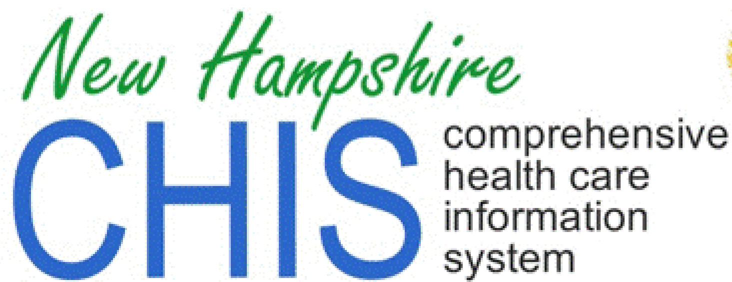

Health Care Processor Quarterly New Hampshire CHIS Update

Volume 5
August 2018

Annual Meeting

The New Hampshire Department of Health and Human Services and the New Hampshire Insurance Department will hold its annual meeting with health care claims processors on **August 29th from 1:00-3:00 PM ET**. The primary agenda topics will be the updates to the 2016 CHIS Field and Quality Checks with, some of which require open discussion at the meeting. For these topics, attendance is important.

Meeting Location

Room 468
DHHS Brown Building
129 Pleasant Street
Concord, NH
Please RSVP if you are attending in person. If you cannot attend in person, you may participate via WebEx using the following information:

Teleconference Information

Dial-In Toll-Free Number: 1-866-913-6864 (US)
Conference Code: 128-928-9836

WebEx Information

https://milliman.webex.com/milliman/j.php?MTID=mb3a5d5100f2de7c9a037b15ddac4fc78

Topic: NH CHIS 2018 Annual Health Care Claim Processors Meeting
Date: Wednesday, August 29, 2018
Time: 1:00–3:00pm, Eastern Daylight Time (New York, GMT-04:00)
Meeting Number: 794 166 267
Meeting Password: This meeting does not require a password.

Field Thresholds & SQL Quality Checks

DHHS and NHID decided in 2018 to evaluate the NH baseline thresholds for ALL Field checks (Minimum population %), Valid Value checks (Valid Value %) and Quality Checks. NH baseline thresholds were purposely set low when file submission commenced in 2013 and when new fields were added in 2016.

Milliman, NH DHHS and NHID, have reviewed how often payers are populating fields, meeting valid value checks, and the results of all quality checks. This was a necessary step in order to adjust the NH Baseline for Field check population, Valid Value checks and Quality Checks.

Separate reference documents are attached for payers to review the changes that will be implemented. Also, the NH MedInsight File, Field and Quality Check User Guide will be updated with all changes. Please review the reference documentation for full details. A summary of the modifications are as follows:

Field Population and Valid Value Updates: (Modifications will fall into these categories)

- Valid Value Field Checks created
- Open thresholds updated to have realistic thresholds
- All financial fields will need to be populated 100%, with a zero being used to indicate no positive or negative value.
- Member First Name and Member Last Name are expected to be fully populated.

Quality Check Updates: (Modifications will fall into these categories)

- The majority of Quality Checks will have no modifications
- Some Quality Checks will have their description changed
- Many Quality Checks will have their Logic modified
- Several Quality Checks will be disabled
- New Quality Check will be created

FFQC Fields for Open Discussion Topics: (Please be prepared to discuss at the Annual Meeting)

- Population of Member SSN in the Eligibility (ME011) and Claim files (MC010, PC010, and DC010) – Are payers able to provide this information? What are the issues providing this information?
- Population of Pharmacy Name (PC020) - Are payers able to provide this information? What are the issues providing this information?
- Population of Provider DEA Number (MP015) – This is a low populated field in Pharmacy files – what are the issues providing this information?
- Population of Provider State License Number (MP017) - This is a low populated field in Pharmacy files – what are the issues providing this information?
- Provider Entity Type Qualifier (MC027 and DC021) – How is a "Group" interpreted when populating this field.
- How are payers populating deductibles in the Pharmacy file?

Pharmacy Claims – Final Version

We would like to hear how the payers can provide the final version for pharmacy claims. This will be an open discussion topic at the Annual Meeting.

NH Exception Requests

After many years of reviewing and ruling NH Exception requests from payers, NH DHHS and NHID have compiled a list of helpful feedback for submitting exception requests.

Do:

- Submit your exception request within 10 days of a file failure notification. If an exception request is not received, your failed file will expire and a new file will need to be resubmitted.
- Submit threshold changes for failed field and quality checks.
- Provide reasoning why you aren't able to meet the threshold – reiterating the description of the quality check is not reasoning why you aren't able to meet the threshold.
- Request the exception request based on your annualized needs for threshold changes instead of monthly needs for a threshold change.

Don't: These will cause your exception request to automatically be ***rejected.***

- Submit files to be accepted as is with no threshold changes.
- Leave the Notes section empty
- Reiterate the description of the quality check in the "Reason For Request".

NH CHIS Registration Website

If you would like staff to receive file email notifications or to have permissions to submit exception requests, then add the new personnel to the payer's NH registration. Milliman will be notified when new contacts are added to payer's registration and will set up new accounts and permissions to submit exception requests.

Likewise, if staff is no longer with a payer, please remove them from the payer's registration. Milliman is also notified with contacts are removed so permissions are disabled as well.

NH CHIS Data Status

Milliman has received and processed files for Commercial business from more than 50 licensed health care claims processors, which cover the period paid from June 2012 to February 2018, and has added those files to the data warehouse.

Data Audit Results

Carve-Outs

In general, the data supplied by the NH health care claims processors continues to be of high quality. As mentioned previously, there continue be some problems resulting from the practice of carriers "carving out" pieces of coverage (pharmacy and/or dental) for their members, and the coverage being administered through a contract with a third party. The most serious problems encountered, which impact the quality of the data during the data consolidation phase, are the following:

- Inability to associate members' medical claims with pharmacy and/or dental claims because the hashed identifiers (SSN, contract number, and name fields) don't always match across the eligibility files submitted by separate entities.
- Inability to accurately aggregate members by group number due to the assignment of different group numbers for the same employer by the different payers submitting data for the same individual members.
- Inability to easily segregate and match claims for each carrier when data files are submitted by a third party in aggregate on behalf of multiple carriers.
- In addition, when individual health care claims processors submit files from multiple platforms, it is sometimes difficult to match the claims files with the appropriate eligibility files, especially if the relationships change over time.

The New Hampshire Insurance Department (NHID) and the Department of Health and Human Services (DHHS) has asked that Milliman contact all health care claims processors submitting data for the New Hampshire Comprehensive Health Care Information System (NH CHIS) to reinforce and clarify one section of the New Hampshire data submission rules that addresses carved out services (Chapter Ins 4000 – Uniform Reporting System for Health Care Claims Data Sets).

Section Ins 4004.01 (f) of the rules reads as follows: "In instances where more than one entity is involved in the administration of a policy, the health carrier shall be responsible for submitting the claims data on policies that it has written, and the third party administrator shall be responsible for submitting claims data on self-insured plans that it administers."

NHID and DHHS interpret this section to mean that all medical or pharmacy claims processed by a third party administrator (TPA) or pharmacy benefits managers (PBM) under contract with a carrier (the entity receiving the premium) for carved-out services are to be submitted by the carrier with unified member IDs in all files.

In addition, NHID and DHHS interpret Section Ins 4004.01 (f) to also apply to behavioral health services that have been separated (carved out) from the medical coverage of a carrier to another entity within the corporation (even if that entity is separately licensed). This means that all behavioral health claims processed by an entity not receiving the premium for those services are to be submitted with unified member IDs in all files submitted by the carrier in the same corporate structure that has received the premium.

It is expected that a carrier who is contracting with a TPA or PBM for carved-out services, or a carrier who has carved out the behavioral health services to another entity within the corporation, to clearly communicate with each other to ensure that Milliman does not receive duplicate submissions of the eligibility and claims files.

If you are a carrier currently contracting with a TPA or PBM for carved out medical or pharmacy services and the TPA or PBM is submitting the claims directly to Milliman on your behalf, or are a carrier that has carved out the behavioral health coverage to another entity within the corporation, NHID and DHHS expect that the system be modified such that you begin the process of receiving, unifying, and submitting the data to Milliman.

If you have any questions about this clarification of the NH submission rules, please contact us at:
NHCHISsupport@milliman.com

NH CHIS knows that these common data submission problems are complicated and are not easily resolved. We welcome any ideas that you may have to address these problems and improve the data quality.
For further information on properly submitting claims data, refer to the rules on the NH CHIS website.