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

September 22, 2017

Medicare-Medicaid Plans (MMPs) submit encounter data to CMS for all covered services. Data must be submitted on different files based on whether they are traditionally covered by Medicare vs. Medicaid (see Q1 below), and then further, by file type (see Q3 below). Please note that Prescription Drug Event data for Medicare Part D covered prescriptions must be submitted separately, per standard Medicare requirements for those data.

Encounter data are critical to supporting effective evaluations of the demonstrations using the capitated model of the Financial Alignment Initiative (FAI), and are also used to risk adjust Medicare payments.

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

MMP Submission Requirements

Q1: 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), CMS requires MMPs to 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[1], however, MMPs have flexibility in establishing a reasonable methodology by which to attribute claims to a particular payer. CMS does not require that each individual claim be adjudicated against separate coverage rules.

Q2: 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 Q3 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 Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes for Demonstration Year 1 and Demonstration Years 2-3, which are available here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

[1] Please see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MMPEncounterData.pdf

Q3: What are CMS' Requirements for successful MMP Submission of Encounter Data for purposes of quality withhold?

A: CMS has two main requirements: frequency and timeliness (a third – start date – is applicable only to new plans). The two requirements are discussed in more detail below.[2]

- Frequency: Plans must 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. Medicare DME (837P DME)
  4. Medicaid Institutional (837I)
  5. Medicaid Professional (837P)
  6. Medicaid DME (837P DME)
  7. Medicaid Additional Drugs (NCPDP PA 4.2)
  8. Medicaid Dental services (837D; if a covered service)
- Timeliness: MMP encounter data must be submitted within 180 days from the ending date of service.

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

Q4: What if an MMP has no encounters to report in one of the required files?

A: CMS will not penalize MMPs that have no encounters to report in one of the required 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.

Q5: How do encounter submission requirements for MMPs differ from those of Medicare Advantage?

A: The frequency requirements are similar to those for Medicare Advantage plans and for MMPs, though for MMPs these also apply to the Medicaid files. The timeliness requirements do differ: for MMPs, each encounter must be submitted within 180 days of the end date of service. For Medicare Advantage, the deadline for the submission of encounter data records is the final risk adjustment data submission deadline, which is announced annually by CMS but is no earlier than January 31 of the year following the payment year.

Rolling Three-Month Feedback Reports

Q6: What are the "Rolling Three Month" Feedback Reports on Processing of MMP Encounter Data and how will they assist MMPs with the encounter submission process?

A: In early 2017, CMS created two new Feedback Reports to provide individual MMPs with information about the encounters that CMS has processed from that plan. There are two categories of reports, both of which provide MMPs with tools to target identifying missing encounters. The first report focuses on encounters submitted but not successfully processed; the second report identifies beneficiaries for whom encounters were never submitted during the three month period (see further down in this response for additional details). The goal is to

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

ensure that CMS' and MMP's encounter submission figures match, and to identify any discrepancies early in the submission process, so they can be addressed on a flow basis. These reports are further described in the HPMS memo dated 3/15/2017 titled "New Feedback Reports on Medicare-Medicaid Plan Encounter Submissions." [3]

The Feedback Reports are generated on a rolling basis, as follows:

April, July, October, January
- California
- South Carolina
- Texas

May, August, November, February
- Massachusetts
- Michigan
- Ohio
- Rhode Island
- Virginia

June, September, December, March
- Illinois
- New York

The two Feedback Reports are:

1. MMP Error Report for Encounter Data Submission: This report includes information regarding the degree to which encounters from the three most recent months were successfully transmitted, for each major step of the processing of those data. This report helps MMPs to easily identify rejected encounters and errors and expedite correction and resubmission.

   The Error Report includes:

   - Counts of the following:
     - Total number of encounters received;
     - Total number of encounters rejected by CMS' Front End System (with front end acceptance checks conducted by Palmetto, GBA);
     - Total number of encounters rejected by the Back End System, (only Medicare encounters are handled through CMS' Encounter Data Processing System (EDPS), with back end checks using the MAO 002 reports); and
     - Total number of encounters successfully loaded into the CMS Integrated Data Repository (IDR) from the three most recent months prior to the send and distribute date.

[3] Please see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MMPEncounterDataSubmissionsFeedbackReports03152017.pdf

- The Top Error Codes and descriptions triggered by the Front End System and Back End System (for Medicare only).

The data on these reports pinpoints for MMPs where an intended acceptance may have failed, to help MMPs more quickly identify where to focus resources to resolve outstanding submission issues.

2. The No Medicare/Medicaid Encounters List: Given that dually eligible individuals tend to be a group with a high need for services, CMS would expect that they would generally begin to use services not long after enrolling in an MMP. With this in mind, CMS analyzes the encounter data that MMPs submit to CMS and identifies beneficiaries for whom there were no encounters submitted for a given calendar year.

   CMS shares password-protected No Medicare/Medicaid Encounter List with MMPs that identifies each beneficiary with zero Medicare and Medicaid Encounters ever reported. CMS asks affected MMPs to research the list of zero encounter beneficiaries in order to identify and submit any "missing" encounters. If no encounters are found, CMS requests that MMPs share their thoughts regarding why this group of beneficiaries has no record of receiving services.

Ensuring Completeness for the Evaluation of the Financial Alignment Initiative

Q7: Why are encounter data so critical to the evaluation of the demonstrations?

A: Timely and complete submission of encounter data is critical to ensuring the independent evaluator, RTI International, can analyze utilization rates for each capitated model demonstration.

Q8: 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 right away because the encounters are time sensitive for evaluation purposes. RTI needs access to complete encounter data to produce the required annual report for the evaluation of each demonstration. The CMS MMP Encounter Team aims to work closely with MMPs to facilitate the encounter submission process in order to assure that a complete set of encounters are available for analysis in the evaluation.

Q9: 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 reach out to each MMP to work with their staff to assess and drive towards complete submission of encounters for that year. The CMS MMP Encounter Team will share the "MMP Encounter Claims Count for DY*," which contains the latest encounter claim counts observed in the CMS' IDR for a particular MMP for a given demonstration year. This report is different from the two Rolling Three Month Feedback Reports (see Q6) because it includes a greater level of granularity, showing the changing numbers of encounters submitted over time, corresponding utilization rates, and the ratio by each file/service type submitted. The CMS MMP Encounter Team will ask that MMPs carefully

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.

Q10: What should MMPs expect when CMS is ready to assess encounter data completeness for a given demonstration year?

A: The CMS MMP Encounter Team follows up with an MMP shortly after sending the MMP Encounter Claims Count for DY* report (see Q9) to that plan. The team schedules a call with 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.

Three additional items that CMS discusses 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 MMP Error Report for Encounter Data Submission. The CMS MMP Encounter Team can assist with resolving these errors. For example, if an MMP notes that a greater number encounters were submitted than were actually accepted into the IDR, the CMS MMP Encounter Team can provide Internal Control Numbers (ICNs) to help with the reconciliation process. CMS might also suggest that MMPs send an encounter status update by file type and quarter to CMS in response to the "Rolling Three Month" Feedback Report (see Q6).

2) Enrolled beneficiaries who do not appear to have any encounters submitted so far. Given their dual eligible status, MMP enrollees often tend to have a high need for services, so CMS would generally expect them to be utilizing services shortly after enrollment. These individuals are identified in the No Medicare/Medicaid Encounters List.

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, so CMS encourages MMPs to closely engage with them about the need to do so.

Additional Technical Details on Feedback Reports

Q11: How does a CMS feedback report count the number of encounter claims by file type?

A: For both the rolling three-month as well as the demonstration year reports, the data counts are based on unique claims, not on individual service lines within a given claims. CMS uses the ending date of service (DOS) to determine the month of submission. Finally, CMS maps certain bill codes to file types; the Data Dictionary in Table 1 below indicates which bills are included in each of the service lines.

Table 1 Encounter Submission Data Dictionary	
File Type	Bills Included
Professional file	Everything encounter submitted for the 837 Professional bill for Medicare and Medicaid. Medicare Professional files and Medicaid Professional files are submitted separately.
Institutional file	Though one Institutional file is submitted, it is broken down into 4 different encounter types: 1) Inpatient services are captured 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	There is a separate file submission for Professional DME.
Dental	There is a separate file submission for Dental.
Medicaid drugs	There is a separate file submission for Medicaid drugs.

Q12: What are TA1 Response Files?

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

Q13: 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, more than one (1) functional group with multiple encounters within the functional group can be populated 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 the functional group(s) were accepted or rejected.

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 Encounter data file is submitted 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.

Q14: 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 are used to acknowledge the acceptance or rejection of encounters submitted, and are provided for both Medicare and Medicaid encounter files. If encounters are rejected, the 277CA Response File provides the error codes that identify why the encounter was rejected.

Q15: Are CMS's encounter counts based on 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. All rejected records should be corrected and resubmitted to CMS, and tracked to net an accurate count of submissions accepted by CMS.

Q16: Are CMS's counts based on the Date of Service at the Claim Header or Claim Line?

A: They are based on the Claim Header level.

Q17: Are CMS's counts based on the Begin or End Date of Service?

A: They are based on the End Date of Service, the Claim Thru Date, and accepted status.

Q18: 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). Hospice services are not covered by the demonstration (i.e., they are carved out and covered by Original Medicare) so Type of Bills 81 and 82 are also excluded. Institutional Outpatient represent all the bills that are not bucketed into the other service lines.

Q19: Are multiple void encounters for the same encounter accepted or rejected by CMS?

A: CMS can accept a regular 837P/I submission when multiple void encounters negate the same encounter. However, an encounter can only be voided once, so encounters voided more than once will be rejected in the MAO-002 report.

Contacts for Additional Questions

Q20: Who should I contact with MMP encounter-related questions or concerns?

A: Please notify the CMS MMP Encounter Team members Joe Del Pilar (joseph.delpilar@cms.hhs.gov), Larry Chan (larry.chan@cms.hhs.gov), or Lisa Briggs (lisa.briggs@cms.hhs.gov), and copy the CMS state lead.