OFFICE OF HEALTH ANALYTICS
All Payer All Claims Data Reporting Program

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Memorandum

To: All Payer All Claims Mandatory Reporters

From: Karen Hampton
Interim Research & Data Manager

Date: June 24, 2019

Subject: Version 2019.1 and 2020.0 of APAC data file layouts

This memorandum announces revisions to the data file layouts for the All Payer All Claims (APAC) Data Reporting Program. Version 2019.1 and 2020.0 implements the changes listed on pages 10-13, which are briefly summarized here:

Reordered appendices and renamed them in some cases.

Appendix A: Eligibility File. Revised list of valid values for ME001 and ME003 to accommodate submission of dental claims from dental plans; added data elements pertaining to dental claims; modified descriptions of some data elements to not require the information from dental plans.

Appendix B: Medical Claims File. Moved lookup tables MC001 and MC003 into Eligibility File as those lookup tables are applicable to several files.

Appendix C: Pharmacy Claims File.

Appendix D: Dental Claims File. New file added.

Appendix E: Provider File.

Appendix F: Subscriber Billed Premium File.

Appendix G: Control Totals File. Removed list of mandatory reporters; added control totals for dental claims file.

Schedule A: Renamed “Data Submission Schedule”. Updated to extend through 2022.

OAR 409-025: Added and revised some definitions, added new section specific to Payment Arrangement File reporting, expanded section on data release, added references to dental claims.

The revisions above constitute Version 2020.0 and become effective for submission dates beginning January 2020. Please see the Data Submission Schedule for more

information regarding submission due dates.

Appendix 1: Payment Arrangement File. Revised instructions to require submission by all Mandatory Reporters except Pharmacy Benefit Managers; modified some element names; revised list of valid values for PRAPM103; revised some definitions.

Appendix 2: Payment Arrangement Control File. Revised instructions to require submission by all Mandatory Reporters except Pharmacy Benefit Managers.

These two revisions constitute Version 2019.1 and become effective for submission dates beginning September 2019. Please see the Data Submission Schedule for more information regarding submission due dates.

If you anticipate difficulty meeting submission deadlines, please complete Form APAC-1 (Waiver or Exception of Reporting Requirements). Completed APAC-1 forms should be submitted to APAC.Admin@dhsoha.state.or.us well before the data submission. Form APAC-1 and the Data Submission Schedule are available at the APAC web site: http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx.

APAC Mandatory Reporters

OAR 409-025-0110 states that the following entities, as defined in ORS 442.464, shall be Mandatory Reporters to APAC:

- Carriers and licensed TPAs with calculated mean total lives of 5,000 or higher (as identified by OHA using information collected by the Department of Consumer and Business Services);
- All PBMs;
- All CCOs;
- All reporting entities with Dual Eligible Special Needs Plans in Oregon;
- All insurers providing coverage funded under Parts A, B, or D of Title XVIII of the Social Security Act;
- All insurers offering a health benefits plan in Oregon's health insurance exchange;
- All insurers providing group health insurance plans to PEBB and OEBB members; and
- All dental plans.

Every year, OHA uses the above criteria to identify all APAC Mandatory Reporters.

Mandatory reporters contracting with another entity to provide services remain responsible for having all reportable lines of business submitted to APAC. If the mandatory reporter elects to have the contractor report directly to APAC, the mandatory reporter must notify OHA and provide contact information for the contractor.

Reporting Requirements
All APAC Mandatory Reporters must submit all required APAC Files by the submission due dates found in the Data Submission Schedule. Mandatory Reporters who anticipate difficulty meeting submission deadlines, should submit Form APAC-1. Voluntary Reporters may elect to participate by notifying OHA in writing. A matrix outlining the required files, by payer type, follows:

File name	Carrier*	TPA	PBM	Dental plans (incl. stand-alone dental plans or part of other carrier benefits)	CCO's
Appendix A: Eligibility	✓	✓	✓	✓	
Appendix B: Medical Claims	✓	✓			
Appendix C: Pharmacy Claims	✓		✓		
Appendix D: Dental Claims				✓	
Appendix E: Provider	✓	✓		✓	
Appendix F: Subscriber Billed Premium	✓	✓	✓	✓	
Appendix G: Control Totals	✓	✓	✓	✓	
Appendix 1: Payment Arrangement	✓	✓		✓	✓
Appendix 2: Payment Arrangement Control	✓	✓		✓	✓

* In the table above, "carrier" includes Medicaid plans and Medicare plans.

Mandatory and voluntary reporters shall include all required lines of business in the required APAC files, unless otherwise noted in the instructions at the top of each file. If they wish, mandatory and voluntary reporters may submit data for the voluntary lines of business and may not submit data files for any excluded lines of business.

- Required lines of business include:
  - (A) Medicare (parts C and D);
  - (B) Medicaid;
  - (D) Individual;
  - (E) Small employer health insurance;
  - (F) Large group;
  - (G) Associations and trusts;
  - (H) PEBB and OEBB health insurance plans;
  - (I) Self-insured plans not subject to ERISA; and
  - (J) Dental insurance

- Voluntary lines of business include:
  - Self-insured plans subject to ERISA

- Excluded lines of business include:
  - (A) Accident policy;
  - (B) Disability policy;

(C) Hospital indemnity policy;
(D) Long-term care insurance;
(E) Medicare supplemental insurance;
(F) Specific disease policy;
(G) Stop loss only policy;
(H) Student health policy;
(I) Supplemental insurance that pays deductibles, copays or coinsurance;
(J) Vision-only insurance; and
(K) Workers compensation.

Appendix Inclusion Criteria

Each APAC file has its own file-specific inclusion criteria (as defined in OAR 409-025-0100).

- Appendix A: Eligibility File
  The inclusion criteria for the Eligibility File are:
  1. Member's residence is in Oregon; or
  2. Member's residence is outside Oregon and member is enrolled in a plan for which the state is the payer (such as PEBB and OEBB)

  The Eligibility file shall include eligible spouse and/or dependent(s) covered by a member that meets at least one of the inclusion criteria above—regardless of the mailing address of eligible spouse or dependent(s).

- Appendix B – D: Medical Claims, Pharmacy Claims, and Dental Claims File
  The inclusion criteria for the Medical Claims, Pharmacy Claims, and Dental Claims files are:
  All final medical, pharmacy, and dental claims associated with the individuals included in the Eligibility File.

  Substance use data must be reported to OHA. OHA will only report the substance use data at an aggregate level. It will not report, or release, claim-level substance use data.

- Appendix E: Provider File
  The inclusion criteria for the Provider file are:
  All providers associated with the claims reported in the Medical Claims, Pharmacy Claims, or Dental Claims files. **PBMs are not required to submit a provider file since all of the pharmacy/provider information they have is already captured in the pharmacy claims file.**

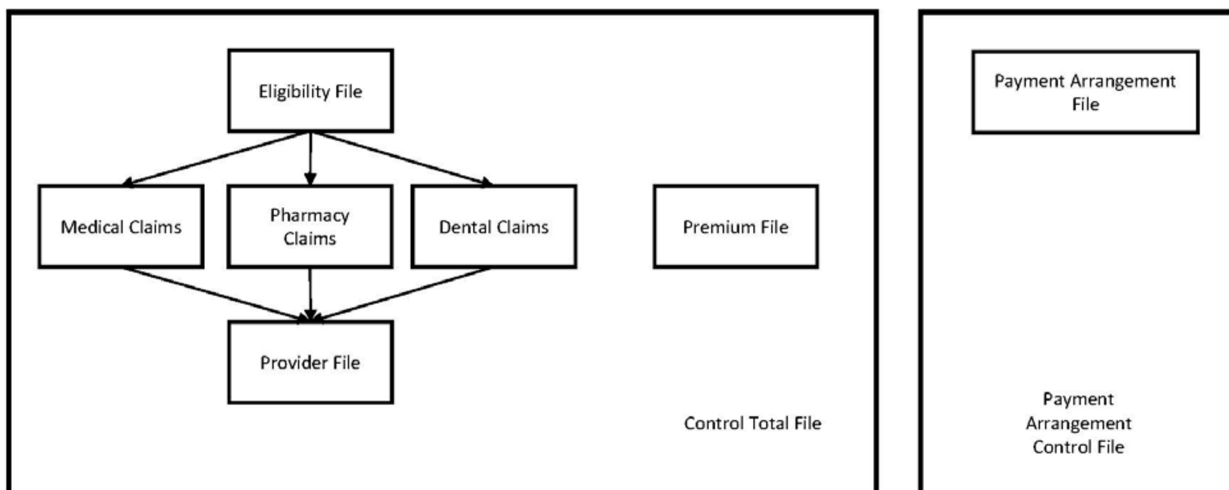
- Appendix F: Subscriber Billed Premium File
  The inclusion criteria for the Premium file are:

Premium data associated with the individuals included in the Eligibility File who are enrolled in fully-insured commercial and Medicare Advantage plans.

PBMs that offer stand-alone prescription drug plans and dental plans, are also required to submit this file. A stand-alone prescription drug plan is a prescription drug plan for which the PBM collects premiums, administer claims, and pays claims. Subscribers to such plans, and their premium amounts, should be included in the Premium File. **PBMs that contract with an insurance carrier to offer prescription drug plans, and that do not collect premiums for such plans, are not required to submit this file.** In these cases, the insurance carriers that collect the premiums for these plans will submit the data. See "APAC Subscriber Billed Premium File: FAQs" (further in this document) for additional information.

- Appendix G: Control Totals File
  The inclusion criteria for the Control file are:
  Summary data pertaining to the Eligibility File, Provider File, Premium File, and all submitted Claims Files

- Appendices 1-2: Payment Arrangement File and Payment Arrangement Control File
  These two files are unrelated to the Eligibility File or any of the other APAC files. The inclusion criteria for the Payment Arrangement Files are:
  Contract entities that received payments under insurance policies that align with NAIC/SERFF inclusion criteria, and for which the Mandatory Reporter was the primary payer.



Relationship between APAC Data Files

As outlined in the section above, some APAC files are interrelated. For example, the Eligibility File serves as the starting point for identifying claims, providers, and subscriber billed premiums to be included in the associated files (see diagram below).

The Payment Arrangement and Payment Arrangement Control File have no relation to any of the other (claims) data files.

File Submissions
For new mandatory reporters, test files shall be submitted on a schedule that is mutually agreeable to Milliman and the mandatory reporter. Production files are due on or before the due dates listed in the Data Submission Schedule. Data file naming conventions are given in the Control Totals File and the Payment Arrangement Control File. All files shall be tab delimited unless otherwise specified in the data file layouts. Files shall be transmitted to Milliman's secure FTP site and shall be encrypted prior to transmission. Mandatory reporters shall consult with Milliman on acceptable encryption methods.

Submit Final Paid Claims
Each submission shall include final claims (paid, denied, or encounter only) for dates of service within the range specified in the Data Submission Schedule. For example, the January 31, 2020 submission shall include claims with dates of service from January 1, 2019 to December 31, 2019. Do not include claims with dates of service outside the range specified in the Data Submission Schedule. Similarly, the Eligibility File shall not include enrollment segments which terminated prior to the date range specified in the Data Submission Schedule. For example, a member with eligibility that terminated May 15, 2018 should be excluded from the January 31, 2020 submission, which covers eligibility from January 1, 2019 to December 31, 2019.

Subsequent submissions shall include four calendar quarters and shall fully replace claims (paid, denied, or encounter only) in overlapping quarters. See the Data Submission Schedule for more details on the date ranges to be included with each submission. The eligibility, provider, and subscriber monthly premium files shall also be fully replaced with each submission. The eligibility file shall not include enrollment segments which terminated prior to the submission's date range.

Data System Limitations
If you anticipate difficulty extracting any required data fields, please file Form APAC-1 (Waiver or Exception of Reporting Requirements) with this office as soon as possible. This form is available at the APAC website. Do not file Form APAC-1 for data fields that are not required. Populate as many of the inpatient diagnosis and procedure codes as is feasible within the limitations of your data system. Payment fields for institutional claims may be populated at the first revenue line if paid only at the header level; in this case payment fields for additional claim lines shall be left blank (do not enter zero).

Please email APAC.Admin@dhsoha.state.or.us if you have additional questions.

File layout changes

Appendix A: Eligibility File – Effective January 1, 2020

1. Edited instruction to require this file from all Mandatory Reporters
2. Edited location for lookup tables ME001 and ME003
3. Edited the following elements to make them situational and reflect that they are not required when ME001 = E
    a. ME009C
    b. ME018
    c. ME019
    d. ME201
    e. ME203
    f. ME204
4. Added value of “E” to lookup table ME001
5. Added the following values to lookup table ME003
    a. DPPO
    b. DPOS
    c. DHMO
    d. DSIP
    e. DSIF
    f. DSIH

Appendix B: Medical Claims File – Effective January 1, 2020

1. Edited location for lookup tables ME001 and ME003
2. Removed references to dates of service from elements MC058K and MC058L

Appendix C: Pharmacy Claims File – Effective January 1, 2020

1. Edited location for lookup tables ME001 and ME003

Appendix D: Dental Claims File – Effective January 1, 2020

1. New file to capture dental claims elements

Note: Dental files will not be submitted until July 31, 2020.

Appendix E: Provider File – Effective January 1, 2020

1. Renamed Provider File (formerly Medical Provider File)

Appendix F: Subscriber Billed Premium File – Effective January 1, 2020

1. Edited instruction to only exempt CCO's from submission requirement.

Appendix G: Control Totals File – Effective January 1, 2020

1. Edited instruction to exempt only CCO's from submission requirement
2. Included "dental" in the description and calculation of the following elements:
    a. CFCT2
    b. CFCT4
    c. CFCT5
3. Added control total rows for dental submissions: number of data rows, amount billed, amount paid, member months
4. Removed lookup table CFCT1; list of Mandatory Reporters

Appendix 1: Payment Arrangement File – Effective July 1, 2019

1. Renamed Payment Arrangement File (formerly Annual Supplemental Provider Level APM Summary)
2. Edited instruction to only exempt PBM's from submission requirement
3. Edited name and description for PRAPM003
4. Added the following instruction to PRAPM018, "If PRAPM103=2Ai, then report the PCPCH Practice ID in this field"
5. Edited name and description for PRAPM103
6. Edited description for PRAPM106
7. Revised lookup Table PRAPM103 as follows:
    a. Removed the following valid values:
        i. P
        ii. S
        iii. G
        iv. L
        v. C
        vi. B
        vii. I
        viii. H

ix. O
x. F

b. Added the following new valid values:

1A	Fee for Service with Link to APM	Payments based on the volume of services, that are made on behalf of patients or enrollees who are subject to an APM, regardless of whether the billing provider or entity holds the APM contract (i.e. bears the risk) for these patients/enrollees.
1	Fee for Service Without Known Link to APM	Payments based on volume of services, on behalf of patients or enrollees with no known link to an APM
2Ai	Payments based on Patient Centered Primary Care Home (PCPCH) tier level	Payment for recognition as a PCPCH, or per-member per-month payment for members in a PCPCH.
2Aii	Foundational payments for infrastructure and operations – that are not based on PCPCH tier level	Foundational payments to improve care delivery, such as care coordination fees and payments for investments in HIT.
2B	Pay for Reporting	Bonus payments for reporting data on quality, or penalties for not reporting data.
2C	Pay for Performance	Bonus payments for high performance on clinical quality measures, or penalties for poor performance.
3A	Alternative Payment Models with Shared Savings	Payments made under arrangements that are based on cost (and occasionally utilization) performance, as long as quality targets are met. Examples include: Bundled payment with upside risk only; episode-based payments for procedure-based clinical episodes with shared savings only.
3B	Alternative Payment Models with Shared Savings and Downside Risk	Payments or penalties made under arrangements that both reward and penalize cost (and occasionally utilization) performance, as long as quality targets are met. Examples include: Episode-based payments for procedures and comprehensive payments with upside and downside risk.
3N	Risk Based Payments Not Linked to Quality	Payments that do not take quality into account
4A	Condition-Specific Population-Based Payment	Prospective, population-based payment for a certain set of condition specific-services (e.g. oncology, mental health, diabetes) or for care

		delivered by particular types of clinicians (e.g. primary care, orthopedics).
4B	Comprehensive Population-Based Payment	Prospective, population-based payments for all of an individual's health care needs.
4C	Integrated Finance and Delivery System	Payments for comprehensive care that integrate the financing arm with a delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, and in others, they consist of delivery systems that offer their own insurance products.
4N	Capitation Payments Not Linked to Quality	Payments that do not take quality into account.

c. Edited description of valid value "V", as follows: "enrollment should be reported for members in payment categories 2Ai, 4A, 4B, 4C, and 4N".

Appendix 2: Payment Arrangement Control File – Effective July 1, 2019

1. Renamed Payment Arrangement Control File (formerly Control totals for Annual Supplemental Provider Level APM Summary)
2. Edited instruction to only exempt PBM's from submission requirement