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NEWS RELEASE

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FOR RELEASE

January 9, 2020

Auditor of State Rob Sand today released a report on Medicaid encounter data from the Iowa Medicaid Enterprise, a division of the Department of Human Services (DHS), for the period April 1, 2016 through December 31, 2018. The review was conducted in conjunction with the audit of the financial statements of the State of Iowa and in accordance with Chapter 11 of the *Code of Iowa*. The planned scope of the review was to determine if Home Health Services provided and reimbursed by DHS were allowable and supported by sufficient documentation. The planned scope also included determining if supporting documentation maintained by the providers was complete and filed in a timely manner.

Sand reported it was apparent various sets of the encounter data provided by DHS over an extended period of time to evaluate Home Health Services claims were not usable for testing the allowability of reimbursements to providers. The data provided included duplicate claims and other irregularities.

In addition, Sand reported after eight months of working with and waiting to obtain reliable data from DHS (six months passed due to Office of Auditor of State internal operations), data was subsequently provided from which a sample could be selected. However, the process of obtaining accurate data consumed nearly all resources allotted for the review. In addition, during this period, other areas of the Medicaid program for which testing could be pursued in a more efficient and effective manner were identified. As a result, the scope of the planned review was revised to assess the processes used by DHS related to encounter data.

A copy of the report is available for review on the Auditor of State's web site at <http://auditor.iowa.gov/reports/audit-reports/>.

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**A REVIEW OF
ENCOUNTER DATA
FROM THE
IOWA MEDICAID ENTERPRISE
WITHIN THE
DEPARTMENT OF HUMAN SERVICES**

**FOR THE PERIOD
APRIL 1, 2016 THROUGH DECEMBER 31, 2018**

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To the Governor, Members of the General Assembly,
the Director of the Department of Human Services
and the Director of the Iowa Medicaid Enterprise:

In conjunction with our audit of the financial statements of the State of Iowa and in accordance with Chapter 11 of the *Code of Iowa*, we have attempted to conduct a review of claims (the encounter data) for the Home Health Services administered by the Iowa Medicaid Enterprise (IME), a division of the Department of Human Services (DHS). The planned scope also included determining if supporting documentation maintained by the providers was complete and filed in a timely manner. However, various sets of encounter data provided to us by DHS over an extended period of time to evaluate Home Health Services claims were not appropriate for selecting a sample to test the allowability of reimbursements to providers and we were unable to perform the procedures as planned. As a result, the procedures performed were limited to those related to encounter data for the period April 1, 2016 through December 31, 2018:

- (1) Interviewed personnel from DHS administration to gain an understanding of encounter data received from Managed Care Organizations (MCOs) and evaluated internal controls over the processing and validation of the encounter data.
- (2) Obtained and reviewed multiple sets of encounter data for Home Health Services paid for by MCOs.
- (3) Worked with DHS personnel in response to phone calls from providers regarding errors in the population of encounter data provided to us for Home Health Services.
- (4) Interviewed personnel from DHS to discuss issues with obtaining an accurate and complete population of encounter data for Home Health Services.

In accordance with section 11.4 of the *Code of Iowa*, we have assessed the Department's operations and developed a recommendation to the Department to ensure encounter data is reliable and can be obtained in an efficient, effective, and timely manner, which we believe should be considered by the Governor, the General Assembly, the Department of Human Services and the Iowa Medicaid Enterprise.

The procedures described above do not constitute an audit of financial statements conducted in accordance with U.S. generally accepted auditing standards. Had we performed additional procedures other matters might have come to our attention that would have been reported to you.


Rob Sand
Auditor of State

July 19, 2019

Introduction

Medicaid Background

Title XIX of the Social Security Act is the legal basis for Medicaid. Medicaid is a state administered program which provides medical assistance to financially needy adults, children, parents with children, people with disabilities, elderly people, and pregnant women who meet certain eligibility criteria. As part of the Social Security Act, each state establishes its own guidelines regarding eligibility and services.

At the federal level, the program is administered by the Centers for Medicare and Medicaid Services (CMS) in the U. S. Department of Health and Human Services. In order to participate in Medicaid, the state legislature must appropriate funds and designate a state agency to administer the program.

The Medicaid program in Iowa is managed by the Iowa Department of Human Services (DHS). Medicaid pays for health care services for individuals with limited income and resources who meet Medicaid eligibility requirements. Section 249A.3 of the *Code of Iowa* states mandatory medical assistance shall be provided to individuals residing in the State of Iowa who meet eligibility requirements. Medicaid is funded by both the state and federal government and costs are shared, ranging from a state participation rate of approximately 6% to 42%, based primarily on the member group.

DHS released a Request for Proposal (RFP) for Medicaid Modernization (managed care) on February 16, 2015. The RFP requested bids from potential vendors as the State moved toward a risk-based managed care approach for Iowa's Medicaid program. On August 17, 2015, DHS issued a notice of intent to award contracts to four Managed Care Organizations (MCOs) to administer the program – Amerigroup Iowa, AmeriHealth Caritas Iowa, United Healthcare Plan of the River Valley, and WellCare of Iowa. On December 18, 2015, the selection of WellCare of Iowa was terminated.

DHS intended to make the switch to managed care on January 1, 2016; however, CMS determined additional time was needed to make the transition. Based on available documentation, CMS indicated the state failed to meet certain implementation goals, such as MCO provider networks were not fully developed and lacked key providers. As a result, DHS transitioned most Iowa Medicaid members to a Medicaid managed care system called IA Health Link on April 1, 2016. AmeriHealth Caritas Iowa exited the managed care program in November 2017 which left 2 MCOs providing services. United Healthcare Plan of River Valley exited the managed care program in June 2019; however, DHS established a contract with the MCO Iowa Total Care – Centene which was effective July 1, 2019. As a result, services have been provided by 2 MCOs since November 2017.

Prior to implementation of managed care, Medicaid services were primarily paid using a fee-for-service method. Under the fee-for-service method, health care providers were paid for each allowable covered service provided to a Medicaid beneficiary. Payments were made by DHS, Iowa Medicaid Enterprise (IME) after receipt of a claim from a provider. Under managed care, IME pays a monthly capitation payment to the MCO for each member enrolled in the plan. The MCO then pays providers for the allowable services provided to Medicaid beneficiaries. A capitation payment, similar to an insurance premium, is the payment made each month by the State to the MCO on behalf of each beneficiary enrolled in the plan, based on the actuarially determined capitation rate for the provision of services under the State plan.

Each MCO is licensed as a Health Maintenance Organization (HMO) through the State of Iowa and is required to comply with all rules applicable to HMOs. Under the MCO structure, DHS still retains control over eligibility determinations, sets policy, and determines level of care (LOC) for each individual deemed eligible under Medicaid. In addition, DHS still enrolls Medicaid providers; however, the providers must also enroll with the MCOs.

Eligibility determination is performed by staff in DHS local offices throughout the State, by the Centralized Facility Eligibility Unit or, for certain groups, by staff of the Social Security Administration or by qualified providers. Income maintenance workers are responsible for maintaining the Medicaid eligibility records for all members. Each member's eligibility information is entered into a centralized automated system.

To be eligible for Medicaid an individual must:

- Live in Iowa.
- Be a U.S. citizen or an alien who is in this country legally.
- Provide a Social Security number or proof that they have applied for one.
- Provide other information (such as financial and size of family).

Eligibility for Medicaid is based primarily on an individual's financial situation. The federal government requires states provide coverage for:

- A child under the age of 21.
- A parent living with a child under the age of 18.
- A woman who is pregnant.
- A person who is elderly (age 65 or older).
- A person who is disabled according to Social Security standards.
- A woman in need of treatment for breast or cervical cancer.
- In addition, others who may qualify:
 - Adults aged 19 to 64 with income up to and including 133 percent of the Federal Poverty Level.
 - If an individual's income is too high for Medicaid but their medical costs are so high that it uses up most of their income, they may qualify for some payment help through the Medically Needy plan.
 - If an individual's income is low and they have a hard time paying Medicare premiums, Medicaid may be able to help pay the premiums.
 - If individuals are between the ages of 12 and 54, Iowa's family planning program may be able to help with the cost of family planning related services.
 - Individuals 65 or older, blind, or disabled and have a special financial need not met by Social Security, may be eligible for an additional benefit through State Supplementary Assistance.

In addition to determining eligibility, DHS is responsible for ensuring the claims submitted by the MCOs are accurate and complete. According to DHS representatives, a staff member reviews claims submitted by the MCOs and if there are any errors identified, the whole claim is rejected and sent back to the MCOs. This process continues until the entire claim is complete and accurate. This process is commonly called the "MCO churn" by DHS representatives. After the claims have been reviewed and are error free, the claims are accepted by DHS.

Home Health Services

The Home Health Services program (HHS) provides in-home medical services by Medicare-certified home health agencies and individuals. Types of services include skilled nursing care; medical social services; physical, occupational, and/or speech therapy; and Home Health Aide. In order to be

covered by Medicaid, home health services must be medically necessary to treat illness or injury and ordered by a physician. Medicaid does not cover home care services to help people meet personal family and domestic needs, full-time nursing care at home, and private-duty nursing services at home, except for persons up to age 21 when the care is medically necessary and pre-authorized.

Home health agencies and individuals must be certified to be eligible to participate in the Medicaid program. The HHS program is meant to provide an alternative to unnecessary institutionalization. The requirements to fall under the HHS program are as follows:

- Services must be provided at the member's home.
- Services must be provided by a registered nurse, licensed practical nurse, a home health aide, speech pathologist, physical therapist, or occupational therapist.

Services performed under the HHS program are reimbursed on the low utilization payment amount (LUPA) methodology. Services are billed on a per unit basis, with a unit being equal to a visit. Services paid by Medicaid are limited, depending on the service type.

- Skilled Nursing – 5 visits maximum per week.
- Home Health Aide – 28 hour maximum, converted to visit, per week.
- Physical Therapy – Visits per week based on medical need.
- Speech Language Therapy – Visits per week based on medical need.
- Occupational Therapy – Visits per week based on medical need.
- Medical Social Services - Visits per week based on medical need.

A physician must certify that a member has medical need for HHS through a face to face meeting. A detailed plan of care is to be developed and reviewed every 60 days by the physician. By signing the plan of care, the physician is authorizing services as a medical need. The plan must include all services, regardless of the funding source, to prevent duplication of the same or similar services and to ensure the individual's needs are met. The physician is also required to coordinate and communicate with caregivers, legal representatives, providers of other services, and DHS case workers, who may be working with that individual.

Objectives, Scope and Methodology

Objectives

We planned our review to determine:

- whether internal controls are sufficient throughout the process of delivering, billing, reporting, and paying for HHS to detect or prevent potential error or fraud,
- whether provided services reimbursed by DHS were allowable and supported by sufficient documentation, and
- whether supporting documentation maintained at the provider level is complete and filed in a timely manner.

Scope and Methodology

To gain an understanding of HHS, we:

- interviewed representatives of DHS responsible for administration of the Medicaid program, including HHS and
- attempted to obtain and review data from DHS to identify HHS providers and recipients.

However, it was apparent the encounter data provided by DHS was not usable for testing the allowability of reimbursements to providers. The data provided included duplicate claims and other irregularities. As a result, we were unable to use the encounter data to select services for testing.

Because we were unable to vet the data for testing, we were also unable to determine the allowability of the reimbursements to providers for Home Health Services. However, we determined we had sufficient information to assess DHS' processes related to encounter data. During the course of our review, it became apparent that a report aimed at this issue would result in the most benefit to taxpayers for the amount of resources consumed. In addition, the Office of Auditor of State (AOS) is required by section 11.4 of the *Code of Iowa* to assess the operations of departments and determine if they are efficiently conducted. As a result, we revised the scope of our planned procedures and have summarized our findings in this report.

Administration

As previously stated, part of DHS' responsibilities are ensuring the completeness and accuracy of the data provided by the MCOs. As a result, we requested data from DHS for all claims coded to Home Health Services for the period April 1, 2016 through March 31, 2018. However, we were unable to obtain a reliable population of these claims within a timely manner.

Table 1 summarizes the dates data was requested and subsequent interactions with DHS staff regarding concerns with the data we were provided as a result of our requests.

Table 1

Date	Description
04/27/18	Requested data population of paid Home Health Services claims for the period April 1, 2016 through March 31, 2018.
1 st week of May 2018	Received the data file from DHS; however, on May 10, 2018, received an e-mail from an IME employee stating the file was not correct.
05/11/18	Received a CD with new data. AOS staff started stratifying the data and pulling the sample to be tested. According to DHS representatives, there were no control totals related to the data for us to reconcile to in order to ensure completeness of population. For verification of the data provided, we requested DHS re-run the query to ensure the same results would be received.
05/29/18	Received 2 nd data file of the May 11, 2018 population. We identified differences between the 2 files. Due to the discrepancies, we requested DHS re-run the query a 3 rd time to determine completeness and reliability of the data.
06/13/18	Held entrance conference with DHS officials. Walked through a comprehensive overview of our methodology for selecting the population and the sample to be tested. Obtained concurrence with DHS officials they would be responsible for notifying the providers they had been selected for review.
06/20/18	Received 3 rd data file of the May 11, 2018 population. This file matched the file obtained on May 29, 2018. As a result, we selected a sample for testing from the matched data set.
Early-Mid July 2018	DHS staff informed auditors certain aspects of the claims data were available through Medicaid Management Implementation System (MMIS), so we could start our testing. However, during our review, we determined the specific details of the claims we were looking for were not available in the MMIS but rather would be maintained by the provider. As a result, we were unable to start our testing procedures until the providers were contacted.

07/19/18	Provided our sample to DHS along with a Health Insurance Portability and Accountability Act (HIPPA) letter so notifications could be sent to the selected providers informing them the Office of Auditor of State would be in contact with them to perform an on-site visit and review selected records.
Late July-Early August 2018	Several e-mail correspondences between DHS staff and the AOS staff regarding if the providers had been notified, if auditors could begin scheduling our visits, and clarification regarding who was notifying the providers they had been selected for testing. Based on the initial e-mail correspondences, providers selected had not been notified by DHS as had been agreed to during the June 13, 2018 meeting.
08/07/18	We prepared a draft notification letter for DHS to send to selected providers. A draft notification letter was also provided to DHS to send to the MCOs. A sample of a notification letter sent to a provider is included in Appendix 1 .
Late August-Early September 2018	A representative of DHS and a representative of the AOS began receiving phone calls from providers who received notification letters stating their facilities did not provide any home health services. As a result, we contacted representatives of DHS and IME to determine why these providers were included in the population.
08/27/18	Based on conversations with representatives from DHS, a crosswalk was used when DHS converted from fee-for-service to MCOs which had been used to help resolve the issues with the population. AOS requested copies of the crosswalks for review. According to DHS representatives, the crosswalks were internal codes created during the conversion process to ensure codes used from MCOs for the various types of services were recorded properly.
09/05/18	According to DHS representatives, the crosswalks were “fixes coded into the system.” Therefore, crosswalks could not be provided.
Early-Mid September 2018	Based on conversations with DHS representatives, it was determined the population provided to AOS included all skilled nursing codes rather than only skilled nursing codes related to home health services.
09/18/18	AOS prepared a draft retraction letter for DHS to send to the selected providers pending a new population and sample being identified. A copy of the draft retraction letter is included in Appendix 2 .
Late September 2018	Held a meeting with DHS personnel to determine why the populations provided were not accurate and discussed how to obtain a data set containing only the information requested.
10/08/18	Received a new population from DHS personnel. However, AOS staff who had previously worked with the data were not readily available to review the new data set until early 2019 because they were completing other engagements with year-end deadlines.
02/19/19	Because several months had passed, AOS requested to add the time period April 1, 2018 through December 31, 2018 for paid Home Health Service claims.

02/19/19	<p>In response to the request for additional data, we received a message from a DHS representative which stated the Executive Assistant to the Medicaid Director “should be the primary contact on all audits.” The Executive Assistant also responded on February 19, 2019 stating, “No matter when the initial audit was started or if this is a follow up, ALL State Auditor requests for the IME come through me for assignment to internal IME staff.”</p> <p>As a result, we included the Executive Assistant in subsequent communications regarding requests for data; however, we also directed our inquiries for clarifications and/or corrections regarding the data provided to the DHS staff who had been responsive and had apparently been assigned the task of response.</p>
02/28/19	Because information had not yet been received for the February 19, 2019 request, we contacted a DHS representative to obtain a status update.
03/11/19	Received a CD for the February 19, 2019 request.
03/15/19	In order to determine if data was consistent, we requested paid Home Health Claims data for the period April 1, 2016 through December 31, 2018 to compare to previous data files provided by DHS. Because there were no other ways to reconcile population received to any reports or any control numbers, we attempted to reconcile the population to itself.
03/18/19	Received a CD of the data requested on March 15, 2019.
03/19/19	After reviewing the data received on March 18, 2019, we identified service dates outside the period requested. According to a DHS representative, there was some data included in the population which should not have been. As a result, they agreed to pull another data run to eliminate data which should not have been included.
03/23/19	Received a CD of the data requested on March 19, 2019.
03/25/19	Unable to open CD received on March 23, 2019 due to an error. Requested a new CD from DHS.
03/26/19	Received a second CD of the data requested on March 19, 2019. However, the population did not reconcile to itself. We identified transactions included in one data set but not the other data set which resulted in the overall amounts reimbursed not agreeing with each other. A phone call was made to a DHS staff member to discuss the differences identified.
03/27/19	Received an e-mail from DHS including a disclaimer regarding the reliability of the data. The e-mail states “The data provided by the Iowa Medicaid Enterprise (IME) in response to your request is provided “as is.” The IME cannot ensure the accuracy, completeness, or reliability of the data. The encounter validation process is not yet complete and a one percent (1%) error rate has not yet been achieved. Users accept the quality of the data they receive and acknowledge that there may be errors, omissions, or inaccuracies in the data provided. Further, the IME is not responsible for the user’s interpretation, misinterpretation, use or misuse of the data. The IME does not warrant that the data meets the user’s needs or expectations.”
05/01/19	Requested query language used to run data.
05/02/19	Received query language from DHS personnel for the 3 most recent requests. According to DHS personnel we spoke with, the query language was not available for earlier requests. We compared the languages used to run the various data sets and could not identify anything significant which would have resulted in the populations changing.

06/13/19	Met with DHS representatives to discuss the issues with the populations and to obtain a better understanding of how the data was pulled. During this meeting, DHS representatives suggested the “MCO churn” may be the cause for the inconsistent data. Prior to this meeting, AOS staff had not been informed of this process. At the end of the meeting, we requested a new population for the period April 1, 2016 through December 31, 2018.
07/01/19	Received CD with new population for the period April 1, 2016 through December 31, 2018.
07/09/19	We reviewed the population received on July 1, 2019 and tried to reconcile it to itself. The data did not reconcile, so we e-mailed DHS staff to determine why.
07/16/19	AOS e-mailed DHS staff with populations’ totals to determine if AOS totals agreed with DHS totals.
07/17/19	Received new data for period of review. Determined previously received data was not reliable due to conversion difficulties. With the new data, the data reconciled.

As illustrated by the **Table**, we worked with representatives of DHS for approximately 14 months in order to obtain a population of claims paid for home health services. In February 2019, we were instructed to run all data requests and questions through the Executive Assistant to the Medicaid Director, who was not responsible for processing data. According to an email from the Executive Assistant, she was responsible for assigning inquiries and requests to IME staff. If we were to be restricted from contacting certain DHS staff, in accordance with professional standards, we would have to consider the restriction a scope limitation regarding our procedures.

As a result, we included the Executive Assistant in subsequent communications regarding requests for data so she was able to track the communications; however, we also continued to direct our inquiries for clarifications and/or corrections regarding the data provided to the DHS staff who had provided data to us. It was apparent to us the DHS staff to whom we sent our inquiries had been assigned the task of response and, in an effort to be efficient, we directed subsequent inquiries regarding clarifications, corrections, concerns, or problems with accessing, understanding, or vetting the data directly to the individual who provided it, while also copying the Executive Assistant in on the communication. It was clear to us the Executive Assistant would not be able to respond directly to our concerns and, based on previously encountered response times, we anticipated we would obtain an answer directly from the DHS knowledge-specific employee in a more timely manner rather than waiting for the Executive Assistant to forward our request to them.

On May 3, 2019 we received the following message from the Executive Assistant, “Again, all requests for the Auditor’s Office come through me, do not send any requests directly to program staff.” While we continued to direct our inquiries to knowledge-specific staff while also copying the Executive Assistant in on the communication, it was apparent to us the knowledge-specific staff had been directed to provide their responses only to the Executive Assistant who was to forward them on to us. This directive resulted in delayed responses or no responses at all. Due to the restrictions imposed on the DHS staff regarding direct responses to us, a scope limitation was again considered; however, ultimately data was received.

During a meeting between Auditor of State Sand and Director Randol of IME on June 5, 2019 the restriction on the lines of communication imposed by DHS was discussed. As a result of this meeting, all parties agreed AOS staff would contact the appropriate person directly and carbon copy the Executive Assistant on the e-mail exchange for tracking purposes. This discussion should have ended the practice of limiting our communications to only the Executive Assistant. However, despite this, we still experienced resistance and delays on subsequent requests and requests for other engagements. Specifically, we received an email from the Executive Assistant on August 22, 2019 which stated, “Again, please stop reaching out to Mark directly. The IME has repeatedly asked that you submit all requests through [me]”. A response was sent to the Executive Assistant on

August 22, 2019 which stated, “Auditor Sand and Director Randol agreed that you would be CC’d on all emails for tracking purposes; however, we will continue to reach out to the staff who have the ability to answer our questions.” We did not receive a response to this message.

During the 14 months between our initial request on April 27, 2018 and when we ultimately received a population of HHS claims on July 17, 2019, we actively worked on obtaining and reviewing populations for approximately 6 months and 2 months were spent waiting for responses from DHS. The remaining 6 months were primarily spent waiting for assigned audit staff to become available. As a result, to obtain responses and data populations from DHS used approximately 8 months of the 14 months time period. Based on correspondence with DHS representatives, there was some confusion and miscommunications between the DHS and AOS representatives which resulted in additional meetings and time spent communicating/explaining the process for paying HHS claims and how the claims are coded.

Because of the extended time it took to receive a population of these claims, we contacted other states to determine their processes for requesting information and obtaining populations and the average amount of time it takes to obtain a reliable population. Based on information from the states who responded to our inquiry, the amount of time to obtain populations typically ranges from 6 weeks to 6 months. According to correspondence with other states, one of the states receives data monthly and another state has direct access and is able to obtain a population at any given time. In addition, we received a specific time frame for 4 states to obtain information and have discussions with appropriate personnel. Based on those time frames, the average turnaround time for obtaining a population and having discussions with appropriate personnel was approximately 4 months.

In addition, we contacted a representative of the Office of Inspector General (OIG) to discuss the timeliness of obtaining information they request. According to the OIG representative we spoke with, prior to the states submitting Medicaid data through CMS, it would usually take approximately 9 months to obtain accurate data. States currently submit Medicaid data to CMS on a monthly basis. According to an OIG representative we spoke with, OIG obtains Medicaid data from CMS each quarter; however, some states still submit incomplete and inaccurate data so additional follow up is necessary.

Conclusion

Historically, under the fee-for-service model of administration, DHS had the ability to provide claim data specific to a service type which could be verified using payment data. This allowed DHS and monitoring agencies, such as AOS and OIG, to efficiently select samples which could be easily vetted. With the transition to MCOs, encounter data is now provided to DHS by the MCOs and there is not an efficient and effective manner in which the encounter data can be vetted. As previously stated, DHS now pays a monthly capitation payment, similar to an insurance premium, to the MCOs under the managed care model of administration. Because DHS makes capitation payments to the MCOs rather than paying providers for specific services, DHS must rely on the MCOs to provide accurate and complete encounter data in a timely manner. The nature of the payments now made by DHS does not provide a reliable method to ensure completeness and accuracy of the encounter data as was possible with the fee-for-service model. In addition, the coding used for specific services is not consistent between the MCOs. As a result, a specific subset of claims within the population served by Medicaid cannot be efficiently identified, vetted, and reviewed to ensure the services provided were properly authorized, sufficient supporting documentation is maintained, and appropriate services were provided to the recipients.

As previously stated, we were unable to use the data provided by DHS to evaluate Home Health Services because we were unable to ensure the reliability of the data in a timely manner. Because the reliability of the data and the process of obtaining it used nearly all resources allotted to the review and exposed concerns regarding data quality, availability for use, and administration resistance or inefficiency, we concluded that a review instead focused on those issues would be beneficial to DHS and to the public.

Finding and Recommendation

Encounter Data – Section 11.4 of the *Code of Iowa* requires the Auditor of State to assess if the operations of departments are efficiently conducted and if the maximum results for money expended is obtained. The *Code* also requires the Auditor of State to make recommendations for greater simplicity, accuracy, efficiency, or economy in the operations of departments.

We determined the process used by DHS for obtaining the encounter data is not efficient or effective. It used nearly all resources allotted to the review. In addition, we identified concerns regarding data quality and its availability for use. We also experienced resistance from certain administrative staff which caused inefficiencies.

Ultimately, we were unable to efficiently and effectively select a sample of HHS claims to determine allowability of the reimbursements to providers.

Recommendation – DHS officials should ensure encounter data is reliable and can be obtained in an efficient, effective, and timely manner. DHS should consider requiring MCOs to use a state-mandated set of coding for encounter data to ensure uniformity. This would ensure more consistent and appropriate payments, and more efficient and accurate measures of care cost and quality. This would have the added benefit of ensuring that providers can consistently use one set of codes, no matter which MCO is involved or whether MCOs are joining or leaving the program. In addition, DHS officials should not cut off lines of communication between audit staff and DHS knowledge-specific staff, to ensure any questions regarding encounter data or other issues can be addressed by the appropriate staff in a timely and efficient manner. Finally, DHS officials should ensure that a query log is kept, so that queries of encounter data can reliably and fairly be based on or compared to previous queries.

Response – The transition from a fee-for-service to a managed care system is, effectively, a paradigm shift that touches all aspects of the State Medicaid Agency's administration of the Medicaid program. Even in stable state scenarios, Medicaid data is highly complex. When individuals request data related to Medicaid, there is education delivered to the requestor through the process of data delivery to ensure that the data provided is addressing the needs of the requestor. We certainly agree that communication needs to be open and fulsome. To that end, IME uses a single point of contact to ensure that the State Auditors are receiving timely, accurate information from specific subject matter experts who are located throughout the IME. We suggest that in the future any time the State Auditor's Office wishes to open a review, a conference call or in person meeting is arranged to ensure that the intent of the request is well understood and that the right individuals and correct data elements are identified early in the process. Ad hoc requests for data are addressed individually based on the information received in the request. However, data requests are entered into an online system that serves to both assign the work and memorialize requests. If a request for data is anticipated to be an ongoing or repeated request that can be identified by the requestor and the query can be set up on a scheduled basis.

The Auditor's recommendation considers DHS using a state-mandated coding set for encounter data to ensure consistent, appropriate payment to providers and accurate measures of care cost and quality. Encounter data is most simply defined as records of the health care services for which MCOs pay. Services that are billed by providers follow common code sets applicable across all payers. These codes are not set at the State level, they follow national level nomenclature. For example, Current Procedural Terminology (CPT) coding is used for medical, surgical and diagnostic procedures. Managed Care Organizations and Iowa Medicaid are required to follow national guidance for coding of procedures and that information, representing the health care services for which the MCOs pay, is reflected in the encounter data transmitted by MCO's to the IME. Additionally, there are requirements under HIPAA that govern the transmittal of encounter data.

Conclusion – Meetings were held to discuss the nature of this engagement and information requested. As documented in **Table 1**, an entrance conference for this engagement was held on June 13, 2018 for those purposes. Also as illustrated by the **Table**, information was requested prior to the entrance conference to determine what data, if any, was available and to identify any concerns which should have been included in the scope of the engagement. It is not efficient to hold entrance conferences prior to ensuring data is available. We believe there will be an improved collaborative effort between the agencies for future engagements to ensure data is obtained in an efficient and effective manner.

We also acknowledge there is federally-prescribed coding for medical, surgical, and diagnostic procedures. However, the recommendation is referencing service types, such as home health, dental, or therapeutic, rather than specific medical procedures. As stated in **Table 1**, after selecting a sample of providers from the population received from DHS in June 2018, we began receiving phone calls from providers who had been selected stating their facilities did not provide any home health services. As a result, we met with DHS representatives to determine how those providers had been included in the population. Based on that meeting and subsequent conversations with DHS representatives, a crosswalk was used when DHS converted from fee-for-service to MCOs. We requested copies of the crosswalks to help in determining an appropriate sample and were informed the crosswalks were internal codes created during the conversion process. Specifically, a DHS representative stated the crosswalks were “fixes coded into the system.” This limitation on the data was the primary inhibitor to our ability to obtain a population of home health providers from which to select a sample.

Prior to receiving DHS’ response to the recommendation, DHS representatives had not discussed CPT coding or its use with representatives from AOS. If the CPT coding could have been used to define a home health population from which to select a sample for testing, it is unclear why DHS did not provide this option at that time. It is further unclear why, if CPT coding is relevant, DHS did not simply use it when they attempted to pull data, rather than using a method that pulled providers who do not provide home health services.

In addition, based on information we have obtained from various health care providers who submit claims to more than one MCO, they have encountered inefficiencies and rejected claims because DHS allows each MCO to use different coding systems. If DHS’ response on this point were fully transparent, it would acknowledge this wasteful inefficiency. This means every provider must learn different codes for each MCO, and each MCO leaving or joining the state makes their work less efficient and more costly. IME has the ability to correct this inefficiency by requiring MCOs consistently use one set of codes. This can be accomplished by adding a more specific provision to contracts with MCOs. Or DHS could simply utilize Contract Clause 13.4.5, “Coordination among Contractors,” which states “successful [MCO] contractors shall collaborate to provide consistent practices, such as on-line billing, for claims submission to simplify claims submission and ease administrative burdens for providers in working with multiple contractors.” That DHS has not already done so, and fails to acknowledge the issue in their response, should be concerning for anyone who does not believe our Medicaid program has problems.


Ultimately, however, it is essential to have accurate data readily available. DHS acknowledged that fact in every MCO Contract at Clause 14.1: “Performance monitoring *and data analysis* are critical components in assessing how well the Contractor is maintaining and improving the quality of care delivered to members” (emphasis added). If reliable data cannot be obtained for analysis within a reasonable timeline, then by DHS’ own contracts, it may not be possible for DHS to meet their fiduciary duty to protect taxpayer dollars or Medicaid members.

A Review of the Encounter Data
from the Iowa Medicaid Enterprise
within the Department of Human Services

Staff

This review was conducted by:

Jennifer Campbell, CPA, Manager
Melissa J. Finestead, CFE, Manager


Annette K. Campbell, CPA
Deputy Auditor of State

Appendices

A Review of the Encounter Data
from the Iowa Medicaid Enterprise
within the Department of Human Services

Copy of Notification Letter



Iowa Department of Human Services

Kim Reynolds
Governor

Adam Gregg
Lt. Governor

Jerry R. Foxhoven
Director

August 17, 2018

ADVANCED HOME HEALTH CARE INC
550 S ROOSEVELT AVE
BURLINGTON, IA 52601

To Whom It May Concern:

The Office of Auditor of State is conducting a performance review on Medicaid Home Health Services. As a result, a representative from that Office will be contacting you to schedule a date and time to be on-site to review internal controls and certain client files.

Please find enclosed a copy of the HIPAA Privacy letter provided by the Office of Auditor of State for this review.

Should you have any questions or concerns, please don't hesitate to contact either Sara Schneider with the Iowa Medicaid Enterprise at (515) 974-3281 or Jennifer Campbell with the Office of Auditor of State at (515) 281-5834.

Sincerely,

Michael Randol
Medicaid Director

Enclosure

ME/ss

A Review of the Encounter Data
from the Iowa Medicaid Enterprise
within the Department of Human Services

Copy of Draft Retraction Letter

September 18, 2018

To whom it may concern:

Your facility previously received a notification letter stating a representative of the Office of Auditor of State would be contacting you to schedule a date and time to be on-site to review internal controls and certain client files in relation to a performance review on Medicaid Home Health Services.

At this time, please disregard that notification. After further review, DHS representatives have determined the population of claims provided to the Office of Auditor of State to select their sample was not correct. We are currently working to provide that Office a revised population.

After the revised population has been provided, that Office will select a new sample of providers to perform testing. Should your facility be selected again, a new notification letter will be provided.

We apologize for any inconvenience. Should you have any additional questions or concerns, please don't hesitate to contact either Jennifer Campbell with the Office of Auditor of State at (515) 281-5834 or [REDACTED].

Sincerely,