

Health Plan Data Submission Documentation Requirements

Comments: One commenter asked about the extent and necessity of a policy within the DSG requesting detailed documentation from health plans. The commenter requested more information on this policy.

Response: Communication and descriptions for certain data components will be important and necessary to ensure the APCD can be standardized across all submitters. One example is the mapping and submission of homegrown codes by health plans. In the event the health plan performs a mapping, the APCD may request details on how that mapping was performed. Conversely, the health plan will also be allowed to submit a standardized lookup table to communicate descriptions for homegrown values.

In other instances, the APCD may ensure that the programmatic definition of a given variable is consistent across the carriers. For example, Allowed Amount is derived by subtracting Contracted Amount from Billed Charge Amount. The difference between allowed amount and billed amount must be consistent in definition between the payers.

When requesting documentation, the APCD will focus on key strategic variables and processes. Discussions and documentation may require additional information on areas which typically vary across submitters. A few examples of these include: details on claims adjudication systems and the impact on claims submission, delivery of enrollment information, and unexpected variance in variables required for APCD functionality.

15th Day Month Rule for Member Eligibility

Comments: One commenter requested clarification of the ‘15th day of the month’ rule for eligibility determination. Another commenter suggested that data should be submitted quarterly.

Response: Based on conversations with submitters, the data submission rule for eligibility will be changed. The new rule is a monthly rolling 12-month eligibility submission. This approach provides a more accurate estimate of true eligibility, and mitigates many concerns about retroactive adjustments. We will work with reporting entities to implement this request in the coming months.

APCD reporting obligations require monthly submission of claims and eligibility. The APCD will cooperate with health plans to ensure this process can be automated to the greatest extent possible.

15th Day Month Rule for Provider Data

Comments: One commenter requested clarification of the ‘15th day of the month’ rule for provider determination, because this definition contradicts provider requirements found in later sections of the DSG.

Response: The ‘15th’ day of the month rule has been removed from Section II.6.c of the DSG because it provided contradictory information for provider data submission. Provider information should be sent as it appeared for the reporting period in which claims are sent.

File & Data Formats

Comments: The Policies and Procedures and Data Submission Guide contained a requirement for health plans to submit file control totals in a separate table. An appeal was made to eliminate the requirement for separately submitted control total files, and to instead utilize a header/trailer method to capture control totals. The commenter stated the header/trailer method would more closely align CT APCD with APCDs from other states.

Response: The CT APCD researched this issue by looking at other APCDs, and also consulting with the carriers. The APCD decided to change the control total submission process by embedding the header/trailer within each file as requested. This change is reflected in the Data Submission Guide.

Comments: One commenter requested greater detail, regarding external code sources and references, be added to the DSG.

Response: The APCD will communicate various sources and reference tables directly with the carriers’ work groups. The APCD is also adding an external code reference section to the DSG appendix.

Comments: Several commenters with health plan affiliations wanted to get more clarification on various technical aspects of file layout.

Response: The APCD is taking steps to improve communication of requirements to submitters. Measures to increase clarity of technical specifications include: weekly meetings with carriers during implementation, creation of a data submitter FAQ, establishment of a data submitter communication channel for open questions, and ongoing improvements and versioning to the DSG.

Adoption of X12 Standard Data Format

Comments: A request was made for the CT APCD to conform to existing ASC X12 standards, and to modify the existing standard as needed. It was also requested that in addition to adoption of the ASC X12 standard by the CT APCD, a timeline and transition plan be imposed for carriers who do not currently have the ability to produce input data in the X12 format.

Response: The ASC X12 standard does not contain all components needed for Connecticut’s reporting needs and initiatives. Furthermore, not all health plans were prepared to submit data using the ASC PACDR X12 standard. Several states, including Maine, Massachusetts, and New Hampshire currently share very similar data collection requirements for their respective APCDs. In an effort to increase programming and delivery efficiencies for data submitters, the CT APCD data requirements were closely aligned with the requirements for those related states. In the event PACDR X12 standards are further developed and adopted within the industry, the CT APCD may revisit this topic in the future.

Industry codes

Comments: One commenter asked whether SIC codes could be submitted for ME077 instead of the specified NAICS codes.

Response: Currently ME077 intends to capture Member's North American Industry Code (NAICS). However, if any health plan is capturing Standard Industry Classification (SIC) code, they will be required to map it to NAICS standard using a standard reference tables and provide the APCD with their documentation about the mapping.

Race, Ethnicity, and Language (REL)

Comments: A few commenters emphasized that REL information should be collected, so that it can be used to provide meaningful analyses and reports to various stakeholders in their efforts to reduce disparities in care.

Response: Traditionally, REL information was not captured by health insurance companies. But that strategy has changed, and many health insurance carriers are collecting this information to improve compliance, reduce disparities and improve quality. The APCD is fully committed to collecting REL data from various payers. Medicare and Medicaid collect this information. Commercial carriers in Connecticut are sensitive to this issue and are doing their best to collect this data. The CT APCD will work with the carriers and other stakeholders to improve this collection effort.

Data Thresholds

Comments: A few commenters have expressed concerns about setting threshold values for data completion. They wanted to understand how these threshold values were determined and how they will be applied to compliance.

Response: The main objective of constructing the APCD is to control health care costs, improve quality of care, and eliminate health disparities. The current threshold benchmarks utilize findings from other APCDs with similar missions. Without any threshold value benchmarks, it becomes very difficult to gauge and monitor improvements in future data collection. The APCD will discuss the attainment target for each carrier consultatively, and provide opportunities to improve upon the benchmarks.

Provider Identifiers

Comments: One commenter questioned the value in collecting providers' Social Security numbers because it will serve no purpose, and could pose risks if that information is divulged.

Response: Providers' Social Security numbers are needed to improve matching and attribution methodologies between members and providers. As with all data collected by the APCD, we take privacy and security very seriously.