UPDATE (04/24/20): Due to health plan focus on COVID-19 activities, Florida Medicaid has moved the implementation date of Special Feed Elimination to July 1st, 2020. Starting May 8th, 2020, Florida Medicaid will be monitoring submissions of the new requirements and will be providing feedback, and outreach to health plans needing corrections related to the new requirements. This provides an opportunity to verify compliance with the new requirements prior to the new July 1st, 2020 implementation date. On July 1st, 2020 health plans will be held accountable for compliance with the new requirements and may be required to resubmit any, or all encounters found to be absent or in error of those requirements.

Note: Health plans will still be required to continue submission of special feed data on their regular schedule until notified to discontinue that process.

Beginning 07/01/20: Encounters must include payments to capitated network providers. The Agency for Health Care Administration is continuing its efforts to transition from the special feed to FMMIS encounter data for capitation rate setting and to reconcile between the encounter, the health plan’s database, the ASR reporting and the data submitted by the providers within the health plan’s network.

This tip sheet provides the information for submitting encounters used in the Encounter Based Rebate Assessment process:

- Encounter data financial payment reporting.

In instances where a health plan has capitated relationship with a network provider, health plans are required to report the downstream payments for services perform within the encounter data submissions.

There are two types of providers networks which health plans have capitated relationship:

1. A capitated relationship with a subcontracted service provider (example a Managed Care Plan) where there is a downstream paid claim.
   - In this scenario, the health plan should submit:
     i. ‘05’ in CN101 within the 2300 loop of their X12 transaction.
     ii. The downstream (service provider submitted) paid amount for the services, in SVD02 within the 2430 loop of their X12 transactions.

2. A capitated relationship with a subcontracted service provider (example a Physician Network) where there is not a downstream paid claim.
   - In this scenario, the health plan should submit:
     i. ‘06’ in CN101 within the 2300 loop of their X12 transactions.
     ii. The health plan’s internally determined amount, calculated price, or allowed amount for the service in the SVD02 within the 2430 loop of their X12 transactions.

NOTE: As with Fee for Service (FFS), encounter X12 transactions must balance between all applicable data elements i.e., SVD02, CAS, AMT02, CLM02, and SV203.

NOTE: As a reminder, allowed dollar amounts reported within CN102 are limited to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) and are not part of X12 balancing. CN102 FQHC and RHC pricing reporting are to continue.
• Continuing a CN101 value of ‘09’, Representing an FFS relationship between the health plan and their network providers, requires a SVD02 Paid Amount value >$0.
• Effective 07/01/2020, a CN101 value of ‘05’, Representing a type of capitated relationship between the health plan and their network providers, requires a SVD02 Paid Amount value > $0. (Initially will be operationally enforced vs systematically enforced)
• Effective 07/01/2020, the CN101 value of ‘06’ representing a type of capitated relationship between the health plan and their network providers will be accepted and requires a SVD02 Paid Amount value > $0. Initially will be operationally enforced vs systematically enforced). For capitation relationship CN101 reporting, if there is any single claim line without a downstream dollar amount; report ‘06.’

Encounters must include a 20 character prepend to the Line Item Control number. The health plans will be required to prepend 20 characters to the ‘line item control number’ (REF section of Loop 2400 with a ‘6R’ identifier) within their encounter X12 transaction submissions.

**Line Item Control Number specifications:**

<table>
<thead>
<tr>
<th>TPID (the last three characters)</th>
<th>Region (2 characters)</th>
<th>Adjudication Date (YYMMDD)</th>
<th>Sequence Number (9 characters with leading zeros)</th>
<th>Network Provider Submitted control number (up to 30 characters)</th>
</tr>
</thead>
<tbody>
<tr>
<td>999</td>
<td>99</td>
<td>999999</td>
<td>99999999999999999999</td>
<td>9999…</td>
</tr>
</tbody>
</table>

**Example:**

TPID: 1001201  
Region: 02  
Date: September 2, 2019  
Sequence of line process for the day: 351,892  
Submitted from Network Provider: 5897458732  
Result: 201021909020035118925897458732

**NOTE:** For Adjustments and Resubmissions, the original Line Item Control Number should not be re-used recycled from the original encounter. It should be a newly generated Line Item Control Number following the same rules as an original encounter.

**NOTE:** The Line Item Control Number, as submitted by the health plan, in its entirety, will be returned on their corresponding X12 835. Future FLMMIS modifications will be required to return all 50 characters of the Line Item Control Number back on the X12 277U transactions.

**NOTE:** Edits related to the Line Item Control Number:

- For 07/1/2020, there will be no edits associated with the Line Item Control Number. In the future, there will be the following edits: (health plans will be notified of any editing changes)
- TPID (Last 3 characters) Character positions 1-3 – values between 823-877 or 993  
- Region (2 characters) Character positions 4-5 - values between 01-11
• Adjudication Date (YYMMDD) – Character positions 6-7 YY – values between 19-27
• Character positions 8-9 MM – values between 01-12
• Character positions 10-11 DD – values between 01-31

**Note:** The network Provider Submitted Control Number is what the health plan received from their network provider and is allowed to be in whatever format they received it in or forward to Florida Medicaid. It is not used by FLMMIS for any purpose.

**Additional Information**

**Monitoring Tools:**

• **Accuracy Reports:** The Accuracy reports will be undergoing a number of modifications to more accurately report health plan compliance.

• **Resubmission reporting:** The Resubmission reports will be undergoing a number of modifications to more accurately report health plan compliance and provide health plan visibility to these reports.

• **X12 Testing:** Health plans can begin testing Special Feed Elimination for X12 5010 EDI batch files. All health plans have access to the X12 testing environment (Florida Medicaid Web Portal BETA). If you wish to test Special Feed Elimination for X12 5010 EDI batch files or need assistance with testing, please contact healthplan.support@dxc.com

For more information about X12 encounter transactions testing, refer to the **X12 Testing** page.

**Helpful Resources**

**To learn more about the Special Feed Elimination process, visit:** AHCA’s Program website and navigate to the [Statewide Medicaid Managed Care](https://ahca.myflorida.com/) page.

**Encounter Support Contacts available to Health Plans**

Please review the **Special Feed Elimination FAQ** for additional assistance and information.

Health plans are encouraged to monitor future alerts for additional information regarding the new requirements and may contact the Florida Health Plan Support team at healthplan.support@dxc.com for additional assistance.

For more information on successfully processing encountered containing plan paid amounts, Health plans can refer to the **EDI companion guides**.

For assistance with EDI transactions and other EDI-related inquiries, please contact EDI Encounter Support at edi.encounter.support@dxc.com.

For further information on health plans contact resources, please review the **SMMC Encounter Support Contact Sheet**.
Provider Resources

For assistance with provider enrollment related matters—such as group linking, application completion, and accessing enrollment forms—providers should contact HP Provider Enrollment at 1-800-289-7799, Option 4. Providers may also obtain information from the Provider Enrollment area of the Florida Medicaid Web Portal. FQHC/RHC providers may contact the call center at 1-800-289-7799, Option 7, or their local field representative for questions regarding their wraparound payment.