



## Challenges in Encounter Data Submissions

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## EXECUTIVE SUMMARY

One risk-based health care provider payment method—long used in California but less common elsewhere—is capitation, or fixed per-person, per-month payments, to provide covered services to patients. In lieu of claims data commonly used for fee-for-service payment, health plans using capitation rely on patient encounter data, which detail a patient's clinical conditions and services provided, to track both health care quality and costs and to adjust provider payment levels. Complete, timely, and accurate encounter data are critical to risk-adjusting provider payments, yet many challenges hamper exchange of encounter data among contracting parties.

As a contingency of Centene's acquisition of Health Net, the California Department of Managed Health Care (DMHC) required Health Net to invest \$50 million in improving encounter data submissions in California, with a focus on Managed Medi-Cal providers. To facilitate Health Net's strategic decision-making process related to encounter data investments, the Integrated Healthcare Association (IHA) was awarded a grant to complete a market research study to assess what blend of investments would maximize improvement in both the volume and quality of managed Medi-Cal encounter submissions.

Sixty interviews with frontline physicians, practice staff who submit encounter data, clearinghouses, billing agencies, and vendors were completed between November 2017 and January 2018. The findings indicate that a variety of factors contribute to the degradation of encounter data submission quality, including:

- Lack of understanding and education among stakeholders regarding encounter data and its importance in analyzing quality and cost trends and in ensuring accurate provider payment.
- Inadequate training on the data submission process at the clinic level.
- Technological challenges, especially concerning electronic health record (EHR) and practice management systems.
- Insufficient quality control and auditing within physician organizations, including physician practices and independent practice associations (IPAs).

- Physician organization confusion about handling encounter data rejections from health plans and clearinghouses.
- Poor communication among all parties involved in the submission process.
- Lack of standardization, specifically around coding.
- Issues specific to Medi-Cal patients, such as increased likelihood of fragmented care, difficulty verifying coverage, and data gaps in patient-entered questionnaires.

Working with practice-level staff, IHA tested several potential solutions to improve the accuracy and completeness of encounter data, including training on standard encounter data processes, increasing technology resources to allow automatic submission processes, and proposing financial incentives to offset costs and staff time associated with submissions. Overall, technological improvements were identified as the area of biggest impact regardless of operational size.

Based on the findings from the market research project, IHA recommends the development of an overarching governance structure to orchestrate, coordinate, and oversee a multi-pronged approach focused on education and training, technology improvements, standardization, and incentives. To address the knowledge gap in the industry, any investment should be coupled with a robust training and educational campaign to ensure physician practices and organizations understand the importance of collecting and reporting encounter data. Additionally, to maximize impact on the volume and quality of submissions, IHA recommends substantial investments in technology. These investments could include upgrading and standardizing EHR functionality across practices, as well as investing in a statewide technology platform for encounter data submissions. A single, statewide technology platform for all health plans and providers would greatly simplify and streamline the submission process through greater standardization to ease reporting burden and improve accuracy of encounter data submissions.

## INTRODUCTION

Medi-Cal, the state-federal health program for low-income people, now covers more than one in three Californians—about 13.3 million people in 2017, an increase of almost 4 million since passage of the Affordable Care Act (ACA). As Medi-Cal enrollment increased overall, the State also increased its reliance on managed care to serve Medi-Cal enrollees. Today, the majority of Medi-Cal enrollees, roughly 11 million, get care through managed care plans. While Medi-Cal represents a huge portion of the overall insured individuals in California, Medi-Cal enrollees are increasingly being cared for by provider organizations that serve multiple lines of business, including Medicare Advantage, commercial, and Medi-Cal, making encounter data submission critical for multiple participant organizations in California.

In managed care delivery systems, financial risk is shared between health plans and provider organizations through capitated payment arrangements. Under capitation, providers typically receive prospective per-member, per-month payments to provide most or all contracted patient care instead of filing fee-for-service claims for individual services post visit. Capitated payment arrangements rely on encounter data submissions as a substitute for fee-for-service claims data. Encounter data are used to track detailed information about individual services provided by a capitated entity and are essential for setting and adjusting payment rates and measuring quality of care. However, with few if any direct financial incentives for providers to submit complete and timely encounter information, health plans have struggled to collect information about the services provided. The reimbursement structure used in capitated arrangements leads to many of the challenges associated with encounter data exchange.

Since 2016, IHA has led a multi-stakeholder process to standardize several key encounter data exchange processes. Following an [initial assessment](#) period to understand encounter data challenges more broadly, in January 2016, IHA convened stakeholders from across the industry and product lines with the goal of establishing industry-wide standards for encounter data submission processes between provider organizations and health plans. The work focused on three

main components deemed by participating plans and providers as the most critical for standardization: (1) standardization of the “outbound” 837 form from physician organizations to plans; (2) standardization of the edit and rejection reports from plans/clearinghouses back to physician organizations; and (3) standardization of volume and quality threshold reporting. Of note, these standardization efforts were designed to apply to multiple product lines inclusive of Medi-Cal, Medicare Advantage, and commercial.

Also in 2016, the DMHC announced approval of [Centene’s](#) acquisition of Health Net, which included a requirement for [Health Net](#) to invest up to \$50 million in improving encounter data submissions in California, with a focus on managed Medi-Cal. As part of this work and with awareness of IHA’s ongoing work in encounter data standardization, Health Net awarded a grant in 2017 to IHA to conduct market research to provide information and insights that will facilitate Health Net’s strategic decision-making process related to encounter data investments.

## METHODOLOGY

In support of this effort, IHA contracted with a consulting group to complete 60 interviews with the following individuals and organizations: physicians who generate encounter data; IT, administration, and operations staff who submit encounter data; and staff from billing services, clearinghouses, physician organizations (POs), and management services organizations (MSOs) that process encounter data. The purpose of these interviews and the resulting analysis was to identify challenges in the data submission process and evaluate potential frameworks for investments, specifically related to outreach and education, technology, incentives, and standardization.

To be selected as an interviewee, participants must have had personal experience handling encounter data. Physicians and other practice-based staff must have worked at practices that participated in managed Medi-Cal and maintained a patient load that was at least 25 percent capitated Medi-Cal patients. Recruitment was conducted through telephone, email, and fax-based outreach directed toward nearly 2,000 individuals pulled from a list provided by IHA.

A total of 49 interviews were conducted with practice staff. Of the 49 practice-based interviews, 24 were with physicians and 25 were with non-physicians. Based on prior market research, IHA identified that providers within specific size segments have commonalities related to administrative staffing levels, technology infrastructure, and operational capacity. To map the provider market effectively and model potential investment impact, IHA conducted interviews across three different sized segments (see Exhibit 1). To obtain a representative size-based distribution, practices were categorized as small, medium, or large, and quota targets were set for each category.

- Small practices were defined as solo or single-location practices with a few providers.
- Medium practices were those with multiple doctors and other medical staff (nurses, physician assistants, etc.) spread across a small number of locations. These practices typically had between 30,000 and 100,000 Medi-Cal patients.
- Large practices were organizations with multiple locations spread across one or more counties. These were usually multi-specialty organizations employing many different types of doctors. Large practices generally had more than 100,000 Medi-Cal patients.

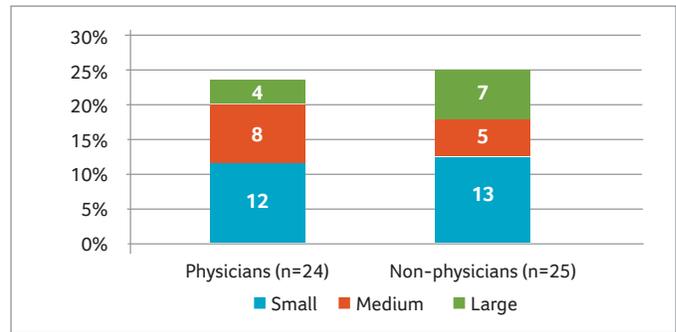
To obtain a representative geographic distribution, the geographic coverage of each practice in the sample was determined and then the practices were grouped into the combined statistical areas defined by the U.S. Office of Management and Budget (see Exhibit 2). Geographic quota targets were set based on the sample distribution.

In addition to the interviews conducted with practice staff, there were 11 interviews with non-practice staff, including four with clearinghouses, three with billing services, three with POs/MSOs, and one with an EHR software provider.

**BARRIERS TO COMPLETE & TIMELY ENCOUNTER DATA SUBMISSIONS IN MEDI-CAL**

To support Health Net’s strategic decision-making process related to encounter data investments, IHA first wanted to better understand the barriers frontline physicians and staff faced with encounter data submissions. The following findings outline barriers to high-quality encounter data exchange.

**Exhibit 1. Practice Staff by Type and Size (n=49)**



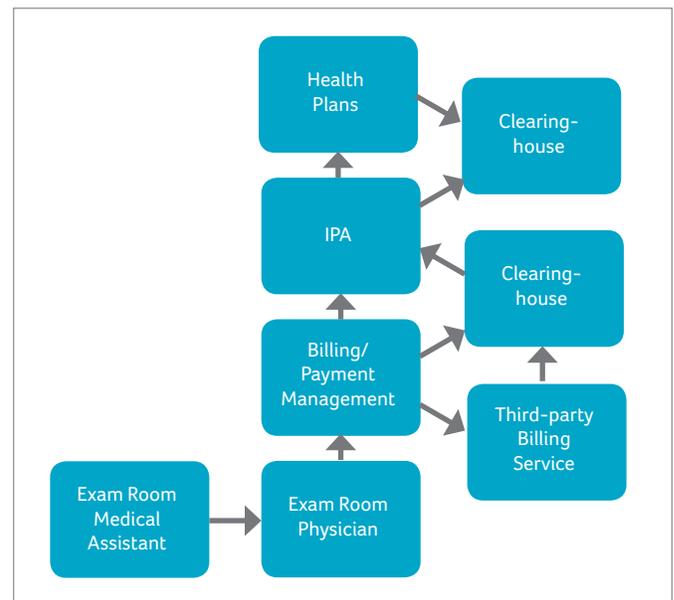
**Exhibit 2: Geographic Distribution of Practices by Size and Overall**

Practice Participants by Region (n=49)				
Combined Statistical Area (CSA)	Small	Medium	Large	Total
Los Angeles - Long Beach - Riverside	14	5	2	21
San Jose - San Francisco - Oakland	3	2	4	9
Sacramento - Arden Arcade - Yuba City		3	1	4
Fresno - Madera			1	1
Other/Unidentified	8	3	3	14
<b>Total</b>	<b>25</b>	<b>13</b>	<b>11</b>	<b>49</b>

**Physicians Confused by Encounter Data**

Encounter data can be passed from anywhere between three to six handlers before reaching a health plan. The more handlers there are, the greater the potential for data loss or distortion (see Exhibit 3).

**Exhibit 3. Encounter Data Flow**



In general, data capture is a problem in the exam room as a whole, regardless of whether it is encounter data or claims data. Data flow begins in the exam room where time constraints and other demands create challenges for doctors to generate and submit accurate data. A foundational issue is clinicians receive little to no training on how to code and submit data. As a result, some physicians have no or very limited knowledge of what encounter data is and are unaware of its importance for accurate payment. Even those physicians who have some knowledge of encounter data are often unaware of the importance of complete and accurate data submissions. As a result, many practices submit encounter data that is incomplete or inaccurate.

According to interviewees, data loss occurs for a variety of reasons. Primary among them is incorrect coding. Part of the challenge is the coding schemes themselves. They demand a high level of specificity that makes them cumbersome to navigate. Common conditions may be attended by a long list of codes intended to capture a diagnosis with a high level of detail. If doctors are unable to devote the time to find a precise code, they may default to something simpler, or even settle for using “unspecified.”

Some physicians acknowledged they were aware that their immediate reimbursement is not tied to the specificity or accuracy of codes they enter for a particular patient. It was reported that some doctors code with less detail to reduce the time they expend on coding, while others prioritize spending quality time with their patients or seeing a high volume of patients over accurate coding.

Doctors are required to enter International Classification of Disease-10 (ICD-10) and Current Procedural Terminology (CPT) codes. Some interviewees reported that they skipped ICD-10 and CPT codes if they didn't perceive a need for them. Quality measures that interpret results also are not always recorded. Additionally, quality control and auditing often are limited at the practice level, especially in smaller practices.

Some practices lacked the resources needed to submit accurate and complete encounter data; some were short-staffed, while others still used paper-based or faxed submissions, creating problems for POs receiving encounter data submissions. Additionally, some practices reported that when key personnel go on vacation or when patient visits are scheduled for

evenings or weekends, the submission process may be put in the hands of less-experienced staff, resulting in inaccurate or incomplete submissions.

Some practices stated that they receive little in the way of feedback once data are submitted. If practices submitting incomplete or inaccurate data don't receive feedback, they may never know about problems. Additionally, some practices reported that they don't even receive confirmation that their submissions have been received. As such, practice staff often don't find out about data-loss incidents until months or even years later.

Most practices indicated, however, that they receive notice when their submissions have been rejected. With no consequence for inaction, some practices choose not to respond to rejection notices. In some cases, if the practice receives a rejection, staff will redo the coding in a simpler fashion to push it through. If a rejection or denial is not dealt with, that information is lost forever.

## TECHNOLOGICAL ISSUES

Respondents commented on a host of issues related to EHR and practice management systems, beginning with the simple fact that they are all different from one another. EHR systems are seen as inflexible and rigid. In addition, they may not always be programmed correctly. They can be cumbersome to deal with; doctors often complain that there are too many clicks required or too many different screens to deal with. Smaller offices often don't have the resources to construct or redo EHR templates—a problem acutely felt when upgrades require EHR templates to be redone.

Interviewees also reported that when regulations change, it might take six months for those changes to be fully coded into an update patch. The code for whether data are for a fee-for-service claim or encounter data is a situational code. Some EHRs automatically populate the code, others do not. When the code is not automatically populated, some doctors may forget to enter it. As a result, the information may wind up being incorrectly coded as a fee-for-service claim at a clearinghouse. An EHR software developer interviewed for the project provided several valuable insights, including:

- EHRs are built on systems that are outdated and unwieldy.
- Those responsible for writing regulations may not

understand EHR capabilities and limitations, resulting in software updates being cumbersome.

- Self-administered questionnaires can pose a burden to patients and are not necessarily tested to the patients' educational levels.
- Doctors take an individual approach to dealing with a patient, yet EHRs take them down a cookie-cutter path that they wouldn't naturally take.

### PROBLEMS UP THE BILLING CHAIN

In addition to practice staff, 11 staff members from billing services, clearinghouses, POs, and MSOs were interviewed. From their perspective, the biggest problems with encounter data submission relate to lack of standardization and poor communication among the involved parties.

Some POs and billers reported that Medi-Cal codes aren't standardized across health plans. Some assumed that clearinghouses were accounting for this, but not every provider organization uses a clearinghouse, and it's likely that not all clearinghouses are dealing with this issue effectively.

To illustrate how lack of standardization creates problems, one respondent described the various ways health plans identify and track newborns. Some plans assign the newborn a unique ID, while others use the mother's ID number. Some plans that assign a unique number might derive it from the same root number as the mother's ID, which provides a means of linking the two. Others will assign a number that does not link to the mother's in any obvious way.

Some interviewees also advised more guidance from the state Department of Health Care Services (DHCS), which administers Medi-Cal, is needed. They believed Medi-Cal is unclear about what it needs from health plans, which results in ambiguous rules open to interpretation. As a result, plans devise their own standards for doing things, which can create confusion for everyone involved in the encounter data submission process.

Additionally, according to interviewees, coding updates often introduce complications. For example, new codes for 2019 will be announced in October 2018, but Medi-Cal won't allow those codes to be updated until October 2019. If anyone uses the new codes for a Medi-Cal patient between January 2019 and October 2019, they won't be recognized by the system. Meanwhile, other coding updates will be announced monthly, but not

all health plans process updates at the same time. As a result, there may be some codes at any given time that are accepted by some plans and rejected by others.

Respondents also shared that some patient encounters are never submitted because the practice can't determine which PO the patient is associated with. This is especially true if patients' coverage changes. When eligibility can't be confirmed, a patient may pay cash, and those encounters are never submitted. If a practice learns afterward that a patient was ineligible, the visit is written off and the encounter is never submitted. In other cases, health plan directories of participating specialists are not always up to date, which may result in a doctor referring a patient to a specialist who is out of network. If the specialist sees the patient, the visit is never submitted as encounter data.

Another common theme shared across all interviews was that communication issues are experienced not just by the practices but seemingly by all stakeholders at every level. POs, MSOs, and other related entities deal with multiple health plans, each of which has its own communication methods. Some are better at communicating than others. For example, a respondent advised that if a plan rejects an encounter data submission, the clearinghouse has to speak with a person at the plan to get it resolved. This plan provides no automated way to resolve the issue. Another respondent advised that there is no point person at the POs or the health plans dedicated to answering questions. Even if a point of contact can be established, it can be difficult to maintain as people come and go or move around within a company.

Additionally, many interviewees found communicating with DHCS challenging. One biller said that Medi-Cal (and at least one PO) limits the number of patients that can be asked about per call to three, which impedes the follow-up process. Another said that Medi-Cal will often announce changes without warning, catching those who need to implement the changes off guard.

Overall, a lack of clear accountability creates an environment where it's easy to point fingers at one another. Some MSOs and POs blame the practices and vice versa. Other respondents said that the breakdown in communication happens somewhere between the clearinghouse and the PO or between the PO and the plan. Overall, the lack of communication across all parties is problematic, and blame is passed when errors are made.

**PROBLEMS SPECIFIC TO MEDI-CAL PATIENTS**

Another theme arising from the interviews related to the Medi-Cal population itself. Some respondents stated that care for Medi-Cal patients likely may be fragmented because they’re seeing different doctors or getting care at a variety of locations, such as doctors’ offices, urgent care clinics, and the emergency department. They believed such fragmentation may lead to incomplete coding because patients’ data may not be in one place. In addition, some interviewees indicated that Medi-Cal patients also may be more likely to have multiple conditions, which limits the amount of time clinicians can devote to each condition.

According to other respondents, changes in insurance—between Medi-Cal and Covered California, or even between Medi-Cal plans—also can disrupt the data chain. They stated that this is especially true if a plan change can be enacted at any point, including retroactively, adversely affecting encounter data that have already been submitted. Additionally, respondents reported that Medi-Cal may have more cash-pay patients, none of whose records are being submitted. This often happens when a practice is unable to verify a patient’s coverage.

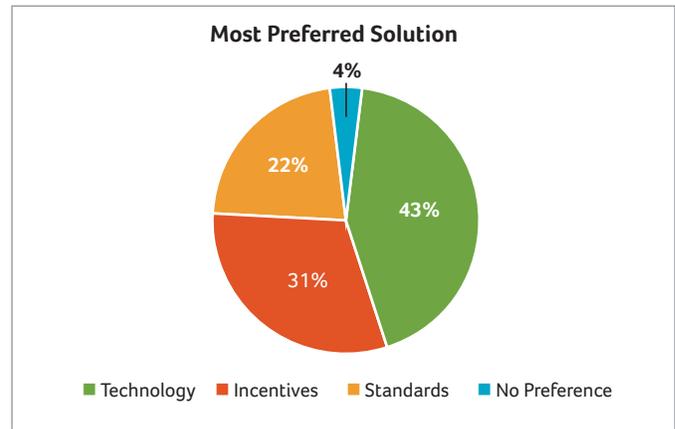
Patients dually eligible for Medicare and Medicaid also present unique issues, according to interviewees. It was unclear to some respondents whether encounter data for these dual-eligibles are being reported to both Medicare and Medi-Cal. Additionally, respondents expressed concern that information from patient-entered questionnaires may be incomplete or inaccurate because the patients don’t always understand the questions or that patients whose preferred language is not English experienced translation problems.

Finally, physicians interviewed shared that they spend less time documenting because they are spending more time coordinating care. As a result, patient interactions with care coordinators or peer navigators may not be submitted.

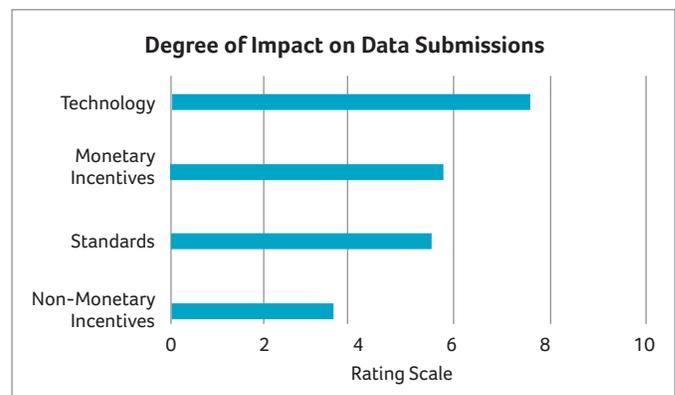
**INVESTMENT OPPORTUNITIES TO IMPROVE ENCOUNTER DATA SUBMISSIONS**

Respondents were presented with three potential solutions for improving encounter data submissions—technology improvements, an incentives program, and greater standardization—and were asked which would create the largest impact (see Exhibit 4).

**Exhibit 4: Preferred Solutions to Encounter Data Submission Challenges**



**Exhibit 5: Perceived Effectiveness of Proposed Solutions**

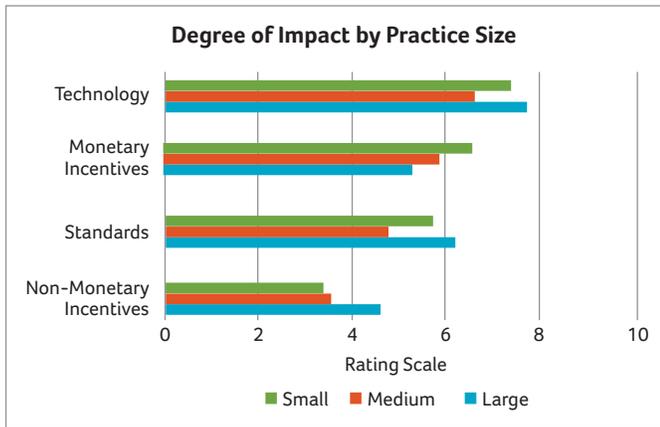


Respondents also were asked to rate how effective each solution might be on a scale of 1 (no impact) to 10 (a huge impact) (see Exhibit 5). Overall, they believed that improvements to technology would have the most impact, followed by monetary incentives, and then creation of standards. Non-monetary incentives were seen as the least effective.

In breaking down the responses to proposed solutions by practice size, technology was again seen as the solution with the potential for the largest impact across all practices, regardless of organizational size. Small and medium practices aligned with each other across the other solutions (see Exhibit 6). Both practice types believed that technology improvements would have the greatest impact, followed by monetary incentives, and then standardization.

Large practices differed in some key ways. While they agreed that technology improvements would have the greatest impact, they believed standardization

### Exhibit 6: Perceived Effectiveness of Proposed Solutions, by Practice Size



would be more effective than monetary incentives. And though they too gave it their lowest rating, large practices rated non-monetary incentives more highly than small and medium practices did.

While the differences between these groups are small, they may be meaningful. The interviews revealed that larger organizations are generally better equipped to dedicate resources to promoting complete and accurate encounter data submissions. For example, larger organizations have the financial resources to hire specialists solely dedicated to monitoring and auditing encounter data submissions. While improved EHR technology and standardized coding would impact all practices in the same way, incentivizing practices or individual physicians may only work for practices that do not already have staff on hand solely focused on this effort.

#### POTENTIAL INVESTMENT OPPORTUNITIES

This market research project helped to identify many of the barriers to high-quality encounter data exchange experienced by Medi-Cal providers and other key stakeholders. Based on the findings, IHA recommends the development of a governance body to oversee and coordinate a multi-pronged approach focused on education and training, technology improvements, standardization, and incentives.

Recognizing that stakeholder engagement will be critical to the success of any effort, the development of a governance body that can facilitate and oversee the initiatives and promote consensus-based decision making across the industry is key. While much of the work to improve encounter data has been made by

individual plans and providers, encounter data is a systemic problem in the industry. IHA recommends a long-term, cross-industry effort to support encounter data improvements, including establishing a single, multi-stakeholder governing body that will be responsible for effectively and efficiently coordinating and overseeing various efforts.

One key strategy the governance body would direct is the development of a well-coordinated outreach and education campaign designed to produce more complete and accurate encounter data submissions. Education and training should be offered to all practices. For some individual doctors or practices, this might start simply with a lesson on what encounter data is and its importance. For others, training could emphasize why submitting encounter data is important and what they could be doing to submit data completely and correctly. Training and education should be ongoing, with practices being shown the actual mistakes that are being made in coding.

Investments in training Medi-Cal, physician organizations, and health plan support staff would also improve communications among stakeholders. In addition, coordinators who can act as liaisons between physician practices and POs and plans may be beneficial. As an aside, many respondents indicated support staff for the plans should be available during all hours of operation, which sometimes includes evenings and weekends.

Another key component the governance body would oversee is technology improvements. Based on interviewees' feedback and identified problems, the development of a single technology platform for encounter data submissions, not just for Medi-Cal health plans and providers but for all payer/provider combinations, could provide significant value. A single platform used for data submission, aggregation, validation, and tracking could transform a fragmented and overly complex system, challenged by multiple handoffs and rejection points that compromise the flow of data. Accuracy and completeness could improve with a standardized and digitized process, allowing providers to submit data with less administrative burden and freeing up time to focus on clinical care. It would also reduce the ambiguity inherent in the current system. No longer would each individual plan need to devise its own standards and processes. The development of a centralized standards

body that sets codes and interprets the guidelines for the plans could help immensely. When codes or guidelines change, the change should happen simultaneously across all parties.

Other technological improvements that could have significant impact include standardization across EHRs. Additionally, new guidelines for EHRs that emphasize fewer clicks, more automated screens, more probes, and more logic so that screens are pre-populated could help. Any solution that would condense key clicks onto one screen would be useful.

An incentive program might work as part of a package of improvements but might not have as much impact as other strategies. Currently, only a few practices reported receiving financial incentives from a few POs. A neutral governance body could engage plans and POs to share current best practices and discuss opportunities for collaboration on the development of a set of encounter data quality metrics focused on completeness, accuracy, and timeliness. Funds could be used to pilot a coordinated incentive program with several plans and provider organizations.

Finally, reforming the Medi-Cal managed care reimbursement model could address the lack of financial incentives to submit accurate and timely encounter data. One potential solution would be to withhold a percentage of monthly capitation payments and redistribute those funds contingent on submission of complete and accurate encounter data. However, any fundamental reform to the payment system in managed Medi-Cal would require an in-depth, multi-stakeholder process led by DHCS, which is responsible for overseeing all Medi-Cal managed care plans. While such a process could and should take place, it would most likely take several years to reach agreement and would not be an immediate fix.

## CONCLUSION

Complete, timely, and accurate encounter data are critical to risk-adjusting provider payments to account for the health differences in patient populations enrolled in managed care products. As the interviews revealed,

however, there are a number of factors hampering the exchange of accurate encounter data among contracting parties. From the physicians generating encounter data to the plans collecting and analyzing the data, each player in the process has its own set of issues to address.

While there is no silver bullet to resolve the challenges of submitting timely, accurate, and complete encounter data, this analysis has identified multiple recommendations to improve encounter data submissions. First and foremost, providing outreach and training to physicians, billers, and other relevant staff could help establish a common and more workable knowledge base of encounter data. A single, statewide clearinghouse could greatly streamline and simplify the process by eliminating the barriers associated with the multiple handoffs and would be less administratively burdensome for providers, provider organizations, and health plans. Streamlining and simplifying EHR systems and standardizing coding schemes could ease many of the burdens in generating encounter data. Providing incentives might help to motivate completeness and accuracy in submissions. Ultimately, poor quality and missing encounter data remain a major challenge for the entire health care industry, not limited to Medi-Cal. An industry-wide solution across all product lines and geographies is needed to improve the quality and timeliness of encounter data and to reduce the administrative burden associated with data exchange.

Based in Oakland, Calif., the nonprofit Integrated Healthcare Association (IHA) convenes diverse stakeholders—



including physicians, hospitals and health systems, purchasers, and health plans—committed to high-value, integrated care that improves quality and affordability for patients across California and the nation.

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