QMED 2.0: Review September Webinar Questions

October 29, 2025

Data Reporting and Monitoring Webinar Series

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Agenda

- Encounter Data Background: Federal and Contractual Requirements Recap
- Contractual and Federal Data Submission Obligations
- September Webinar Questions
  - Encounter Submission Lagtime Measure
  - Encounter Submission Turnaround Time Measure
- Encounter Data Improvement Project (EDIP) Update

Questions & Answers

- For **GENERAL** questions, please submit your question to the WebEx chat and please ensure that your questions are visible to all participants, because the host is not monitoring private chat to the host.
- For **SPECIFIC** questions, please reach out to the appropriate Data Mailbox as will be instructed closer to the end of this presentation.

Before we move on

- Today's webinar is being recorded for documentation purposes.
- Link to Part One of the Encounter Data Improvement Series – November 2024
- Link to Part Two of the Encounter Data Improvement Series – February 2025
- Link to Part Three of the Encounter Data Improvement Series – June 2025
- Link to Part Four of the Encounter Data Improvement Series – September 2025
- The recorded video, script, and presentation materials will be uploaded to Data Reporting and Monitoring Webinar Series
- The glossary and FAQs are also updated regularly every month.

September 2025 Webinar Questions on QMED 2.0

Christine Fesler
Chief, Data Quality Reporting Unit
Health Information Management Division

DHCS

Encounter Data:
Federal and Contractual Requirements Recap

Encounter Data Requirements

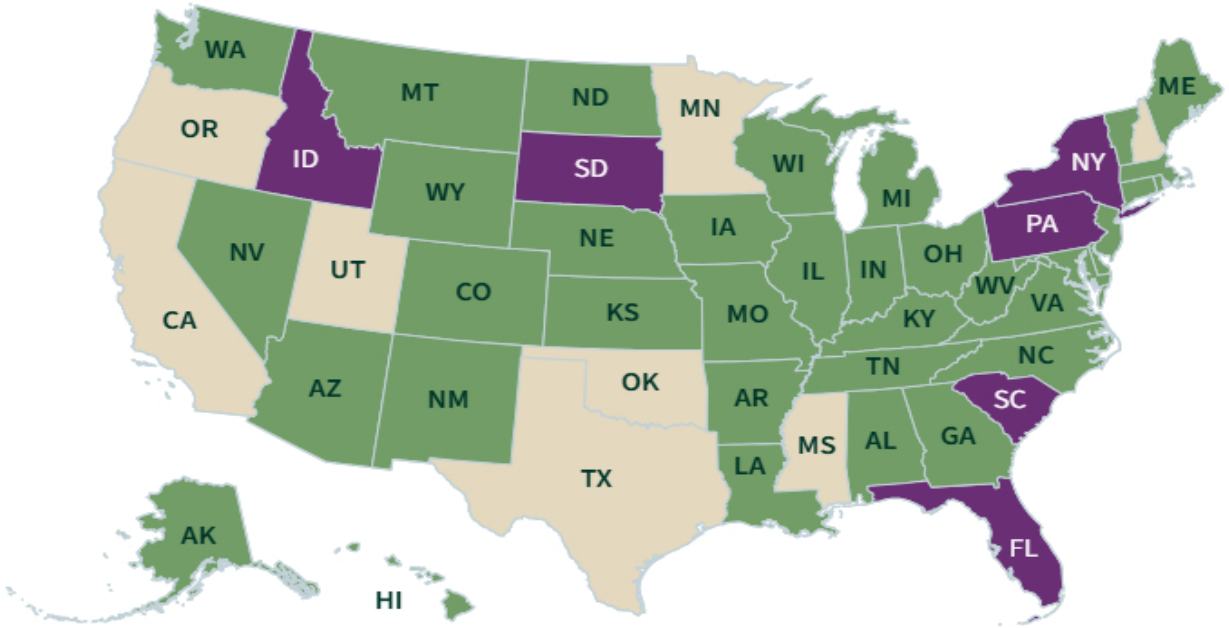
- The state is failing to meet federal requirements for quality and completeness of encounter data
- DHCS requires complete, accurate, reasonable, and timely data from plans to meet federal encounter data submission requirements
- If the state cannot meet data reporting requirements, Federal Financial Participation for technical systems may be at risk

Funding Consequences to Low Quality Encounter Data

Chart exported from the 2024 Medicaid and CHIP Scorecard

T-MSIS DATA QUALITY: OUTCOMES BASED ASSESSMENT
Data Quality Outcomes Based Assessment

Criteria: **Overall OBA**
Year: **2024**



How to read this chart

- **Meets OBA targets: Meets target on critical priority, high priority, and expenditures**
- **Does not meet OBA targets: Does not meet target on high priority and/or expenditures, meets target on critical priority**
- **Does not meet OBA targets: Does not meet target on critical priority**

VT NH
MA RI
CT NJ
MD DE
DC

PR VI

- Expectations for Encounter Data Submissions: CMS Medicaid and CHIP Managed Care Final Rule (§438.242) and (§438.818).
- **CA has failed to meet T-MSIS OBAs in 2022, 2023, and 2024**

[Medicaid and CHIP Scorecard - T MSIS Data Quality Outcomes Based Assessment]

Encounter Data

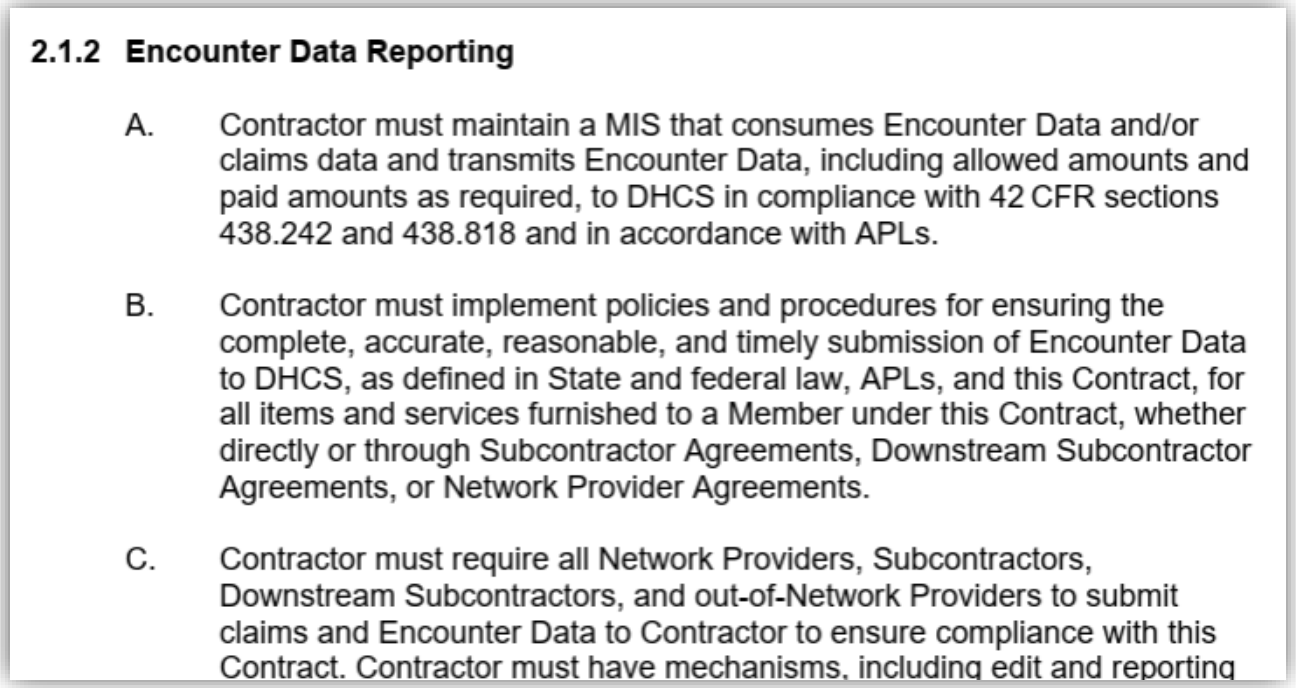
Encounters are records of services provided to Medi-Cal members enrolled in capitated health plans.

- Encounter records provide DHCS **documentation of Medi-Cal service utilization**
- DHCS relies on this data to **support program oversight, facilitate population health management,** and **fulfill federal reporting requirements,** such as:
  - Capitated rate calculation
  - Quality measure calculation
  - Audits and investigations
  - Reporting to CMS
  - Population health management
  - Incentive payment programs
  - Public dashboards

Encounter Data – Contractual Obligations

From June 2025 Webinar: The submission of complete, accurate, and timely encounter data is critical for maintaining program integrity and to comply with state and federal requirements.

- Plans are **contractually obligated** to submit encounter data for services provided to beneficiaries
- DHCS expects complete, accurate, reasonable, and timely encounter submissions
- *Note:* DHCS' reporting standards align with CMS requirement for national standard file formats to meet state and federal Medicaid and HIPAA reporting requirements



2.1.2 Encounter Data Reporting

A. Contractor must maintain a MIS that consumes Encounter Data and/or claims data and transmits Encounter Data, including allowed amounts and paid amounts as required, to DHCS in compliance with 42 CFR sections 438.242 and 438.818 and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Encounter Data to DHCS, as defined in State and federal law, APLs, and this Contract, for all items and services furnished to a Member under this Contract, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers to submit claims and Encounter Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting

Source: MCP boilerplate contract

Encounter Data – Federal Obligations

§438.242 (Health Information Systems)

(c) ***Enrollee encounter data.*** Contracts between a State and a MCO, PIHP, or PAHP must provide for:

(1) Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.

(2) Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs.

(3) Submission of all enrollee encounter data, including allowed amount and paid amount, that the State is required to report to CMS under § 438.818.

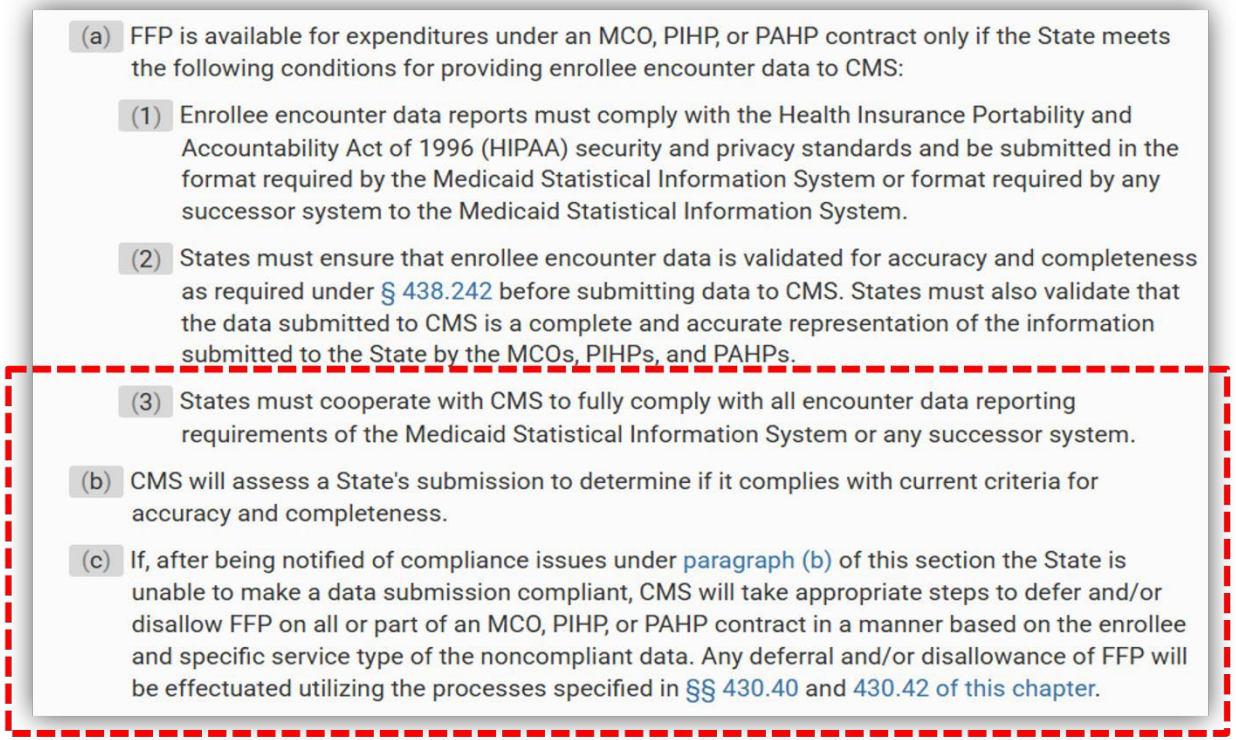
(4) Specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.

- **The CMS Medicaid and CHIP Managed Care Final Rule lays out expectations for encounter data submissions (§438.242) and the financial consequences for noncompliant plans (§438.818).**

- **Key takeaway**: Plans must keep detailed records (encounters) of services paid for (and how much was paid), and report those records regularly to the state using standard formats.

Encounter Data – Federal Obligations and Plans

§438.818 (Enrollee Encounter Data)



(a) FFP is available for expenditures under an MCO, PIHP, or PAHP contract only if the State meets the following conditions for providing enrollee encounter data to CMS:

(1) Enrollee encounter data reports must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards and be submitted in the format required by the Medicaid Statistical Information System or format required by any successor system to the Medicaid Statistical Information System.

(2) States must ensure that enrollee encounter data is validated for accuracy and completeness as required under § 438.242 before submitting data to CMS. States must also validate that the data submitted to CMS is a complete and accurate representation of the information submitted to the State by the MCOs, PIHPs, and PAHPs.

(3) States must cooperate with CMS to fully comply with all encounter data reporting requirements of the Medicaid Statistical Information System or any successor system.

(b) CMS will assess a State's submission to determine if it complies with current criteria for accuracy and completeness.

(c) If, after being notified of compliance issues under paragraph (b) of this section the State is unable to make a data submission compliant, CMS will take appropriate steps to defer and/or disallow FFP on all or part of an MCO, PIHP, or PAHP contract in a manner based on the enrollee and specific service type of the noncompliant data. Any deferral and/or disallowance of FFP will be effectuated utilizing the processes specified in §§ 430.40 and 430.42 of this chapter.

- **Section §438.818 (Enrollee Encounter Data) indicates that *plans'* funding could be at risk if encounter data is not properly collected and reported by the state to the CMS via T-MSIS.**

- **Key takeaway**: Funding for the state's managed care contracts may be impacted if encounter data is not properly collected and reported by the state to the federal government. If data problems are not fixed, CMS could cut funding for the **specific types of patients or services affected by the data problems.**

Encounter Data – T-MSIS Reporting

Furthermore, eligibility for enhanced FFP for Medicaid Enterprise System (MES) systems expenditures requires states to meet federal reporting requirements and maintain compliance with federal regulations, including 42 CFR 433.116. T-MSIS data must be:

a. submitted and received in a required format for processing,
b. complete, timely, and accurate,[6] and

c. submitted and recorded without deleting or degrading historical data submissions.

CMS will address T-MSIS reporting compliance issues through the process outlined in the May 24, 2023, Center for Medicaid and CHIP Services (CMCS) Information Bulletin (CIB), *Medicaid Enterprise Systems Compliance and Reapproval Process for State Systems with Operational Costs Claimed at the 75 Percent Match Rate*[7] hereinafter referred to as the **MES Compliance and Reapproval Process**.

Source: May 28, 2025, State Health Official Letter

- **States must report Medicaid and CHIP encounter data along with enrollment, claims, provider, and plan data to CMS monthly via Transformed Medicaid Statistical Information System (T-MSIS) files.**
- **Key takeaway:** State failure to submit high quality T-MSIS data to CMS puts federal funding for the state's technical infrastructure at risk.

Questions on Encounter Submission Lagtime Measure

QMED 2.0: Encounter Submission Lagtime Measure

- **Context:**
  - September 24, 2025, webinar MCP questions regarding the Encounter Submission Lagtime Measure.
  - Assesses the **percentage of <u>original accepted</u> encounters submitted to DHCS** within 60 days from the Date of Service.

- Timeliness Measure (T4.): **Submission Lagtime - Professional Encounters =**

$$\left(\frac{\text{Num. of 837P } \textbf{original accepted} \text{ encounters in the reporting quarter where the Date of Service } - \text{Submission Date} \leq 60 \text{ days}}{\text{Num. of 837P } \textbf{original accepted} \text{ encounters submitted in the reporting quarter}} \right) * 100$$

Note: *There are two separate measures for Submission Lagtime – one for professional encounters and one for institutional encounters; this slide only shows the calculation for the professional encounters measure.*

Definition of Lagtime

Question: Is the lag time of 60-days calculated from date of service, date of receipt, or date of payment?

- Lagtime is the time, in calendar days, between the Date of Service ("DOS") and the date the MCP submits the post-adjudicated **original and accepted** encounter records to DHCS PACES (the "Submission Date").
- In cases of a long length of stay (e.g., a long-term hospitalization) the measure is calculated from discharge date.
- DHCS is looking to use Date of Payment in future QMED 2.0 updates.

Submission Lagtime Requirements for Adjustment/ Reversal Claims

Question: Is the submission lagtime of 60-days from DOS the same for adjustments / reversal claims?

- Lagtime uses Date of Service[1] for 837I and 837P original and accepted encounters
  - Aligns with focus on timeliness of claim processing by Plans to submitting encounters to DHCS PACES
- Measure includes only **original and accepted** encounters
- Uses Encounter End Date of service to account for hospital services that may be rendered after Encounter Begin Service Date.

QMED Alignment with Contractual Requirements

Question: How does 90% within 60 days correlate Medi-Cal timely filing and clean claim payment days timelines. Are we expected to hold our providers to a higher standard?

- The requirements that are proposed in QMED 2.0 are aligned with DHCS MCP contractual requirements as well as T-MSIS reporting requirements.
- The MCP contract requires adherence to federal Medicaid requirements which dictate 90% of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, be paid within 30 days of the date of receipt.
- Plans are required to submit encounters to DHCS within 6 days following the month of payment.

Feasibility of Meeting Encounter Submission Lagtime Measure Threshold

Question: Was there analysis done on the feasibility of 90% within 60 days?

- Analysis was done to look at compliance outcomes on various time periods; however, purpose is to align with Contract. Only includes Original and Accepted encounters.
- Contract stipulates Plans should have systems and edits to process and validate encounter claims from Providers prior to sending X12 encounter transactions to DHCS PACES.
- Iterative measure development:
  - Empirical analysis of plan performance on current QMED 1.0 measures.
  - Per MCP Contract, if MCP has provider(s) that are not submitting claims in a timely manner (30 days), those timeliness issues should be addressed with the provider.
  - DHCS has set the threshold for this measure at 90% and includes only **original accepted encounters**.
  - Flexibility in 90% threshold; provides Plans time to communicate issues with encounter claims Providers submit to Plans.

MCP Input on QMED 2.0

Question: Did DHCS discuss QMED 2.0 with any Managed Care Plans? [*90% within 60 days is a lot different than 80% within 180 days*]

- Managed care plans will have an opportunity to provide input on the QMED 2.0 APL and associated documentation via the public comment process.
- The measures for QMED 2.0 were developed based on an empirical analysis of plan performance on current measures and DHCS priorities.
- The QMED 2.0 measures are intended to drive data quality improvements to make progress on further aligning with contractual requirements, supporting DHCS data needs, and facilitating meeting federal reporting requirements.

Impact of Resubmission of Encounter Data

Question: How will DHCS evaluate Managed Care Plans on timeliness requirements if DHCS requests resubmissions of encounter data from prior quarters or years?

- This measure is only calculated based on **original and accepted** encounter submissions; resubmissions are not considered for the timeliness measure.
- DHCS has set the threshold for timeliness of original and accepted encounters at 90%.
- If Plans are submitting encounters that are DENIED and Plan Systems did not validate Provider claim as expected (prior to sending to DHCS PACES), the QMED score should reflect poor timeliness of data.

Questions on Denied Encounters Turnaround Time Measure

Denied Encounters Turnaround Time Measure

- **Context:**
  - September 24, 2025, webinar MCP questions on the Denied Encounter Turnaround Time Measure
  - Percentage of **resubmitted encounters that have been denied but corrected** within 15 days
- **Contractual Requirement:**
  - "Contractor must ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law."

Denied Encounter Turnaround - Professional Encounters

$$\left(\frac{\text{Num. of 837P encounters denied in the reporting quarter BUT corrected within 15 days of PACES VRF}}{\text{Num. of 837P encounters denied in the reporting quarter that are } \mathbf{correctable}} \right) * 100$$

Note: *There are two separate measures for Denied Encounter Turnaround Time – one for professional encounters and one for institutional encounters; this slide only shows the calculation for the professional encounters measure.*

Definition of “Correctable”

Question: Will we get a definition of “correctable”?

- “Correctable” encounters include all encounters except for those that are:
  - Denied replacement encounters
  - Denied void encounters
  - Encounter denied for invalid frequency type

- These types of encounters will not be included as part of the Denied Encounters Turnaround Time measure. More details are also included in the DHCS Documentation Center, PACES Error technical document.

Duplicate Rejections

Question: Are duplicate rejections considered correctable and included in calculations?

- Yes. Duplicates are considered correctable and are not one of the categories excluded from correctable encounters (as outlined on the prior slide).
- This means that duplicates should be addressed within 15 calendar days. If they are not addressed, they will not be included in the numerator for the timeliness of corrections measure.

Informational vs. Threshold Measures

Question: For QMED 2.0, if a plan's denial rate is under 5%, would the measure for the timeliness of denial corrections still be considered "Informational" as it is currently?

- To reduce complexity of measures, QMED 2.0 will not include Informational measures in the Report Card.
- At initial implementation of QMED 2.0, all measures are considered threshold measures, and MCPs will be held accountable for their performance across all measures, even if they have a denial rate less than 5%.
- Remains a contract requirement that Plans correct denied encounters within 15 days. This means being below 5% denial rate does not bypass contract requirements.

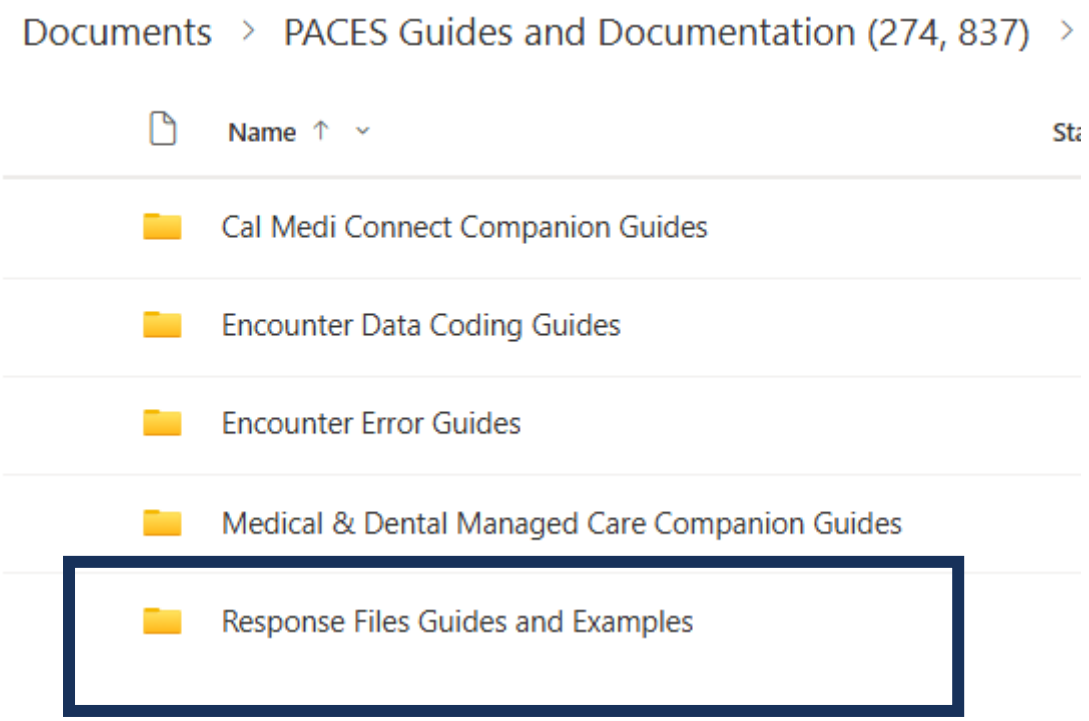
Denied Encounters Resources

Question: Do we have a document to define the exact error logic for claim and service line level for all error ids from DHCS?

DHCS Documentation Center

MMC-Encounter-Data-PACES-Validation-Response-File-Description v1.2.pdf

- The purpose of this document is to describe the DHCS PACES System's Encounter Validation Response (EVR) XML Schema Definition (XSD).
- The EVR XML files generated by PACES include outcomes of the data validation rules applied on the X12 HIPAA encounter transactions.
- This document describes the XSD used to structure the Encounter Validation Response XML documents.



QMED 2.0 Available Documentation

Question: Is QMED 2.0 documentation available and where is it located? Latest version we have is v1.2?

- To implement QMED 2.0, DHCS will be releasing an All Plan Letter (APL) that incorporates a methodology document providing detail on the QMED 2.0 measures and grading.
- The APL will be released for public comment. DHCS has previously presented to managed care plans on the proposed approach for QMED 2.0 which can be found across these three webinars:
  - Encounter Data Quality Improvement Efforts: Part One
  - Encounter Data Quality Improvement Efforts: Part Two
  - Encounter Data Quality Improvement Efforts: Part Three

Consequences to Low Quality Encounter Data

Question: If no plans pass - is there a bigger issue than contracting and what would be the consequences?

- DHCS has analyzed plan performance on the proposed measures and based on the current data that has been received there are some QMED 2.0 measures where all plans will fail.
- DHCS is building in time to ensure MCPs have a runway to bring encounter data quality standards into compliance.

EDIP Update

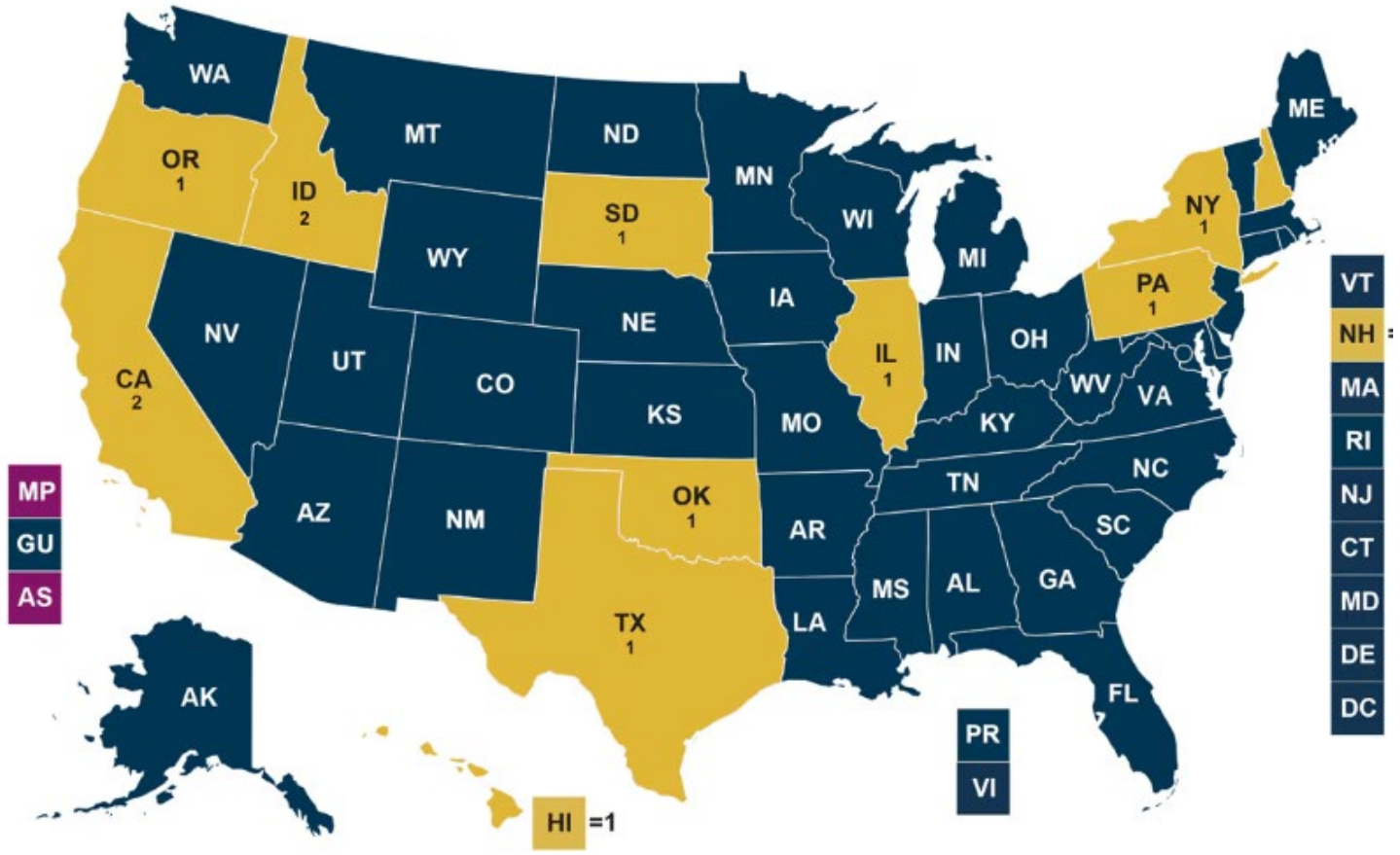
Debra Dixon
Chief, Data Quality Reporting Branch
Health Information Management Division

DHCS

EDIP Update

- Webinars
  - Various education topics
- Quality Measures for Encounter Data (QMED) 2.0
  - Updated score card
- Managed Care Hub Website
  - Resources for Plans
  - Public facing

Data Quality and T-MSIS



Meets OBA targets: Pass on critical priority, high priority and expenditures (N=43)

Does not meet OBA targets: Fail on critical priority (N=0)

Does not meet OBA targets: Fail on high priority and/or expenditures, pass on critical priority (N=11)

Does not yet submit T-MSIS Data

Data Quality and T-MSIS

- T-MSIS - The Centers for Medicare & Medicaid Services (CMS) requires all states* to submit data through the Transformed Medicaid and CHIP Statistical Information System (T-MSIS), including data on:
- Enrollment
- Demographics
- Service Utilization
- Payments
- Managed Care Plans
- Providers

- DQ Atlas - DQ (Data Quality) Atlas includes data quality information that supports insightful, methodologically sound analyses using the T-MSIS Analytic Files (TAF). Topics such as enrollment, claims, expenditures, and service use.

DHCS MCO Hub for Encounter Data Resources

Webpage Milestone	Timeline
Public Page go-live: Completed - QMED 2.0 Report Cards to be posted	1H 2026
Plan-Specific Webpage: Encounter Data Website Resources	1Q 2026

- Frequently Asked Questions
- DHCS News and Events Section
  - Data Quality Focus
  - PACES delays (file queues)
  - Upcoming Webinars
- Frequently Asked Questions
- Links to DHCS Documentation Center
- Data Quality Reports (QMED 2.0 and Encounter Data Monthly Reports)
- **X12 Encounter Data Training and Documentation**
- **Technical Support – Ticketing (no more e-mails!)**

Data Quality Reports

QMED

A program by the California Department of Health Care Services (DHCS) that evaluates the quality, accuracy, and timeliness of encounter data submitted by Managed Care Plans (MCPs) and their sub-plans (HCPs).

Overall compliance grade

Fail

Scoring: **Pass** - all HCPs pass threshold; **Fail** - at least one HCP does not pass threshold.

Managed care plan (MCP)

Anthem

Plan definition: Anthem Blue Cross operates as a Medi-Cal Managed Care Plan, contracted by DHCS to provide healthcare services to Medi-Cal members across many California counties. This managed-care model allows Anthem to coordinate your care through a network of primary care providers, specialists, hospitals, and other support services.

Measure performance overview

Measures name	Current	Q4 (2024)	Q3 (2024)	Q2 (2024)
U1 - Duplicate encounters	PASS	FAIL	PASS	FAIL
U2 - Duplicate service lines - INST	FAIL	PASS	FAIL	FAIL
U3 - Duplicate service lines - PROF	FAIL	FAIL	PASS	FAIL
C1 - Type 1 rending NPI	FAIL	PASS	PASS	FAIL
A1 - Denials not corrected	PASS	PASS	FAIL	PASS
R1 - Denied encounters	PASS	PASS	FAIL	FAIL
T1 - Denied turn around time - INST	FAIL	PASS	FAIL	PASS

Measure details

Duplicate encounters

HCP number	Current	Q4 (2024)	Q3 (2024)	Q2 (2024)
101	PASS (100%)	FAIL (62%)	FAIL (72%)	FAIL (88%)
102	FAIL (92%)	PASS (100%)	FAIL (56%)	PASS (100%)
103	PASS (100%)	FAIL (92%)	PASS (100%)	FAIL (92%)
104	FAIL (92%)	PASS (100%)	PASS (100%)	PASS (100%)
105	PASS (100%)	PASS (100%)	FAIL (12%)	PASS (100%)
106	FAIL (92%)	FAIL (99%)	FAIL (34%)	FAIL (92%)
107	PASS (100%)	FAIL (92%)	PASS (100%)	PASS (100%)

Questions – Please Put in Meeting Chat

DHCS

Next Webinar Preview

- **For November 2025, we will focus on Plan Data Feed.**
- Meeting Information
  - Date: November 19, 2025
  - Time: 10 a.m. to 11:30 a.m.

Please send any questions and comments to MCDSS@dhcs.ca.gov

Thank you!