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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 409
OREGON HEALTH AUTHORITY
HEALTH POLICY AND ANALYTICS

FILED
06/30/2022 4:07 PM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Improve data quality of All Payer All Claims and expedite agency data requests.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 07/21/2022 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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421 SW Oak St
Ste 850
Portland,OR 97204

Filed By:
Pete Edlund
Rules Coordinator

HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 07/19/2022
TIME: 2:05 PM - 2:55 PM
OFFICER: Pete Edlund
ADDRESS: REMOTE MEETING ONLY
421 SW Oak St
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Portland, OR 97204
SPECIAL INSTRUCTIONS:
Please note that this is a joint public rules hearing for all proposed changes to 409-025 All Payer All Claims program rules.

Join ZoomGov Meeting
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A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made at least 48 hours before the meeting. Please contact peter.m.edlund@dhsoha.state.or.us.

NEED FOR THE RULE(S)

The All Payer All Claims (APAC) program is amending rules to improve the data quality received. These changes include adding definitions, clarifying the process to withhold data, clarifying the need to unique member identification within a single mandatory reporter, requiring at least one active user in the data submission solution and excluding agency data requests from review by the Data Review Committee prior to providing data. One rule will have duplicative language removed.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

None.

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

The program does not interact with individuals, providers or community groups. The All Payer All Claims program does not establish eligibility for coverage, determine services to be provided or establish the cost or payment for any services. The program receives administrative data from insurers, third party administrators, pharmacy benefit managers and other insurer-types on services provided including to whom, service, service provider, billed amount and paid amount.

In the near future, the program plans to work with community groups and Equity and Inclusion to determine the best way to acknowledge and document the structural racism underlying data received to mitigate propagating inequities in the guise of quantitative unbiased data.

FISCAL AND ECONOMIC IMPACT:

Mandatory reporters will be impacted in staff time to update coding to improve data quality and add several data fields. Cost is anticipated to be minor in relation to size of business and annual revenue.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). None.
(2) Effect on Small Businesses:
(a) Zero
(b) None
(c) No reporting requirements due to change in rules anticipated for small businesses.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Small businesses were not involved in the development of these rules because the program is unable to identify small businesses that would be affected (employees count and annual revenue not reported to APAC). Most mandatory reporters are national organizations. No mandatory reporter has identified themselves as a small business.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? NO IF NOT, WHY NOT?

Under an exemption, the program consulted with the Technical Advisory Group consisting of mandatory reporters and data requesters in lieu of a Rule Advisory Committee that includes public members. Members of the public are welcome to attend any Technical Advisory Group monthly meeting; however, the current attendees do not include members of the public.

RULES PROPOSED:
409-025-0100, 409-025-0110, 409-025-0120, 409-025-0130, 409-025-0140, 409-025-0150, 409-025-0170

AMEND: 409-025-0100

RULE SUMMARY: Amending 409-025-0100 to clarify waivers, exemptions and extensions; removing APM as not used in rules or file layouts

CHANGES TO RULE:

409-025-0100
Definitions ¶

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~~5) "Attending provider" means the individual health care provider who delivered the health care services, equipment, or supplies specified on a health care claim. ¶
(~~7~~6) "Authority" means the Oregon Health Authority. ¶
(~~8~~7) "Billing provider" means the individual or entity that submits claims for health care services, equipment, or supplies delivered by an attending provider. ¶
(~~9~~8) "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~~9) "Carrier" shall have the meaning given that term in ORS 743B.005. ¶
(1~~1~~0) "Certificate of authority" shall have the meaning given that term in ORS 731.072. ¶
(1~~2~~1) "Charges" means the actual dollar amount charged on the claim. ¶
(1~~3~~2) "Claim" means an encounter or request for payment under the terms of an insurance policy, health benefits plan, Medicare, or Medicaid. ¶
(1~~4~~3) "Coinsurance" means the percentage an enrollee pays toward the cost of a covered service. ¶
(1~~5~~4) "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.¶
(1~~6~~5) "Coordinated Care Organization (CCO)" shall have the meaning given that term in ORS 414.025. ¶
(1~~7~~6) "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. ¶
(1~~8~~7) "Data file" means electronic health information including medical claims files, e~~ligibility~~nrollment 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. ¶
(1~~9~~8) "Data set" means a collection of individual data records, whether in electronic or manual files. ¶
(~~20~~19) "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. ¶
(2~~1~~0) "DCBS" means the Oregon Department of Consumer and Business Services. ¶
(2~~2~~1) "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. ¶
(2~~3~~2) "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. ¶
(2~~4~~3) "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.¶
(2~~5~~4) "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. ¶
(2~~6~~5) "Disability policy" means an insurance policy that provides benefits for losses due to a covered illness or disability. ¶
(2~~7~~6) "Disclosure" means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information. ¶
(2~~8~~7) "DRC" means Data Review Committee. ¶
(2~~9~~8) "Dual eligible special needs plan" means a special needs plan that enrolls beneficiaries entitled to both Medicare and Medicaid. ¶
(~~30~~29) "E~~ligibility~~nrollment 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. ¶
(3~~1~~0) "Eligible employee" shall have the meaning given that term in ORS 743B.005. ¶
(3~~2~~1) "Employee" shall have the meaning given that term in ORS 654.005. ¶
(3~~3~~2) "Employer" shall have the meaning given that term in ORS 654.005. ¶
(3~~4~~3) "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. ¶
(3~~5~~4) "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. ¶
(3~~6~~5) "Enrollee" means enrollee as defined in ORS 743B.005.¶
(3~~7~~6) "ERISA" means the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. ? 1001.¶
(3~~8~~7) "Exemption" means a requested variance from a validation rule on data format or quality threshold.¶
(38) "Extension" means a requested variance from the Data Submission schedule incorporated by reference under OAR 409-025-0120 and 409-025-0125.¶
(39) "Facility" means a health care facility as defined in ORS 442.015. ¶
(~~39~~40) "Genetic test" shall have the meaning given that term in ORS 192.531. ¶
(4~~0~~1) "Group health insurance" shall have the meaning given that term in ORS 731.098. ¶
(4~~1~~2) "Health benefit plan" shall have the meaning given that term in ORS 743B.005.¶
(4~~2~~3) "Health care" shall have the meaning given that term in ORS 192.556. ¶
(4~~3~~4) "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<u>5</u>) "Health care provider" shall have the meaning given that term in ORS 192.556. ¶
(45<u>6</u>) "Health information" shall have the meaning given that term in ORS 192.556. ¶
(46<u>7</u>) "Health insurance exchange" shall have the meaning given that term in ORS 741.300. ¶
(47<u>8</u>) "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<u>9</u>) "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<u>50</u>) "Hospital indemnity policy" means an insurance policy that provides benefits only for covered hospital stays. ¶
(50<u>1</u>) "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<u>2</u>) "Individual", when used in a list of required lines of business, means individual health benefit plans. ¶
(52<u>3</u>) "Individually identifiable health information" shall have the meaning given that term in ORS 192.556. ¶
(53<u>4</u>) "Insurance" shall have the meaning given that term in ORS 731.102. ¶
(54<u>5</u>) "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<u>6</u>) "Large group" means health benefit plans for employers with more than 50 employees. ¶
(56<u>7</u>) "Long-term care insurance" shall have the meaning given that term in ORS 743.652. ¶
(57<u>8</u>) "Mandatory reporter" means any reporting entity defined as a mandatory reporter in OAR 409-025-0110. ¶
(58<u>9</u>) "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<u>60</u>) "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<u>1</u>) "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<u>2</u>) "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<u>3</u>) "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<u>4</u>) "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.¶
(100) "Waiver" means an approved variance from the types of files submitted under OAR409-025-0120 and 409-025-0125.
Statutory/Other Authority: ORS 443.373
Statutes/Other Implemented: ORS 443.373, ORS 442.372

AMEND: 409-025-0110

RULE SUMMARY: Amending 409-025-0110 on need and process for withholding data (other than ERISA self-insured or federal employees) from APAC submissions.

CHANGES TO RULE:

409-025-0110
General Reporting Requirements ¶

(1) Determination of "mandatory reporter":¶
(a) For carriers and licensed third-party administrators, the Authority shall identify mandatory reporters using information collected by DCBS including, but not limited to, data from the Health Insurance Member Enrollment Report. ¶
(A) The Authority shall aggregate the most recent four quarters of data. ¶
(B) The Authority shall calculate the mean total lives for each carrier and licensed third-party administrator. Mean total lives shall be calculated by using the total covered lives in the following lines of business for each carrier and licensed third-party administrator:¶
(i) Large group;¶
(ii) Small group;¶
(iii) Individual market;¶
(iv) Medicare Advantage; and¶
(v) Self-insured.¶
(C) All carriers and licensed third-party administrators with calculated mean total lives of 5,000 or higher shall be mandatory reporters. ¶
(b) All PBMs shall be mandatory reporters. ¶
(c) All CCOs shall be mandatory reporters. ¶
(d) All reporting entities with Dual Eligible Special Needs Plans in Oregon shall be mandatory reporters. ¶
(e) All insurers providing coverage funded under Part D of Medicare shall be mandatory reporters. ¶
(f) All insurers offering a health benefits plan in Oregon's health insurance exchange shall be mandatory reporters. ¶
(g) All insurers providing group health insurance plans to PEBB and OEBB members shall be mandatory reporters.¶
(2) If an organization believes a determination by the Authority of its mandatory status to be in error, the organization must contact the Authority to contest the determination as described in the notice no later than 90 days prior to the first scheduled date of submission of production files.¶
(3) Any carrier or licensed third-party administrator who has been identified as a mandatory reporter and believes their entity has fewer than 5,000 mean total lives due to ERISA self-insured shall notify the Authority by filing a request for waiver under OAR 409-025-0140.¶
(4) An organization may elect to participate as a voluntary reporter by notifying the Authority in writing. ¶
(5) Mandatory and voluntary reporters shall submit data files for all required lines of business. They may submit data files for the voluntary lines of business and may not submit data files for any excluded lines of business. ¶
(a) Required lines of business include: ¶
(A) Medicare Advantage Part C and Medicare Part D; ¶
(B) Medicaid; ¶
(C) Individual; ¶
(D) Small employer health insurance; ¶
(E) Large group; ¶
(F) Associations and trusts; ¶
(G) PEBB and OEBB group health insurance plans; ¶
(H) Self-insured plans not subject to ERISA; and¶
(I) Dental insurance. ¶
(b) Voluntary lines of business include self-insured plans subject to ERISA. ¶
(c) Excluded lines of business include: ¶
(A) Accident policy; ¶
(B) Disability policy; ¶
(C) Hospital indemnity policy; ¶
(D) Long-term care insurance; ¶
(E) Medicare supplemental insurance; ¶
(F) Specific disease policy; ¶

(G) Stop-loss plans; ¶
(H) Student health policy; ¶
(I)-Supplemental insurance that pays deductibles, copays or coinsurance;¶
(J) Vision-only insurance; and ¶
(K) Workers compensation. ¶
(d) A mandatory reporter that contracts with another entity remains responsible for reporting all required lines of business.-If the mandatory reporter elects to have the data reported by a contracted entity, the mandatory reporter shall notify the Authority and provide contact information for the contracted entity.¶
(6) Mandatory and voluntary reporters shall comply with data file layout, format, and coding requirements in OAR 409-025-0120. ¶
(7) Mandatory and voluntary reporters shall comply with data submission requirements in OAR 409-025-0130. ¶
(8) ~~Unless otherwise required by~~A mandatory reporter who plans to withhold data must submit a waiver of reporting in compliance with OAR 409-025-0140. If the mandatory reporter believes that the data are prohibited from disclosure under state or federal ~~rul~~statutes, regulations or ~~statutes, mandatory and voluntary reporters may not submit claims subject to stricter disclosure limits imposed by state or federal rules~~rules, then the waiver request must state the data prohibited from disclosure and the statute, regulation~~s,~~ or ~~statutes.~~ rule that requires withholding the data.¶
(9) The Authority shall provide written notification by July 1 of each year to all mandatory reporter's subject to the reporting requirements of OAR 409-025-0100 to 409-025-01~~7~~50 for the following calendar year. ¶
(10) New mandatory reporters submitting for the first time, or mandatory reporters that did not submit data in the previous year, shall submit test files before production files are due. The mandatory reporters shall submit test files no later than 60 days before the ~~mandatory reporter's first~~first scheduled date of submission of production files.
Statutory/Other Authority: ORS 442.466
Statutes/Other Implemented: ORS 442.464 & 442.466

AMEND: 409-025-0120

RULE SUMMARY: Amending 409-025-0120 to clarify requirement for unique member, subscriber, contract and provider identifiers in submitted files; not a change from current practice.

CHANGES TO RULE:

409-025-0120
Data File Layout, Format, and Coding Requirements ¶

(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) Mandatory reporters must include plan-specific identifiers for members, subscribers, providers and contracts in required files. Mandatory reporters authorized by the Centers for Medicare and Medicaid Services or contracted through an insurer must provide the member's identifier for those organizations in addition to the mandatory reporters' member specific identifier. All identifiers must be: ¶
(a) Sufficient length to be unique within the mandatory reporters' solution;¶
(b) Assigned to a single individual, entity or contract;¶
(c) Consistent across all files for the submission; and¶
(d) Persistent over time unless change in identifier is required due to change in coverage or contract.¶
(4) 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. ¶
(45) 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.¶
(56) 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.¶
(67) 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. ¶
(78) 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. ¶
(89) The pharmacy claims file shall be submitted by PBMs and carriers using the approved layout, format, and coding described in Appendix C, Pharmacy Claims. ¶
(910) 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.¶
(101) All data elements are required unless specified as optional or situational within the file layout. ¶
(112) All required data files shall be submitted as delimited ASCII files. ¶
(123) 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. ¶
(134) 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 requestthat passes all quality and edit checks or receive an approved exemption 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 requestreceive an approved extension or exemption 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

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

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; this identifier value should be consistent between files and over time	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; this identifier value should be consistent between files and over time	0.0%
ME012	Relationship code	Numeric	2	Yes	See lookup table ME012	1.2%
ME013	Member ~~gender~~sex	Text	1	Yes	Valid values: M (male) F (female) and U (unknown)	1.2%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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. Format: street number predirectional street name street designator postdirectional Example: 123 N Main Street	1.2%
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%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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%
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%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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%
ME208	Additional member identifier	Text	30	Yes	~~For future implementation~~Member level unique identifier received from contracting organization for the member; If coverage is associated with Medicare, value should be the Medicare Beneficiary Identification; for Third Party Administrators and Pharmacy Benefit Managers contracting with insurer or employer, value should be unique member identifier received from insurer or employer	~~NA~~5.0%
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; this identifier value should be consistent between files and over time	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%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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%
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%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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%
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%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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%
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%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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%
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%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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%
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 applied	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 applied	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
MC067	Deductible applied	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~~ Do not populate; blank/null required	~~0.0%~~ NA for 2023; 0.0% starting 2024
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%
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%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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~~Payment type	Text	2	Yes	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 07=Other See lookup table MC207 for definitions. ~~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
5	Critical Access Hospital
6	Residential Facility
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.

Lookup Table MC207 – Payment type

Code	Value
01	Capitation is a healthcare payment in which a provider or facility is paid a fixed amount per patient for a list of services per unit of time regardless of services provided within that time
02	Fee for service is payment based on the service received by the member. Payment may be the full billed amount or less.
07	Other will include payment types not known to be capitation or fee for service

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~~ Member ID	30	Text	Yes	332-CY	P	Unique identifier for member; this identifier value should be consistent between files and over time	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%

Data element	Name	Max. length	Type	Required?	NCPDP Field	NCPDP Source	Description/valid values	Error threshold
PC026	NDC	11	Text	Yes	407-D7	C	National Drug Code (NDC)	1.2%
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%

Data element	Name	Max. length	Type	Required?	NCPDP Field	NCPDP Source	Description/valid values	Error threshold
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%
PC040	Co-pay applied	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 applied	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 applied	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~~ Do not populate; leave blank/null	~~0.0%~~ NA for 2023; 0.0% starting 2024
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; this identifier value should be consistent between files and over time	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 %

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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%
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%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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%
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 applied	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 applied	Numeric	12	Yes	Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00	1.2%
DC067	Deductible applied	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~~ Do not populate; leave blank/null	NA for 2023; 0.0% starting 2024~~1.2%~~

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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%
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%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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%
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%

Data element	Name	Type	Max. length	Required?	Description/valid values	Error threshold
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
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

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~~0.1%
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~~0.1%

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~~0.1%
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~~0.1%
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~~0.1%

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: 409-025-0130

RULE SUMMARY: Amending 409-025-0130 to require mandatory reporters to keep active users in HSRI portal as needed for timely submission of files and reminder alerts.

CHANGES TO RULE:

409-025-0130
Data Submission Requirements ¶

(1) Mandatory reporters shall submit data files as specified in the Data Submission Schedule. Voluntary reporters may consult with the Authority to submit healthcare claims data files on an alternative schedule. ¶
(2) Mandatory and voluntary reporters shall submit data files directly to the data vendor unless otherwise specified by the Authority. Each mandatory reporter is required to maintain an active user in the data vendor's reporting portal to receive communications on deadlines and submit files and resolve validation issues in a timely manner.¶
(3) Mandatory and voluntary reporters shall transmit data files using one of the following approved processes: ¶
(a) Secure file transfer protocol (SFTP) including separate strong encryption of data files prior to SFTP transmission; or ¶
(b) Any process incorporating strong encryption that is approved in writing by both the Authority and the data vendor.~~¶~~
~~[NOTE: Data Submission Schedule referenced is available from the agency.]~~
Statutory/Other Authority: ORS 442.466
Statutes/Other Implemented: ORS 442.464 & 442.466

AMEND: 409-025-0140

RULE SUMMARY: Amending 409-025-0140 extensively for language but no change to current practice other than formally decreasing time for agency to respond to requests; clarifying when waiver, exemption and extensions are used by purpose/outcome and timing.

CHANGES TO RULE:

409-025-0140
Waivers and Exceptions ¶

(1) The Authority may grant a waiver, deadline extension, or exeemption to the reporting and validation requirements.¶
(2) A mandatory reporter is required by law and rule to submit all required data files no later than the submission deadline and at sufficient quality to meet or exceed the published validation requirements. Mandatory reporters shall notify the Authority of their inability to meet any requirements within the timeline stated in rule or incorporated by reference.¶
(a3) A mandatory reporter shall submimay request a Wwaiver or Exception of Rreporting Rrequirements Form (APAC-1) to the Authority.. The request shall be submitted 60 calendar days prior to the applicable reporting deadline using the APAC-1a form. ¶
(a) Mandatory reporters may submit an APAC-1 formrequest a waiver of reporting for the following reasons:¶
(A) To request an exception to the data file layout, format or threshold prior to data submission. The request shall be submitted 14 calendar days prior to A mandatory reporter who is a carrier or a third party administrator and, either due to decrease in covered lives or covered lives excluded as reporting to the federal Department of Labor under the Employment Retirement Income Security Act (ERISA), has fewer than 5,000 covered lives in Oregon to report; ¶
(B) A mandatory reporter does not bill subscribers for premiums (Appendix F only); ¶
(C) A mandatory reporter has no contracts sitused in Oregon for Appendices 1 and 2 under OAR 409-025-0125; or¶
(D) A mandatory reporter whose data is reported by another applicable reporting deadline;ffiliated or contracted Oregon All Payer All Claims mandatory reporter if submitting files would create duplicate claims.¶
(Bb) To request a deadline extension for any of the following scenarios: initial submission, data correction or validation. The request shall be submitted 14 calendar days prior to the applA mandatory reporter who intends to withhold data under OAR 409-025-0110(8) must request a waiver and receive approval prior to withholding data.¶
(c) Mandatory reporters other than carriers and third party administrators may request a waiver of reporting based on the number of covered lives potentially reported. The Authority may approve a waiver if it determines the burden of reporting outweighs the value of the data in understanding services and costs in Oregon. ¶
(d) Waivers are required only for the file types identified for the mandatory reporter type under OAR 409-025-0120 and OAR 409-025-0125.¶
(e) The Authority shall approve or deny the waiver request and provide written notification to the requestor within 14 calendar days of receipt of the request.¶
(f) Waivers of reporting are approved for one cablendar year and may cover partial reporting dyeadline; orrs. Waivers must be requested each year that the reason for waiver continues to be in effect.¶
(C4) To request a waiver of all reportingA mandatory reporter may request a deadline extension for initial submission or correction orf validation errors of requirementd files. The request shall be submitted 60within the APAC vendor's reporting portal at least 14 calendar days prior to the applicable reporting deadline.¶
(ba) MThe mandatory reporters seeking exception requests for data element formats or thresholds during the current data file submissions shall submit a request to the Authority's data vendor, using the data vendor's online interface. Requests must be made at time of quarterly submission must explain why sufficient data or resources are not allocated to reporting to meet the published expectations for timing and data quality. The request must include the organization's plan to mitigate future incidents and whether the plan has been approved and resources allocated to accomplish the activity within the stated timeline.¶
(b) The Authority shall approve or deny the extension request and provide notification to the requestor within seven (7) calendar days of receipt of the request.¶
(c) Extensions are approved for one reporting period. Failure to submit acceptable files at the end of the extension may result in a civil penalty under OAR 409-025-0150.¶
(5) A mandatory reporter may request an exemption for validation rules identified as Exemption' level. The request must be submitted through the APAC vendor's reporting portal and cannot be submitted in advance of

validation failure.¶
(a) Specific review of the failed validation results is required prior to requesting an exemption. Mandatory reporters must explain why the validation rule cannot be met and should not rely on receipt of poor-quality data as a reason for exemption. Requests that are not specific to the validation rule and data file submitted will be denied.¶
(~~c~~b) The Authority shall approve or deny the ~~waiver or exce~~exemption request and provide ~~written~~ notification to the requestor ~~within 14 calendar days of receipt of the request.¶~~
~~(d~~through the APAC vendor's reporting portal within seven (7) calendar days of receipt of the request.¶
(c) Exemptions are approved for a single submission or up to one calendar year. Failure to submit acceptable files based on approved exemptions may result in a civil penalty under OAR 409-025-0150.¶
(6) If the Authority denies the request, 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 for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. The requestor shall have the burden to prove a compelling need for the waiver or exception.¶
~~(e) The waiver or exception shall expire at the end of the calendar year unless otherwise specified by the Authority.¶~~
~~[ED. NOTE: Forms referenced are available on the agency's website at http://www.oregon.gov/oha/hpa/analytics/Pages/All-Payer-All-Claims.aspx]~~
Statutory/Other Authority: ORS 442.466
Statutes/Other Implemented: ORS 442.464, 442.466

AMEND: 409-025-0150

RULE SUMMARY: Amending 409-025-0150 to add requirement to maintain an active user in portal; as with other potential civil penalties, this would require a thirty-day notice as an opportunity to cure before the civil penalty is assessed.

CHANGES TO RULE:

409-025-0150
Compliance and Enforcement ¶

(1) Unless approved by a waiver or ex~~cept~~tension, failure to comply with general reporting requirements includes but is not limited to: ¶
(a) Failure to submit data files for a required line of business; or ¶
(b) Submitting health information for an excluded line of business. ¶
(2) Unless approved by a waiver or ex~~e~~emption, failure to comply with data file requirements includes but is not limited to: ¶
(a) Submitting a data file in an unapproved layout; ¶
(b) Submitting a data element in an unapproved format; ¶
(c) Submitting a data element with unapproved coding; ¶
(d) Failure to submit a required data element; or¶
(e) Failure to comply with validation and quality control efforts, including resubmitting or correcting data as requested by the Authority. ¶
(3) Unless approved by a waiver or ex~~cept~~tension, failure to comply with data submission requirements includes but is not limited to: ¶
(a) Failure to maintain an active user in the data vendor reporting portal; ¶
(b) Failure to submit test files as specified by the data vendor; ¶
(~~b~~c) Submitting data files later than five days after the submission due date as detailed in Data Submission Schedule; ¶
(~~c~~d) Rejection of a data file by the data vendor that is not resubmitted or corrected by the submitter within 14 calendar days from notification of error; or ¶
(~~d~~e) Transmitting data files using an unapproved process. ¶
(4) The Authority shall provide mandatory reporters written notification of each failure to comply prior to imposing a civil penalty under this rule. Mandatory reporters will have 30 calendar days to come into compliance.¶
(5) The Authority may impose civil penalties against mandatory reporters for each failure to comply that is not resolved within 30 calendar days of written notification. If a mandatory reporter does not come into compliance within 30 days of written notification, penalties will be assessed starting from the date the mandatory reporter was notified of non-compliance. Pursuant to ORS 442.993, the Authority adopts the following schedule of civil penalties:¶
(a) Up to $400.00 per day for violations of OAR 409-025-0150(1);¶
(b) Up to $300.00 per day for violations of OAR 409-025-0150(2) or OAR 409-025-0140(2)(a); and¶
(c) Up to $200.00 per day for violations of OAR 409-025-0150(3);¶
(6) If a mandatory reporter was issued a final order imposing civil penalties within 24 months from the date the Authority issues a notice of intent to impose a civil penalty, the Authority may impose an additional $100.00 per day for each of the category of violations listed in section (5) of this rule.¶
(7) If a mandatory reporter has made documented efforts to comply with these rules, the Authority may consider this a mitigating factor before imposing civil penalties against the mandatory reporter.~~¶~~
~~[NOTE: Data Submission Schedule referenced is available from the agency.]~~
Statutory/Other Authority: ORS 442.466~~ &~~, 442.993
Statutes/Other Implemented: ORS 442.464, 442.~~466 &~~993, 442.~~993~~466

AMEND: 409-025-0170

RULE SUMMARY: Amendments to -0170 align it with existing language in -0180.

CHANGES TO RULE:

409-025-0170
Public Disclosure ¶

~~(1)~~ The Authority and applicable contractors, shall perform data analyses and publish data and reports that serve the public's interest. This may include, but is not limited to:¶
(~~a~~1) Comparing healthcare cost and quality;¶
(~~b~~2) Assessing health care utilization;¶
(~~c~~3) Assessing the capacity and distribution of healthcare resources;¶
(~~d~~4) Assessing health care purchasing decisions;¶
(~~e~~5) Assessing the effectiveness of public health programs; or¶
(~~f~~6) Assessing disparities in health care delivery and outcomes.¶
~~(2) The Authority may convene advisory groups to advise the Authority on topics related to the All Payer All Claims Reporting Program. The advisory groups shall include, but not be limited to representatives from:¶~~
~~(a) Mandatory reporters, including carriers, TPAs, PBMs, and CCOs; and;¶~~
~~(b) Other stakeholders and interested parties.~~
Statutory/Other Authority: ORS 442.466
Statutes/Other Implemented: ORS 442.464, 442.466