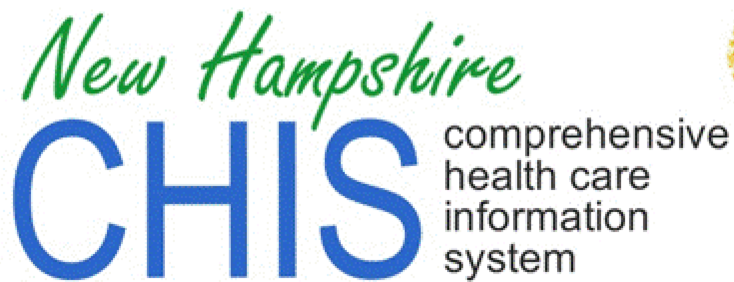

Health Care Processor Quarterly New Hampshire CHIS Update

Volume 3
June 2014

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 **July 22, 2014 from 1:00-3:00 PM ET**. The primary agenda topics will be the upcoming legislation and rule changes, as well as a demo of the automated data submission process that will be installed in 2014. For these topics, attendance is important.

Meeting Location

Auditorium/Room
DHHS Brown Building
129 Pleasant Street
Concord, NH
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: 239 521 0224

Web Ex Information

https://milliman.webex.com/milliman/j.php?ED=183055427&UID=480282937&RT=MiMxMQ%3D%3D
Topic: NH CHIS Health Care Processor Annual Meeting
Date: Tuesday, July 22, 2014
Time: 1:00–3:00pm, Eastern Daylight Time (New York, GMT-04:00)
Meeting Number: 637-622-904
Meeting Password: This meeting does not require a password.

For Assistance

1. Go to https://milliman.webex.com/milliman/mc
2. On the left navigation bar, click "Support."

To add this meeting to your calendar program (e.g., Microsoft Outlook), click this link:
https://milliman.webex.com/milliman/j.php?MTID=m4451379e9b51713fce393894a222b17f
To check whether you have the appropriate players installed for UCF (Universal Communications Format) rich media files, go to https://milliman.webex.com/milliman/systemdiagnosis.php.

Updating Registration Information

Applicability

All health care claims processors meeting the Ins. 400 rules must provide their annual registration information updates for the New Hampshire Comprehensive Health Care Information System (NH CHIS).
Registrations should have been completed by March 15, 2014.
Each health care claims processors should have received an email prompting them to update their registration information for the upcoming period. The registration site can be accessed at any time by visiting the NH CHIS website and logging on.
We realize staff changes can occur throughout the year and appreciate your assistance in keeping this important information up to date as changes occur. We utilize the contact information in the registration system to transmit data submission reports and other NH CHIS-related information. We've recently encountered issues where the information was not current, and therefore important notifications were not received by some health care claims processors.
To transfer or share registration responsibility, log onto the site, then add the contact information of new users and assign them with the role of "Registrant." The newly identified registrant(s) will receive an email providing their login credentials. For assistance with user IDs or passwords, contact NHCHISSupport@milliman.com
The following parties must be registered based on NH CHIS standards:

- All carriers licensed to write accident and health insurance in the state of New Hampshire that write more than $250,000 in insurance premiums in the calendar year must register annually and submit claims data. Carriers are licensed to write accident and health insurance if they have Paragraph 4 authorization on their New Hampshire license.
- A licensed or registered third party administrator (TPA) must register and submit data only if it provides administrative services for coverage that constitutes creditable coverage for 2,400 or more covered life months (i.e., 200 covered lives). TPAs must include their number of covered lives as of December 31, 2013, in the data. Covered lives/members are individual members eligible to have claims paid for them, not accounts. Membership is based on the definition of "member" and "subscriber," as provided in the New Hampshire Chapter Ins 4000 rules, and may include New Hampshire residents with an account site out of state. If the actual number of covered lives is not available to the TPA, the TPA must estimate the number of covered lives and provide the estimate in the registration form.

Modifications to Chapter Ins. 4000 Uniform Reporting System for Health Care Claims Data Sets

The NH Insurance Department is in the process of modifications to its rules governing the submission of health care claims data sets over the next few months. Proposed modifications will include new (or reassignment of) data elements, corrections to code sets, and updates to the file mapping tables. NHID has retained Freedman HealthCare (FHC) to assist with the rule modifications. As part of this process, FHC is seeking input from health care claims processors regarding clarifications and improvements to the rules. To set up a time for a conference call, please contact Linda Green, Project Director, at lgreen@freedmanhealthcare.com or 617.243.9509 x.203. The recent addition of Primary Care Physician

(PCP) and tooth number fields will be part of the modifications in the rule changes. For these data elements, the DHHS/NHID is requesting that the health care claims processors use their best efforts to provide this information until the rule is modified.

New Data Submission System Demonstration

Milliman has constructed a new automated system to receive the data files that health care claims processors are submitting for the NH CHIS. The new system will continue to initially evaluate the files (specifically data type, length, and codes) to determine if they are in the correct format. If the files are accepted for processing, they will be run through the MedInsight File, Field, and Quality Checks (FFQC) system. If they are not accepted, the new system will provide health care claims processors with a description of the causes for the "catastrophic" failure so that the deficiencies can be corrected and the files can be resubmitted.

The new system will also generate tables for all of the File, Field, and Quality Checks in a much shorter period of time, and will allow health care claims processors to request (if necessary) a threshold exception for each File, Field, and Quality Check directly from the automated tables. The exception requests will be forwarded to the Department of Health and Human Services (DHHS) and the New Hampshire Insurance Department (NHID) for consideration. A table with their final decision will be automatically returned to the health care claims processor. The new system will then adjust the appropriate thresholds. Depending upon the decision, the file(s) may or may not need to be resubmitted.

Milliman will send a notice to provide health care claims processors with a demonstration and training of the new system, and will relay the timing for the implementation.

NH CHIS Data Status

Historical Data

The majority of the historical commercial data (January 2005 – March 2014) has been processed and reconciled.

Milliman Processed Data

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 March 2014, and has added those files to the data warehouse. In addition, New Hampshire Medicaid fee-for-service data has been loaded for the paid period January 2010 through March 2013. The data is currently being reviewed by the Department of Health and Human Services and the New Hampshire Insurance Department. Files submitted between for data paid through April 2014 are currently being processed through the edits and threshold reports.

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 by July 1, 2014.

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

Versioning

Since multiple claims systems exist, the process for sending the final version of claims data has varied. In order to properly submit claims data, refer to the following instructions from the NH CHIS website:

- **Version Number.** When more than one version of a fully-processed claim service line is submitted, each version of a claim service line shall be enumerated sequentially with a higher version number (MC005A) so that the latest version of that service line is the record with the highest version number (MC005A) and the same claim number + line counter.
- **Fully-Processed Claim Lines.** Only fully-processed claim service lines that have gone through an accounts payable run and been booked to the health plan ledger shall be included on medical and pharmacy claims data submissions.
- **Denied Claims.** Denied claims shall be excluded from all medical and pharmacy claims file submissions whenever possible so that when a claim contains both fully-processed paid service lines and partially processed or denied service lines, an effort shall be made to include only the fully-processed, paid service lines as part of the health care claims data set submittal.
- **Subsequent Incremental Claims.** Subsequent incremental claims submissions shall include all reversal and adjustment/restated versions of previously submitted claim service lines and all new, fully-processed service lines associated with the claim, provided that they have paid dates in the reporting period:
    - Each version of a claim service line shall be enumerated sequentially with a higher line version number (MC005A); and
    - Reversal versions of a claim service line shall be indicated by a claim status code = '22' (Field MC038).
- **Global Payment Arrangements.** If a claim contains service lines that have been denied because their costs are covered on another line of the claim line, such as under a global payment arrangement, those denied line(s) shall be:
    - Included in the data submission; and
    - Clearly indicated by a claim status code = '04' (Field MC038).
- **Exclusions of Denied Claims or Service Lines.** Carriers and health care claims processors that are unable to exclude denied claims or service lines without compromising the completeness of their claims submission may submit all versions of fully-processed paid and denied claims service lines, provided that lines and versions thereof are clearly indicated by a claim status code = '04', and the line version number is sequentially noted on any reversal and adjustment versions of those lines to clearly indicate the order in which all changes to these lines were processed.

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.

Establishment of a NH CHIS Health Care Claims Processor Stakeholder Team

In the prior NH CHIS Newsletters, NH DHHS, NHID, and Milliman asked if any health care claims processors were interested in serving on a stakeholder team. We heard from a number of the processors but decided not to convene a meeting until the historical and current data had been processed and audited. We are close to finalizing the processing and auditing of the data and again ask the processors to consider participating as members of the stakeholder team.

The purpose of the team is to facilitate collaboration, share best practices, and address issues and concerns that may arise during the NH CHIS implementation and operational processes. One of the primary functions of the stakeholder team will be to evaluate the proposed modifications to the NH

claims data reporting rules (Chapter Ins. 4000). The specific date and time, with additional information, will be provided in the near future.

If you would like to be part of the NH CHIS stakeholder team, please contact Al Prysunka at Milliman via email at al.prysunka@milliman.com.