21. ENCOUNTER DATA REPORTING

A. Encounter Data Submission Requirements

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) IPAs.

POLICY:

A. IEHP ensures complete, accurate, reasonable, and timely submission of encounter data for all items and services furnished to its Members, whether directly or through its IPAs, including capitated Providers.

B. On an annual basis, IEHP re-evaluates the validity and adequacy standards based on state and federal regulatory changes, results of the Healthcare Effectiveness Data and Information Set (HEDIS®) audit and historical encounter data experience.

C. IEHP is responsible for monitoring and picking up all response files in a timely manner.

PURPOSE:

A. IPAs are required to submit this accurate encounter data to enable IEHP to comply with regulatory requirements, capture data for various medical programs, and help improve medical and financial performance in a timely manner.

PROCEDURES:

A. IEHP must conform with the Center for Medicare and Medicaid Services (CMS) Quality Measures for Encounter Data.[1]

B. IPAs must submit, via Secure File Transfer Protocol (SFTP), the appropriate encounter information in the Health Insurance Portability and Accountability Act (HIPAA) Compliant 837 Version 5010 transaction set format (ASC X12 Health Care Claim Type 3 Technical Report (TR3)), referred to as the Implementation Guide (IG). This is in conformance with the IEHP companion guide as outlined by IEHP's Electronic Data Interchange (EDI) Manual and Encounter Data Companion Guide.

C. Encounter and utilization data must be submitted to IEHP within three (3) months after the month in which services are rendered to a Member.

D. IPAs must submit data for *all* covered services provided to a Member, including Primary Care Provider (PCP) visits and delegated services.

E. Each month, the encounter data submitted to IEHP must meet three (3) requirements as set forth by IEHP**: Timeliness, Validity,** and **Adequacy**. Each month is reviewed on an aggregate basis.

[1] State Medicaid Agency Contract (SMAC), Exhibit A, Attachment 1, Provision 17, Medicare Encounter Data Requirements

21. ENCOUNTER DATA REPORTING

A. Encounter Data Submission Requirements

1. **Timeliness:** Encounter data Timeliness is measured by the lag time based on days, between the Date of Service (DOS) and the Submission Date to IEHP. IEHP analyzes the percentage of encounters by four lag categories.
2. The four lag categories are:
   a. % encounters where lag time is zero to 90 days
   b. % encounters where lag time is zero to 180 days
   c. % encounters where lag time is zero to 365 days
   d. % encounters where lag time is greater than 365 days

Expected Outcome				
File Type	**Lag of 0 to 90 Days**	**Lag of 0 to 180 Days**	**Lag of 0 to 365 Days**	**Lag > 365 Days**
Institutional	60%	80%	95%	5%
Professional	65%	80%	95%	5%

3. **Validity:** A compilation of the initial monthly submission and any subsequently corrected data for the same receipt month must be at minimum 95% valid.
4. **Adequacy:** A compilation of valid data received within the month for the specified timeframe, must meet 100% of the following adequacy standards:

Encounter Category	PMPY Standard	Provider
Facility Encounters – Total	**2.29**	IPA
Inpatient Facility	0.26	IPA & Hospital
ER Facility	0.79	IPA & Hospital
Other Facility	1.24	IPA
Professional Encounters - Total	**16.00**	IPA
Evaluation & Management	9.00	IPA
Lab & Radiology	4.00	IPA
Other Professional	3.00	IPA

*Per Member Per Year (PMPY) = encounters / member months x 12

**Adequacy standards based on state/federal regulatory guidelines, HEDIS® audit results and historical encounter data experience.

F. Within three (3) business days of receipt of the encounter data file, IEHP processes the data and places error reports that summarize the data received and rejected due to errors on the SFTP portal in the IPA's specified file location.

G. IEHP utilizes the "Official ICD-10-CM Guidelines for Coding and Reporting" as part of the validation process.

H. Age and gender rules for Current Procedural Terminology (CPT) codes will be enforced.

I. For all IPA medical encounters, the Individual ('person type') National Provider Identifier (NPI) is required to be submitted as Provider ID for Billing and Rendering Provider.[2] According to ASC X12 837 Implementation Guides the exceptions are limited to the atypical providers. Examples: taxi drivers, carpenters, personal care providers, etc.

J. For all hospital encounters, the Individual ('person type') NPI, must be submitted as the "Attending Provider ID."

K. For all hospital encounters, the Individual ('person type') NPI must be submitted as the "Rendering Provider" or the "Operating Provider."

L. It is the responsibility of the IPA to retrieve the error reports; then correct and resubmit the encounter data rejected due to errors within the specified timeframe. All encounters that are rejected MUST be resubmitted, regardless of whether or not the threshold has been met (See EDI Manual Section 7C, "Encounter Data File Due Date Schedule" for timeframes)[3].

M. In addition, IEHP places reports on the SFTP portal that indicate whether or not the validity and adequacy standards have been met. These reports identify if a standard has not been met in a given month.

N. IEHP works with each IPA to ensure that any problem areas can be corrected in a timely manner. For assistance in working through the details of encounter submission, e-mail the IEHP Encounter IT – Production Support Team at EncounterData@iehp.org.

O. Failure to submit encounter data that meets IEHP's submission requirements for Timeliness, Validity, and Adequacy may result in IEHP temporarily deducting one percent (1%), unless successfully appealed, of the Provider's monthly capitation for the first month the encounter data fails to meet the Timeliness, Validity, or Adequacy requirements. IEHP may deduct three percent (3%) of the Provider's monthly capitation for the second month, and five percent (5%) for each subsequent month the encounter data fails to meet the Timeliness, Validity, or Adequacy requirement and notified by issuance of an Encounter Data Penalty Letter. If the IPA has failed to meet the Timeliness, Validity and Adequacy standards for six (6) consecutive months during the calendar year, the Provider may be ineligible to participate in the IPA Pay for Performance Program (P4P).

    1. If the IPA is able to meet the adequacy and validity requirements at the end of the year through the submission of additional encounter data, the Provider may be eligible to receive half of the total amount of capitation deducted during the calendar year.

[2] Centers for Medicare and Medicaid Services (CMS), "Standard Companion Guide Transaction Information: Instructions related to the 837 Health Care Claim: Institutional Transaction based on ASC X12 Technical Report Type 3 (TR3), version 005010A2," January 30, 2018

21. ENCOUNTER DATA REPORTING

A. Encounter Data Submission Requirements

P. HEDIS® medical record abstraction data will be used to identify "missed" encounters. IPAs found to have more than 25% of encounters unsubmitted may be notified by issuance of an Encounter Data Corrective Action Plan (CAP) Request Letter and required to submit a Corrective Action Plan (CAP) outlining the steps taken to resolve the issue.

Q. IPAs will need to provide primary source verification data to IEHP upon request to support encounter data validation activities.

R. Additionally, when encounter data does not meet the submission requirements for either Validity of any two (2) months of receipt in a rolling four (4) month period, or Adequacy for any two (2) months of service in a rolling four (4) month period, or if IEHP identifies any other systemic data completeness issues, IEHP may request a CAP from the IPA to remedy the problem, as follows:

1. IEHP sends an Encounter Data CAP Request Letter to the IPA requesting a CAP the following:
    a. The months that the encounter data did not meet the requirements;
    b. The dates when the encounter data was due to IEHP;
    c. The file names for all encounter data files that did not meet the requirements;
    d. The reasons the encounter data did not meet the requirements, whether it be timeliness, validity, adequacy, or a combination of the three (3);
    e. The date the CAP is due to IEHP; and
    f. Request for submission of valid and adequate encounter data for the timeframes in question.
2. The IPA must submit a CAP to IEHP within 30 days from the date of the CAP Request letter. The CAP must include the following:
    a. The name of the person responsible for implementing the CAP;
    b. A list of specific actions to be taken to ensure that encounter data meets the submission requirements;
    c. Completion dates for each of the corrective actions; and
    d. A valid and adequate encounter data file.
3. IEHP sends the IPA a letter of acceptance or rejection of the CAP within 30 days of receipt of the CAP.
    a. IEHP includes the specific reasons for rejection of any CAP.
    b. Any rejected CAP must be resubmitted within 15 days to IEHP.
    c. Timeframes can be altered at the discretion of IEHP depending on specific circumstances.

4. IPAs who fail to submit an acceptable CAP within the required timeframes and/or valid and adequate encounter data, are frozen to new enrollment until such time that the CAP and/or data is approved and meets standards.

S. IPAs that receive a request for CAP twice within a one (1) year period are immediately frozen to enrollment and are subject to one of the following actions:

1. IPAs are required to subcontract with a Management Services Organization (MSO) or Third-Party Administrator (TPA) for handling and submitting encounter data;
2. Hospitals are required to convert from a Capitated contract to a Per Diem Agreement; or
3. Termination of the IEHP Capitated Agreement.

T. IPAs wishing to appeal an adverse decision may do so in accordance with Policy 16C3, "Grievance and Appeal Resolution Process for Providers – IPA, Hospital and Practitioner." Providers must cite specific reasons for their appeal.

U. For a comprehensive outline of the SFTP, Encounter Data error reports, etc., please refer to the EDI Manual located on IEHP website.

V. The responsibility for Encounter Data reporting as outlined above continues until all services rendered during the timeframe of a Capitated Agreement have been reported.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2007	
Revision Effective Date:	January 1, 2024	

21. ENCOUNTER DATA REPORTING

B. Medicare Risk Adjustment and Hierarchical Condition Categories

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Providers, Provider Subcontractors and Independent Physician Associations (IPAs).

POLICY:

A. IEHP and its Provider network are responsible for providing accurate encounter and medical record data to support Centers for Medicare & Medicaid (CMS) Medicare risk adjustment data validation and audits.[1]

B. CMS selects a subset of Part C contracts for each annual Improper Payment Measure (IPM) audit cycle. Members are sampled from each health plan to estimate payment error related to risk adjustment. Once the Members have been selected, IEHP is required to submit medical records to support all CMS-Hierarchical Condition Categories (HCCs) in the sampled beneficiaries' risk scores for the payment year.[2]

C. Additionally, each IPA and subcontractor will be required to fully comply with and participate in any auditing and monitoring activities performed by IEHP and/or CMS or other State or Federal agencies, consistent with IEHP's contract with CMS and in compliance with IEHP's Medicare Advantage contractual requirements.

PROCEDURES:

A. CMS uses the International Classification of Diseases Tenth Revision (ICD-10 CM) diagnostic codes to calculate a risk score for each Medicare Advantage beneficiary that reflects his or her overall health status on an annual basis.[3] Payments from CMS are based on Member risk scores. It is therefore important that all encounter and supplemental data submitted includes as much detail as possible. IEHP conducts regular reviews of medical records to validate that the diagnosis codes reported to CMS are accurate and supported in the medical record with appropriate documentation consistent with CMS medical record coding standards. All ICD codes for existing and chronic conditions should be documented at least once each calendar year for each Medicare patient and shall have sufficient documentation in the medical record to support the diagnoses. All diagnoses codes should be submitted to IEHP via encounter and/or supplemental data submissions within ninety (90) days from the date of service.[4]

[1] Health Plan Management System (HPMS) Memo, "Contract-Level Risk Adjustment Data Validation Medical Record Reviewer Guidance," March 20, 2019
[2] Ibid.
[3] American Academy of Professional Coders (AAPC): HCC Model https://www.aapc.com/risk-adjustment/hcc-model.aspx
[4] HPMS Memo, "Contract-Level Risk Adjustment Data Validation Medical Record Reviewer Guidance," March 20, 2019

21. ENCOUNTER DATA REPORTING

B. Medicare Risk Adjustment and Hierarchical Condition Categories

B. IPAs are responsible for ensuring that risk adjustment data submitted to IEHP is complete and accurate and is supported by medical record documentation, consistent with CMS medical record coding guidelines/standards.[5]

C. Each IPA and subcontractor shall ensure that all encounter and supplemental data are submitted to IEHP consistent with Policy 21A, "Encounter Data Submission Requirements."

D. The IPA or subcontractor shall not only conduct its own auditing and monitoring activities but shall comply with and actively participate in all IEHP and CMS audits, including but not limited to ensuring:

1. Availability of and access to its administrative staff and Providers;
2. Access to its Provider offices and Provider medical records within the scope of the audit; and
3. Timely response to all interview and medical record (and other documentation) requests.

E. Part C Improper Payment Measure (IPM): CMS performs both National and Contract data validation audits to verify that information submitted by Medicare Advantage Organizations is supported by the patient's medical record documentation. This ensures the integrity and accuracy of risk adjusted payments to the Medicare Advantage Organization (MAO). CMS notifies IEHP when any IEHP Members are included in a IPM audit. If any IEHP Members are included, IEHP may request medical record documentation, including signed attestations from the IPA or its Providers.

1. Given that there may be associated fines or penalties associated with any failed IPM audit, each IPA or subcontractor will be responsible for the respective fines or penalties associated with each of its Members selected for the audit.
2. Based on any CMS IPM audit findings and associated penalties (if applicable) IEHP may pass on these financial penalties to the IPA or subcontractor, based on the membership assignment of the IPA or subcontractor and service/assignment dates impacted by the penalties.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☒ CMS
	☒ DMHC	☐ NCQA
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Revision Effective Date:	January 1, 2024	

[5] HPMS Memo, "Contract-Level Risk Adjustment Data Validation Medical Record Reviewer Guidance," March 20, 2019

21. ENCOUNTER DATA REPORTING

C. Encounter Data Submission Requirements for Directly Contracted Capitated Providers

APPLIES TO:

A. This policy applies to all directly contracted and capitated IEHP DualChoice (HMO D-SNP) Providers.

POLICY:

A. IEHP ensures complete, accurate, reasonable, and timely submission of encounter data to Center for Medicare and Medicaid Services (CMS) for all items and services furnished by directly contracted capitated Providers to its Members.[1]

PURPOSE:

A. Directly contracted capitated Providers are required to submit accurate encounter data to enable IEHP to comply with regulatory requirements, capture data for various medical programs and help improve medical and financial performance in a timely manner.

DEFINITION:

A. Directly contracted Capitated Providers - Providers with a capitation agreement with IEHP for services including: Primary Care Services, Laboratory Services, Dental Services, Pharmacy services, Inpatient and Outpatient Services.

PROCEDURES:

A. IEHP must conform with the Centers for Medicare and Medicaid Services (CMS) Quality Measures for Encounter Data.

B. Directly contracted capitated Providers must submit the CMS 1500 or EDI form and all appropriate encounter information to IEHP within 30 days after the month in which the services are rendered to a Member. Submission can be done through IEHP's secure Provider portal or via mail to the IEHP Claims Department at P.O. Box 4349 Rancho Cucamonga, CA 91729-4349.

C. Directly contracted capitated Providers must submit data for all covered services provided to a Member, including Primary Care Provider (PCP) visits and sub-capitated services, and must include all available diagnosis codes related to the service provided.

D. Each month, the encounter data submitted to IEHP must meet the following three (3) requirements as set forth by IEHP: **Timeliness, Validity,** and **Adequacy**. Each month is reviewed on an aggregate basis.

[1] State Medicaid Agency Contract (SMAC), Exhibit A, Attachment 1, Provision 17, Medicare Encounter Data Requirements

1. **Timeliness**: 100% of encounter data must be received by IEHP within 30 days after the month in which services are rendered to IEHP Members.
2. **Validity:** A compilation of the initial monthly submission and any subsequently corrected data for the same receipt month must be at minimum 95% valid.
3. **Adequacy**: A minimum quantity of encounters in a specified time frame. All Capitated Providers are targeted to submit a minimum of 3.0 primary care encounters per Member per year.

E. On an annual basis, IEHP re-evaluates the adequacy standards based on state regulatory changes, results of the Healthcare Effectiveness Data and Information Set (HEDIS®) audit and historical encounter data experience.

F. IEHP utilizes the "Official ICD-10-CM Guidelines for Coding and Reporting" as part of the validation process.

G. Age and gender rules for Current Procedural Terminology (CPT) codes will be enforced.

H. For all medical encounters submitted, the Provider's individual National Provider Identifier (NPI) is required to be submitted as the "Rendering Provider ID."

I. IEHP monitors and works with each Provider to ensure that any problem areas can be corrected in a timely manner. For assistance in working through the details of encounter submission please e-mail the IEHP Encounter Team at EncounterData@iehp.org.

J. When encounter data does not meet IEHP's submission requirements for timeliness or adequacy, IEHP may request a Corrective Action Plan (CAP) from the Provider. The Provider must submit a CAP within 30 days from the date of the CAP Request letter. The CAP must include the following:

1. The name of the person responsible for implementing the CAP;
2. A list of specific actions to be taken to ensure that encounter data meets the submission requirements;
3. Completion dates for each of the corrective actions; and
4. A valid and adequate number of encounters.

K. Directly contracted capitated Providers who fail to submit an acceptable CAP within the required timeframes may be frozen to new enrollment until such time that the CAP is approved and meets standards. Capitated Providers that continue to be non-compliant with encounter data submission will result in conversion from PCP capitation to a fee-for-service arrangement with IEHP.

L. Directly contracted Capitated Providers wishing to appeal an adverse decision may do so in accordance with Policy 20A2, "Claims Processing – Provider Payment Dispute Resolution." Capitated Providers must cite specific reasons for their appeal.

21. ENCOUNTER DATA REPORTING

C. Encounter Data Submission Requirements for Directly Contracted Capitated Providers

M. The responsibility for Encounter Data reporting as outlined above, continues until all services rendered during the timeframe a Capitated Agreement was in place are reported.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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