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PERMANENT ADMINISTRATIVE ORDER

FILED
09/02/2021 9:22 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

OHP 3-2021

CHAPTER 409
OREGON HEALTH AUTHORITY
HEALTH POLICY AND ANALYTICS

FILING CAPTION: Updates to All Payer All Claims rules; Repeal Primary Care Services Reporting rules

EFFECTIVE DATE: 09/02/2021

AGENCY APPROVED DATE: 08/31/2021

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RULES:
409-025-0100, 409-025-0120, 409-025-0125, 409-025-0160, 409-027-0005, 409-027-0015, 409-027-0025

AMEND: 409-025-0100

RULE TITLE: Definitions

NOTICE FILED DATE: 07/14/2021

RULE SUMMARY: Updated to recognize use of Appendix 1 for reporting requirements of Sections 1, 3, 4 and 5, chapter 575, Oregon Laws 2015.

RULE TEXT:
The following definitions apply to OAR 409-025-0100 to 409-025-0190:
(1) “Accident policy” means an insurance policy that provides benefits only for a loss due to accidental bodily injury.
(2) “Allowed amount” means the actual amount of charges for healthcare services, equipment, or supplies that are covered expenses under the terms of an insurance policy or health benefits plan.
(3) “APAC” means all payer all claims.
(4) “APM” means alternative payment methodology.
(5) “Association” means any organization, including a labor union, that has an active existence for at least one year, that has a constitution and bylaws and that has been organized and is maintained in good faith primarily for purposes other than that of obtaining insurance.
(6) “Attending provider” means the individual health care provider who delivered the health care services, equipment, or supplies specified on a health care claim.
(7) “Authority” means the Oregon Health Authority.
(8) “Billing provider” means the individual or entity that submits claims for health care services, equipment, or supplies delivered by an attending provider.
(9) “Capitated services” means services rendered by a provider through a contract in which payments are based upon a fixed monthly dollar amount for each enrollee.
(10) “Carrier” shall have the meaning given that term in ORS 743B.005.
(11) “Certificate of authority” shall have the meaning given that term in ORS 731.072.

(12) “Charges” means the actual dollar amount charged on the claim.
(13) “Claim” means an encounter or request for payment under the terms of an insurance policy, health benefits plan, Medicare, or Medicaid.
(14) "Coinsurance" means the percentage an enrollee pays toward the cost of a covered service.
(15) “Control totals file” means a data set containing summary information on medical, pharmacy and dental claims, members, providers, and premiums used to validate the detailed files submitted.
(16) “Coordinated Care Organization (CCO)” shall have the meaning given that term in ORS 414.025.
(17) "Copayment" means the fixed dollar amount an enrollee pays to a health care provider at the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.
(18) “Data file” means electronic health information including medical claims files, eligibility files, medical provider files, pharmacy claims files, dental claims files, control totals files, subscriber-billed premiums files, payment arrangement files and any other related information specified in these rules.
(19) “Data set” means a collection of individual data records, whether in electronic or manual files.
(20) “Data vendor” means the entity under contract with the Authority to administer in whole or in part the all payer all claims database and related functions.
(21) “DCBS” means the Oregon Department of Consumer and Business Services.
(22) “Deductible” means the total dollar amount an enrollee pays toward the cost of covered services over an established period before the carrier or third-party administrator makes any payments under an insurance policy or health benefit plan.
(23) “De-identified health information” means health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.
(24) “Dental claims file” means a data set comprised of dental health care service level remittance information for all adjudicated claims for each billed service including but not limited to 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-resident who is a member of a PEBB or OEBB group health insurance plan.
(25) “Direct personal identifier” means information relating to an individual patient or enrollee that contains primary or obvious identifiers, including:
(a) Names;
(b) Business names when that name would serve to identify a person;
(c) Postal address information other than town or city, state, and 5-digit zip code;
(d) Specific latitude and longitude or other geographic information that would be used to derive postal address;
(e) Telephone and fax numbers;
(f) Electronic mail addresses;
(g) Social security numbers;
(h) Vehicle identifiers and serial numbers, including license plate numbers;
(i) Medical record numbers;
(j) Health plan beneficiary numbers;
(k) Certificate and license numbers;
(L) Internet protocol (IP) addresses and uniform resource locators (URL) that identify a business that would serve to identify a person;
(m) Biometric identifiers, including finger and voice prints; and
(n) Personal photographic images.
(26) “Disability policy” means an insurance policy that provides benefits for losses due to a covered illness or disability.
(27) “Disclosure” means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.
(28) “DRC” means Data Review Committee.
(29) “Dual eligible special needs plan” means a special needs plan that enrolls beneficiaries entitled to both Medicare

and Medicaid.
(30) “Eligibility file” means a data set containing demographic information for each individual enrollee eligible for medical benefits for one or more days of coverage at any time during a calendar month 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.
(31) “Eligible employee” shall have the meaning given that term in ORS 743B.005.
(32) “Employee” shall have the meaning given that term in ORS 654.005.
(33) “Employer” shall have the meaning given that term in ORS 654.005.
(34) “Encrypted identifier” means a code or other means of identification to allow individual patients or enrollees to be tracked across data sets without revealing their identity.
(35) "Encryption" means a method by which the true value of data has been disguised to prevent the identification of individual patients or enrollees and does not provide the means for recovering the true value of the data.
(36) “Enrollee” means enrollee as defined in ORS 743B.005.
(37) “ERISA” means the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001.
(38) “Facility” means a health care facility as defined in ORS 442.015.
(39) “Genetic test” shall have the meaning given that term in ORS 192.531.
(40) “Group health insurance” shall have the meaning given that term in ORS 731.098.
(41) “Health benefit plan” shall have the meaning given that term in ORS 743B.005.
(42) “Health care” shall have the meaning given that term in ORS 192.556.
(43) “Health care operations” means certain administrative, financial, legal, and quality improvement activities that are necessary to run programs including, but not limited to, conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, case management and care coordination, evaluating practitioner, provider, or health plan performance, and underwriting, enrollment, premium rating and other activities related to creation, renewal, or replacement of a health insurance contract.
(44) “Health care provider” shall have the meaning given that term in ORS 192.556.
(45) “Health information” shall have the meaning given that term in ORS 192.556.
(46) “Health insurance exchange” shall have the meaning given that term in ORS 741.300.
(47) “Healthcare Common Procedure Coding System (HCPCS)” means a medical code set, maintained by the United States Department of Health and Human Services, that identifies health care procedures, equipment, and supplies for claim submission purposes.
(48) “HIPAA” means Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d, et seq. and the federal regulations adopted to implement the Act.
(49) “Hospital indemnity policy” means an insurance policy that provides benefits only for covered hospital stays.
(50) “Indirect personal identifier” means information relating to an individual patient or enrollees that a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods could apply to render such information individually identifiable by using such information alone or in combination with other reasonably available information.
(51) “Individual”, when used in a list of required lines of business, means individual health benefit plans.
(52) “Individually identifiable health information” shall have the meaning given that term in ORS 192.556.
(53) “Insurance” shall have the meaning given that term in ORS 731.102.
(54) “Labor union” means any organization which is constituted for the purpose, in whole or in part, of collective bargaining or dealing with employers concerning grievances, terms or conditions of employment or of other mutual aid or protection in connection with employees.
(55) “Large group” means health benefit plans for employers with more than 50 employees.
(56) “Long-term care insurance” shall have the meaning given that term in ORS 743.652.
(57) “Mandatory reporter” means any reporting entity defined as a mandatory reporter in OAR 409-025-0110.
(58) “Medicaid” means medical assistance provided under 42 U.S.C. section 1396a (section 1902 of the Social Security Act) or Children’s Health Insurance Program (CHIP) medical assistance provided under 42 U.S.C section 1397aa-mm

(section 2103 of the Social Security Act), as administered by the Division of Medical Assistance Programs.
(59) “Medicaid fee-for-service” (Medicaid FFS) means that portion of Medicaid where a health care provider is paid a fee for each covered health care service delivered to an eligible Medicaid patient.
(60) “Medical claims file” means a data set composed of health care service level remittance information for all adjudicated claims for each billed service including but not limited to 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.
(61) “Medicare” means coverage under Part A, Part B, Part C, or Part D of Title XVIII of the Social Security Act, 42 U.S.C. 135 et seq., as amended.
(62) “Non-claims based primary care expenditures” means resources given to a primary care provider or practice for services and are not otherwise in a fee-for-service arrangement.
(63) “OEBB” means the Oregon Educators Benefit Board.
(64) “OMIP” means the Oregon Medical Insurance Pool.
(65) “Paid amount” means the actual dollar amount paid for claims.
(66) “Patient” means any person in the data set who is the subject of the activities of the claim performed by the health care provider.
(67) “Patient-Centered Primary Care Home” or “PCPCH” means a health care team or clinic as defined in ORS 414.655 that meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.
(68) “Payment arrangement file” means a data set composed of total and primary care-related dollars disbursed, by payment arrangement and line of business.
(69) “PEBB” means the Oregon Public Employees’ Benefit Board.
(70) “Person” shall have the meaning given that term in ORS 731.116.
(71) “Pharmacy benefit manager (PBM)” means a person or entity that performs pharmacy benefit management, including a person or entity in a contractual or employment relationship with a person or entity performing pharmacy benefit management for a health benefits plan.
(72) “Pharmacy claims file” means a data set containing service level remittance information from all adjudicated claims including, but not limited to provider information, charge and payment information, and national drug 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.
(73) “Policy” shall have the meaning given that term in ORS 731.122.
(74) "Prepaid amount" means the fee for the service equivalent that would have been paid for a specific service if the service had not been capitated.
(75) “Premium” shall have the meaning given that term in ORS 743B.005.
(76) “Primary care” means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.
(77) “Primary care provider” means:
(a) A physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care.
(b) A health care team or clinic certified by the Authority as a PCPCH.
(78) “Principal investigator (PI)” means the person in charge of a research project that makes use of limited data sets. The PI is the custodian of the data and shall comply with all state and federal restrictions, limitations, and conditions of use associated with the data release.
(79) “Protected health information” shall have the meaning given that term in ORS 192.556.
(80) “Provider file” means a data set containing information about health care providers providing health.
(81) “Public health authority” means the Public Health Division of the Authority or local public health authority as defined in ORS 431A.005.

(82) “Public health purposes” means the activities of a public health authority for preventing or controlling disease, injury, or disability including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, investigations, and interventions.
(83) “Registered entity” means any person required to register with DCBS under ORS 744.714.
(84) “Reporting entity” means:
(a) An insurer as defined in ORS 731.106 or fraternal benefit society as defined in ORS 748.106 required to have a certificate of authority to transact health insurance business in Oregon;
(b) A health care service contractor as defined in ORS 750.005 that issues medical insurance in Oregon;
(c) A third-party administrator required to obtain a license under ORS 744.702;
(d) A pharmacy benefit manager or fiscal intermediary, or other person that is by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service;
(e) A coordinated care organization as defined in ORS 414.025; and
(f) An insurer providing coverage funded under Part A, Part B, or Part D of Title XVIII of the Social Security Act, subject to approval by the United States Department of Health and Human Services.
(85) “Research” means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalized knowledge.
(86) “Self-insured plan” means any plan, program, contract, or any other arrangement under which one or more employers, unions, or other organizations provide health care services or benefits to their employees or members in this state, either directly or indirectly through a trust or third-party administrator.
(87) “Small employer health insurance” means health benefit plans for employers whose workforce consists of at least two but not more than 50 eligible employees.
(88) “Special Needs Plan” means a Medicare health benefit plan created by the Medicare Modernization Act that is specifically designed to provide targeted care to individuals with special needs.
(89) “Specific disease policy” means an insurance policy that provides benefits only for a loss due to a covered disease.
(90) “Strongly-encrypted” means an encryption method that uses a cryptographic key with many random keyboard characters.
(91) “Subscriber” means the individual responsible for payment of premiums or whose employment is the basis for eligibility for membership in a health benefit plan.
(92) “Subscriber-billed Premium File” means the data set that includes premium information at the subscriber level for medical, pharmacy and dental insurance.
(93) “Summarized data” means data aggregated by one or more categories. Summarized data created from protected health information may not contain direct or indirect identifiers.
(94) “Third-party administrator (TPA)” means any person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on, residents of Oregon or residents of another state from offices in Oregon, in connection with life insurance or health insurance coverage; or any person or entity who must otherwise be licensed under ORS 744.702.
(95) “Transact insurance” shall have the meaning given that term in ORS 731.146.
(96) “Trust” means a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association.
(97) “Vision policy” means a health benefits plan covering only vision health care.
(98) “Voluntary reporter” means any registered or reporting entity, other than a mandatory reporter, that voluntarily elects to comply with the reporting requirements in OAR 409-025-0100 to 409-025-0170.

STATUTORY/OTHER AUTHORITY: ORS 443.373

STATUTES/OTHER IMPLEMENTED: ORS 443.373, ORS 442.372

AMEND: 409-025-0120

RULE TITLE: Data File Layout, Format, and Coding Requirements

NOTICE FILED DATE: 07/14/2021

RULE SUMMARY: Updated 409-025-0120 to align title of appendix (from Eligibility to Enrollment) with technical documentation including file naming conventions.

RULE TEXT:

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

(2) Claims-based data files shall include:

(a) Enrollment;

(b) Medical claims;

(c) Pharmacy claims;

(d) Dental claims;

(e) Provider;

(f) Subscriber-billed premiums; and

(g) Control totals files.

(3) The enrollment file shall be submitted by all mandatory reporters except CCOs using the approved layout, format, and coding described in Appendix A, Enrollment.

(a) Mandatory reporters shall report race and ethnicity data as outlined in Appendix A, Enrollment. This layout aligns with the Office of Management and Budget's (OMB) Federal Register Notice of October 30, 1997 (62 FR 58782-58790).

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

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

(A) To the greatest extent practicable, race, ethnicity, and preferred 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 files shall be submitted by all mandatory reporters except CCOs using the approved layout, format, and coding described in Appendix G, Membership Total and Claims Control.

(5) The subscriber-billed premium file shall be submitted by all mandatory reporters except CCOs using the approved layout, format, and coding described in Appendix F, Subscriber-Billed Premium.

(6) The provider file shall be submitted by all mandatory reporters other than PBMs and CCOs using the approved layout, format, and coding described in Appendix E, Provider.

(7) The medical claims file shall be submitted by all mandatory reporters other than PBMs, CCOs, and dental carriers using the approved layout, format, and coding described in Appendix B, Medical Claims.

(8) The pharmacy claims file shall be submitted by PBMs and carriers using the approved layout, format, and coding described in Appendix C, Pharmacy Claims.

(9) 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 Appendix D, Dental Claims.

(10) All data elements are required unless specified as optional or situational within the file layout.

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

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

(a) Negative values are allowed for quantities, charges, payment, co-payment, co-insurance, deductible, and prepaid amount.
(b) Negative values shall be preceded by a minus sign.
(13) All data files shall pass edit checks and validations implemented by the Authority or the Authority's 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 by the Authority or the Authority's data vendor of the 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 mandatory reporter's 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.

STATUTORY/OTHER AUTHORITY: ORS 442.466

STATUTES/OTHER IMPLEMENTED: ORS 442.464, 442.466

Claims data files must include data for all claims where the subscriber's residence is in Oregon or the subscriber is enrolled in a plan for which the State of Oregon is the payer. OAR 409-025-0120

Appendix A: Enrollment

All Mandatory Reporters must submit this file. OHA acts as the data submitter for CCOs by contract.

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
ME001	Payer type	Text	1	Yes	See lookup table ME001	0.0%
ME003	Product code	Text	4	Yes	See lookup table ME003	0.0%
ME004A	Eligibility date	Date	8	Yes	CCYYMMDD (example 20200501) Dates before the submission date range are not valid. See Schedule A for submission date range	0.0%
ME005A	Termination date	Date	8	Yes	CCYYMMDD Use 99991231 if termination date is open-ended	0.0%
ME007	Subscriber ID	Text	30	Yes	Plan-specific unique identifier for subscriber	1.2%
ME009	Plan specific contract number	Text	30	Yes	Plan specific contract number, AKA group number	1.2%
ME009A	PEBB flag	Numeric	1	Yes	Public Employees Benefits Board Valid values: 1 (PEBB group) 0 (otherwise)	0.0%
ME009B	OEBB flag	Numeric	1	Yes	Oregon Educators Benefits Board Valid values: 1 (OEBB group) 0 (otherwise)	0.0%
ME009C	Medical home flag	Numeric	1	Situational	Valid values: 1 (Medical home plan) 0 (otherwise) Not required when ME001 = E (Dental)	0.0%
ME010	Member ID	Text	30	Yes	Plan-specific unique identifier for member	0.0%
ME012	Relationship code	Numeric	2	Yes	See lookup table ME012	1.2%
ME013	Member gender	Text	1	Yes	Valid values: M (male) F (female) and U (unknown)	1.2%
ME014	Member date of birth	Date	8	Yes	CCYYMMDD (example: 19570402) Leave blank if unavailable	1.2%
ME015A	Member's street address	Text	50	Yes	Member's primary street address. If member's address is missing, default to subscriber's address. Example: 123 Main Street	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
ME015	Member city	Text	30	Yes	Example: Grants Pass	1.2%
ME016	Member state	Text	4	Yes	Example: OR	1.2%
ME017	Member ZIP	Text	10	Yes	Example: 97209-1234 or 97209	1.2%
ME018	Medical coverage flag	Text	1	Situational	Valid values: Y (yes) or N (no). Not required when ME001 = E.	0.0%
ME019	Prescription drug coverage flag	Text	1	Situational	Valid values: Y (yes) or N (no). Not required when ME001 = E.	0.0%
ME101	Subscriber last name	Text	35	Yes		1.2%
ME102	Subscriber first name	Text	25	Yes		1.2%
ME103	Subscriber middle name	Text	25	Situational	Populate if available.	N/A
ME104	Member last name	Text	35	Yes		1.2%
ME105	Member first name	Text	25	Yes		1.2%
ME106	Member middle name	Text	25	Situational	Populate if available.	N/A
QC013					Do not populate; blank/null required.	0.0%
QC014					Do not populate; blank/null required.	0.0%
QC015					Do not populate; blank/null required.	0.0%
QC016					Do not populate; blank/null required.	0.0%
QC017					Do not populate; blank/null required.	0.0%
QC018					Do not populate; blank/null required.	0.0%
QC019					Do not populate; blank/null required.	0.0%
QC020					Do not populate; blank/null required.	0.0%
RE1	Member race	Text	1	Yes	See lookup table RE1.	1.2%
RE2	Member ethnicity	Text	1	Yes	See lookup table RE2.	1.2%
RE3	Primary spoken language	Text	3	Yes	See lookup table RE3.	1.2%
OHLC3					Do not populate; blank/null required.	0.0%
OHLC4					Do not populate; blank/null required.	0.0%
OHLC5					Do not populate; blank/null required.	0.0%
OHLC6					Do not populate; blank/null required.	0.0%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
OHLC7					Do not populate; blank/null required.	0.0%
ME009D	OMIP flag	Numeric	1	Yes	Valid values: 1 (OMIP member), 0 (otherwise)	1.2%
ME009E	HKC flag	Numeric	1	Yes	Valid values: 1 (Healthy Kids Connect plan), 0 (otherwise)	1.2%
ME201	Medicare coverage flag	Text	2	Situational	Type of Medicare coverage. Valid values: A (Part A), B (Part B), AB (Parts A and B), C (Part C only), D (Part D only), CD (Parts C and D), X (other), Z (none). Not required when ME001 = E.	1.2%
ME202	Market segment	Text	2	Yes	See lookup table ME202.	0.0%
ME203	Metal Tier	Text	1	Situational	Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the Patient Protection and Affordable Care Act, Public Law 111-148, Section 1302: Essential Health Benefits Requirements. Valid values: 0 (Not a QHP or catastrophic plan), 1 (Catastrophic), 2 (Bronze), 3 (Silver), 4 (Gold), 5 (Platinum). Not required when ME001 = E.	0.0%
ME204	HIOS Plan ID	Text	14	Situational	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. Not required when ME001 = E.	0.0%
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)	1.2%
ME206	Primary Insurance Indicator	Text	1	Yes	Valid values: Y (primary insurance), N (secondary or tertiary insurance). If unknown, default to Y.	0.0%
ME207	Dental Coverage Flag	Text	1	Situational	Valid values: Y (member had dental coverage in this period), N (member did not have dental coverage in this period). Not required when ME001 = P.	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
ME208					For future implementation	NA
ME209					For future implementation	NA
ME210					For future implementation	NA

File naming convention is

For medical and pharmacy:

<payer abbreviation>_<submitter abbreviation>_enrollment_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_enrollment_2015Q2_20150521_010101.dat

For dental:

<payer abbreviation>_<submitter abbreviation>_dental_enrollment__<quarter>_<file created date_timestamp>.dat

Note: There is a double underscore between 'dental_enrollment' and <quarter>.

Example: OMIP_OMIP_dental_enrollment__2015Q2_20150521_010101.dat

Lookup Table ME001: Payer Type

This field contains a single letter identifying the payer type.

Code	Value
C	Carrier
D	Medicaid
G	Other government agency
P	Pharmacy benefits manager
T	Third party administrator
U	Unlicensed entity
E	Dental

Lookup Table ME003: Product Code

This field contain the insurance type or product code that indicates the type of insurance coverage the individual has.

Code	Value
MDE	Medicaid dual eligible HMO
MD	Medicaid disabled HMO
MLI	Medicaid low income HMO
MRB	Medicaid restricted benefit HMO
MR	Medicare Advantage HMO
MP	Medicare Advantage PPO
MPD	Medicare Part D only*
MC	Medicare Cost
PPO	Commercial PPO
POS	Commercial POS
HMO	Commercial HMO
SN1	Special needs plan – chronic condition
SN2	Special needs plan – institutionalized
SN3	Special needs plan – dual eligible
CHP	Special Children's Health Insurance program (SCHIP)
MDF	Medicaid fee-for-service
SIP	Self insured PPO
SIF	Self insured POS
SIH	Self insured HMO
PH	Pharmacy benefits only*
IN	Commercial Indemnity
EPO	Commercial EPO
SL	Commercial stop loss
DPPO	Dental PPO
DPOS	Dental POS
DHMO	Dental HMO
DSIP	Dental self insured PPO
DSIF	Dental self insured POS
DSIH	Dental self insured HMO

*** Please note** that codes 'PH' and 'MPD' must be used in conjunction with the appropriate lines of business. 'PH' should be used for Commercial lines of business only, while 'MPD' should be used for Medicare membership only.

Lookup Table ME012: Relationship code

This field contains the member's relationship to the subscriber or the insured.

Code	Value
1	Spouse
4	Grandfather or Grandmother
5	Grandson or Granddaughter
7	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
18	Self
19	Child
20	Employee
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner

Lookup Table RE1

This field contains a single letter identifying the member's race.

Code	Value
A	Asian
B	Black or African American
I	American Indian or Alaska Native
P	Native Hawaiian or Pacific Islander
W	White
O	Other (or multiple races)
R	Refused
U	Unknown

Lookup Table RE2

This field contains a single letter identifying the member's ethnicity.

Code	Value
H	Hispanic
O	Not Hispanic
R	Refused
U	Unknown

Lookup Table RE3

This field contains the ANSI/NISO three-character string identifying the member's primary spoken language. Please refer to most recent version of ANSI/NISO Z39.53 (Codes for the Representation of Languages for Information Interchange); the 2001 version is freely available here: https://groups.niso.org/apps/group_public/download.php/6541/.

Lookup Table ME202

This field contains an integer indicating the market segment.

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 the 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 the exchange
7	Policies sold and issued directly to employers having 100 or more employees
8	Self-funded plans administered by a TPA, or a carrier acting as a TPA, where the employer has purchased stop-loss or group excess insurance coverage
9	Self-funded plans administered by a TPA, or a carrier acting as 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

Appendix B: Medical Claims file layout and dictionary

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC001	Payer type	Text	1	Yes	See lookup table ME001 (in Eligibility file)	0.0%
MC003	Product code	Text	4	Yes	See lookup table ME003 (in Eligibility file)	0.0%
MC004	Claim ID	Text	80	Yes	Payer's unique claim identifier	0.0%
MC005	Service line counter	Numeric	4	Yes	Increments of 1 for each claim line	0.0%
MC010	Member ID	Text	30	Yes	Plan-specific unique member identifier	0.0%
MC017	Payment date	Date	8	Situational	CCYYMMDD (example: 20090624). Blanks allowed for denied claims only	0.0%
MC018	Admission date	Date	8	Situational	CCYYMMDD (example: 20090624). Required only for institutional claims	1.2%
MC023	Discharge status	Text	2	Situational	See lookup table MC023. Required only for institutional claims	1.2%
MC024	Rendering provider ID	Text	30	Yes	Identifier for the rendering provider as assigned by the reporting entity	1.2%
MC036	Type of bill	Numeric	3	Situational	See lookup table MC036. Required only for institutional claims	1.2%
MC037	Place of service	Text	2	Situational	See lookup table MC037. Required only for professional claims	1.2%
MC038	Claim status	Text	1	Yes	Was claim paid, denied, CCO encounter, or MCO encounter only? Valid values: P (paid), D (denied), C (CCO encounter), E (other managed care encounter)	0.0%
MC038A	COB status	Text	1	Yes	Was claim a COB claim? Valid values: Y (yes), N (no)	1.2%
MC041	Principal diagnosis	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC041P	POA flag 1	Text	1	Situational	Present on admission flag for principal diagnosis. See lookup table MC041P. Required only for inpatient claims.	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC042	Diagnosis 2	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC042P	POA flag 2	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC043	Diagnosis 3	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC043P	POA flag 3	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC044	Diagnosis 4	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC044P	POA flag 4	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC045	Diagnosis 5	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC045P	POA flag 5	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC046	Diagnosis 6	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC046P	POA flag 6	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC047	Diagnosis 7	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC047P	POA flag 7	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC048	Diagnosis 8	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC048P	POA flag 8	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC049	Diagnosis 9	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC049P	POA flag 9	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC050	Diagnosis 10	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC050P	POA flag 10	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC051	Diagnosis 11	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC051P	POA flag 11	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC052	Diagnosis 12	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC052P	POA flag 12	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%
MC053	Diagnosis 13	Text	8	Yes	ICD-10 diagnosis code. Include all characters (example: E10.359).	1.2%
MC053P	POA flag 13	Text	1	Situational	Present on admission flag for diagnosis 2. Required if MC042 is populated. See lookup table MC041P. Required only for inpatient claims.	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC054	Revenue code	Text	4	Situational	Include all digits (example:0320). Required only for institutional claims.	1.2%
MC055	CPT/CPT II/HCPCS/ HIPPS Procedure code	Text	5	Yes	CPT. CPT II, HCPCS or HIPPS code. Include all digits (examples: 29870 or G0289)	1.2%
MC056	Procedure modifier 1	Text	2	Yes	CPT or HCPCS code. Include all digits (examples: 50 or AA)	1.2%
MC057	Procedure modifier 2	Text	2	Yes	CPT or HCPCS code. Include all digits (examples: 50 or AA)	1.2%
MC057A	Procedure modifier 3	Text	2	Yes	CPT or HCPCS code. Include all digits (examples: 50 or AA)	1.2%
MC057B	Procedure modifier 4	Text	2	Yes	CPT or HCPCS code. Include all digits (examples: 50 or AA)	1.2%
MC058	Principal inpatient procedure code	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058A	Inpatient procedure code 2	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058B	Inpatient procedure code 3	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058C	Inpatient procedure code 4	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058D	Inpatient procedure code 5	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058E	Inpatient procedure code 6	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC058F	Inpatient procedure code 7	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058G	Inpatient procedure code 8	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058H	Inpatient procedure code 9	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058J	Inpatient procedure code 10	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC058K	Inpatient procedure code 11	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC057L	Inpatient procedure code 12	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC057M	Inpatient procedure code 13	Text	8	Situational	ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims.	1.2%
MC059	Date of service – From	Date	8	Yes	CCYYMMDD (example: 20090603)	0.0%
MC060	Date of service - Thru	Date	8	Yes	CCYYMMDD (example: 20090603)	0.0%
MC061	Quantity	Numeric	11	Yes	Count of units sent on claim line	0.0%
MC062	Charges	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC062A	Allowed amount	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MC063	Payment	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC064	Prepaid amount	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC065	Co-payment	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC066	Co-insurance	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC067	Deductible	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC067A	Patient pay amount	Numeric	12	Situational	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
MC070	Discharge date	Date	8	Situational	Required only for institutional claims. Use 99991231 if patient has not discharged. CCYYMMDD (example: 20090605). Required only for institutional claims.	1.2%
MC076	Billing provider ID	Text	30	Yes	Identifier for the billing provider as assigned by the reporting entity.	1.2%
QC05					Do not populate; blank/null required	0.0%
QC06					Do not populate; blank/null required	0.0%
QC22					Do not populate; blank/null required	0.0%
QC23					Do not populate; blank/null required	0.0%
QC37					Do not populate; blank/null required	0.0%
QC38					Do not populate; blank/null required	0.0%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
QC39					Do not populate; blank/null required	0.0%
OHLC1					Do not populate; blank/null required	0.0%
OHLC2					Do not populate; blank/null required	0.0%
MC008	Plan specific contract number	Text	30	Yes	Plan specific contract number (aka group number)	0.0%
MC201	ICD version code	Text	2	Yes	Specifies the claim's ICD version. Valid values: 9 (ICD-9) or 10 (ICD-10)	0.0%
MC202	Network	Text	1	Yes	See lookup table MC202	0.0%
MC203	Admission Type	Text	1	Situational	Required for inpatient claims. Populate this field only if claim is inpatient. Valid values: 1 (Emergency), 2 (Urgent), 3 (Elective), 4 (Newborn), 5 (Trauma Center), 9 (Information Not Available)	1.2%
MC204	Admission Source	Text	1	Situational	Required for inpatient claims. Populate this field only if claim is inpatient. See lookup table MC204	1.2%
MC205	Admitting Diagnosis	Text	8	Situational	Required for inpatient claims. ICD-10 diagnosis code for dates of service beginning 10/01/2015. Include all characters (example: E10.359), ICD-9 diagnosis code from dates of service before 10/01/2015. If ICD-9 include all digits and exclude decimal point (example: 01220). Required only for inpatient claims.	1.2%
MC206	Pay to Patient Flag	Text	1	Yes	Valid values: Y (patient was directly reimbursed), N (patient was not directly reimbursed). If unknown, default to N.	0.0%
MC207	Empty field				For future implementation	N/A
MC208	Empty field				For future implementation	N/A
MC209	Empty field				For future implementation	N/A
MC210	Empty field				For future implementation	N/A

File naming convention is

<payer abbreviation>_<submitter abbreviation>_medical_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_medical_2015Q2_20150521_010101.dat

Lookup Table MC023: Discharge status

This field contains the status for the patient discharged from the hospital.

Code	Value
01	Discharged to home or self care
02	Discharged/transferred to another short term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to nursing facility (NF)
05	Discharged/transferred to a designated cancer center or children's hospital
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a Home IV provider
09	Admitted as an inpatient to the hospital
20	Expired
21	Discharged/transferred to court/law enforcement
30	Still patient or expected to return for outpatient services
40	Expired at home
41	Expired in a medical facility
42	Expired place unknown
43	Discharged/transferred to a Federal hospital
50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to a hospital based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital
63	Discharged/transferred to a long-term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a critical access hospital (CAH)
70	Discharged/transferred to another type of health care institution not defined elsewhere in this code list

Lookup Table MC036: Type of Service

This field is required for institutional claims and must not be populated for professional claims. The values of the second digit are situational depending on the value of the first digit.

First digit: type of facility

Code	Value
1	Hospital
2	Skilled Nursing
3	Home Health
4	Christian Science Hospital
5	Christian Science Extended Care
6	Intermediate Care
7	Clinic
8	Special Facility

Second Digit if First Digit = 1 – 6

Code	Value
1	Inpatient (including Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
5	Nursing Facility Level I
6	Nursing Facility Level II
7	Intermediate Care – Level III Nursing Facility
8	Swing Beds

Second Digit if First Digit = 7

Code	Value
1	Rural Health
2	Hospital Based or Independent Renal Dialysis Center
3	Free Standing Outpatient Rehabilitation Facility (ORF)
5	Comprehensive Outpatient Rehabilitation Facility (CORF)
6	Nursing Facility Level II
7	Community Mental Health Center
9	Other

Second Digit if First Digit = 8

Code	Value
1	Hospice (Non Hospital Based)
2	Hospice (Hospital-Based)
3	Ambulatory Surgical Center
4	Free standing Birthing Center
9	Other

Third Digit: claim frequency

Code	Value
1	Admit Through Discharge
2	Interim – First Claim
3	Interim – Continuing Claims
4	Interim – Last Claim
5	Late Charge Only
7	Replacement of Prior Claim
8	Void/Cancel of a Prior Claim
9	Final Claim for a Home Health Encounter

Lookup Table MC037: Place of Service

For professional claims, this field records the type of facility where the service was performed. This field should not be populated for institutional claims.

Code	Value
00	Not supplied
01	Pharmacy
02	Telehealth
03	School
04	Homeless Shelter
05	Indian Health Services Freestanding Facility
06	Indian Health Services Provider-Based Facility
07	Tribal 638 Freestanding Facility
08	Tribal 638 Provider-Based Facility
09	Prison/Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Facility

57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

Lookup Table MC041P: POA flag

This field contains the inpatient present on admission (POA) flag as reported by the provider. Do not populate if not reported by the provider.

Code	Value
Y	Yes
N	No
W	Clinically undetermined
U	Information not in record
1	Diagnosis exempt from POA reporting

Lookup Table MC202: Network

This field contains a single digit indicating whether the provider was paid under a network contract.

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: Admission Source

This field contains a single character indicating source of referral for an inpatient admission. Populate this field only for institutional claims. Do not populate this field for professional claims. Use codes on the next page if MC203=4.

Code	Value if MC203 <> 4
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 Assignment. Prior to 3/08, HMO referral: The patient was admitted upon the recommendation of a health maintenance organization (HMO) physician.
4	Transfer from a 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.
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 the 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

Code	Value if MC203 = 4
1	Normal delivery – A baby delivered without complications. ***Invalid for discharges after 12/31/2011.***
2	Premature delivery – A baby delivered with time and/or weight factors qualifying it for premature status. ***Invalid for discharges after 12/31/2011.***
3	Sick baby – A baby delivered with medical complications, other than those relating to premature status. ***Invalid for discharges after 12/31/2011.***
4	Extramural birth – A baby delivered in a non-sterile environment. ***Invalid for discharges after 12/31/2011.***
5	Born inside this hospital.
6	Born outside this hospital.
7-8	Reserved for national assignment.
9	Information not available.

Appendix C: Pharmacy Claims file layout and dictionary

Note: This layout intends to maintain consistency with Version 1.0 of the NCPDP Uniform Healthcare Payer Data Implementation Guide.

Data element	Name	Max. length	Type	Required?	NCPDP Field	NCPDP Source	Description/valid values	Error threshold
PC001	Payer type	1	Text	Yes	N/A	N/A	See lookup table ME001 (in Eligibility file)	0.0%
PC008	Plan-specific contract number	30	Text	Yes	246	P	Plan-specific contract number (aka group number)	1.2%
PC010	Patient ID	30	Text	Yes	332-CY	P	Unique identifier for member	0.0%
PC003	Insurance type/ product code	4	Text	Yes	New	P	See lookup table ME003 (in Eligibility File)	1.2%
PC021	Pharmacy NPI	15	Text	Yes	201-B1	C/P	The pharmacy's National Provider Identifier (NPI)	1.2%
PC021A	Pharmacy alternate identifier	15	Text	Situational	201-B1	P	The pharmacy's alternate identifier as assigned by the payer; required if NPI is not available	N/A
PC020	Pharmacy Name	35	Text	Yes	833-5P	P		1.2%
PC022	Pharmacy city	30	Text	Yes	728	P		1.2%
PC023	Pharmacy state	2	Text	Yes	729	P		1.2%
PC024	Pharmacy ZIP	15	Text	Yes	730	P		1.2%
PC048	Prescribing provider NPI	15	Text	Yes	411-DB	C	Identifier for provider who prescribed the medication as assigned by the reporting entity	1.2%
PC047							Do not populate; null/blank required	0.0%
PC025	Claim status	3	Text	Yes	399	P	Was claim paid, denied, CCO, or encounter only? Valid values: P (paid), D (denied), C (CCO encounter), E (other managed care encounter)	0.0%
PC026	NDC	11	Text	Yes	407-D7	C	National Drug Code (NDC)	1.2%

Data element	Name	Max. length	Type	Required?	NCPDP Field	NCPDP Source	Description/valid values	Error threshold
PC032	Date filled	8	Date	Yes	401-D1	C	Date the prescription was filled. CCYYMMDD (example: 20090624)	0.0%
PC017	Payment date	8	Date	Situational	216	P	CCYYMMDD (example: 20090624). Blanks allowed for denied claims only.	0.0%
PC033	Quantity dispensed	10	Numeric	Yes	442-E7	C		1.2%
PC028A	Alternate refill number	2	Numeric	Situational	403-D3	C	Required if PC028 (calculated refill number) is not available	N/A
PC034	Days supply	4	Numeric	Yes	405-D5	C	Days supply of the prescription	1.2%
PC030	Dispense as written code	1	Text	Yes	408-D8	C	See look-up table PC030	1.2%
PC028	Calculated refill number	2	Numeric	Yes	254	P	Processor's calculated refill number. If the processor is not able to calculate, the alternate refill number (PC028A) is to be used.	1.2%
PC031	Compound drug indicator	1	Numeric	Yes	406-D6	C	Indicates if this is a compound drug. Valid values: 1 (no), 2 (yes)	1.2%
PC004	Claim ID	30	Text	Yes	993-A7	P	Payer's unique claim control number	0.0%
PC036	Payment	12	Numeric	Yes	281	P	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
PC035	Charges	12	Numeric	Yes	430-DU	P	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
PC037	Ingredient cost/list price	12	Numeric	Yes	506-F6	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
PC039	Dispensing fee paid	12	Numeric	Yes	506-F7	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%

Data element	Name	Max. length	Type	Required?	NCPDP Field	NCPDP Source	Description/valid values	Error threshold
PC040	Co-pay	12	Numeric	Yes	518-F1	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
PC041	Coinsurance	12	Numeric	Yes	572-4U	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
PC042	Deductible	12	Numeric	Yes	517-FH	C	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
PC043	Patient pay amount	12	Numeric	Situational	505-F5	C	Required if any of PC040, PC041, or PC042 are missing. Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	0.0%
PC201							For future implementation	N/A
PC202							For future implementation	N/A
PC203							For future implementation	N/A
PC204							For future implementation	N/A
PC205							For future implementation	N/A
PC206							For future implementation	N/A
PC207							For future implementation	N/A
PC208							For future implementation	N/A
PC209							For future implementation	N/A
PC210							For future implementation	N/A

File naming convention is

<payer abbreviation>_<submitter abbreviation>_pharmacy_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_pharmacy_2015Q2_20150521_010101.dat

Look-up Table PC-030: Dispense as Written Code

This field contains the NCPDP Dispense as Written Code.

Code	Value
0	No product selection indicated
1	Substitution not allowed by provider
2	Substitution allowed – patient requested product dispensed
3	Substitution allowed – pharmacist selected product dispensed
4	Substitution allowed – generic drug not in stock
5	Substitution allowed – brand drug dispensed as generic
6	Override
7	Substitution not allowed – brand drug mandated by law
8	Substitution allowed – generic drug not available in marketplace
9	Other

Appendix D: Dental Claims file layout and dictionary

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
DC001	Payer type	Text	1	Yes	See lookup table ME001 (in Eligibility file)	0.0%
DC003	Insurance Type/ Product code	Text	4	Yes	See lookup table ME003 (in Eligibility file)	0.0%
DC004	Claim ID	Text	80	Yes	Payer's unique claim identifier (i.e. claim control number) used to internally track the claim	0.0%
DC005	Service line counter	Numeric	4	Yes	Increments of 1 for each claim line	0.0%
DC008	Plan specific contract number	Text	30	Yes	Plan specific contract number (aka group number)	0.0%
DC010	Member ID	Text	30	Yes	Plan-specific unique member identifier	0.0%
DC017	Payment date	Text	8	Situational	CCYYMMDD (example: 20090624). Blanks allowed for denied claims only.	0.0%
DC024	Rendering provider ID	Text	30	Yes	Identifier for the rendering provider as assigned by the reporting entity	1.2%
DC037	Place of service	Text	2	Situational	See lookup table MC 037. Required only for professional claims.	1.2%
DC038	Claim status	Text	1	Yes	Was claim paid, denied, CCO encounter, or MCO encounter only? Valid values: P (paid), D (denied), C (CCO encounter), E (other managed care encounter)	0.0%
DC038A	Denial reason	Text	5	Situational	Report the Claim Adjustment Reason Code (CARC) that defines the reason why the claim was denied. Required when DC038 = D.	1.2 %
DC039	CDT Code	Text	5	Yes	Report the Common Dental Terminology Code for the dental procedure on the claim. CDT codes are maintained by the American Dental Association.	0.0%
DC039A	Procedure Modifier – 1	Text	2	Situational	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated CDT code. Blanks allowed.	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
DC039B	Procedure Modifier – 2	Text	2	Situational	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated CDT code. Blanks allowed.	1.2%
DC040	Dental Quadrant	Text	2	Situational	Report the standard quadrant identifier when CDT code indicates procedure on 3 or more consecutive teeth. Up to four dental quadrant fields can be entered. See lookup table DC040. Blanks allowed.	0.0%
DC040A	Dental Quadrant - 2	Text	2	Situational	Report the second standard quadrant identifier if applicable. See lookup table DC040. Blanks allowed.	1.2%
DC040B	Dental Quadrant - 3	Text	2	Situational	Report the third standard quadrant identifier if applicable. See lookup table DC040. Blanks allowed	1.2%
DC040C	Dental Quadrant - 4	Text	2	Situational	Report the fourth standard quadrant identifier if applicable. See lookup table DC040. Blanks allowed	1.2%
DC041	Diagnosis	Text	8	Situational	ICD-10 Diagnosis code when applicable. Required when CDT code is within the ranges of D7000-D7999 or D9220-D9221.	1.2%
DC059	Date of Service - From	Date	8	Yes	CCYYMMDD (example: 20090603)	0.0%
DC060	Date of Service - Thru	Date	8	Yes	CCYYMMDD (example: 20090603)	0.0%
DC062	Charges	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC062A	Allowed amount	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC063	Payment	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
DC064	Prepaid amount	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC065	Co-payment	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC066	Co-insurance	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC067	Deductible	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC067A	Patient pay amount	Numeric	12	Situational	Required if any of DC065, DC066, or DC067 are missing. Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC076	Billing provider ID	Text	30	Yes	Identifier for the billing provider as assigned by the reporting entity.	1.2%
DC202	Network	Text	1	Yes	See lookup table MC202 (in medical claims file)	0.0%
DC207	Tooth Number/Letter (1)	Text	2	Situational	Report the tooth identifier. Required when CDT code is within the range of D2000 – D2999. Up to four tooth number/letter fields can be entered through DC207, DC209, DC211 and DC213. Blanks allowed.	0.0%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
DC208	Tooth 1 - Surface 1	Numeric	1	Situational	Report the tooth surface on which the service was performed. See lookup table DC208. Required when DC207 is populated and CDT code is within the range of D2000 – D2709. Up to six tooth surface fields can be entered for each tooth number/letter.	0.0%
DC208A	Tooth 1 - Surface 2	Numeric	1	Situational	See comment under DC208. Blanks allowed.	0.0%
DC208B	Tooth 1 - Surface 3	Numeric	1	Situational	See comment under DC208. Blanks allowed.	0.0%
DC208C	Tooth 1 - Surface 4	Numeric	1	Situational	See comment under DC208. Blanks allowed.	0.0%
DC208D	Tooth 1 - Surface 5	Numeric	1	Situational	See comment under DC208. Blanks allowed.	0.0%
DC208E	Tooth 1 - Surface 6	Numeric	1	Situational	See comment under DC208. Blanks allowed.	0.0%
DC209	Tooth Number/Letter (2)	Text	2	Situational	Report the tooth identifier. Required when CDT code is within the range of D2000 – D2999. Up to four tooth number/letter fields can be entered through DC207, DC209, DC211 and DC213. Blanks allowed.	0.0%
DC210	Tooth 2 - Surface 1	Numeric	1	Situational	Report the tooth surface on which the service was performed. See lookup table DC208. Required when DC209 is populated and CDT code is within the range of D2000 – D2709. Up to six tooth surface fields can be entered for each tooth number/letter.	0.0%
DC210A	Tooth 2 - Surface 2	Numeric	1	Situational	See comment under DC210. Blanks allowed.	0.0%
DC210B	Tooth 2 - Surface 3	Numeric	1	Situational	See comment under DC210. Blanks allowed.	0.0%
DC210C	Tooth 2 - Surface 4	Numeric	1	Situational	See comment under DC210. Blanks allowed.	0.0%
DC210D	Tooth 2 - Surface 5	Numeric	1	Situational	See comment under DC210. Blanks allowed.	0.0%
DC210E	Tooth 2 - Surface 6	Numeric	1	Situational	See comment under DC210. Blanks allowed.	0.0%
DC211	Tooth Number/Letter (3)	Text	2	Situational	Report the third tooth identifier, if applicable on which the service was performed. See comment under DC207. Blanks allowed.	0.0%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
DC212	Tooth 3 - Surface 1	Numeric	1	Situational	Report the tooth surface on which the service was performed. See lookup table DC208. Required when DC211 is populated and CDT code is within the range of D2000 – D2709. Up to six tooth surface fields can be entered for each tooth number/letter.	0.0%
DC212A	Tooth 3 - Surface 2	Numeric	1	Situational	See comment under DC212. Blanks allowed.	0.0%
DC212B	Tooth 3 - Surface 3	Numeric	1	Situational	See comment under DC212. Blanks allowed.	0.0%
DC212C	Tooth 3 - Surface 4	Numeric	1	Situational	See comment under DC212. Blanks allowed.	0.0%
DC212D	Tooth 3 - Surface 5	Numeric	1	Situational	See comment under DC212. Blanks allowed.	0.0%
DC212E	Tooth 3 - Surface 6	Numeric	1	Situational	See comment under DC212. Blanks allowed.	0.0%
DC213	Tooth Number/Letter (4)	Text	2	Situational	Report the fourth tooth identifier, if applicable on which the service was performed. See comment under DC207. Blanks allowed.	0.0%
DC214	Tooth 4 - Surface 1	Numeric	1	Situational	Report the tooth surface on which the service was performed. See lookup table DC208. Required when DC213 is populated and CDT code is within the range of D2000 – D2709. Up to six tooth surface fields can be entered for each tooth number/letter.	0.0%
DC214A	Tooth 4 - Surface 2	Numeric	1	Situational	See comment under DC214. Blanks allowed.	0.0%
DC214B	Tooth 4 - Surface 3	Numeric	1	Situational	See comment under DC214. Blanks allowed.	0.0%
DC214C	Tooth 4 - Surface 4	Numeric	1	Situational	See comment under DC214. Blanks allowed.	0.0%
DC214D	Tooth 4 - Surface 5	Numeric	1	Situational	See comment under DC214. Blanks allowed.	0.0%
DC214E	Tooth 4 - Surface 6	Numeric	1	Situational	See comment under DC214. Blanks allowed.	0.0%
DC299	CCO Identifier	Text	15	Situational	Populated by Medicaid only. Blank otherwise.	N/A

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
DC300					For future implementation	N/A
DC301					For future implementation	N/A
DC302					For future implementation	N/A
DC303					For future implementation	N/A
DC304					For future implementation	N/A

File naming convention is

<payer abbreviation>_<submitter abbreviation>_dental_dental__<quarter>_<file created date_timestamp>.dat

Note: There is a double underscore between 'dental_dental' and <quarter>.
Example: OMIP_OMIP_dental_dental__2015Q2_20150521_010101.dat

Lookup Table DC040: Dental Quadrant

This field contains the dental quadrant associated with the dental procedure.

Code	Value
00	Entire Oral Cavity
01	Maxillary arch
02	Mandibular arch
10	Maxillary (upper) right
20	Maxillary (upper) left
30	Mandibular (lower) right
40	Mandibular (lower) left
UL	Upper left
UR	Upper right
LL	Lower left
LR	Lower right

Lookup Table DC208: Tooth Surface

This field contains the tooth surface associated with the dental procedure.

Code	Value
B	Buccal
D	Distal
F	Facial
I	Incisal
L	Lingual/Palatal
M	Mesial
O	Occlusal

Appendix E: Provider File layout and dictionary

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MP003	Provider ID	Text	30	Yes	Identifier for the provider as assigned by the reporting entity	1.2%
MP004	Provider Tax ID	Text	9	Yes	Tax ID of the provider (example: 1234567890)	1.2%
MP006	Provider first name	Text	25	Situational	First name of the provider (example: John); null if provider is an organization entity	1.2%
MP007	Provider middle initial	Text	1	Situational	Middle initial of the provider (example: M); null if provider is an organization entity	1.2%
MP008	Provider last name or organization	Text	100	Yes	Last name of the provider or organization entity name	1.2%
MP010	Provider specialty	Text	10	Yes	See lookup table MP010	1.2%
MP010A	Provider second specialty	Text	10	Situational	Required if available. See lookup table MP010	1.2%
MP010B	Provider third specialty	Text	10	Situational	Required if available. See lookup table MP010	1.2%
MP011A	Provider street address1	Text	50	Yes	First line of physical address of practice. Example: 123 Main Street	1.2%
MP011B	Provider street address2	Text	50	Situational	Required if available. Second line of physical address of practice. Example: Bldg. A, Suite 100	1.2%
MP011	Provider city	Text	30	Yes	Physical address of practice. Example: Grants Pass	1.2%
MP012	Provider state	Text	2	Yes	Physical address of practice. Example: OR	1.2%
MP013	Provider ZIP	Text	10	Yes	Physical address of practice. Examples: 97209-1234 or 97209	1.2%
MP017					Do not populate; blank/null required	0.0%
MP018	Provider NPI	Text	10	Yes	NPI of the provider (example: 1234567890)	1.2%
MP201					For future implementation	N/A
MP202					For future implementation	N/A
MP203					For future implementation	N/A
MP204					For future implementation	N/A

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MP205					For future implementation	N/A
MP206					For future implementation	N/A
MP207					For future implementation	N/A
MP208					For future implementation	N/A
MP209					For future implementation	N/A
MP210					For future implementation	N/A

File naming convention is

For medical:

<payer abbreviation>_<submitter abbreviation>_provider_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_provider_2015Q2_20150521_010101.dat

For dental:

<payer abbreviation>_<submitter abbreviation>_dental_provider__<quarter>_<file created date_timestamp>.dat

Note: There is a double underscore between ‘dental_provider’ and <quarter>.

Example: OMIP_OMIP_dental_provider__2015Q2_20150521_010101.dat

Lookup Table MP010: Provider specialty

Report the HIPAA-compliant health care provider taxonomy code. The reference code set is extensive and is published semi-annually: version 12.0 (updated effective April 1, 2012) is freely available at the National Uniform Claims Committee's web site: http://www.nucc.org/. To access the taxonomy files, point to the Code Sets menu, then point to the Taxonomy menu, and then click on either PDF (if you want a PDF file) or CSV (if you want a comma-delimited text file).

Appendix F: Subscriber Billed Premium File layout and dictionary

Note: All mandatory reporters other than CCO's are required to file this report for subscribers in fully-insured commercial and Medicare Advantage plans. PBM's that offer stand-alone prescription drug plans are also required to submit this report. Mandatory reporters do not have to file a Form APAC-1 (waiver or exception of reporting requirements), for subscribers in plans which are not required to file this report.

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
PB001	Payer type	Text	1	Yes	See lookup table ME001 (Appendix A)	0.0%
PB003	Product code	Text	4	Yes	See lookup table ME003 (Appendix A)	0.0%
PB202	Market segment	Text	2	Yes	See lookup table ME202 (Appendix A)	0.0%
PB007	Subscriber ID	Text	30	Yes	Plan-specific unique identifier for subscriber	0.0%
PB008	Premium billed month	Date	6	Yes	Month in which subscriber and related members had coverage for which subscriber was billed. CCYYMM	0.0%
PB009	Covered members in premium billed month	Numeric	3	Yes	Number of members with coverage for which subscriber was billed in the premium billed month	0.0%
PB010	Total Premium Billed for Premium Billed Month	Numeric	12	Yes	Total premium amount subscriber was billed for coverage in premium billed month. Premium billed to subscriber for premium billed month may differ from premium paid by subscriber in premium billed month if, for example, subscriber pays for more than 1 month of coverage in premium billed month. Report premium billed, not premium paid or another amount. Enter 0 if amount equals zero. Example: 15102.00	0.0%

File naming convention is

For medical and pharmacy:

<payer abbreviation>_<submitter abbreviation>_premium_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_premium_2015Q2_20150521_010101.dat

For dental:

<payer abbreviation>_<submitter abbreviation>_dental_premium__<quarter>_<file created date_timestamp>.dat

Note: There is a double underscore between ‘dental_premium’ and <quarter>.

Example: OMIP_OMIP_dental_premium__2015Q2_20150521_010101.dat

Appendix G: Control Totals

Note: The control totals file consists of two separate tab-delimited data files. All Mandatory Reporters other than CCOs must submit these files each quarter.

1. Claims file control totals

a. Claims file control totals layout and dictionary

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
CFCT1	Payer	Text	7	Yes	Payer abbreviation See Oregon Mandatory Reporters and Abbreviations table on website: https://www.oregon.gov/oha/HPA/ANALYTICS/APAC%20Page%20Docs/2020-APAC-mandatory-reporters-abbreviations.pdf	0.0%
CFCT2	File	Text	10	Yes	Valid values: medical, pharmacy, dental, enrollment, provider, and premium	0.0%
CFCT3	Data_ Rows	Numeric	8	Yes	Count of data rows in the submitted file	0.0%
CFCT4	Amt_ Billed	Numeric	14	Yes	Sum of MC062 (medical), PC035 (pharmacy), DC062 (dental), or PB010 (premium). Two explicit decimal places. Do not populate if File is enrollment or provider	0.0%
CFCT5	Amt_ Paid	Numeric	14	Yes	Sum of MC063 (medical), PC035 (pharmacy), DC062 (dental), or PB010 (premium). Two explicit decimal places. Do not populate if File is enrollment or provider.	0.0%

b. Claims file control totals example

Example when all file types are submitted

Payer	File	Data_Rows	Amt_Billed	Amt_Paid
OMIP	Medical	12345678	123456789.12	123456789.12
OMIP	Pharmacy	12345678	123456789.12	123456789.12
OMIP	Enrollment	12345678		
OMIP	Provider	123456		
OMIP	Premium	12345	123456789.12	
OMIP	Dental	12345	123456789.12	123456789.12

Example when only some file types are submitted

Payer	File	Data_Rows	Amt_Billed	Amt_Paid
OMIP	Medical	0	0	0
OMIP	Pharmacy	12345678	123456789.12	123456789.12
OMIP	Enrollment	12345678		
OMIP	Provider	0		
OMIP	Premium	12345	123456789.12	
OMIP	Dental	0	0	0

c. File naming convention is

For medical and pharmacy:

<payer abbreviation>_<submitter abbreviation>_totals_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_totals_2015Q2_20150521_010101.dat

For dental:

<payer abbreviation>_<submitter abbreviation>_dental_totals__<quarter>_<file created date_timestamp>.dat

Note: There is a double underscrore between ‘dental_totals’ and <quarter>.

Example: OMIP_OMIP_dental_totals__2015Q2_20150521_010101.dat

2. Member months control totals

a. Member months control totals layout and dictionary

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
MMCT1	Payer	Text	7	Yes	Payer abbreviation. See Oregon Mandatory Reporters and Abbreviations table on website: www.oregon.gov/oha/HPA/ANALYTICS/APAC%20Page%20Docs/2020-APAC-mandatory-reporters-abbreviations.pdf.	0.0%
MMCT2	Method	Text	1	No	Placeholder for future compatibility	N/A
MMCT3	Month	Date	6	Yes	CCYYMM	0.0%
MMCT4	Medical_ Members	Numeric	8	Situational	Count of members with medical coverage as of first of month. The count should match the number of rows, not the distinct members, with medical coverage (ME018) in the corresponding Enrollment file. Do not include members with coverage starting after the first of the month. Do not populate if no medical members.	0.0%
MMCT5	Pharmacy _Members	Numeric	8	Situational	Count of members with pharmacy coverage as of first of month. The count should match the number of rows, not the distinct members, with medical coverage (ME018) in the corresponding Enrollment file. Do not include members with coverage starting after the first of the month. Do not populate if no pharmacy members.	0.0%
MMCT6	Dental Members	Numeric	8	Situational	Count of members with dental coverage as of first of month. The count should match the number of rows, not the distinct members, with medical coverage (ME018) in the corresponding Enrollment file. Do not include members with coverage starting after the first of the month. Do not populate if no dental members.	0.0%

b. Member months control totals example

Payer	Method	Month	Medical_Members	Pharmacy_Members	Dental_Members
OMIP		201001	12345678	12345678	0
OMIP		201002	12345678	12345678	0
OMIP		201003	12345678	12345678	0
OMIP		201004	12345678	12345678	0
OMIP		201005	12345678	12345678	0
OMIP		201006	12345678	12345678	0
OMIP		201007	12345678	12345678	0
OMIP		201008	12345678	12345678	0
OMIP		201009	12345678	12345678	0
OMIP		201010	12345678	12345678	0
OMIP		201011	12345678	12345678	0
OMIP		201012	12345678	12345678	0

c. File naming convention is

For medical and pharmacy:

<payer abbreviation>_<submitter abbreviation>_membership_<quarter>_<file created date_timestamp>.dat

Example: OMIP_OMIP_membership_2015Q2_20150521_010101.dat

For dental:

<payer abbreviation>_<submitter abbreviation>_dental_membership__<quarter>_<file created date_timestamp>.dat

Note: There is a double underscore between ‘dental_membership’ and <quarter>.

Example: OMIP_OMIP_dental_membership__2015Q2_20150521_010101.dat

AMEND: 409-025-0125

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

NOTICE FILED DATE: 07/14/2021

RULE SUMMARY: Update 409-025-0125 to recognize use of Appendix 1 for reporting requirements of Sections 1, 3, 4 and 5, chapter 575, Oregon Laws 2015.

RULE TEXT:

(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 described in Appendix 1; and

(b) Payment arrangement control file described in Appendix 2.

(3) The Payment arrangement file shall be submitted using the approved layout, format, and coding described in Appendix 1, Payment Arrangement File.

(4) The Payment arrangement control file shall be submitted using the approved layout, format, and coding described in Appendix 2, Payment Arrangement Control File.

(5) All data elements are required unless specified as optional or situational in the file layout.

(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 quantities, charges, payment, copayment, coinsurance, deductible, and prepaid amount.

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

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

(a) Data vendor 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 by the Authority or the Authority's data vendor of the 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, coinsurance, copayments, 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 or request an extension.

(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.

(9) These submissions shall meet the requirement that all Coordinated Care Organizations report primary care services to the Oregon Health Authority each year through 2027 for the prior calendar year's data. The findings generated from these submissions will be presented to the legislature no later than February 1 of each year through 2028.

[NOTE: Appendices and Schedules referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: ORS 442.373

STATUTES/OTHER IMPLEMENTED: ORS 442.373, ORS 442.372

Payment Arrangement Files

All mandatory reporters except Pharmacy Benefit Managers must report payment arrangements on an annual basis. Payment arrangement files must include data for group contracts situsedin Oregon and data for individual contracts where the subscriber resides in Oregon. OAR 409-025-0125

Appendix 1: Payment Arrangement File

Note: PBM's that offer stand-alone prescription drug plans are not required to file this report, nor do they have to file a Form APAC-1 (waiver or exception of reporting requirements).

When 'null' is used in the description, the field should be blank. Do not submit 'NULL' within the field.

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
PRAPM003	Contract ID	Text	30 Min. length 2	Yes	Internal ID of the entity receiving the payment or bearing the risk. Contract ID can be proprietary (i.e. specific to the payer reporting the data) but should be consistent throughout all reporting so that all payments/risk attributed to the same Contract ID can be summed up to capture the total payments/risk attributable to that contract entity by the payer. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM018	Billing Provider or Organization NPI	Text	10	Yes	NPI for the billing provider or organization which received the payment from the mandatory reporter If PRAPM103 = 2Ai, then report the PCPCH Practice ID in this field If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%

Payment Arrangement File Lookup Tables -1

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
PRAPM004	Billing Provider or Organization Tax ID	Text	9	Yes	Federal taxpayer's ID of the billing provider or organization/facility which received the payment from the mandatory reporter. Include leading zeros and do not include dashes. Example: 012345678 If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM008	Billing Provider Last Name or Organization	Text	100	Yes	Last name of the billing provider or the full name of the organization which received the payment from the mandatory reporter If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM006	Billing Provider First Name	Text	25	Situational	First name of the billing provider which received the payment from the mandatory reporter. Leave blank if the provider is an organization or facility. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM101	Billing Provider or Organization Entity Type	Numeric	2	Yes	Valid Values:1 – Person, 2 – Facility, 3 – Professional Group, 4 – Retail Site, 5 – E-Site, 6 – Financial Parent, 7 – Transportation, 8 – Other See Lookup Table PRAPM101 (Appendix 1) If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM102	Line of Business	Text	4	Yes	Indicates insurance line of business. Only report the following lines of business using the codes below:	0.0%

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
					COMM = Commercial MADV = Medicare Advantage CCO = Medicaid CCOs PEBB = Public Employees' Benefit Board OEBB = Oregon Educators' Benefit Board	
PRAPM102	Payment Model	Text	1	Yes	Indicates the payment model type that is being reported. See Lookup Table PRAPM103 (Appendix 1) If there is more than one payment type with a single Contract ID, then separately report each payment type. Note: All Payment Models are mutually exclusive with respect to payments and payments to the same Contract ID will be summed up to capture the total payments to that contract. Valid value "A" and "V" must be reported once for every distinct line of business (PRAPM102)	0.0%
PRAPM103	Performance Period Start Date	Date	8	Yes	Effective date of performance period for reported Insurance Line of Business and Payment Arrangement Type. CCYYMMDD If varying performance periods apply to a billing provider or organization (for a particular line of business and payment arrangement type), report results on separate lines. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	2.0%
PRAPM104	Performance Period End Date	Date	8	Yes	End date of performance period for reported Insurance Line of Business and Payment Arrangement Type. CCYYMMDD	2.0%

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
					If varying performance periods apply to a billing provider or organization (for a particular line of business and payment arrangement type), report results on separate lines. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	
PRAPM105	Member Months	Numeric	7	Situational	Total number of members in reported stratification that participate in the reported payment arrangement, expressed in months of membership Membership should align with what is reported in annual NAIC/SERFF filings and should only be reported for those members for whom the mandatory reporter is the primary payer. No decimal places; round to nearest integer. Example: 12345 Report this field only when PRAPM103 = 2Ai, 4A, 4B, 4C or 4N.	2.0%
PRAPM106	Total Primary Care Claims Payments	Numeric	14	Yes	Sum of all associated primary care claims payments (paid claims only), including patient cost-sharing amounts, that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings. Reference the way OHA operationalizes OAR 836-053-1500 through 836-053-1510 and any supplemental documents referenced in those OARs for the definition of primary care. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization	1.0%

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
					has to pay the mandatory reporter. Enter 0 if no primary care claims payments made. This value should never exceed the amount of Total Claims Payments (PRAPM109). If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	
PRAPM107	Total Primary Care Non-Claims Payments	Numeric	14	Yes	Sum of all associated non-claims payments that pertain to primary care, that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings. Reference the way OHA operationalizes OAR 836-053-1500 through 836-053-1510 and any supplemental documents referenced in those OARs for the definition of primary care. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care non-claims payments made. This value should never exceed the amount of Total Non-Claims Payments (PRAPM110). If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM108	Total Claims Payments	Numeric	14	Yes	Sum of all associated claims payments (paid claims only), including patient cost-sharing amounts, that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings.	1.0%

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
					Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no claims payments made. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	
PRAPM109	Total Non-Claims Payments	Numeric	14	Yes	Sum of all associated non-claims payments that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no non-claims payments made If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM201					For future implementation.	N/A
PRAPM202					For future implementation.	N/A
PRAPM203					For future implementation.	N/A
PRAPM204					For future implementation.	N/A
PRAPM205					For future implementation.	N/A
PRAPM206					For future implementation.	N/A
PRAPM207					For future implementation.	N/A
PRAPM208					For future implementation.	N/A
PRAPM209					For future implementation.	N/A
PRAPM210					For future implementation.	N/A

File naming convention is

For payers submitting medical files:
<payer abbreviation>_<submitter abbreviation> _APMProvider_<Year>_<file created date_timestamp>.dat

Example OMIP_OMIP_APMProvider_2020_20210930_010101.dat

For payers submitting dental files:
<payer abbreviation>_<submitter abbreviation> _DENTAL_APMProvider__<Year>_<file created date_timestamp>.dat

Note: There is a double underscore between file type and year for all dental files.

Example OMIP_OMIP_DENTAL_APMProvider__2020_20210930_010101.dat

Lookup Table PRAPM101: Billing Provider or Organization Entity Type

This field contains all valid values for types of billing provider or organization entity types

Code	Value	Definition/Example
1	Person	Physician, clinician, orthodontist, and any individual that is licensed/certified to perform healthcare services
2	Facility	Hospital, health center, long-term care, rehabilitation, and any building that is licensed to transact healthcare services
3	Professional Group	Collection of licensed/certified healthcare professionals that are practicing healthcare services under the same entity name and Federal Tax ID Number
4	Retail Site	Brick-and-mortar licensed/certified place of transaction that is not solely a healthcare entity (i.e., pharmacies, independent laboratories, vision services)
5	E-Site	Internet-based order/logistic system of healthcare services, typically in the form of durable medical equipment, pharmacy, or vision services.
6	Financial Parent	Financial governing body that does not perform healthcare services itself but directs and finances healthcare service entities, usually through a board of directors
7	Transportation	Any form of transport that conveys a patient to/from a healthcare provider
8	Other	Any type of entity not otherwise defined that performs health care services

Lookup Table PRAPM103: Payment Models

This field contains all valid values for types of payment models. These values are based on the HCP-LAN framework. For more information on HCP-LAN and some of the models below, see: https://hcp-lan.org.

Code	Value	Definition/Example
1A	Fee for Service With Link to APM	Payments based on the volume of services, for services that are subject to an APM, regardless of whether the billing provider or entity holds the APM contract (i.e. bears the risk) for the service. **Note: if a mandatory reporter cannot identify payments that qualify for this category, default to category 1 – Fee for Service Without Known Link to APM.**
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

Code	Value	Definition/Example
		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.
A	All Member Months	Total enrollment during the previous calendar year. Enrollment should be reported (in de-duplicated member months) for insurance policies that align with the inclusion criteria of annual NAIC/SERFF filings and should only be reported for those members for whom the mandatory reporter was the primary payer. This value must be reported only once for every distinct line of business (PRAPM102)
V	Alternative Arrangement Member Months	Total enrollment in alternative payment arrangements during the previous calendar year. Enrollment should only be reported for members in payment categories 2Ai, 4A, 4B, 4C and 4N. Enrollment should be reported (in de-duplicated member months) for insurance policies that align with the inclusion criteria of annual NAIC/SERFF filings and should only be reported for those members for whom the mandatory reporter was the primary payer. This value must be reported only once for every distinct line of business (PRAPM102). Note: In many cases, the value reported for code "V" will be a subset of the value reported for code "A".

***Note: Although they are valid values for PRAPM103, codes "A" and "V" are not payment arrangement categories. Instead, these values capture total enrollment, as specified, in policies that align with the inclusion criteria of annual NAIC/SERFF filings.

Appendix 2: Payment Arrangement Control File

Note: PBM's that offer stand-alone prescription drug plans are not required to file this report, nor do they have to file a Form APAC-1 (waiver or exception of reporting requirements).

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
PRAPMCT101	Submitted File	Text	60	Yes	Data File Name Example: *ABCD_ABCD_SupplAPM_Provider_201609_20160918.dat.*	0%
PRAPMCT102	Data Rows	Numeric	10	Yes	Number of data rows in the submitted file	0%
PRAPMCT103	Member Months	Numeric	10	Yes	Sum of member months. No decimal places; round to nearest integer. Example: 12345	0%
PRAPMCT104	Total Primary Care Claims Payments	Numeric	14	Yes	Sum of Total Primary Care Claims Payments	0%
PRAPMCT105	Total Primary Care Non-Claims Payments	Numeric	14	Yes	Sum of Total Primary Care Non-Claims Payments	0%
PRAPMCT106	Total Claims Payments	Numeric	14	Yes	Sum of Total Claims Payments	0%
PRAPMCT107	Total Non-Claims Payments	Numeric	14	Yes	Sum of Total Non-Claims Payments	0%

File naming convention is
For payers submitting medical files:
<payer abbreviation>_<submitter abbreviation> _APMTotals_<Year>_<file created date_timestamp>.dat

Example: OMIP_OMIP_APMTotals_2020_20210930_010101.dat

For payers submitting dental files:
<payer abbreviation>_<submitter abbreviation> _DENTAL_APMTotals__<Year>_<file created date_ timestamp>.dat

Note: There is a double underscore between file type and year for all dental files.
Example: OMIP_OMIP_DENTAL_APMTotals__2020_20210930_010101.dat

AMEND: 409-025-0160

RULE TITLE: Data Access and Release

NOTICE FILED DATE: 07/14/2021

RULE SUMMARY: Updated 409-025-0160 to include dental and remove a combined file type.

RULE TEXT:

(1) The Authority shall comply with all relevant state and federal data privacy, security, and antitrust regulations, including The Health Insurance Portability and Accountability Act (HIPAA), when sharing APAC data.

(2) The Authority may collect payment to recoup costs when APAC data requests are fulfilled.

(3) The Authority shall provide a public use data set, which shall include de-identified health information, in compliance with applicable Authority policies and state and federal rules, regulations, and statutes.

(a) The Authority shall maintain a list of data elements that may be included in APAC public use data sets.

(b) Requestors seeking access to an APAC public use data set shall complete a Pre-Application for APAC Data Files (APAC-2) and submit full payment as follows:

(A) Actual cost with a maximum cost of $500 per data year for Medical Claims;

(B) Actual cost with a maximum cost of $500 per data year for Pharmacy Claims;

(C) Actual cost with a maximum cost of $500 per data year for Dental Claims; and

(D) Enrollment file requested in conjunction with Medical, Pharmacy or Dental Claims will be provided without additional charge.

(c) The Authority may approve or deny the completed request and provide written notification to the requestor within 30 calendar days of receipt of the request.

(d) The Authority shall deny the completed request for reasons which include, but are not limited to:

(A) Requestor or any person who will have access to the data has previously violated a data use agreement with the Authority.

(B) The Authority finds that the specific details of the request do not sufficiently explain the proposed use.

(C) The Authority finds that the specific details of the request violate any state or federal rule, regulation, or statute.

(D) Full payment is not included with the application.

(e) If the Authority denies the Pre-Application for APAC Data Files (APAC-2):

(A) The Authority shall provide written notification stating the reason for the denial and process return of payment; and

(B) The requestor may appeal the denial by requesting a contested case hearing. The appeal must be filed within 30 business days of the denial. The appeal process is conducted pursuant to ORS chapter 183 and the Attorney General's Uniform and Model Rules of Procedure, OAR 137-003-0501 to 137-003-0700. The requestor shall have the burden to prove that the Authority unreasonably denied the application.

(f) The public use data sets may not be used to identify any individual, including but not limited to patients, physicians, and other health care providers. The requestor may not use outside information to attempt to ascertain the identity of individuals who are the subject of public use data sets.

(4) The Authority shall provide limited data sets, in compliance with applicable Authority policies and state and federal rules, regulations, and statutes. Limited data sets may include protected health information.

(a) The Authority shall maintain a list of data elements that may be included in APAC limited data sets if approved for a specific request.

(b) APAC limited data sets may be disclosed for purposes allowed by state and federal regulations, including research, public health, and health care operations.

(c) Requestors seeking access to APAC limited data sets shall complete the Application for APAC Data Files (APAC-3).

(d) Requestors must identify each data element requested and explain the use of the data element within the description of activity in the application. The Authority will determine which data elements will be released after review under HIPAA and other applicable laws, regulations, and rules.

(e) The Authority shall determine the hours required to complete the data request and inform the requestor of the cost

of the resulting data set.
(5) Requests for public use data set or limited data sets must be made using the form and manner prescribed by the Authority that is available on the agency's website. The form shall collect sufficient information to evaluate any request for APAC data.
(6) Requestors who receive a limited data set must maintain Institutional Review Board (IRB) approval, if required for the data use agreement, throughout the span of authorized use of the data and until the data is destroyed. Requestors must submit updated documentation authorizing continued activity prior to the expiration of the previous authorization.
(7) Requesters who receive a limited data set must submit an amendment to the Authority when there is a change in the proposed use of the data within the scope of the original data request.
(a) Requestors shall file such an amendment when any of the following is anticipated:
(A) A change in persons accessing the data;
(B) Additional data elements are requested;
(C) Additional years of data are requested;
(D) Any change in the use of the data including linking or the addition of research questions; or
(E) Any change in research protocol, regardless of approval by an IRB.
(b) Changes or additions to use that are outside of the scope of the original data request will not be approved.
(c) Requestors may not implement any change related to access or use of data prior to receiving approval from the Authority.
(d) Changes in data elements, data use or research protocol must be reviewed by the Data Review Committee (DRC) described in OAR 409-025-0190. In addition, a recommendation by the DRC may be sought for additional years of data or new project staff for limited data sets the Authority determines to include vulnerable populations.
(e) The Authority shall review for completeness all applications and provide requestors written notification of completeness within 30 calendar days of receipt of the request. If the Authority determines that the application is incomplete, the requestor shall have 30 calendar days from notification of incompleteness to complete the application. Incomplete applications that are not completed shall be discarded without further notification to the requestor.

STATUTORY/OTHER AUTHORITY: ORS 442.373

STATUTES/OTHER IMPLEMENTED: ORS 442.373, ORS 442.372

REPEAL: 409-027-0005

RULE TITLE: Purpose and Scope

NOTICE FILED DATE: 07/14/2021

RULE SUMMARY: Repealing rules requiring separate reporting of primary care services by Coordinated Care Organizations to the Oregon Health Authority. Reports submitted to Oregon Health Authority All Payer All Claims program will be used in the future for the reports presented to the legislature no later than February 1 of each year through 2028.

RULE TEXT:

These rules (OAR 409-027-0005 to 409-027-0025) define primary care services that must be reported by all Coordinated Care Organizations to the Oregon Health Authority no later than October 1 each year through 2027 for the prior calendar year's data. The findings generated from these reports will be presented to the legislature no later than February 1 of each year through 2028.

STATUTORY/OTHER AUTHORITY: ORS 413.042, Ch. 575, Sec. 1 - 4 (OL 2015), Ch. 26, Sec. 7 (OL 2016), Ch. 489, Sec. 19 (OL 2017)

STATUTES/OTHER IMPLEMENTED: Ch. 575, Sec. 1 - 4 (OL 2015), Ch. 26, Sec. 7 (OL 2016), Ch. 489, Sec. 19 (OL 2017)

REPEAL: 409-027-0015

RULE TITLE: Definitions

NOTICE FILED DATE: 07/14/2021

RULE SUMMARY: Repealing rules requiring separate reporting of primary care services by Coordinated Care Organizations to the Oregon Health Authority. Reports submitted to Oregon Health Authority All Payer All Claims program will be used in the future for the reports presented to the legislature no later than February 1 of each year through 2028.

RULE TEXT:

The following definitions apply:

(1) “Authority” means the Oregon Health Authority.

(2) “Coordinated care organization (CCO)” has the meaning given that term in ORS 414.025.

(3) “Non-claims based primary care expenditures” means resources given to a primary care provider or practice for the following services or arrangements:

(a) Capitation and salaried arrangements with primary care providers or practices not billed or captured through claims.

(b) Risk-based reconciliation for arrangements with primary care providers or practices not billed or captured through claims.

(c) Payments to Patient-Centered Primary Care Homes or Patient-Centered Medical Homes based upon that recognition or payments for participation in proprietary or other multi-payer medical home initiatives.

(d) Retrospective incentive payments to primary care providers or practices based on performance aimed at decreasing cost or improving value for a defined population of patients.

(e) Prospective incentive payments to primary care providers or practices aimed at developing capacity for improving care for a defined population of patients.

(f) Payments for Health Information Technology structural changes at a primary care practice such as electronic records and data reporting capacity from those records.

(g) Workforce expenses including payments or expenses for supplemental staff or supplemental activities integrated into the primary care practice such as practice coaches, patient educators, patient navigators, and nurse care managers.

(4) “Non-claims based total health care expenditures” means resources given to a provider or practice for the following services or arrangements:

(a) Capitation or salaried arrangements with providers or practices not billed or captured through claims.

(b) Risk-based reconciliation for arrangements with providers or practices not billed or captured through claims.

(c) Payments to Patient-Centered Primary Care Homes, Patient-Centered Medical Homes, or Patient-Centered Specialty Practices based upon that recognition or payments for participation in proprietary or other multi-payer medical home or specialty care practice initiatives.

(d) Retrospective incentive payments to providers or practices based on performance aimed at decreasing cost or improving value for a defined population of patients.

(e) Prospective incentive payments to providers or practices aimed at developing capacity for improving care for a defined population of patients.

(f) Payments for Health Information Technology structural changes at a practice such as electronic records and data reporting capacity from those records.

(g) Workforce expenses including payments or expenses for supplemental staff or supplemental activities integrated into the practice such as practice coaches, patient educators, patient navigators, and nurse care managers.

(5) “Patient-Centered Medical Home (PCMH)” means a practice or provider who has been recognized as such by the National Committee for Quality Assurance.

(6) “Patient-Centered Primary Care Home (PCPCH)” means a health care team or clinic as defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.

(7) “Patient Centered Specialty Practice (PCSP)” means a practice or provider who has been recognized as such by the National Committee for Quality Assurance.
(8) “Practice” means an individual, facility, institution, corporate entity, or other organization which provides direct health care services or items, also termed a performing provider, or bills, obligates and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term provider refers to both performing providers and BPs unless otherwise specified.
(9) “Primary care” means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.
(10) “Primary care provider” means:
(a) A physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care.
(b) A health care team or clinic certified by the Authority as a PCPCH.

STATUTORY/OTHER AUTHORITY: ORS 413.042, Ch. 575, Sec. 1 to 4 (OL 2015), Ch. 26, Sec. 7 (OL 2016), Ch. 489, Sec. 19 (OL 2017)

STATUTES/OTHER IMPLEMENTED: Ch. 575, Sec. 1 to 4 (OL 2015), Ch. 26, Sec. 7 (OL 2016), Ch. 489, Sec. 19 (OL 2017)

REPEAL: 409-027-0025

RULE TITLE: Coordinated Care Organization (CCO) Reporting Requirements

NOTICE FILED DATE: 07/14/2021

RULE SUMMARY: Repealing rules requiring separate reporting of primary care services by Coordinated Care Organizations to the Oregon Health Authority. Reports submitted to Oregon Health Authority All Payer All Claims program will be used in the future for the reports presented to the legislature no later than February 1 of each year through 2028.

RULE TEXT:

(1) No later than October 1 of each year through 2027 each CCO shall submit all non-claims based primary care expenditures as defined in OAR 409-027-0020 for the prior calendar year's data [Example: January 1, 2018 through December 31, 2018 data needs to be submitted by October 1, 2019] using the approved file layout and format available at: http://www.oregon.gov/OHA/HPA/Pages/Rulemaking.aspx.

(2) No later than October 1 of each year through 2027 each CCO shall submit all non-claims based total health care expenditures as defined in OAR 409-027-0020 for the prior calendar year's data [Example: January 1, 2018 through December 31, 2018 data needs to be submitted by October 1, 2019] using the approved file layout and format available at: http://www.oregon.gov/OHA/HPA/Pages/Rulemaking.aspx.

(3) Each category included in the approved file format is mutually exclusive; therefore, expenditures shall only be accounted for in one category.

(4) Claims-based primary care and total health care expenditures will be calculated for each CCO by the Authority using data from the Authority's All-Payer All-Claims Database.

(5) Expenditures for services or activities outside the primary care setting, regardless of a primary care capacity building intent, are not considered primary care expenditures for purposes of this report.

NOTE: Other CCO rules can be found at OAR 410-141-3000 to 410-141-3485.

STATUTORY/OTHER AUTHORITY: ORS 413.042, Ch. 575, Sec. 1 - 4 (OL 2015), Ch. 26, Sec. 7 (OL 2016), Ch. 489, Sec. 19 (OL 2017)

STATUTES/OTHER IMPLEMENTED: Ch. 575, Sec. 1 - 4 (OL 2015), Ch. 26, Sec. 7 (OL 2016), Ch. 489, Sec. 19 (OL 2017)