CCO Allowed Amount Guidance Document

1/17/23

The Oregon Health Authority (OHA) made a change in the CY 2022 coordinated care organization (CCO) contract that requires CCOs to include in their encounter data the Fee-for-Service Equivalent Value for each procedure code billed on the provider's claim (Exh. B, Part 4, Sec. 11, Para. e). For technical reasons, OHA delayed implementation of this requirement to CY 2023.

Effective for dates of service on or after 4/17/23, all accepted liability encounter claims submitted by CCOs to OHA must contain both the paid amount (or reason for zero payment) and the Fee-for-Service Equivalent Value amount, also referred to in this document as the Allowed Amount. The presence of valid information will allow the data to be utilized effectively and accurately in rate setting activities and T-MSIS reporting to CMS.

The inclusion of the Allowed Amount also impacts federal T-MSIS submissions since CMS requires that such data reflects the "true" value of the service. CMS has been questioning the value associated with services that have a zero paid amount and no Allowed Amount. For this reason, OHA must be sure that the encounter data replied upon for T-MSIS submissions appropriately values the services.

With the Allowed Amount data, OHA's Office of Actuarial and Financial Analytics (OAFA) and its actuarial vendor, Mercer, will be better equipped to assess the reasonableness of subcapitated expenditures reported by CCOs in Exhibit L. This data will also be useful for CCOs in their internal monitoring of subcapitated contracts. Both OHA and CCOs can use the data to compare the Allowed Amounts for particular providers for a given period with the CCO's subcapitated payments made to those providers. Such analysis can be used to determine whether the subcapitated payments are in alignment with the value of the services provided or whether there's a need to adjust the subcapitated arrangement.

Additionally, the Allowed Amount data will help OHA determine the true value of encounter data by helping to mitigate the impact of zero paid claims. Zero paid claims mean that there is less data available for rate setting and other pricing exercises, such as pricing new programs and development of risk corridors.

The Allowed Amount data must be sent in the following 837 Loops/Segments:

- 837P and 837D (Professional and Dental) - Loop 2400 HCP
- 837I (Institutional) – Loop 2300 HCP or Loop 2400 HCP
- NCPDP – 430-DU – Gross Amount Due

Edits have been created in the 837 to reflect when no allowed amount was submitted. Those edits are:

- 308 – Header or Detail CCO Allowed Amount Must Be Reported (posts on Outpatient claims only when no allowed amount is on the header or detail)
- 309 – Header CCO Allowed Amount Must be Reported (posts on Inpatient or LTC claims with no allowed amount on the header)
- 310 – Detail CCO Allowed Amount Must be Reported (posts on professional or dental claims with no allowed amount on the detail)

CCOs and their submitters may begin testing with OHA as soon as 2/1/23. Early testing will allow as much time as possible for successful implementation on 4/17/23. Please contact your CCO's Encounter Data Liaison when you are ready to begin.

If you have questions about this guidance document, please contact Mary Durrant, mary.durrant@dhsoha.state.or.us or 503-569-0079.