CHAPTER 1 – OVERVIEW

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1. Introduction

The HFS Encounter Submission Manual (Manual) is a resource for Illinois Medicaid managed care organizations (MCOs) that have a contract with the Illinois Department of Healthcare and Family Services (HFS) to provide services to enrolled members in the HealthChoice Illinois program and the Medicare-Medicaid Alignment Initiative (MMAI). The Manual outlines the methods for submission and correction of encounter data as required by HFS. It contains sections addressing encounter submission, file specifications, void and resubmission requirements, and other encounter related subjects.

2. Encounter Definition

An encounter is record of a claim that has been adjudicated by an MCO for a health care related service rendered by a provider enrolled with HFS to an HFS member enrolled with that MCO on the date the service was provided. An encounter is a record of either a claim that was paid or administratively denied by the MCO.

3. Purpose of Encounter Data Collection

Submission of encounter data to HFS is a mandatory requirement established by the Centers of Medicare and Medicaid Services (CMS) and is the responsibility of the MCO pursuant to its contract with HFS. Complete, accurate, and timely reporting of encounter data is critical to the success of the HFS managed care program. All HFS encounter data is housed in the HFS enterprise data warehouse (EDW). Encounter data is used for a variety of managerial and analytical purposes including but not limited to:

1. *Evaluate health care quality* - As with the fee for service (FFS) Medicaid program, the HFS managed care program is partially funded by CMS. The health care service utilization data is analyzed and used by CMS and HFS to evaluate quality of care.

2. *Evaluate MCO performance* - The data from encounter claims provides HFS with information to evaluate the performance of each MCO. For example, encounters are used to track specific services provided to members while enrolled with a particular MCO, such as immunizations administered to children, and to calculate whether the MCO is meeting minimum performance standards required by HFS. Failure to meet these standards may result in corrective action plans and may lead to related sanctions.

3. *Develop and evaluate capitation rates* - Data used in developing capitation rate assumptions are based on encounter data submitted by MCOs. Encounter data is used by HFS and its actuaries to calculate capitation rate ranges. In addition, encounter data is summarized, compiled and distributed to prospective offerors to assist them in the calculation of their capitation bids.

4. *Determine Disproportionate Share (DSH) payments to hospitals* - Encounter data is used in the calculation of DSH payment allocations to hospitals.

5. *Process reconciliations and risk adjustments* - Encounter data is used in the calculation of reconciliations and risk adjustments associated with benefit and program reimbursement. Accurate calculation of these important MCO revenue sources is based in part on the complete and timely submission of encounter data by the individual MCOs.

4. General Principles

HFS utilizes national industry standards and code sets as published by X12N, NCPDP, and other data standard maintenance organizations for encounter reporting. Some requirements are specific to the HFS program. The MCO should ensure that submitted encounters are consistent with the following general principles.

1. MCO specific identifiers as outlined by HFS are required for all encounter submissions.

2. The MCOs must report the services provided to the members.

3. The member must be HFS eligible and enrolled with the MCO on the date of service.

4. The service provider must be enrolled with HFS on the date of service and be approved to provide the specific coded service(s) on that date of service.

5. A service must have been completed, and the provider's claim or encounter must be finalized as paid or administratively denied by the MCO, before an encounter is submitted to HFS.

6. The HFS Medicaid program is the payor of last resort. Medicare and other third party payment must be accounted for prior to submitting the encounter. Medicare and third-party payment amounts must be entered on the encounter in the appropriate fields.

7. If the MCO makes any adjustment to a provider's claim after it has been accepted by HFS, the MCO must void the encounter accepted by HFS and resubmit an adjusted encounter.

5. Encounter Formats

There are four different types of encounter formats accepted by HFS.

1. *837 Institutional (837I)* - Used for institutional facility based services, such as inpatient or outpatient hospital services, dialysis centers, hospice, birthing centers, nursing facility services, and other institutional services. NOTE: Institutional encounters are further subdivided into three additional claims types for encounter editing purposes: 1. Inpatient hospital services. 2. Outpatient hospital services 3. Long-term care facility service 4. Division of Substance Use Prevention and Recovery (SUPR). Claim type is determined based upon the reported type of bill (bill type code).

2. *837 Professional (837P)* - Used primarily for professional services, excluding dental services. These services include but are not limited to: physician visits, nursing visits, surgical services, anesthesia services, free standing ambulatory surgical treatment centers (ASTC), laboratory tests, radiology services, home and community based services (HCBS), therapy services, durable medical equipment (DME), medical supplies and transportation services.

3. *837 Dental (837D)* - Used for dental services.

4. *NCPDP* – Used for retail pharmacy services, such as prescription medicines and medically necessary over-the-counter items.

6. Timelines Related to Encounter Submission

Generally, medical providers are expected to submit claims for payment to MCOs within 180 days from the date of service. MCOs are expected to pay 90% of claims within 30 days and 99% of claims within 90 days. MCOs are expected to send an encounter 120 days after either payment has been made or a service has been administratively denied.

7. Evaluation of MCO Encounter Claims Submission

HFS formally evaluates MCO encounter claims submission on a quarterly basis through a methodology developed by its consulting actuary, Milliman, Inc. called Encounter Utilization Monitoring (EUM). Each quarter, MCOs submit the amount of claims paid to medical providers for a given 18 month period through a series of templates that break out the paid services by established rate cells. In general, the amount of MCO reported paid claims are compared to the amount of accepted encounters in the HFS EDW for the same 18 month period. A percentage score is calculated (the accepted encounters is the numerator and the amount of paid claims is the denominator). Thresholds are established by quarter which the MCOs are expected to meet. Both financial and auto-assignment sanctions are issued when thresholds are not met.