ENCOUNTER DATA SUBMISSION FAQS FOR MEDICARE-MEDICAID PLANS PARTICIPATING IN THE FINANCIAL ALIGNMENT INITIATIVE

Updated September 30, 2020

Medicare-Medicaid Plans (MMPs) submit encounter data to CMS for all covered services. Plans submit data to CMS on different files based on whether the covered services are traditionally covered by Medicare vs. Medicaid (see Q4 below), and then further, by file type (see Q6 below). Please note that plans submit Prescription Drug Event data for Medicare Part D covered prescriptions separately, per standard Medicare requirements for those data.

Encounter data are critical for evaluation of the demonstrations under the Financial Alignment Initiative (FAI), and to accurately risk adjust Medicare payments.

This list of frequently asked questions shares lessons learned to date. The CMS MMP Encounter Team (in the Medicare-Medicaid Coordination Office [MMCO]) will update the FAQ as we identify additional strategies for improving the timeliness, accuracy, and completeness of MMP encounter data.

New MMPs: Timeframes for Testing, Certification, and Submission of Encounter Data

Q1: What is the timeline for Testing and Certification of Systems Access?

A: Testing and certification of MMP file structures enable access to the CMS encounter data submission system via Palmetto's Customer Service Support Center (CSSC) and may begin as early as 3 months prior to contract effective date.[1]

Q2: Where can I find Medicare Medicaid Plan enrollment packets and companion guides?

A: Plans can download MMP enrollment packets and companion guides from the Palmetto GBA website under the "Medicare-Medicaid (FAI)" section https://www.csscoperations.com/ . All MMPs are to enroll using the provided MMP enrollment packets, regardless of whether the organization has enrolled previously as a Medicare Advantage Plan.

Q3: How do Medicare Medicaid Plans establish connectivity?

A: Prior to submitting encounter data to CMS, MMPs and other entities establish a secure connection to CMS systems. MMPs and other entities use the electronic connection not only to submit data to CMS but also to receive front-end acknowledgement and processing status reports. The Customer Service Support Center (CSSC) works directly with MMPs after they establish connectivity and complete documentation, to ensure plans can complete testing/certification in a timely manner.

[1] Please see HPMS Memo Timeframes for Testing, Certification, and Submission of Encounter Data by MMPs dated 4/29/2014 "https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MMPTimeframesforTestingCertificationandSubmissionofEncounterDataGuidance043014.pdf"

Submitters complete an Electronic Data Interchange (EDI) Agreement with CMS and submit it to CSSC prior to submitting data. The EDI Agreement is a contract between the MMP or other entity and CMS attesting to the accuracy of the data submitted. An officer (e.g., CEO) that represents the MMP or other entity must sign this document. In addition, plans need to fill out the Submitter ID Application, and provide an Authorization Letter (if applicable).

Prior to submitting production files, anyone submitting encounter data (the MMP itself or a third party) must complete testing and certification. CSSC coordinates the application process as well as the testing and certification process.

MMP Submission Requirements

Q4: What are the primary requirements for submitting encounter data to CMS?

A: While MMPs administer an integrated plan, for administrative purposes (including accurate risk adjustment) MMPs distinguish and submit encounters for services primarily covered by Medicare on separate files from those benefits traditionally covered by Medicaid. As noted in our HPMS memo of July 26, 2013[2], however, MMPs have flexibility in establishing a reasonable methodology by which to attribute claims to a particular payer. CMS does not require that MMPs adjudicate each individual claim against separate coverage rules. MMP contracts stipulate that MMPs submit encounter data for Medicare and Medicaid institutional services (837I), professional services (837P), DME (837P DME), Medicaid Dental services (837D), and Medicaid additional drugs (NCPDP PA 4.2) to CMS at least monthly. MMPs (or their third party submitter) may choose to submit more frequently.

Q5: What are the capitation quality withhold requirements related to MMP encounter data submission?

A: CMS withholds a portion of the monthly Medicare and Medicaid capitation rates pending MMPs meeting certain performance metrics. These include meeting the encounter data submission requirements regarding frequency (i.e., at least monthly submission of each required file per Q7 below) and timeliness (i.e., within 180 days of the ending date of a given service). For details on quality withhold, please see the criteria in the Capitated Financial Alignment Model Quality Withhold Technical Notes for each Demonstration Year, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes

Q6: What are CMS' criteria for successful MMP submission of encounter data for purposes of quality withhold?

A: CMS has two main criteria: frequency and timeliness (a third – start date – is applicable only to new plans). Additional details on the two criteria are below.

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[2] Please see HPMS Memo Preliminary Guidance for Encounter Data Reporting for MMPs dated 07/26/13 https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MMPEncounterData.pdf

- Frequency: Plans submit one of each of the following files to CMS at least once per month (and may choose to submit more frequently)
    1. Medicare Institutional (837I)
    2. Medicare Professional (837P)
    3. Medicaid Institutional (837I)
    4. Medicaid Professional (837P)
- Timeliness: MMPs submit encounter data within 180 days from the ending date of service. This applies to all encounter submitted in the 8 files (Medicare and Medicaid institutional, professional, DME, Medicaid Dental, and Medicaid additional drugs (NCPDP)). We only count original accepted encounters. We do not count chart review encounters, voided, adjustments, or rejected encounters.

Please note that states may have additional requirements for encounter data submitted to them.

CMS encourages MMPs to work with their providers to ensure timely submission of claims.

Q7: What if an MMP has no encounters to report for the frequency criteria?

A: CMS will not penalize MMPs that have no encounters to report for a given month in one of the files noted above, e.g., since the previous month's submission, providers did not submit any new encounters and/or the MMP's encounter system has not fully processed new encounters. When CMS reaches out with the results of the quality withhold criteria for a given year, an MMP can certify in the attestation period that they don't have any encounters to submit in a particular file/month.

Q8: How do encounter submission requirements for MMPs differ from those of Medicare Advantage?

A: The frequency requirements are unique to MMPs; there are none for Medicare Advantage plans. MMPs must submit one of each of the 8 files monthly.

The timeliness requirements also differ:

- For MMPs, we calculate the percentage of encounters submitted within 180 days of the end date of service.
- For Medicare Advantage, there isn't a timeliness deadline for the submission of encounter data records.

Q9: What are the submission requirements for Part D Drug Events and Risk Adjustment Process Systems?

A: Part D Drug Events (PDEs) and Risk Adjustment Process Systems (RAPS) submissions for MMPs are the same as the existing Medicare requirement as documented on the CSSC Operations website https://www.csscoperations.com/internet/csscw3.nsf (under the corresponding tabs) and do not fall under separate demonstration guidelines.[3]

Q10: Are encounter submissions required for Risk Adjustment Process System records?

[3] See HPMS Memo Specific Expectations Concerning the Timely Submission of Encounter Data by Medicare-Medicaid dated 08/10/2016 https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Annual-Items/SysHPMS-Memo-Archive-2016-Qtr3

A: Risk Adjustment Processing System (RAPS) records are required for encounters with risk adjustment eligible services and/or CPT/HCPCS codes. Any RAPS record that does not have a corresponding matching Medicare Inpatient encounter may indicate an issue with the completeness of the encounters submitted by the plan. Additionally, MMPs only submit RAPS records for paid claims. MMPs do not submit RAPS for denied claims. Finally, MMPs submit any RAPS for unlinked chart review as Professional RAPS.

Q11: What are strategies to accurately assess if an encounter is a Medicare Skilled Nursing Facility service, or is a Medicaid Long Term Care nursing facility stay?

A: Medicare Skilled Nursing Facility (SNF) stays are those where the facility rendered skilled nursing or skilled rehabilitation services to the beneficiary. Traditional Medicare requires a qualifying inpatient stay within 30 days before admission into the SNF. However, in Medicare Advantage Organizations and Medicare-Medicaid Plans, CMS waives the requirement for an inpatient stay. Long Term Care (LTC) nursing facility stay encounters are for residential or custodial care in which the facility does not provide services related to skilled nursing or skilled rehabilitation to the beneficiary.

Ensuring Completeness for the Evaluation of the Financial Alignment Initiative

Q12: Why are encounter data so critical to the evaluation of the demonstrations?

A: The timely and complete submission of encounter data is critical to ensuring that the FAI's independent evaluator has the data input needed to analyze utilization rates for each capitated model demonstration.

Q13: What should an MMP do if experiencing a submission backlog?

A: If an MMP has a backlog of un-submitted original encounters, please contact the CMS MMP Encounter Team at MMCO_Encounter@cms.hhs.gov right away because the encounters are time sensitive for evaluation purposes. The evaluator needs to access complete encounter data to produce the analyses required for each demonstration. The CMS MMP Encounter Team will work closely with MMPs to facilitate the encounter submission process in order to assure that a complete set of encounters is available for analysis in the evaluation.

Q14: When will the MMP know the due date for encounters required for the next evaluation report?

A: The Contract Management Teams (CMTs) will be in touch with MMPs directly to convey the due date for encounters required for the period covered by the next evaluation report. (Please note, all data are required, this is only to help with prioritization as it pertains to the interim goal of receiving data needed for the reports).[4]

Q15: What additional support and engagement does CMS provide to MMPs to assure encounters are complete for a given demonstration year for evaluation purposes?

A: The CMS MMP Encounter Team will meet with each MMP bi-annually to work with their staff to assess and drive towards complete submission of encounters. The CMS MMP Encounter Team may share some or all of the following:

[4] Please see HPMS Memo Specific Expectations Concerning the Timely Submission of Encounter Data by Medicare-Medicaid dated 08/10/16 https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Annual-Items/SysHPMS-Memo-Archive-2016-Qtr3

- The "MMP Utilization Comparison Charts," which contains the latest Medicare encounter claim counts observed in the CMS' IDR for a particular MMP for a given demonstration year. This report is different from the Monthly Summary Error Report because it includes a greater level of granularity, showing the changing numbers of encounters submitted from demonstration year to demonstration year corresponding utilization rates, and the ratio by each file/service type submitted. It also includes the "Monthly Medicaid chart," which track utilization month to month for the period being analyzed. The CMS MMP Encounter Team will ask that MMPs review the report to determine if CMS has the same number (and types) of claims as those observed in the MMP's system, and to identify and submit any that remain.

- The Medicare Inpatient Risk Adjustment Processing System (RAPS) analysis. The CMS MMP Encounter Team may ask the MMP to identify missing Medicare Inpatient encounters for Inpatient RAPS that does not have a corresponding matching Inpatient encounter.

- The Skilled Nursing Facilities (SNFs) analysis of beneficiaries that did not have a valid inpatient discharge up to 90 days prior to SNF stay admission. The CMS MMP Encounter team will ask that MMPs review the report to identify if they are in agreement with CMS analysis. CMS also provides a subset of SNF analysis of beneficiaries without Skilled Nursing/Skilled Rehab services and ask the MMP to identify if the encounters are SNF or LTC.

Q16: What should MMPs expect when CMS is ready to assess encounter data completeness for a given year?

A: The CMS MMP Encounter Team follows up with an MMP shortly after sending the MMPs select analysis (see Q15) to that plan. The team utilizes the bi-annual calls with the MMP encounter subject matter experts to discuss any differences between the CMS and MMP encounter counts.

During that call, CMS asks the MMP to share the results of the encounter completeness research conducted in response to the reports that CMS shared. The CMS MMP Encounter Team requests MMP feedback about additional claims that the plan expects to submit, or MMP confirmation that the encounters that CMS currently observes in the IDR represent a complete set for a given demonstration period.

Monthly Summary Error Report

Q17: What are the "Monthly Summary Error Reports" and how will they assist MMPs with the encounter submission process?

A: In the spring of 2019, CMS transitioned from Quarterly Feedback Reports to providing the reports monthly. The reports provide individual MMPs with information about the encounters that CMS has processed from that plan. MMPs can use this summary report in conjunction with current submission feedback reports from CMS-Palmetto (Front-End 999/277CA reports and Back-End MAO-002 reports) that detail encounter record rejections, claim by claim.

The report reflects the previous month of encounter submission counts and lists the top errors so MMPs can focus on and correct the most frequent reason(s) for encounter record rejections. Correcting the most frequent errors will reduce the number of encounter re-submissions and maximize acceptance counts for present and future submissions. CMS organizes the report by Medicare and Medicaid record types, and by Professional, Institutional, DME, NCPDP, and Dental encounters. In addition, this report includes the Back End MAO top error codes in descending order of frequency.

Three additional items that CMS may discuss with MMPs after sharing the encounter reports:

1) Rejected encounters and encounters that need corrections for resubmission. These are MMPs' most frequent errors, as indicated in Monthly Summary Error Report for Encounter Data Submission. The CMS MMP Encounter Team can assist with resolving these errors. For example, if an MMP notes that it submitted more encounters than actually accepted into the IDR, the CMS MMP Encounter Team can provide Internal Control Numbers (ICNs) to help with the reconciliation process.

2) Enrolled beneficiaries who do not appear to have any encounters submitted so far. As with many who are dually eligible, MMP enrollees tend to have a high need for services, so CMS would generally expect them to utilize services shortly after enrollment. The No Encounters List identifies individuals without any reported encounters.

3) Third party sub-contractors who should be submitting encounters to MMPs or to CMS on an MMP's behalf. Sometimes these parties do not submit their encounters on a timely basis. CMS encourages MMPs to engage with their sub-contractor about timely submissions.

CMS will only share the information above if necessary.

Additional Technical Details on Feedback Reports

Q18: How does the CMS Monthly Summary Error report count the number of encounter claims submitted by file type?

A: For both the summary error as well as the Utilization Comparison reports, the data counts are of unique claims, not on individual service lines within a given claim. CMS uses the date of submission to determine the month of submission. The date of submission is in the first 5 digits (Julian Date) of the ICN that CMS returns to the MMP. Finally, CMS maps certain bill codes to file types; the Data Dictionary in Table 1 below indicates the bills included in each of the service lines.

Table 1
Encounter Submission Data Dictionary

File Type	Bills Included
Professional file	Encounters submitted for the 837 Professional bill for Medicare and Medicaid. Note: Plans submit Medicare Professional files and Medicaid Professional files separately.

Institutional file	Though one Institutional file is submitted for Medicare and one Institutional file is submitted for Medicaid, plans submit 4 different encounter types: 1) Inpatient services are on bill type 11 and 41. 2) Home health services are on bill type 32 and 33. 3) Skilled Nursing Facility (SNF) services are on bill type 18, 21 and 28. 4) The Outpatient file includes all the other encounters not included in 1-3 above.
Professional DME	Plans submit Medicare Professional DME files and Medicaid Professional DME files separately.
Dental	There is a separate file submission for Medicaid Dental.
Medicaid drugs	There is a separate file submission for Medicaid drugs.

Q19: What are TA1 Response Files?

A: The TA1 Response Files enable Palmetto to notify the MMP when there are problems with the interchange control structure of the Encounter Data file the MMP submitted. TA1 validation of the control segments occur as the Encounter Data file enters the Encounter Data Front End System (EDFES). The MMP receives a TA1 when there are syntax errors in the submitted Encounter Data file. Errors found in this level of the EDFES cause the entire Encounter Data file to reject with no further processing.

Q20: What are 999 Response files?

A: After the Encounter Data file passes the TA1 Edits, the next level of EDFES is to apply Combined Common Edits AND Enhancements (CCEM) edits and verify the syntactical correctness of the functional group(s) (GS\GE). Functional groups allow for organization of like data within an interchange; therefore, plans can populate more than one (1) functional group with multiple encounters within the functional group in an Encounter data file. The 999 response file provides information on the validation of the GS\GE functional group(s) and the consistency of the data. The 999 response file provides MMPs information on whether CMS accepted or rejected the functional group(s).

If a file has multiple functional groups and errors occurred at any point within one of the syntactical level edit validations, the functional group will reject, and processing will continue to the next functional group. For instance, if an MMP submits an encounter data file with three (3) functional groups and there are errors in the second functional group, the first functional group will accept, the second functional group will reject, and processing will continue to the third functional group.

Q21: What are the 277CA Response Files?

A: After the encounter data file accepts at the interchange (TA1) and functional group (999) levels, the third level of editing at the EDFES occurs at the transaction set level within the CCEM in order to create the claim Acknowledgement Transaction (277CA) response file. The CCEM checks the validity of the values within the data elements. For instance, data element N403 must be a valid nine (9)-digit ZIP code. If a non-existent ZIP code is populated, the CCEM will reject the encounter. The 277CA Response Files acknowledges the acceptance or rejection of encounters the MMP submits, and the system provides them both Medicare and Medicaid

encounter files. If the system rejects encounters, the 277CA Response File provides the error codes that identify reason for the encounter rejection.

Q22: How does CMS' encounter counts related to the accepted encounters from the MAO-002 Report or 277CA Response File?

A: For MMP Medicare encounter data records, the count of accepted records is in the MAO-002 report. The MAO-002 report includes record and line level information on both accepted and rejected records and lines. For MMP Medicaid encounter data records, the count of accepted records is in the 277CA Response Files.

Both the MAO-002 Report and the 277CA Response File enable MMPs to track the encounters that they have submitted, and reconcile rejected and accepted submissions. MMPs can then then correct and resubmit rejected records to CMS, and track them to net an accurate count of submissions accepted by CMS.

Q23: Does CMS based its counts on the Date of Service at the Claim Header or Claim Line?

A: CMS bases its counts on the Claim Header level.

Q24: Does CMS base its counts on the Begin or End Date of Service?

A: CMS bases its counts on the End Date of Service and accepted status.

Q25: What are the Type of Bills associated with Institutional Outpatient Encounters?

A: The Types of Bills for Institutional Outpatient Encounters do not include inpatient (11, 41), Home Health (32, 33), and Skilled Nursing Facility (18, 21 and 28). Institutional Outpatient represent all the bills that are not bucketed into the other service lines.

Q26: Are multiple void encounters for the same encounter accepted or rejected by CMS?

A: Plans can void an original or adjusted encounter. However, plans can only void a Medicare encounter once, so CMS will reject subsequent voids to an already voided Medicare encounter in the MAO-002 report. CMS does not process Medicaid encounters through MAO processing so multiple voids are allowed.

Q27: Are MMPs required to submit encounter data if the MMP denies the claim?

A: CMS does not require MMPs to submit encounter data on denied claims.[5]

Contacts for Additional Questions

Q28: Whom should I contact for issues during the submission process?

A: Please bring any unexpected issues encountered during the submission of encounter data to the attention of the staff at CSSC Operations (1-877-534-2772 or csscoperations@palmettogba.com)

[5] Please see HPMS Memo Additional Information on Reporting of Encounter Data by Medicare Medicaid Plans (MMPs) dated 10/24/13 https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MMPEncounterData2.pdf

for resolution.

Q29: Whom should I contact with MMP encounter-related questions or concerns?

A: Please notify the CMS MMP Encounter Team at MMCO_Encounter@cms.hhs.gov, and copy the CMS state lead.