons between PACDR and MDW for reconciliation purposes.
- Netted final encounter records for all 2021 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 2021 auditee selection.
- Programmed and automated benchmark analyses across all MCOs to identify outliers related to identified risk areas.
- Programmed and automated test procedures were 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.

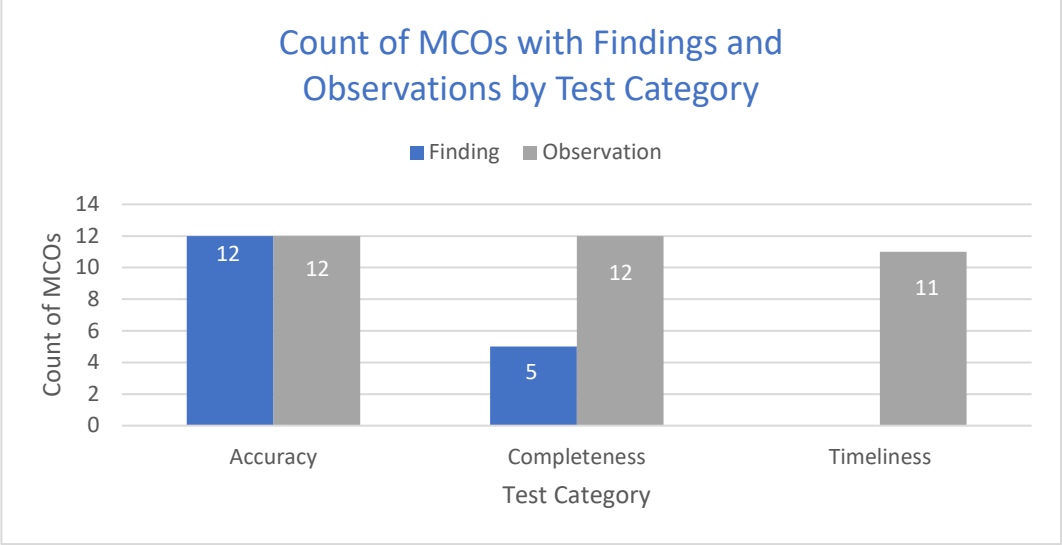
— Reporting results

- 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 how many of the MCOs in the 2021 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 how many of the total tests 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*	13 (Per MCO & LOB)	5	6	5	6
	Benchmark analytics automated through KVAL (per MCO & LOB)	6 (Per MCO & LOB)	0	6	0	6
	Sample testing**	12 (Total # of MCOs)	2	1	2	1
	Auditee questionnaire	12 (Total # of MCOs)	0	0	0	0
	Data reconciliation^	12 (Total # of MCOs)	0	4	0	1
Field	Medical chart review	3 (Total Field Auditees)	3	1	2	1
	Data Metrics comparisons[+]	3 (Total Field Auditees)	2	3	0[+]	1
	Total	**61**	**12**	**21**	**9**	**16**

*Some tests resulted in both findings and observations approved by DOH at an individual auditee level, thus the number of report findings.
**The two instances of sample findings across MCOs are consolidated into two formal findings and one observation for this report.
^The four data reconciliation observations are consolidated into one formal observation for this report.
[+]The two data metrics comparison findings are consolidated into a formal finding and reported with one of the sample testing findings (lack of unresponsiveness). The one observation is reported in formal observation for this report.

As noted in the table above there are 9 findings which are further elaborated in the following pages.

— Findings 1-5 are related to the desk audit test procedures automated through KVAL not including benchmarks analytics.

— Findings 6-7 are related to sample testing and data metrics comparison.

— Findings 8-9 are related to the medical chart reviews conducted during the field audits.

Based on the footnotes of the table, the four distinct observations have been consolidated into two 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 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: Three MCOs, spanning three 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 requirements 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: Four MCOs, spanning five 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: 12 MCOs, spanning 25 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 requirement 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 in which the diagnosis code(s) did not match the demographic of the patient.

Criteria: According to CMS ICD-10-CM Official Guidelines for Coding and Reporting Section IV Part C diagnosis codes are required to be reported accurately by providers on Institutional, Professional, and Dental claims, and thus reported to DOH as an element of an encounter.

Condition: Two MCOs, spanning two unique lines of business, had a percentage of submitted encounters in which the diagnosis codes did not align to the age of the member at the time of the service.

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

Effect: Failure to properly apply diagnosis codes may impact the 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 update their claims processing edits to consider children to be 17 years of age and less (under 18), which is in line with the ICD-10 diagnosis code definitions and to look at all diagnosis point positions in their claims adjudication systems.

Finding 6: Lack of responsiveness resulted in the inability to validate the encounter data.

Criteria: The NYS DOH Model Contracts require 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 the 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 provided initial documentation (data metrics calculations/sample support) as part of their day-25 submission which required follow-up with the MCOs.

- Two MCOs data metric comparison tests had variances greater than 3% which required explanations. Upon follow-up, the MCOs dental vendor, which provided the metrics, was unresponsive.
- One MCO was not able to obtain additional sample testing documentation support from the dental vendor.

Cause: The MCOs made numerous attempts to contact the vendor, however the vendor was unresponsive.

Effect: Inability to reconcile encounters to supporting documentation and data in the sample testing and data metrics testing may indicate risks of accuracy and completeness of 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 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 2021 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 7: 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: Two 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 paid amounts on two encounters did not tie to the support.
   - The paid date on an encounter did not tie to the support.
2. For one MCO:
   - Header level paid amount on the encounter did not tie to the support.

Cause: The auditees noted various reasons for the mismatch of the fields. For the first MCO, items in the first bullet, the auditee indicated there were submission errors that impacted the paid amounts for several encounters. For items in the second bullet, the auditee indicated they were using the date they received the encounter from the vendor, not the actual paid date. The second MCO indicated there were submission errors with their vendor that impacted the paid amounts for several encounters.

Effect: Inability to reconcile encounters to supporting documentation may indicate risks of accuracy of 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 8: Lack of supporting documentation resulted in the inability to validate the Healthcare Common Procedure Code (HCPCS) codes and 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 HCPCS codes and 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. In addition, CMS ICD-10-CM Official Guidelines for Coding and Reporting require that the HCPCS codes billed by the provider are accurately represented on the claim form, and furthermore represent actual services provided as evidenced by medical records. Additionally, AMA provides guidelines for billing National Drug Codes (NDC), these include documenting the need for the drugs by a physician and evidence that the drugs were administered to the patient. The administration of the drugs must be performed or supervised by a physician and documented in progress notes.

Conditions: One MCO's medical chart supporting documentation did not include any information to validate the HCPCS codes or the units of service on the claim form and encounter. The Medical Chart sample tested included four NDC HCPCS codes in which the documentation provided did not include any support that the drugs were administered to the patient.

Cause: The auditee was unable to obtain the entire medical record from the Provider to adequately support the units of service billed, or no support was provided at all.

Effect: Inability to reconcile encounters to supporting documentation in a Medical Chart Review may indicate risks of 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 continue to work with the providers to communicate and address requests for supporting documentation. In addition, in cases that have partial 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 2021 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 9: Lack of a provider's signature resulted in the inability to verify the authentication of the provider's note in the medical record.

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 could not be executed, as a signature was not included on the medical chart.

Cause: The medical chart did not contain a signature from the provider.

Effect: Inability to tie encounters to supporting documentation in a Medical Chart Review may indicate risks of accuracy 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 7-12 are related to desk audit test procedures automated through KVAL. They are reported as observations because the results did not indicate an instance of non-compliance.

— Observation 13 is related to the Sample Selection testwork.

— Observation 14 is related to the Data Reconciliation test procedures.

— Observation 15 is related to the Medical Chart review 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.	5	6
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.	4	5
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.	9	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.	7	9
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.	10	17
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.	12	25
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.	6	15

Observation	Audit Result	# Of MCOs	# Of LOBs
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.	5	14
9	MCO submitted encounters in which the Provider Specialty Type field has a value of "999".	6	14
10	MCO submitted inpatient encounters that have a length of stay equal to 1 day.	9	16
11	MCO submitted replacements and voids greater than 2 years from the date of service.	10	19
12	MCO submitted encounters that do not include the allowed amount or paid amount as required per the 2020 CMS final rule.	12	25
13	MCO sample support provided did not tie to the encounter data.	1	3
14	MCO submitted the reconciliation with a variance greater than 3%.	4	All
15	MCO encounter data and claim form included a non-billable HCPCS code which does not affect rate setting and was therefore considered an observation.	1	1
16	(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 2021 audit objective. As of the date of this report, KPMG will no longer communicate with the MCOs or their representatives regarding the 2021 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 a conduct performance audit of the accuracy, completeness, and timeliness of calendar year 2021 (CY2021) 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 CY2021 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 2021 Encounter Data Audit Report and approves of it becoming the final completed version.

Anesa K. Brkanovic
Deputy Division Director, Division of Health Plan Contracting and Oversight

Contact us

Anthony Trapasso
Managing Director
212-954-8513
atrapasso@kpmg.com

Joseph Cassano
Director
646-210-8786
jcassano@kpmg.com

www.kpmg.com

kpmg.com/socialmedia