Indenting only for review purposes only and must be removed before submitting to Secretary of State

ALL PAYER ALL CLAIMS DATA REPORTING PROGRAM – proposed changes

409-025-0100
Definitions

(23) “Dental claims file” means a data set composed of dental (oral?) health care service level remittance information for all adjudicated claims for each billed service including but not limited to member demographics, provider information, charge and payment information, and clinical diagnosis and procedure codes for an Oregon resident as defined in ORS 803.355 or a non-Oregon resident who is a member of a PEBB or OEBB group health insurance plan.

(54) “LAN group’ means the framework used by the Health Care Payment Learning and Action Network payment arrangement categories. The framework uses six categories to classify payment arrangements.

(a) Category 1 is fee for service with no link to quality or value measures.

(b) Category 2 is fee for service with some link to quality or value and includes foundational payments for infrastructure and operations, pay for reporting data, and pay for performance.

(c) Category 3 is fee for service architecture with alternative payment methodologies built on and includes shared savings and shared risk.

(d) Category 3N is risk-based payments are not linked to quality measures.

(e) Category 4 is population-based payments including condition-specific population-based payments, comprehensive population-based payments and integrated finance and delivery systems.

(f) Category 4N is capitated payments not linked to quality.

(67) “Payment Arrangement File” means a data set composed of total and primary care-related dollars disbursed, by payment arrangement and line of business.

(84) “Special Needs Plan” means a Medicare health benefit plan created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) and the federal regulations adopted to implement the Act that is specifically designed to provide targeted care to individuals with special needs.

1 **409-025-0110**

2 **General Reporting Requirements**

3 (2) If an organization is notified of mandatory reporter status and believes the
4 determination to be in error, the organization must contact the Authority to contest the
5 determination as described in the notice no later than ninety days prior to the first
6 scheduled date of submission of production files.

7 **409-025-0120**

8 **Claims-based Data: File Layout, Format, and Coding Requirements**

9 (1) All mandatory reporters shall submit claims-based data for all claims where the
10 subscriber's residence is in Oregon or the subscriber is enrolled in a plan for which the
11 State of Oregon is the payer.

12 (2) Claims-based data files shall include:

13 (a) Eligibility

14 (b) Membership Total and Claims Controls; ;

15 (c) Subscriber billed premiums ;

16 (d) Provider;

17 (e) Medical claims

18 (f) Dental claims; and

19 (g) Pharmacy Claims.

20 (3) The Eligibility file formerly designated Appendix B shall be submitted by all
21 mandatory reporters using the approved layout, format, and coding described in
22 Eligibility File Layout version 2020.1.

23 (a) Mandatory reporters shall report race and ethnicity data as outlined in the
24 Eligibility File Layout. This layout aligns with the Office of Management and
25 Budget's (OMB) Federal Register Notice of October 30, 1997 (62 FR 58782-
26 58790).

27 (b) Mandatory reporters shall report primary language in accordance with
28 ANSI/NISO guidance using the three-character string outlined in Codes for the
29 Representation of Languages for Information Interchange.

30 (c) Race, ethnicity and primary language data shall be collected in a manner that
31 aligns with the following principles:

32 (A) To the greatest extent practicable, race, ethnicity, and preferred
33 language shall be self-reported.

(i) Collectors of race, ethnicity and primary language data may not assume or judge ethnic and racial identity or preferred signed, written and spoken language, without asking the individual.

(ii) If an individual is unable to self-report and a family member, advocate, or authorized representative is unable to report on his or her behalf, the information shall be recorded as unknown.

(B) When an individual declines to identify race, ethnicity or preferred language, the information shall be reported as refused.

(4) The Membership Total and Claims Control file formerly designated Appendix E shall be submitted by all mandatory reporters using the approved layout, format, and coding described in Claims Control File Layout version 2020.1.

(5) The Subscriber billed premium file formerly designated Appendix F shall be submitted by all mandatory reporters using the approved layout, format, and coding described in Subscriber billed Premium File Layout version 2020.1.

(5) The Provider file formerly designated Appendix C shall be submitted by all mandatory reporters other than PBMs and CCOs using the approved layout, format, and coding described in Provider File Layout version 2020.1.

(6) The Medical Claims file formerly designated Appendix A shall be submitted by all mandatory reporters other than PBMs, CCOs and dental carriers using the approved layout, format, and coding described in the Medical Claims File Layout version 2020.1.

(7) The Dental Claims file shall be submitted by all mandatory reporters other than PBMs and CCOs who provide dental coverage using the approved layout, format, and coding described in the Dental Claims File Layout version 2020.1.

(8) The Pharmacy Claims file formerly designated Appendix D shall be submitted by PBMs and carriers using the approved layout, format, and coding described in the Pharmacy File Layout version 2020.1.

409-025-0125

Payment Arrangement Reporting: File Layout, Format, and Coding Requirements

(1) All mandatory reporters other than PBMs shall report payment arrangements for all contracts sitused in Oregon. For contracts issued at the group level, the contract is considered sitused where the contract is sold. For contracts that are issued at the individual level, the contract is considered sitused where the individual resides.

(2) All data files shall include:

(a) Payment arrangement file formerly designated Appendix G; and

(b) Payment arrangement control totals formerly designated Appendix H.

(3) The payment arrangement file shall be submitted using the approved layout, format, and coding described in the Payment Arrangement File Layout version 2020.1.

(4) The Payment arrangement control file shall be submitted using the approved layout, format, and coding described in Payment arrangement control totals file layout version 2020.1.

(5) All data elements are required unless specified as optional or situational.

(6) All required data files shall be submitted as delimited ASCII files.

(7) Numeric data are positive integers unless otherwise specified.

(a) Negative values are allowed for revenue codes, quantities, charges, payment, co-payment, co-insurance, deductible, and prepaid amount.

(b) Negative values shall be preceded by a minus sign.

(8) All data files shall pass edit checks and validations implemented by the Authority or the data vendor.

(a) Data vendors may perform quality and edit checks on data file submissions. If data files do not pass data vendor edit checks or validation, mandatory reporters must make corrections and resubmit data. Mandatory reporters must submit corrected data or an exception request within 14 calendar days of notification of error.

(b) Mandatory reporters must participate in efforts to validate and check the quality of current and historic APAC data, as prescribed and requested by the Authority.

(A) The Authority may request from any mandatory reporter information from their internal records that is reasonably necessary to validate and check the quality of APAC data. This information may include, but is not limited to, aggregated number of enrolled members, number of claims and claim lines, charges, allowed amounts, paid amounts, co-insurance, co-payments, premiums, number of visits to primary care, emergency department, inpatient, and other health care treatment settings, and number of prescriptions.

(B) Mandatory reporters shall provide the aggregated information within 30 days of the Authority's request.

(C) If the Authority finds errors through edit checks or validation, mandatory reporters must make corrections and resubmit data or submit an exception request within 30 days or at the next regularly scheduled submission due date.