Documents for January 14, 2015 APAC Technical Advisory Group Meeting

1. Agenda
2. List of Proposed Data Fields and TAG Recommendations as of December 9, 2014
3. Final Draft Data Definitions and Values for July 2015 New Fields
4. Background Information on “Tabled” Fields from December 9, 2014 Meeting
5. OHA APAC Validation Plan and Attachments:
    a. APAC Validation Level 1
    b. APAC Validation Level 2
    c. APAC Validation Level 3
6. December 9, 2014 Meeting Summary

Oregon All Payer All Claims Technical Advisory Group (APAC TAG) Meeting Agenda
Wednesday, January 14, 2014
3:00 – 5:00 PM

Location:
Transformation Center Conference Room,
7th Floor
Lincoln Building
421 SW Oak Street
Portland, OR

Remote Attendance Information:
Dial-in number: 1.888.204.5984
TAG member code: 6775634
Public listen-only code: 1277166

Agenda

#	Agenda Item	Presenter	Time
1	Introduction and Meeting Goals	Robin Gumpert, DS Consulting (Facilitator)	3:00 – 3:10 PM
2	Discussion and Action: Review and Approve New Data Field Definitions for July 2015 Submission	Robin Gumpert, DS Consulting (Facilitator)	3:10 – 3:40 PM
3	Presentation: Data Fields "Tabled" for Further Discussion at December 9 Meeting	Jonah Kushner, Office of Health Analytics, Al Prysunka, Milliman	3:40 – 3:55 PM
4	Discussion and Action: Recommendations for Data Fields to Add in January 2016 Submission	Robin Gumpert, DS Consulting (Facilitator)	3:55 – 4:25 PM
5	Public Comment	Robin Gumpert, DS Consulting (Facilitator)	4:25 – 4:40 PM
6	Presentation: OHA APAC Data Validation Plan	Toni Flitcraft, Office of Health Analytics	4:40 – 4:50 PM
7	Conclusion and Next Steps	Robin Gumpert, DS Consulting (Facilitator)	4:50 – 5:00 PM

Data Field	Add to APAC File	Description/Comment	Recommendation	Rank	If Not Yet Discussed, Number of Suppliers that can submit by Jan 2016
HIOS ID	ME	See draft definitions and values	Submit starting July 2015	1	NA
Market Segment	ME	See draft definitions and values	Submit starting July 2015	2	NA
Metal Tier	ME	See draft definitions and values	Submit starting July 2015	3	NA
Network	MC	See draft definitions and values	Submit starting July 2015	4	NA
High Deductible Health Plan Flag	ME	See draft definitions and values	Submit starting July 2015	9	NA
Primary Insurance Indicator	ME	See draft definitions and values	Submit starting July 2015	14	NA
Admission Type	MC	See draft definitions and values	Submit starting July 2015	16	NA
Admitting diagnosis	MC	See draft definitions and values	Submit starting July 2015	17	NA
Pay to Patient Flag	MC	See draft definitions and values	Submit starting July 2015	35	NA
Admit Source	MC	See draft definitions and values	Submit starting July 2015	NA	NA
Allowed Amount	PC	Key component in cost analysis; not in National Council for Prescription Drug Programs (NCPDP) Implementation Guide; as an alternative, Total Amount could be reported	Revisit	5	NA
Payment Arrangement Type	MC	Defines the contracted payment methodology for this claim line; Values: 1 = Capitation, 2 = Fee for Service, 3 = Percent of Charges, 4 = DRG, 5 = Global Payment, 6 = Bundled Payment, 7 = Other; Because Pay for Performance can overlap with other payment arrangement types, a separate field called Pay for Performance Flag would be added to the Medical Provider File to capture providers in pay-for-performance arrangements	Revisit	12	NA
Patient Account Number	MC	Number assigned by clinic or hospital to patient; would be useful for sharing patient-level data with providers	Revisit	31	NA
Carrier Plan Specific Contract Number	ME, MC, PC	A field is needed to associate claims submitted by a PBM or TPA (on behalf of a carrier for carved-out services) with the carrier on whose behalf claims were submitted; Instead of Carrier Plan Specific Contract Number (which is already reported and has a different meaning than in Milliman's national claims reporting model), two fields could be used: Carrier Member ID Number and Carrier Associated with Claim; Carrier Member ID Number would not needed if PBMs and TPAs already report the Member ID used by the carrier on whose behalf they submit (OHA is investigating how data suppliers currently populate this field)	Revisit	37	NA
Group Name	ME	Could help with grouping claims by employer; Would provide an additional employer identifier to group on if a group has multiple Plan Specific Contract Numbers (AKA group numbers) assigned to it (Plan Specific Contract Number is already reported in the Medical Eligibility, Medical Claims, and Pharmacy Claims files)	Revisit	40	NA
APC	MC	Ambulatory Payment Classifications; valuable if the claim is paid based upon an APC	Not yet discussed	6	5
APC Version	MC	Version number of the grouper used; if an APC is used to pay the claim, it is important to know which version	Not yet discussed	7	2
Monthly Premium	ME	Amount subscriber is responsible for on a monthly basis to maintain this line of eligibility; useful in comparing value (e.g., medical loss ratio)	Not yet discussed	10	5
New Coverage	ME	Whether coverage is a benefit design being offered for the first time this reporting year	Not yet discussed	11	0
Postage Amount Claimed	PC	Useful for computing total cost of pharmaceuticals	Not yet discussed	13	3
Version Number	MC, PC	Version number of claim service line; original claim will have version number 0, with next version assigned 1 and each subsequent version incremented by 1 for that service line; important in claim consolidation process, as claims can be adjusted over time; provides a more direct means of identifying and processing different versions of the same claim to arrive at a final adjudicated claim	Not yet discussed	15	4
Date of Death	ME		Not yet discussed	19	3
Denied Amount	MC	For both fully and partially denied claims; need stakeholder clarification on this field	Not yet discussed	23	3
Exchange Enrollment Channel	ME	Whether exchange enrollee received assistance with application/enrollment	Not yet discussed	24	0
HIPPS Code	MC	Health Insurance Prospective Payment System code; would apply only to Medicare patients	Not yet discussed	25	0
Provider Country	MP	Claims incurred outside the US when patients travel are often filtered out of analyses	Not yet discussed	32	3
Employer Characteristics	ME	Set of fields that could include firm size, industry, etc.	Not yet discussed	33	1
Employer ID	ME	Unique identifier for employers in small and large group markets	Not yet discussed	34	4
Smoking/Tobacco Use Flag	ME	Whether patient smokes/uses tobacco	Not yet discussed	36	2
Cross Reference Claims ID	MC	Original Claim ID; used when a new Claim ID is assigned to an adjusted claim and a Version Number is not used; not all health care payers use version numbers when making adjustments to their claims (some payers replace the original Claim ID with a completely new number which is mapped to the original; this field provides means to more directly associate new versions of the claim with the original	Not yet discussed	38	2

Data Field	Add to APAC File	Description/Comment	Recommendation	Rank	If Not Yet Discussed, Number of Suppliers that can submit by Jan 2016
Plan Specific Contract Number	ME	This field cannot necessarily be used to identify carrier when a TPA or PBM processes claims on behalf of the carrier, which is why Milliman proposed adding Carrier Plan Specific Contract Number; Milliman proposes aligning Oregon APAC use of Plan Specific Contract Number with National Model	Not yet discussed	41	4
Increase Diagnosis Codes 25	MC	National Model has 13 diagnosis codes	Drop	26	NA
Increase POAs to 25	MC		Drop	27	NA
Increase Procedure Codes to 25	MC	Would enhance ability to accurately identifying co-morbidities and episode groupers; National Model has 6 procedure codes	Drop	28	NA
Generic Drug Indicator	PC	Useful for comparing cost of branded and generic drugs; brand status (single, multiple, generic) is derived from NDC	NA (already in APAC)	8	NA
Claim Type	MC	Professional (CMS1500) or Facility (UB); can be derived from Type of Bill, captured in APAC	NA (already in APAC)	18	NA
E-Code	MC	Describes an injury, poisoning, or adverse effect; if captured on claim, should be populated in diagnosis field; Milliman states that it would be clearer to collect the E-codes in a separate field	NA (already in APAC)	39	NA
V-Code	MC	Describes encounters with the health care system for reasons other than disease or injury.	NA (already in APAC)	NA	NA
Health System ID	MP	Could be used to link publicly available health system informaton to claims data	NA (field not needed)	20	NA
Hospital ID	MC	Could be used to link publicly available hospital information with claims data	NA (field not needed)	21	NA
Primary Care Clinic ID	MP	Could be used to link to publicly available primary care clinic information to claims data	NA (field not needed)	22	NA
Other Data Elements	PC	To be determined	NA (more definition needed)	29	NA
Part D Data Elements	PC	To be determined	NA (more definition needed)	30	NA

Data Element	Name	Type	Max. Length	Required	Description
MC202	Network	Text	1	Yes	See lookup table MC202
MC203	Admission Type	Text	1	Situational	Required for inpatient claims. Valid values: 1 (Emergency), 2 (Urgent), 3 (Elective), 4 (Newborn), 5 (Trauma Center), 9 (Information Not Available)
MC204	Admit Source	Text	1	Situational	Required for inpatient claims. See lookup table MC204
MC205	Admitting Diagnosis	Text	7	Situational	ICD-10 diagnosis code for dates of service beginning 10/01/2014. Include all characters (example: E10.359). ICD-9 diagnosis code for dates of service before 10/01/2014. If ICD-9 include all digits and exclude decimal point (example: 01220)
MC206	Pay to Patient Flag	Text	1	Yes	Valid values: Y (patient was directly reimbursed), N (patient was not directly reimbursed)
ME202	Market Segment	Text	2	Yes	See lookup table ME202
ME203	Metal Tier	Text	1	Yes	Health benefit plan metal tier as defined in the Patient Protection and Affordable Care Act, Public Law 111-148, Section 1302: Essential Health Benefits Requirements. Valid values: 0 (None), 1 (Catastrophic), 2 (Bronze), 3 (Silver), 4 (Gold), 5 (Platinum)
ME204	HIOS Plan ID	Text	14	Yes	Health Insurance Oversight System ID. Required for qualified health plans (QHPs) as defined in the Patient Protection and Affordable Care Act (ACA). If plan is not a QHP under the ACA, enter 99999999999999.
ME205	High Deductible Health Plan Flag	Text	1	Yes	Valid values: Y (policy meets IRS definition of HDHP), N (policy does not meet IRS definition of HDHP)
ME206	Primary Insurance Indicator	Text	1	Yes	Valid Values: Y (primary insurance), N (secondary or tertiary insurance)

Lookup Table MC202

Code	Value
1	In-network: The plan has a direct contract with the provider that made the claim.
2	National network: The plan does not have a direct contract with the provider that made the claim, but paid a contracted rate through participation in a national network or reciprocal agreement with a plan operating in another state.
3	Out-of-network: The plan did not pay the provider a contracted rate.

Lookup Table MC204

Code	Value for Inpatient/SNF Claims
0	ANOMALY: invalid value, if present, translate to '9'
1	Non-Health Care Facility Point of Origin (Physician Referral): The patient was admitted to this facility upon an order of a physician.
2	Clinic referral: The patient was admitted upon the recommendation of this facility's clinic physician.
3	HMO referral: Reserved for national Prior to 3/08, HMO referral: The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician.
4	Transfer from hospital (Different Facility): The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient.
5	Transfer from a skilled nursing facility (SNF) or Intermediate Care Facility (ICF): The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.
6	Transfer from another health care facility: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list where he or she was an inpatient.
7	Emergency room: The patient was admitted to this facility after receiving services in this facility's emergency room department.
8	Court/law enforcement: The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.
9	Information not available: The means by which the patient was admitted is not known.
A	Reserved for National Assignment. (eff. 3/08) Prior to 3/08 defined as: Transfer from a Critical Access Hospital: patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.
B	Transfer from Another Home Health Agency: The patient was admitted to this home health agency as a transfer from another home health agency.(Discontinued July 1,2010- See Condition Code 47)
C	Readmission to Same Home Health Agency: The patient was readmitted to this home health agency within the same home health episode period. (Discontinued July 1,2010)
D	Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer: The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.
E	Transfer from Ambulatory Surgical Center
F	Transfer from hospice and is under a hospice plan of care or enrolled in hospice program

Lookup Table MC204

Code	Value for Newborn Type of Admission
1	Normal delivery - A baby delivered with out complications.
2	Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status.
3	Sick baby - A baby delivered with medical complications, other than those relating to premature status.
4	Extramural birth - A baby delivered in a nonsterile environment.
5 - 8	Reserved for national assignment.
9	Information not available.

Lookup Table ME202

Code	Value
1	Policies sold and issued directly to individuals (non-group) inside exchange
2	Policies sold and issued directly to individuals (non-group) outside exchange
3	Policies sold and issued directly to employers having 50 or fewer employees inside exchange
4	Policies sold and issued directly to employers having 50 or fewer employees outside exchange
5	Policies sold and issued directly to employers having 51 to 100 employees inside exchange
6	Policies sold and issued directly to employers having 51 to 100 employees outside exchange
7	Policies sold and issued directly to employers having 100 or more employees
8	Self-funded plans administered by a TPA, where the employer has purchased stop-loss or group excess insurance coverage
9	Self-funded plans administered by a TPA, where the employer has not purchased stop-loss, or group excess insurance coverage
10	Associations/Trusts and Multiple Employer Welfare Arrangements (MEWAs)
11	Other

Payment Arrangement Type

- Because Pay-for-Performance can overlap with other payment arrangement types, a separate field called Pay for Performance Flag would be added to the Medical Provider File to capture providers in pay-for-performance arrangements.

File Layout: Payment Arrangement Type					
File	**Name**	**Type**	**Length**	**Required**	**Description**
Medical Claims	Payment Arrangement Type	Text	1	Yes	Defines the contracted payment methodology for this claim line. See Lookup Table.
Medical Provider	Pay for Performance Flag	Text	1	Yes	Valid values: Y (the provider is participating in pay-for-performance or year-end withhold payment arrangement during at least one month of the calendar year), N (the provider is participating in pay-for-performance or year-end withhold payment arrangement)

Lookup Table: Payment Arrangement Type	
Code	**Value**
1	Capitation: Within a capitated contract, the healthcare provider is paid a set dollar amount per month to see patients regardless of how many treatments or the number of times the physician or clinic sees the patient. The agreement is that the provider will get a flat, prearranged payment in advance per month. Whether or not the patient needs services for a particular month, the provider will still get paid the same fee.
2	Fee for service: A payment model where separate payments are made to a health-care provider using established rates for each medical service rendered to a patient.
3	Percent of charges: As part of a contractual arrangement, a health care provider is reimbursed at a pre-established percentage of billed charges for each medical service rendered to a patient.
4	DRG: A payment arrangement where a hospital or other health care facility is reimbursed by DRG rather than the individual components that fall under the definition of the DRG.
5	Global payment: A payment arrangement where a fixed dollar prepayment is made to a group of providers or a health care system for the care that patients may receive in a given time period. Global payments are usually paid monthly per patient over a year. Global payments usually are adjusted to reflect the health status of the group on whose behalf the payments are made.
6	Bundled Payment: Similar to global payments, bundled payments are the reimbursements to health care providers on the basis of expected costs for clinically-defined episodes of care.
7	Other

Carrier Member ID Number and Carrier Associated with Claim

- Needed to associate claims submitted by a PBM or TPA (on behalf of a carrier for carved-out services) with the carrier on whose behalf claims were submitted
- A new field for Carrier Member ID Number would not be needed if PBMs and TPAs already report Member ID used by the carrier on whose behalf they submit in the current file layout (OHA is investigating how data suppliers currently populate these field):

From Current APAC File Layout:			
File	**Data Element**	**Name**	**Description/Values**
Medical Claims	MC010	Member ID	Plan-specific unique member identifier
Medical Eligibility	ME010	Member ID	Plan-specific unique identifier for member
Pharmacy Claims	PC010	Patient ID	Unique identifier for member

- An alternative would be for carrier to submit data currently submitted by PBMs on their behalf.

File Layout: Carrier Associated with Claim and Carrier Member ID Number					
File	**Name**	**Type**	**Length**	**Required**	**Description**
Medical Claims	Carrier Associated with Claim	Varchar	8	Yes	For each claim, the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.
Medical Claims	Carrier Member ID Number	Varchar	128	Yes	For each claim, the carrier Member ID number when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.
Pharmacy Claims	Carrier Associated with Claim	Varchar	8	Yes	For each claim, the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by a PBM under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.
Pharmacy Claims	Carrier Member ID Number	Varchar	128	Yes	For each claim, the carrier Member ID number when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by a PBM under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.

Allowed Amount (Pharmacy Claims File)

- High priority for stakeholders
- Allowed Amount is not explicitly captured in pharmacy data and must be and calculated. At the December 9 meeting, data suppliers indicated they need the industry standard formula for Allowed Amount to calculate and report the field.
- Milliman checked the NCPDP Post Adjudication Implementation Guide for fields needed to calculate Allowed Amount.* It was determined that these fields (COB Primary Payer Allowed Amount and COB Secondary Payer Allowed Amount) had been deleted from the most recent Guide, released October 2014.
- As an alternative to Allowed Amount, Milliman suggests using Total Amount. Definitions for Total Amount, and the nine fields summed to calculate Total Amount, from the NCPDP Telecommunication Standard D.0 and its associated data dictionary are shown below.

Total Amount:

FIELD	NAME OF FIELD	DEFINITION OF FIELD	FIELD FORMAT	STANDARD FORMATS	FIELD LENGTH	VALUES	COMMENTS / EXAMPLES
5Ø9-F9	Total Amount Paid	Total amount to be paid by the claims processor (i.e. pharmacy receivable). Represents a sum of 'Ingredient Cost Paid' (5Ø6-F6), 'Dispensing Fee Paid' (5Ø7-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive Amount Paid' (521-FL), 'Professional Service Fee Paid' (562-J1), 'Other Amount Paid' (565-J4), less 'Patient Pay Amount' (5Ø5-F5) and 'Other Payer Amount Recognized' (566-J5).	s9(6)v99	T,E	8		Comments: Format=s$$$$$$cc Example: If the amount is $5.5Ø this field would reflect: 55{ **Prescription Response Formula:** Ingredient Cost Paid (5Ø6-F6) + Dispensing Fee Paid (5Ø7-F7) + Incentive Amount Paid (521-FL) + Other Amount Paid (565-J4) + Flat Sales Tax Amount Paid (558-AW) + Percentage Sales Tax Amount Paid (559-AX) - Patient Pay Amount (5Ø5-F5) - Other Payer Amount Recognized (566-J5) = Total Amount Paid (5Ø9-F9) **Service Response Formula:** Professional Service Fee Paid (562-J1) + Flat Sales Tax Amount Paid (558-AW) + Percentage Sales Tax Amount Paid (559-AX) + Other Amount Paid (565-J4) - Patient Pay Amount (5Ø5-F5) - Other Payer Amount Recognized (566-J5) = Total Amount Paid (5Ø9-F9)

Fields Used to Calculate Total Amount:

FIELD	NAME OF FIELD	DEFINITION OF FIELD	FIELD FORMAT	STANDARD FORMATS	FIELD LENGTH	VALUES	COMMENTS / EXAMPLES
5Ø6-F6	Ingredient Cost Paid	Drug ingredient cost paid included in the 'Total Amount Paid' (5Ø9-F9).	s9(6)v99 ______ 9(6)v99 or -9(5)v99	T,A ______ Y	8 ______ 8		For T,A: Format=s$$$$$$cc Examples: If the ingredient cost paid is $15Ø.ØØ, this field would reflect: 15ØØ{. For Y: Format=$$$$$$cc or -$$$$$cc Note: -= Negative sign This minus (-) sign occupies a position, so the dollars that can be supported are one digit less than a positive dollar amount. See important information in the Uniform Healthcare Payer Data Standard for dollar field usage.

* The National Council for Prescription Drug Programs (NCPDP) sets national standards for electronic transactions used in prescribing, dispensing, monitoring, managing, and paying for medications and pharmacy services.

5Ø7-F7	Dispensing Fee Paid	Dispensing fee paid included in the ‘Total Amount Paid’ (5Ø9-F9).	s9(6)v99 ——— 9(6)v99 or -9(5)v99	T,A ——— Y	8 ——— 8		For T,A: Format=s$$$$$$cc For T: Examples: If the dispensing fee paid is $3.5Ø, this field would reflect: 35{. For Y: Format=$$$$$$cc or -$$$$$cc Note: -= Negative sign This minus (-) sign occupies a position, so the dollars that can be supported are one digit less than a positive dollar amount. See important information in the Uniform Healthcare Payer Data Standard for dollar field usage.
565-J4	Other Amount Paid	Amount paid for additional costs claimed in ‘Other Amount Claimed Submitted’ (48Ø-H9).	s9(6)v99 ——— 9(6)v99 or -9(5)v99	T,A ——— Y	8 ——— 8		For T,A: Format=s$$$$$$cc Example: If the amount is $5.5Ø this field would reflect: 55{ Comments: Qualified by ‘Other Amount Paid Qualifier’ (564-J3). For Y: Format=$$$$$$cc or -$$$$$cc Note: -= Negative sign This minus (-) sign occupies a position, so the dollars that can be supported are one digit less than a positive dollar amount. See important information in the Uniform Healthcare Payer Data Standard for dollar field usage.
558-AW	Flat Sales Tax Amount Paid	Flat sales tax paid which is included in the ‘Total Amount Paid’ (5Ø9-F9).	s9(6)v99 ——— 9(6)v99 or -9(5)v99	T,A ——— Y	8 ——— 8		For T and A: Format=s$$$$$$cc Examples: If the flat sales tax paid is $2.6Ø. this field would reflect: 26{. For Y: Format=$$$$$$cc or -$$$$$cc Note: -= Negative sign This minus (-) sign occupies a position, so the dollars that can be supported are one digit less than a positive dollar amount. See important information in the Uniform Healthcare Payer Data Standard for dollar field usage.
559-AX	Percentage Sales Tax Amount Paid	Amount of percentage sales tax paid which is included in the ‘Total Amount Paid’ (5Ø9-F9).	s9(6)v99 ——— 9(6)v99 or -9(5)v99	T,A ——— Y	8 ——— 8		For T,A: Format=s$$$$$$ccExamples: If the percentage sales tax paid is $3.62, this field would reflect: 36B. For Y: Format=$$$$$$cc or -$$$$$cc Note: -= Negative sign This minus (-) sign occupies a position, so the dollars that can be supported are one digit less than a positive dollar amount. See important information in the Uniform Healthcare Payer Data Standard for dollar field usage.
562-J1	Professional Service Fee Paid	Amount representing the contractually agreed upon fee for professional services rendered. This amount is included in the ‘Total Amount Paid’ (5Ø9-F9).	s9(6)v99 ——— 9(6)v99 or -9(5)v99	T,A ——— Y	8 ——— 8		For T,A: Format=s$$$$$$cc Examples: If the professional service fee paid is $5.5Ø this field would reflect: 55{. For Y: Format=$$$$$$cc or -$$$$$cc Note: -= Negative sign This minus (-) sign occupies a position, so the dollars that can be supported are one digit less than a positive dollar amount. See important information in the Uniform Healthcare Payer Data Standard for dollar field usage.

5Ø5-F5	Patient Pay Amount	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, etc.	s9(6)v99 ——— 9(6)v99 or -9(5)v99	T,A ——— Y	8 ——— 8		For T,A: Format=s$$$$$$cc Example: If the amount is $5.5Ø this field would reflect: 55{ Examples: If the patient pay amount is $56.96, this field would reflect: 569F. For Y: Format=$$$$$$cc or -$$$$$cc Note: -= Negative sign This minus (-) sign occupies a position, so the dollars that can be supported are one digit less than a positive dollar amount. See important information in the Uniform Healthcare Payer Data Standard for dollar field usage.

565-J4	Other Amount Paid	Amount paid for additional costs claimed in 'Other Amount Claimed Submitted' (48Ø-H9).	s9(6)v99 ——— 9(6)v99 or -9(5)v99	T,A ——— Y	8 ——— 8		For T,A: Format=s$$$$$$cc Example: If the amount is $5.5Ø this field would reflect: 55{ Comments: Qualified by 'Other Amount Paid Qualifier' (564-J3). For Y: Format=$$$$$$cc or -$$$$$cc Note: -= Negative sign This minus (-) sign occupies a position, so the dollars that can be supported are one digit less than a positive dollar amount. See important information in the Uniform Healthcare Payer Data Standard for dollar field usage.

Patient Account Number

- Data users proposed this field as potentially useful for sharing patient-level data with providers. However, at the December 9 meeting data users indicated it was relatively low priority.
- At the December 9 meeting, data suppliers indicated they would be able to provide this field.
- Patient Account Number would be valuable if it allowed linking OHA’s hospital discharge data with APAC data. However, OHA’s hospital discharge dataset does not contain Patient Account Number. Also, Patient Account Number cannot be counted on to uniquely identify patients across multiple encounters because it is populated by the provider and not necessarily consistent across providers.

Group Name or Employer ID

- Could help with grouping claims by employer by providing an additional employer identifier in cases where a group has multiple Plan Specific Contract Numbers (AKA group numbers) assigned to it (Plan Specific Contract Number is already reported in the Medical Eligibility, Medical Claims, and Pharmacy Claims files)
- Alternatives:
  - Another employer identifier in Milliman's national claims reporting model is Employer Name (50-character alphanumeric field that = BLANK if same as Group Name).
  - Employer ID was proposed by stakeholders as a unique identifier for employers in small and large group markets (not defined in Milliman's national claims reporting model).
- Issues:
  - A single employer could have multiple group names.
  - Without an "employer key" linking Group Name to other employer information it would be difficult to analyze claims by employer characteristics (e.g., industry, geography, financial). Analysts could only guess at employer size by counting number of members.
- The TAG should consider interest in analyses that group claims by employer (without other employer information) to Oregon employers and researchers.

File Layout: Group Name					
File	**Name**	**Type**	**Length**	**Required**	**Description**
Medical Eligibility	Group Name	Varchar	128	Situational	IND for individual policies

APAC Validation Plan

Updated: 12/17/2014

Week of

ID	Task	Owner	5-Jan-15	12-Jan-15	19-Jan-15	26-Jan-15	2-Feb-15	9-Feb-15	16-Feb-15	23-Feb-15	2-Mar-15	9-Mar-15	16-Mar-15	23-Mar-15	30-Mar-15	6-Apr-15	13-Apr-15	20-Apr-15	27-Apr-15	4-May-15	11-May-15	18-May-15	25-May-15	1-Jun-15	8-Jun-15	15-Jun-15	22-Jun-15	29-Jun-15	6-Jul-15	13-Jul-15	20-Jul-15	27-Jul-15	3-Aug-15	10-Aug-15	17-Aug-15	24-Aug-15	31-Aug-15	7-Sep-15	14-Sep-15	21-Sep-15	28-S
1	**APAC Data Submission**		**2014 Q4**												**2015 Q1**													**2015 Q2**													
1.01	Data Submitted	Carriers	30-50 days												30-50 days													30-50 days													
1.02	Milliman alerts OHA of any mandatory reporters who have not submitted via weekly Payer Status Reports	Milliman	Weekly updates												Weekly updates													Weekly updates													
1.03	Contact mandatory reporters who have not submitted	OHA	As necessary through submission												As necessary through submission													As necessary through submission													
2	**Level 1 - Milliman / Carrier Validation**		**2014 Q4**												**2015 Q1**													**2015 Q2**													
2.01	Control Total and other quality checks from Carriers via FFQ	Milliman	30-50 days												30-50 days													30-50 days													
2.02	Validation Reports to carriers	Milliman	30-50 days												30-50 days													30-50 days													
2.03	Work with Carriers to correct errors in data	Milliman	30-50 days												30-50 days													30-50 days													
2.04	Data passes/meets threshold	Carrier/Milliman/OHA								3 days												3 days													3 days						
2.05	Summary Report of unresolved submission issues by carrier	Milliman								1 day												1 day													1 day						
3	**Level 2 - Validation of Milliman Processes**										**2014 Q4**												**2015 Q1**													**2015 Q2**					
3.01	MedInsight Staging Procedures (create staging tables)	Milliman									3.64 days												3.64 days													3.64 days					
3.02	Peer Review of Staging Procedure	Milliman									1 day												1 day													1 day					
3.03	MedInsight Processing (move staging tables to production tables)	Milliman										16.48 days												16.48 days													16.48 days				
3.04	Peer Review of MedInsight Processing	Milliman													1 day												1 day													1 day	
3.05	AS Cube Builds	Milliman													1.63 day												1.63 day													1.63 day	
3.06	Transfer (MedInsight loaded with data)	Milliman													1 day												1 day													1 day	
3.07	Create Public and Limited Data Sets	Milliman														3 days												3 days													3 days
3.08	Summary Report of Milliman's validation checks throughout Level 2 (including SUD claims and other categories of exception)	Milliman															5 days												5 days												
3.09	OHA approves report	OHA															2 days												2 days												
3.10	Validate MedInsight tables vs. production tables	OHA																5 days												5 days											
4	**Level 3- OHA / Carrier Validation**										**Historic Data**									**Historic Data**											**2015 Q1**										
4.01	Create reports for historic data and compare with carriers (2012 Q1-Q4, 2013 Q1-Q2)	OHA/Carrier									1-2 weeks									1-2 weeks																					
4.02	If discrepancy is found, work to identify issue	OHA/Carrier									4-6 weeks									4-6 weeks																					
4.03	If discrepancies reflect real issue, work with Milliman/carrier to agree to a plan for any needed changes in historic data	Carrier/Milliman/OHA														5 days									5 days																
4.04	Create reports for current data and compare with carriers	OHA/Carrier																												1-2 weeks										
4.05	If discrepancy is found, work to identify issue	OHA/Carrier																												4-6 weeks										
4.06	If discrepancies reflect real issue, work with Milliman/carrier to agree to a plan for any needed changes in current data	Carrier/Milliman/OHA																																	5 days					

APAC Validation Level 1: Milliman/Carrier Validation

Corresponds to Steps 2.01 - 2.05 of OHA Validation Plan

The tabs in this worksheet list checks that Milliman's file field and quality system (FFQ) will run to validate submissions from data suppliers. These checks will occur after data submission and before validation of Milliman processes (Steps 1.01 - 1.03 and 3.01 - 3.10 respectively).

TABLE NAME	FFQ TYPE	FIELD ORDINAL NUMBER	FIELD NAME	MAXIMUM FIELD LENGTH	MINIMUM FIELD LENGTH	MINIMUM LENGTH THRESHOLD	FIELD FORMAT	BLANKS ALLOWED	VALID VALUES	VALID VALUE THRESHOLD
CONTROL_FILE	FIELD CHECK	1	Payer	6					[dbo].[RFT_Payer_Ids]	100
CONTROL_FILE	FIELD CHECK	2	File	10					Enrollment,Medical,Pharmacy,Provider	100
CONTROL_FILE	FIELD CHECK	3	Data_Rows	8	1	100	Integer			
CONTROL_FILE	FIELD CHECK	4	Amt_Billed	12			Money (Decimal)	Blanks Allowed		
CONTROL_FILE	FIELD CHECK	5	Amt_Paid	12			Money (Decimal)	Blanks Allowed		
CONTROL_MEMBERSHIP	FIELD CHECK	1	Payer	6					[dbo].[RFT_Payer_Ids]	100
CONTROL_MEMBERSHIP	FIELD CHECK	3	Months	6	6	100				
CONTROL_MEMBERSHIP	FIELD CHECK	4	Medical_Members		1	100	Integer			
CONTROL_MEMBERSHIP	FIELD CHECK	5	Pharmacy_members		1	100	Integer			
MEDICAL_CLAIM	FIELD CHECK	1	Payer Type	1					[dbo].[RFT_Payer_type_codes]	100
MEDICAL_CLAIM	FIELD CHECK	2	Product Code	3					[dbo].[RFT_Product_Codes]	100
MEDICAL_CLAIM	FIELD CHECK	3	Claim ID	80	1	100				
MEDICAL_CLAIM	FIELD CHECK	4	Service Line Counter	4	1	100	Integer			
MEDICAL_CLAIM	FIELD CHECK	5	Member ID	30	1	100				
MEDICAL_CLAIM	FIELD CHECK	6	Paid Date	8	8	100	CCYYMMDD (Date)			
MEDICAL_CLAIM	FIELD CHECK	7	Admission Date	8			CCYYMMDD (Date)	Blanks Allowed		
MEDICAL_CLAIM	FIELD CHECK	8	Discharge Status	2					[dbo].[RFT_Discharge_Status_codes]	98.8
MEDICAL_CLAIM	FIELD CHECK	9	Rendering Provider ID	30	1	98.8				
MEDICAL_CLAIM	FIELD CHECK	10	Type of Bill	3						
MEDICAL_CLAIM	FIELD CHECK	11	Place of Service	2					[dbo].[RFT_Site_of_Service_codes]	100
MEDICAL_CLAIM	FIELD CHECK	12	Claim Status	1					C,D,E,P	100
MEDICAL_CLAIM	FIELD CHECK	13	COB Status	1					N,Y	98.8
MEDICAL_CLAIM	FIELD CHECK	14	Principal Diagnosis	7					[dbo].[REF_ICD_DIAG]	98.8
MEDICAL_CLAIM	FIELD CHECK	15	POA Flag 1	1					[dbo].[RFT_POA_Flag]	98.8
MEDICAL_CLAIM	FIELD CHECK	16	Diagnosis 2	7					[dbo].[REF_ICD_DIAG_with_blank]	98.8
MEDICAL_CLAIM	FIELD CHECK	17	POA Flag 2	1					[dbo].[RFT_POA_Flag]	98.8
MEDICAL_CLAIM	FIELD CHECK	18	Diagnosis 3	7					[dbo].[REF_ICD_DIAG_with_blank]	98.8
MEDICAL_CLAIM	FIELD CHECK	19	POA Flag 3	1					[dbo].[RFT_POA_Flag]	98.8
MEDICAL_CLAIM	FIELD CHECK	20	Diagnosis 4	7					[dbo].[REF_ICD_DIAG_with_blank]	98.8
MEDICAL_CLAIM	FIELD CHECK	21	POA Flag 4	1					[dbo].[RFT_POA_Flag]	98.8
MEDICAL_CLAIM	FIELD CHECK	22	Diagnosis 5	7					[dbo].[REF_ICD_DIAG_with_blank]	98.8
MEDICAL_CLAIM	FIELD CHECK	23	POA Flag 5	1					[dbo].[RFT_POA_Flag]	98.8
MEDICAL_CLAIM	FIELD CHECK	24	Diagnosis 6	7					[dbo].[REF_ICD_DIAG_with_blank]	98.8
MEDICAL_CLAIM	FIELD CHECK	25	POA Flag 6	1					[dbo].[RFT_POA_Flag]	98.8
MEDICAL_CLAIM	FIELD CHECK	26	Diagnosis 7	7					[dbo].[REF_ICD_DIAG_with_blank]	98.8
MEDICAL_CLAIM	FIELD CHECK	27	POA Flag 7	1					[dbo].[RFT_POA_Flag]	98.8
MEDICAL_CLAIM	FIELD CHECK	28	Diagnosis 8	7					[dbo].[REF_ICD_DIAG_with_blank]	98.8
MEDICAL_CLAIM	FIELD CHECK	29	POA Flag 8	1					[dbo].[RFT_POA_Flag]	98.8
MEDICAL_CLAIM	FIELD CHECK	30	Diagnosis 9	7					[dbo].[REF_ICD_DIAG_with_blank]	98.8
MEDICAL_CLAIM	FIELD CHECK	31	POA Flag 9	1					[dbo].[RFT_POA_Flag]	98.8
MEDICAL_CLAIM	FIELD CHECK	32	Diagnosis 10	7					[dbo].[REF_ICD_DIAG_with_blank]	98.8
MEDICAL_CLAIM	FIELD CHECK	33	POA Flag 10	1					[dbo].[RFT_POA_Flag]	98.8
MEDICAL_CLAIM	FIELD CHECK	34	Diagnosis 11	7					[dbo].[REF_ICD_DIAG_with_blank]	98.8
MEDICAL_CLAIM	FIELD CHECK	35	POA Flag 11	1					[dbo].[RFT_POA_Flag]	98.8
MEDICAL_CLAIM	FIELD CHECK	36	Diagnosis 12	7					[dbo].[REF_ICD_DIAG_with_blank]	98.8
MEDICAL_CLAIM	FIELD CHECK	37	POA Flag 12	1					[dbo].[RFT_POA_Flag]	98.8
MEDICAL_CLAIM	FIELD CHECK	38	Diagnosis 13	7					[dbo].[REF_ICD_DIAG_with_blank]	98.8
MEDICAL_CLAIM	FIELD CHECK	39	POA Flag 13	1					[dbo].[RFT_POA_Flag]	98.8
MEDICAL_CLAIM	FIELD CHECK	40	Revenue Code	4					[dbo].[REF_MC054_REV_CODE]	98.8
MEDICAL_CLAIM	FIELD CHECK	41	Procedure Code	5					[dbo].[REF_PROC_CODE]	98.8
MEDICAL_CLAIM	FIELD CHECK	42	Procedure Modifier 1	2						
MEDICAL_CLAIM	FIELD CHECK	43	Procedure Modifier 2	2						
MEDICAL_CLAIM	FIELD CHECK	44	Procedure Modifier 3	2						
MEDICAL_CLAIM	FIELD CHECK	45	Procedure Modifier 4	2						
MEDICAL_CLAIM	FIELD CHECK	46	Principal Inpatient Procedure Code	7					[dbo].[REF_ICD_PROC]	98.8
MEDICAL_CLAIM	FIELD CHECK	47	Inpatient Procedure Code 2	7					[dbo].[REF_ICD_PROC]	98.8
MEDICAL_CLAIM	FIELD CHECK	48	Inpatient Procedure Code 3	7					[dbo].[REF_ICD_PROC]	98.8
MEDICAL_CLAIM	FIELD CHECK	49	Inpatient Procedure Code 4	7					[dbo].[REF_ICD_PROC]	98.8
MEDICAL_CLAIM	FIELD CHECK	50	Inpatient Procedure Code 5	7					[dbo].[REF_ICD_PROC]	98.8
MEDICAL_CLAIM	FIELD CHECK	51	Inpatient Procedure Code 6	7					[dbo].[REF_ICD_PROC]	98.8
MEDICAL_CLAIM	FIELD CHECK	52	Inpatient Procedure Code 7	7					[dbo].[REF_ICD_PROC]	98.8
MEDICAL_CLAIM	FIELD CHECK	53	Inpatient Procedure Code 8	7					[dbo].[REF_ICD_PROC]	98.8
MEDICAL_CLAIM	FIELD CHECK	54	Inpatient Procedure Code 9	7					[dbo].[REF_ICD_PROC]	98.8
MEDICAL_CLAIM	FIELD CHECK	55	Inpatient Procedure Code 10	7					[dbo].[REF_ICD_PROC]	98.8
MEDICAL_CLAIM	FIELD CHECK	56	Inpatient Procedure Code 11	7					[dbo].[REF_ICD_PROC]	98.8
MEDICAL_CLAIM	FIELD CHECK	57	Inpatient Procedure Code 12	7					[dbo].[REF_ICD_PROC]	98.8
MEDICAL_CLAIM	FIELD CHECK	58	Inpatient Procedure Code 13	7					[dbo].[REF_ICD_PROC]	98.8
MEDICAL_CLAIM	FIELD CHECK	59	Date of Service – From	8	8	100	CCYYMMDD (Date)			
MEDICAL_CLAIM	FIELD CHECK	60	Date of Service – Thru	8	8	100	CCYYMMDD (Date)			
MEDICAL_CLAIM	FIELD CHECK	61	Quantity	11	1	98.8	Integer			
MEDICAL_CLAIM	FIELD CHECK	62	Charges	12	1	98.8	Money (Decimal)			
MEDICAL_CLAIM	FIELD CHECK	63	Allowed Amount	12	1	98.8	Money (Decimal)			
MEDICAL_CLAIM	FIELD CHECK	64	Paid Amount (Plan Paid)	12	1	98.8	Money (Decimal)			
MEDICAL_CLAIM	FIELD CHECK	65	Prepaid Amount	12			Money (Decimal)	Blanks Allowed		
MEDICAL_CLAIM	FIELD CHECK	66	Co-Pay Amount	12	1	98.8	Money (Decimal)			
MEDICAL_CLAIM	FIELD CHECK	67	Coinsurance Amount	12	1	98.8	Money (Decimal)			
MEDICAL_CLAIM	FIELD CHECK	68	Deductible Amount	12	1	98.8	Money (Decimal)			
MEDICAL_CLAIM	FIELD CHECK	69	Patient Paid/Responsbility Amount	12			Money (Decimal)	Blanks Allowed		
MEDICAL_CLAIM	FIELD CHECK	70	Discharge Date	8			CCYYMMDD (Date)	Blanks Allowed		
MEDICAL_CLAIM	FIELD CHECK	71	Billing Provider ID	39	1	98.8				
MEDICAL_CLAIM	FIELD CHECK	72	Prior Version Claim Number	80						
MEDICAL_CLAIM	FIELD CHECK	73	Claim Receipt Date	8			CCYYMMDD (Date)	Blanks Allowed		
MEDICAL_CLAIM	FIELD CHECK	74	DRG	3						
MEDICAL_CLAIM	FIELD CHECK	75	Type of DRG - MS or CMS	1					[single space],C,M	98.8
MEDICAL_CLAIM	FIELD CHECK	76	LOINC Code	8						
MEDICAL_CLAIM	FIELD CHECK	77	Lab Results	8						

TABLE NAME	FFQ TYPE	FIELD ORDINAL NUMBER	FIELD NAME	MAXIMUM FIELD LENGTH	MINIMUM FIELD LENGTH	MINIMUM LENGTH THRESHOLD	FIELD FORMAT	BLANKS ALLOWED	VALID VALUES	VALID VALUE THRESHOLD
MEDICAL_CLAIM	FIELD CHECK	78	Albumim Results	1						
MEDICAL_CLAIM	FIELD CHECK	79	COB/TPL Allowed Amount	12			Money (Decimal)	Blanks Allowed		
MEDICAL_CLAIM	FIELD CHECK	80	Risk Withhold Amount	12			Money (Decimal)	Blanks Allowed		
MEDICAL_CLAIM	FIELD CHECK	81	Plan Specific Contract Number	30						
MEDICAL_ELIGIBILITY	FIELD CHECK	1	Payer Type	1					[dbo].[RFT_Payer_type_codes]	98.8
MEDICAL_ELIGIBILITY	FIELD CHECK	2	Product Code	3					[dbo].[RFT_Product_Codes]	98.8
MEDICAL_ELIGIBILITY	FIELD CHECK	3	Eligibility Date	8	8	98.8	CCYYMMDD (Date)			
MEDICAL_ELIGIBILITY	FIELD CHECK	4	Termination Date	8	8	98.8	CCYYMMDD (Date)			
MEDICAL_ELIGIBILITY	FIELD CHECK	5	Subscriber ID	30	1	98.8				
MEDICAL_ELIGIBILITY	FIELD CHECK	6	Plan Specific Contract Number	30	1	98.8				
MEDICAL_ELIGIBILITY	FIELD CHECK	7	PEBB Flag	1					0,1	100
MEDICAL_ELIGIBILITY	FIELD CHECK	8	OEBB Flag	1					0,1	100
MEDICAL_ELIGIBILITY	FIELD CHECK	9	Medical Home Flag	1					0,1	100
MEDICAL_ELIGIBILITY	FIELD CHECK	10	Member ID	30	1	98.8				
MEDICAL_ELIGIBILITY	FIELD CHECK	11	Relationship Code	2					[dbo].[RFT_Relationship_codes]	98.8
MEDICAL_ELIGIBILITY	FIELD CHECK	12	Member Gender	1					F,M,U	98.8
MEDICAL_ELIGIBILITY	FIELD CHECK	13	Member Date of Birth	8	8	98.8	CCYYMMDD (Date)			
MEDICAL_ELIGIBILITY	FIELD CHECK	14	Member Street Address	50	1	98.8				
MEDICAL_ELIGIBILITY	FIELD CHECK	15	Member City Name	30	1	98.8				
MEDICAL_ELIGIBILITY	FIELD CHECK	16	Member State or Province	2	1	98.8			[dbo].[rft_StateCodes]	98.8
MEDICAL_ELIGIBILITY	FIELD CHECK	17	Member ZIP Code	10	5	98.8				
MEDICAL_ELIGIBILITY	FIELD CHECK	18	Medical Coverage Flag	1					N,Y	98.8
MEDICAL_ELIGIBILITY	FIELD CHECK	19	Prescription Drug Coverage Flag	1					N,Y	98.8
MEDICAL_ELIGIBILITY	FIELD CHECK	20	Subscriber Last Name	35	1	98.8				
MEDICAL_ELIGIBILITY	FIELD CHECK	21	Subscriber First Name	25	1	98.8				
MEDICAL_ELIGIBILITY	FIELD CHECK	22	Subscriber Middle Name	25						
MEDICAL_ELIGIBILITY	FIELD CHECK	23	Member Last Name	35	1	98.8				
MEDICAL_ELIGIBILITY	FIELD CHECK	24	Member First Name	25	1	98.8				
MEDICAL_ELIGIBILITY	FIELD CHECK	25	Member Middle Name	25						
MEDICAL_ELIGIBILITY	FIELD CHECK	26	Chemical Dependency Inpatient Benefit Flag	1					[dbo].[REF_Y_N_FLAG]	100
MEDICAL_ELIGIBILITY	FIELD CHECK	27	Chemical Dependency DayNight Benefit Flag	1					[dbo].[REF_Y_N_FLAG]	100
MEDICAL_ELIGIBILITY	FIELD CHECK	28	Chemical Dependency Ambulatory Benefit Flag	1					[dbo].[REF_Y_N_FLAG]	100
MEDICAL_ELIGIBILITY	FIELD CHECK	29	Dental Benefit Flag	1					[dbo].[REF_Y_N_FLAG]	100
MEDICAL_ELIGIBILITY	FIELD CHECK	30	Mental Health Inpatient Benefit Flag	1					[single space],N,Y	100
MEDICAL_ELIGIBILITY	FIELD CHECK	31	Mental Health DayNight Benefit Flag	1					[dbo].[REF_Y_N_FLAG]	100
MEDICAL_ELIGIBILITY	FIELD CHECK	32	Mental Health Ambulatory Benefit Flag	1					[dbo].[REF_Y_N_FLAG]	100
MEDICAL_ELIGIBILITY	FIELD CHECK	33	Member Race	1					[dbo].[RFT_Race_codes]	98.8
MEDICAL_ELIGIBILITY	FIELD CHECK	34	Member Ethnicity	1					[dbo].[RFT_Ethnicity_codes]	98.8
MEDICAL_ELIGIBILITY	FIELD CHECK	35	Member Primary Spoken Language	3						
MEDICAL_ELIGIBILITY	FIELD CHECK	36	Oregon HVMH Flag	1					[dbo].[REF_Y_N_FLAG]	98.8
MEDICAL_ELIGIBILITY	FIELD CHECK	37	Oregon HVMH Clinic Name	30						
MEDICAL_ELIGIBILITY	FIELD CHECK	38	Oregon HVMH Eligibility Segment Effective Date	8			CCYYMMDD (Date)	Blanks Allowed		
MEDICAL_ELIGIBILITY	FIELD CHECK	39	Oregon HVMH Eligibility Segment Termination Date	8			CCYYMMDD (Date)	Blanks Allowed		
MEDICAL_ELIGIBILITY	FIELD CHECK	40	Prepaid Amount/PMPM	12						
MEDICAL_ELIGIBILITY	FIELD CHECK	41	OMIP Member Flag	1					[dbo].[REF_bit_flag]	98.8
MEDICAL_ELIGIBILITY	FIELD CHECK	42	Healthy Kids Connect Plan Flag	1					[dbo].[REF_bit_flag]	98.8
MEDICAL_PROVIDER	FIELD CHECK	1	Provider Id	30	1	98.8				
MEDICAL_PROVIDER	FIELD CHECK	2	Provider TIN	9	1	98.8				
MEDICAL_PROVIDER	FIELD CHECK	3	Provider First Name	25						
MEDICAL_PROVIDER	FIELD CHECK	4	Provider Middle Name Initial	1						
MEDICAL_PROVIDER	FIELD CHECK	5	Provider Last Name	100	1	98.8				
MEDICAL_PROVIDER	FIELD CHECK	6	Provider Speciality Code	10					[dbo].[REF_NUCC_TAXONOMY]	98.8
MEDICAL_PROVIDER	FIELD CHECK	7	Provider Second Speciality Code	10					[dbo].[REF_NUCC_TAXONOMY_with_blanks]	98.8
MEDICAL_PROVIDER	FIELD CHECK	8	Provider Third Speciality Code	10					[dbo].[REF_NUCC_TAXONOMY_with_blanks]	98.8
MEDICAL_PROVIDER	FIELD CHECK	9	Provider Street Address 1	50	1	98.8				
MEDICAL_PROVIDER	FIELD CHECK	11	Provider City	30	1	98.8				
MEDICAL_PROVIDER	FIELD CHECK	12	Provider State	2	2	98.8				
MEDICAL_PROVIDER	FIELD CHECK	13	Provider Zip Code	10	5	98.8				
MEDICAL_PROVIDER	FIELD CHECK	14	Provider DEA Number	12						
MEDICAL_PROVIDER	FIELD CHECK	15	Provider NPI	10						
MEDICAL_PROVIDER	FIELD CHECK	16	Provider License Number	15						
MEDICAL_PROVIDER	FIELD CHECK	17	Provider Medicaid Number	12						
MEDICAL_PROVIDER	FIELD CHECK	18	Provider CMS UPIN	12						
MEDICAL_PROVIDER	FIELD CHECK	19	Provider DOB	8			CCYYMMDD (Date)	Blanks Allowed		
MEDICAL_PROVIDER	FIELD CHECK	20	Provider PCP Flag	1					[single space],N,Y	100
MEDICAL_PROVIDER	FIELD CHECK	21	Provider OBGYN Flag	1					[single space],N,Y	100
MEDICAL_PROVIDER	FIELD CHECK	22	Provider Mental Health Flag	1					[single space],N,Y	100
MEDICAL_PROVIDER	FIELD CHECK	23	Provider Eye Care Flag	1					[single space],N,Y	100
MEDICAL_PROVIDER	FIELD CHECK	24	Provider Dental Flag	1					[single space],N,Y	100
MEDICAL_PROVIDER	FIELD CHECK	25	Provider Nephrologist Flag	1					[single space],N,Y	100
MEDICAL_PROVIDER	FIELD CHECK	26	Provider Chemical Dependency Flag	1					[single space],N,Y	100
MEDICAL_PROVIDER	FIELD CHECK	27	Provider Nurse Practitioner Flag	1					[single space],N,Y	100
MEDICAL_PROVIDER	FIELD CHECK	28	Provider Physician Assistant Flag	1					[single space],N,Y	100
MEDICAL_PROVIDER	FIELD CHECK	29	Provider Prescribing Flag	1					[single space],N,Y	100
PHARMACY_CLAIM	FIELD CHECK	1	Payer Type	1					[dbo].[RFT_Payer_type_codes]	100
PHARMACY_CLAIM	FIELD CHECK	2	Plan Specific Contract Number	30	1	98.8				
PHARMACY_CLAIM	FIELD CHECK	3	Member Id	20	1	98.8				
PHARMACY_CLAIM	FIELD CHECK	4	Insurance Type/Product Code	3					[dbo].[RFT_Product_Codes]	98.8
PHARMACY_CLAIM	FIELD CHECK	5	Pharmacy NPI	15	1	98.8				
PHARMACY_CLAIM	FIELD CHECK	6	Provider Alternate ID	15						
PHARMACY_CLAIM	FIELD CHECK	7	Pharmacy Name	35	1	98.8				
PHARMACY_CLAIM	FIELD CHECK	8	Pharmacy City	30	1	98.8				
PHARMACY_CLAIM	FIELD CHECK	9	Pharmacy State	2	1	98.8				
PHARMACY_CLAIM	FIELD CHECK	10	Pharmacy Zip Code	10	1	98.8				
PHARMACY_CLAIM	FIELD CHECK	11	Prescribing Provider NPI	15	1	98.8				
PHARMACY_CLAIM	FIELD CHECK	12	Prescribing Provider DEA Number	12						

TABLE NAME	FFQ TYPE	FIELD ORDINAL NUMBER	FIELD NAME	MAXIMUM FIELD LENGTH	MINIMUM FIELD LENGTH	MINIMUM LENGTH THRESHOLD	FIELD FORMAT	BLANKS ALLOWED	VALID VALUES	VALID VALUE THRESHOLD
PHARMACY_CLAIM	FIELD CHECK	13	Claim Status	3					C,D,E,P	100
PHARMACY_CLAIM	FIELD CHECK	14	National Drug Code	11					[dbo].[REF_NDC]	98.8
PHARMACY_CLAIM	FIELD CHECK	15	Date Filled	8	8	98.8	CCYYMMDD (Date)	Blanks Allowed		
PHARMACY_CLAIM	FIELD CHECK	16	Payment Date	8	8	98.8	CCYYMMDD (Date)	Blanks Allowed		
PHARMACY_CLAIM	FIELD CHECK	17	Quantity	10	1	98.8				
PHARMACY_CLAIM	FIELD CHECK	18	Alternate Refill Number	2			Integer	Blanks Allowed		
PHARMACY_CLAIM	FIELD CHECK	19	Days Supply	3	1	98.8	Integer	Blanks Allowed		
PHARMACY_CLAIM	FIELD CHECK	20	Dispense as Written	1					[dbo].[RFT_Dispense_as_Written_Codes]	98.8
PHARMACY_CLAIM	FIELD CHECK	21	Calculated Refill Number	2			Integer	Blanks Allowed		
PHARMACY_CLAIM	FIELD CHECK	22	Compound Drug Indicator	1			Integer	Blanks Allowed	1,2	98.8
PHARMACY_CLAIM	FIELD CHECK	23	Claim ID (Payer Claim Control Number)	30	1	98.8				
PHARMACY_CLAIM	FIELD CHECK	24	Payment (Plan Paid)	12	1	98.8	Money (Decimal)			
PHARMACY_CLAIM	FIELD CHECK	25	Charge Amount	12	1	98.8	Money (Decimal)			
PHARMACY_CLAIM	FIELD CHECK	26	Ingredient Cost/List Price	12	1	98.8	Money (Decimal)			
PHARMACY_CLAIM	FIELD CHECK	27	Dispensing Fee Paid	12	1	98.8	Money (Decimal)			
PHARMACY_CLAIM	FIELD CHECK	28	Co-Pay Amount	12	1	98.8	Money (Decimal)			
PHARMACY_CLAIM	FIELD CHECK	29	Coinsurance Amount	12	1	98.8	Money (Decimal)			
PHARMACY_CLAIM	FIELD CHECK	30	Deductible Amount	12	1	98.8	Money (Decimal)			
PHARMACY_CLAIM	FIELD CHECK	31	Patient Paid/Responsbility Amount	12			Money (Decimal)	Blanks Allowed		

ACTIVE SQL CHECK	FFQ TYPE	TABLE NAME	SQL CHECK	DESCRIPTION	MIN THRESH	MAX THRESH
1	QUALITY CHECK	MEDICAL_CLAIM	Medical Claim Medicaid Payer Type	Only allows Medicaid Payer Type values to be sent in for DMAP submitted data.	100	100
1	QUALITY CHECK	MEDICAL_CLAIM	Medical Claim Duplicate Check	Medical claim duplicate check on the following fields: CLAIM_ID,SV_LINE,MEMBER_ID,PAID_DATE,SV_STAT	0	1.2
1	QUALITY CHECK	MEDICAL_CLAIM	Admission Date and From Date	Admission Date should be same day or before the From Date	98.8	100
1	QUALITY CHECK	MEDICAL_CLAIM	Admission date not in future	Admit Date should not be a date in the future	98.8	100
1	QUALITY CHECK	MEDICAL_CLAIM	Paid date and From date validation	The paid date should be same day or after the from date.	98.8	100
1	QUALITY CHECK	MEDICAL_CLAIM	Future paid date	Paid date cannot be a date in the future.	98.8	100
1	QUALITY CHECK	MEDICAL_CLAIM	To date and from date check	To date should be same do or after the from date.	98.8	100
1	QUALITY CHECK	MEDICAL_CLAIM	Subscriber ID and Member ID	Subscriber ID values must also be found in Member ID field.	98.8	100
1	QUALITY CHECK	MEDICAL_ELIGIBILITY	Medical Eligibility Medicaid Payer Type	Only allows Medicaid Payer Type values to be sent in for DMAP submitted data.	100	100
1	QUALITY CHECK	MEDICAL_ELIGIBILITY	Eligibility Duplicate Check	MEDICAL_ELIGIBILITY data file has duplicates. Check the values for Member ID, Eligibility date, Termination date, Product code	0	1.2
1	QUALITY CHECK	MEDICAL_PROVIDER	Provider Identifier Check	Medical Provider file should include at least one identifier: Provider NPI, TIN, DEA number, or the state license number.	98.8	100
1	QUALITY CHECK	MEDICAL_PROVIDER	Provider ID duplicate check	Provider ID must be a unique value.	0	0
1	QUALITY CHECK	PHARMACY_CLAIM	Pharmacy Claim Medicaid Payer Type	Only allows Medicaid Payer Type values to be sent in for DMAP submitted data.	100	100
1	QUALITY CHECK	PHARMACY_CLAIM	Pharmacy claim duplicate check	Pharmacy claim duplicate check on the following fields:	0	1.2
0	QUALITY CHECK	MEDICAL_CLAIM	Claim Lines Per Claim	Total number of distinct claim lines divided by total number of distinct claims	1	5
0	QUALITY CHECK	MEDICAL_CLAIM	Claim Lag	Number of records with a Date of Service - From (MC059) of 2 or more years before Date Service Approved/Accounts Payable Date/Actual Paid Date (MC017) divided by the Number of records with a Date of Service - From (MC059) of 2 or more years before Date Service Approved/Accounts Payable Date/Actual Paid Date (MC017) divided by the total number of records	0	0.02
0	QUALITY CHECK	MEDICAL_CLAIM	No Payment Amounts	Number of records with Paid Amount (MC063), Copay Amount (MC065), Coinsurance Amount (MC066), and Deductible Amount (MC067) = 0 divided by the total number of records	0	25
0	QUALITY CHECK	MEDICAL_CLAIM	Billed to Paid Ratio	Total of Paid Amount (MC063) + Copay Amount (MC065) + Coinsurance Amount (MC066) + Deductible Amount (MC067) divided by the total of Charge Amount (MC062)	0.2	1
0	QUALITY CHECK	MEDICAL_CLAIM	Paid Per Claim Line	Total of Paid Amount (MC063) + Copay Amount (MC065) + Coinsurance Amount (MC066) + Deductible Amount (MC067) divided by the total number of number of distinct claim lines	25	250
0	QUALITY CHECK	MEDICAL_CLAIM	Member Paid	Number of records with Copay Amount (MC065), Coinsurance Amount (MC066) and Deductible Amount (MC067) = 0 divided by the total number of records	0	60
0	QUALITY CHECK	MEDICAL_CLAIM	Medical Code Populated	Number of records where the Procedure Code (MC055), Revenue Code (MC054), and ICD9/10 CM Principal Procedure Code (MC058) = NULL or blank divided by the total number of records	0	0.01
0	QUALITY CHECK	MEDICAL_CLAIM	Inpatient Admit Date	Number of inpatient records, based upon Type of Bill (MC036) = `11x` or `12x` or Rev Code (MC054) = `0100-0219`, with Admission Date (MC018) = NULL or blank divided by the total number of inpatient records	0	0.03
0	QUALITY CHECK	MEDICAL_CLAIM	TOB or POS	Type of Bill (MC036) or Place of Service (MC037) must be populated	100	100
0	QUALITY CHECK	MEDICAL_CLAIM	Billing Prov Equal Servicing Prov for Prof Claims	% Professional records with billing provider number = service provider number	0	50
0	QUALITY CHECK	MEDICAL_CLAIM	Thru Date Prior to From Date	Number of records with the Date of Service - From (MC059) on or equal to the Date of Service - Thru (MC060) divided by the total number of records	99.5	100
0	QUALITY CHECK	MEDICAL_CLAIM	Institutional Records with Rev Code	Number of institutional records, based upon Type of Bill - Institutional (MC036) being populated, with Revenue Code (MC054) populated divided by the total number of institutional records	95	100
0	QUALITY CHECK	MEDICAL_CLAIM	Admit Date on non IP Hosp Professional Claims	Number of professional records, based upon Place of Service - Professional (MC037) being populated, containing Admission Date (MC018) when Place of Service - Professional (MC037) does not equal `21` divided by the total number of professional records	99	100
0	QUALITY CHECK	MEDICAL_CLAIM	Professional Claims with Discharge Status	Number of professional records, based upon Place of Service - Professional (MC037) being populated, with Discharge Status (MC023) populated and Place of Service - Professional (MC037) does not equal `21` divided by the total number of professional records	99	100
0	QUALITY CHECK	MEDICAL_CLAIM	Professional Claims with Rev Code	Number of professional records, based upon Place of Service - Professional (MC037) being populated, with Revenue Codes (MC054) populated when Place of Service - Professional (MC037) does not equal `21`, `22`, or `23` divided by the total number of professional records	99	100
0	QUALITY CHECK	MEDICAL_CLAIM	% Incurred month/year = paid month/year	Number of records with incurred month/year, derived from Date of Service - From (MC059) = paid month/year, derived from Accounts Payable Date/Actual Paid Date (MC017) divided by the total number of records	0	99
0	QUALITY CHECK	MEDICAL_CLAIM	% Service dates > paid date	Number of records with Date of Service - From (MC059) later than the Date Service Approved/Accounts Payable Date/Actual Paid Date (MC017) divided by the total number of records	0	98
0	QUALITY CHECK	MEDICAL_CLAIM	% Records with CPT codes on outpatient facility cl	Number of outpatient records, based upon Type of Bill - Institutional (MC036) = `13x`, with Procedure Code (MC055) populated divided by the total number of hospital outpatient records	70	100
0	QUALITY CHECK	MEDICAL_CLAIM	% Inpatient records with discharge status = home	Number of inpatient records, based upon Type of Bill (MC036) = `11x` or `12x` or Rev Code (MC054) = `0100-0219`, with Discharge Status (MC023) =`01` or `81` divided by the total number of inpatient records	50	100
0	QUALITY CHECK	MEDICAL_CLAIM	% Inpatient records with discharge status = died	Number of inpatient records, based upon Type of Bill (MC036) = `11x` or `12x` or Rev Code (MC054) = `0100-02	0	3
0	QUALITY CHECK	MEDICAL_CLAIM	% Records with both paid amount and prepaid amount	Number of records with the Paid Amount (MC063) and the Prepaid Amount (MC064) not equal to 0 divided by	0	3
0	QUALITY CHECK	MEDICAL_ELIGIBILITY	Gender Ratio	Number of records where Member Gender = `M` divided by the total number of records.	35	65
0	QUALITY CHECK	MEDICAL_ELIGIBILITY	Unknown Gender Check	Number of records where Gender = `Unknown` divided by the total number of records.	0	5
0	QUALITY CHECK	MEDICAL_ELIGIBILITY	Average Age Dependent Child	Total age of dependent children divided by the total number of dependent children.	6	18
0	QUALITY CHECK	MEDICAL_ELIGIBILITY	Age 65+ Non-Medicare	Number of records with members older than 65 and not enrolled in a Medicare Product divided by the total nu	0	17
0	QUALITY CHECK	MEDICAL_ELIGIBILITY	Extreme Ages	Number of records with members older than 115 or where DOB is after expiry of membership divided by the to	0	3
0	QUALITY CHECK	MEDICAL_ELIGIBILITY	Valid Oregon Zip	Number of records with Member Zip Code not belonging to primary state divided by the total number of recor	0	5
0	QUALITY CHECK	MEDICAL_ELIGIBILITY	Subscriber Name	Number of records with subscriber name not member name and Individual Relationship Code) is `18` or `20` c	0	1
0	QUALITY CHECK	MEDICAL_PROVIDER	ProviderToFacilityRatio	Number of records where Provider First Name and Provider Middle Name are empty or spaces and Provider La	0	85

TABLE 1	TABLE 2	CROSS FILE CHECK
MEDICAL_CLAIM	MEDICAL_PROVIDER	The Rendering Provider ID value in the MEDICAL_CLAIM data file does not match to any value in Provider ID in the MEDICAL_PROVIDER data file
MEDICAL_CLAIM	MEDICAL_PROVIDER	The Billing provider ID value in the MEDICAL_CLAIM data file does not match to any value in Provider ID in the MEDICAL_PROVIDER data file
MEDICAL_CLAIM	MEDICAL_ELIGIBILITY	The Member ID value in the MEDICAL_CLAIM data file does not match to any value in Member ID in the MEDICAL_ELIGIBILITY data file
PHARMACY_CLAIM	MEDICAL_ELIGIBILITY	The Patient ID value in the PHARMACY_CLAIM data file does not match to any value in Member ID in the MEDICAL_ELIGIBILITY data file
MEDICAL_ELIGIBILITY	MEMBERSHIP_CONTROLS	The Medical and Pharmacy member months in MEDICAL_ELIGIBILITY should match the summarized totals in the MEMBERSHIP file
CONTROL_FILE	PROVIDER, ELIGIBILITY AND CLAIMS	Record counts and dollars should match the summarized totals in the CONTROL_FILE

APAC Validation Level 2: Validation of Milliman Processes

Corresponds to Step 3.01 – 3.10 of OHA APAC Validation Plan

This table describes steps that Milliman will take to ensure the validity of data available through SQL views, Public Use and Limited Data Set extracts, and the MedInsight portal. These steps come after validation of data supplier submissions by Milliman's file field and quality system (FFQ), and before OHA validation with carriers (Steps 2.01 – 2.05 and 4.01 – 4.06 respectively).

Process	Category	Description
MedInsight Staging	MedInsight Process	Source data moved into MedInsight staging database.
	Data Quality	At the aggregate level, membership and claims are reviewed by month and compared to prior refreshes staging totals.
		At the payer level, claims, membership and PMPMs are reviewed by month and compared to data found in production database.
	Notes	• In 2015 we are hoping to run/review MedInsight data quality audits by payer each refresh after staging runs. ETA 3rd Quarter 2015. • Claims are loaded incrementally (12 months of claims are processed through staging and will completely replace that Payer's paid month's data in the production database).
MedInsight Processing	MedInsight Process	Staging data loaded/combined with other processed data, analytic engines are run.
	Data Quality	At the aggregate level, membership and claims are reviewed by month and compared to prior refreshes values.
		At the payer level, claims, membership and PMPMs are reviewed by month and compared to data found in production database.
		Engine output reviewed: HCG grouper, Benchmarks, IBNR, EBMs, Episodes
	Notes	• As part of MedInsight processing, Substance Abuse related claims are deleted from the claims fact and will cause discrepancies compared to claims data found in staging database.
AS Cube Build	MedInsight Process	Two Analysis Services cubes are processed that serve as the data sources for OHA's MedInsight portal.
	Data Quality	Membership and claims are confirmed to match the values in the SQL database.
Transfer	MedInsight Process	MI_OAP SQL database and both AS cubes are transferred from the processing server to the frontend server for OHA to access.
	Data Quality	MedInsight confirms cubes and SQL database transferred successfully.
Notification	Notification	MedInsight sends email notification to OHA that data has been updated and is available for use.
Public and Limited Data Sets	MedInsight Process	Public use extracts created on a quarterly basis. Limited extract table built on frontend server.
	Data Quality	Confirmation that no errors occurred in creation of Public Use Extract files.
		Row count reviewed after creation of Limited Data Set.
Notification	Notification	MedInsight sends email notification to OHA that data sets are available.

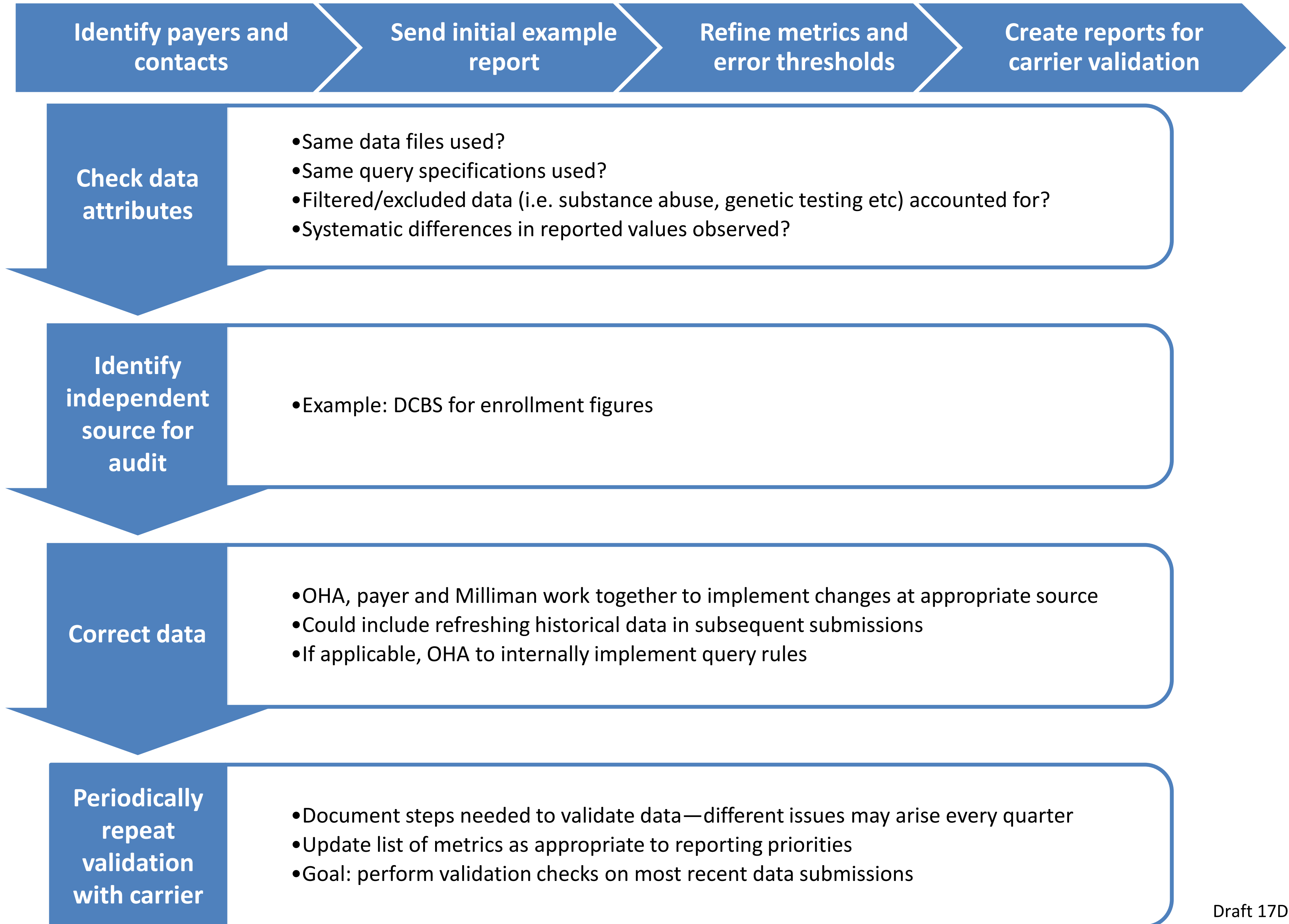
Draft Measures for Validation

Corresponds to Steps 4.01 - 4.04 of OHA APAC Validation Plan

Heading	Metrics	Time period	Stratification
Dollars	Billed Paid Allowed amounts Cost-sharing (total)	2012, 2013 Q1 and Q2	Total and PMPM Payer LOB Incurred year/mo
Enrollment	Medical MM Rx mm Unique individuals	2012, 2013 Q1 and Q2	Payer LOB Incurred year/mo
Utilization	Scripts	2012, 2013 Q1 and Q2	Total and /1000 Payer LOB Incurred year/mo

Draft Process for Resolving OHA/Carrier Report Discrepancies

Corresponds to Steps 4.02 - 4.05 and 4.03 - 4.06 of OHA APAC Validation Plan



Draft 17Dec2014

All Payer All Claims Technical Advisory Group (TAG)
December 9, 2014 Meeting Summary

ATTENDANCE

Members

- ☑ Wendy Apland, PeaceHealth
- ☑ Ben Chan, CHSE
- ☐ Krista Collins, OPCA
- ☑ Bill Dwyer, Moda Health
- ☑ Bernadette Inskeep, United Health
- ☐ Joe Lyons, SEIU
- ☑ John Limm, LifeWise
- ☑ Cindi McElhaney, Q Corp
- ☑ Colleen McManamon, Regence
- ☐ Leif Rustvold, CORE
- ☑ Brian Sikora, Kaiser Permanente
- ☐ Jeanette Sims, PacificSource
- ☐ Danielle Sobel, OMA

Other Attendees

- Chris Alman
- Ethan Baldwin, DCBS
- Betsy Boyd-Flynn, Q Corp
- Lori Coyner, OHA
- Al Prysunka, Milliman
- Michael Sink, DCBS
- Will Wiegel, Milliman
- Gayle Woods, DCBS

Facilitator: Robin Gumpert, DS Consulting

SUMMARY

1. **APAC Data Sharing with DCBS**
   OHA introduced Toni Flitcraft, its new APAC Project Manager, and updated the TAG on the status of a draft data use agreement to share APAC data with DCBS.
   - The TAG discussed how the location of health plan members represented in APAC data would affect its use for DCBS's rate review process (APAC data are for members with Oregon residential addresses; DCBS considers data on employers with Oregon addresses, but some of these employers may have employees with residential addresses outside Oregon). DCBS stated that APAC data would be sufficient for rate review.

2. **Data Validation Plan and Timeline**
   OHA updated the TAG on preparation of an APAC validation plan and timeline.
   - OHA anticipates that it will be able to share a preliminary APAC report with statewide metrics in March 2015.

3. **Process for Adding Fields to APAC**
   Milliman presented on the process and timeline for adding fields to APAC (slide deck posted to APAC TAG website).
   - For the July 2015 submission, which would contain proposed fields recommended by the TAG, Milliman stated that it could accommodate data going back to January 2015.
   - A data supplier representative informed the TAG that there is a core format for claims database submissions that has been vetted by the national All Payer Claims Database (APCD) Council, which several states use. Adoption of this format across states would shorten turnaround time for data suppliers that submit in multiple states.
   - Milliman added that adoption of the APCD format would facilitate comparison of claims based measures across states. If switching to the format would represent a big change,

states should consider costs and benefits to themselves, payers, and other stakeholders.

4. **Recommendations for Data Fields to Add in July 2015 Submission**
   The TAG discussed the refined list of proposed fields prepared by OHA (posted to website) and categorized each field into one of four buckets:

Category	Field
Consensus: The TAG reached consensus on recommending the field for inclusion in submissions beginning July 2015. The first submission would include data back to January 2014. Consensus was measured using the Five-Finger Consensus Tool introduced at the October meeting (posted to website).	Admission Type
	Admit Source
	Admitting Diagnosis
	High Deductible Health Plan Flag
	Pay to Patient Flag
	Primary Insurance Indicator
Table for now: The field is potentially important, but more information or a detailed definition is needed before the TAG can recommend that it be included in submissions. The TAG will revisit the field and consider it for a submission period after July 2015.	Allowed Amount, Pharmacy Claims File
	Carrier Plan Specific Contract Number
	Group Name
	Payment Arrangement Type
	Patient Account Number
Already in APAC: The field is already in APAC or can be derived from a field already in APAC.	Claim Type
	E-Code
	Generic Drug Indicator
	V-Code
Drop: The field is not sufficiently important for further consideration right now.	Increase Diagnosis Codes to 25
	Increase Procedure Codes to 25

5. **Public Comment**
   Kris Alman gave public comment on issues that she asked the TAG to examine during their work together. Her (written comments were distributed to the TAG in advance of the meeting). She was thanked for taking the time to participate.

STAFF ACTION ITEMS

#	Action	Due Date
1	Poll TAG members on preferences for a standard meeting date and time (e.g., first Thursday of each month)	12/19/14
2	Share an updated draft validation plan and timeline with TAG members.	01/09/15
3	Working with Milliman , collect more information or propose detailed definitions for fields in the “Table” bucket and distribute to TAG. • For Allowed Amount, Pharmacy Claims File: – Identify and distribute industry standard formula for calculating Allowed Amount. – Data supplier representatives will determine how their organization calculates Allowed Amount internally and report back. • Collect information on data definitions for Payment Arrangement Type used by other states implementing this field; present information and propose options. • Research and propose options for Carrier Plan Specific Contract Number, Group Name, and Patient Account Number (Group Number and Parent Group Number might be alternatives to Group Name).	01/09/15