Health Care Processor Semi-Annual New Hampshire CHIS Update

Volume 4
June 2015

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 28, 2015 from 1:00-3:30 PM ET**. The primary agenda topics will be the newly adopted Chapter Ins 4000 (Uniform Reporting System for Health Care Claims Data Sets) rule changes and a presentation of the MedInsight File, Field, and Quality Checks (FFQC) data file intake verification and processing system. For these topics, attendance is important.

Meeting Location

Room 468
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: 128-928-9836

Web Ex Information

https://milliman.webex.com/milliman/j.php?MTID=m3d2203041c09ee9dba0ddea91ecaae84
Topic: NH CHIS Health Care Processor Annual Meeting
Date: Tuesday, July 28, 2015
Time: 1:00–3:30pm, Eastern Daylight Time (New York, GMT-04:00)
Meeting Number: 631 960 627
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=m3d2203041c09ee9dba0ddea91ecaae84
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

As a reminder, all health care claims processors meeting the Ins. 4000 rules must provide their registration information updates for the New Hampshire Comprehensive Health Care Information System (NH CHIS) by **March 15th** of each year or whenever changes occur that warrant a registration modification.

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

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

The State of New Hampshire is moving through the final stages of adopting significant modifications to its health care claims data submission rules (Ins 4000 *Uniform Reporting System for Health Care Claims Data Sets)*. Some of the major proposed modifications are as follows:

- State-specific code lists have been standardized across all files.
- A provider file is now required.
- Carriers offering Medicare Supplemental ("Medigap") coverage are now required to submit files.
- Denied claims are now to be included in claims files.
- All files must use consistent member and subscriber identifiers to support accurate alignment of member information across files, including files provided by subcontractors such as behavioral health organizations and pharmacy benefit managers.
- Claims files must include record of service under alternative payment arrangements with zero paid amounts.
- Additional data elements for Medicaid FFS and Medicare Managed Care Organizations.
- New data elements to enhance the use of NHCHIS to validate NHID Supplemental Filing reports, including plan identification numbers, metallic value and plan characteristics information.
- Retrospective Updates - the Member Eligibility file will include information for the reporting month and any retrospective updates that correspond to previously submitted member eligibility records.

- Carriers and third-party administrators that fall below the de minimus threshold must provide 180 days of claims run out for those members.
- New data elements in the Medical Claims file have been added to improve data quality:
    - Prior claim transaction identification number
    - Addition of five procedure code fields
    - ICD 9/ICD 10 flag
    - Payment arrangement type to signal capitated or other non FFS payment arrangements
    - Denied claims flag and denied claim reason codes.

The link to the final proposal of the rule is:
http://www.nh.gov/insurance/legal/documents/ins4000fpatinstruction.pdf

The estimated schedule for final adoption and implementation of the rules is as follows:

- JLCAR Public hearing of final proposal: June 19, 2015 (JLCAR register link: http://www.gencourt.state.nh.us/rules/register/2015/2015.htm)
- Final adoption date: July 1, 2015
- Implementation period: July 1, 2015 – December 31, 2015
- Effective date: January 1, 2016

MedInsight File, Field, and Quality Checks (FFQC) System

Milliman has constructed a highly-automated data audit system for data file intake verification and processing that will be used to receive the data files submitted by health care claims processors. The system, which is referred to as the MedInsight File, Field, and Quality Checks (FFQC) System, checks data files submitted through a SFTP for conformity to NH CHIS data submission requirements. The FFQC is a self-service, online tool designed to provide feedback that allows data suppliers to identify and take action on resolving data quality issues.

As the files are submitted the FFQC will evaluate the following: data file structure; field detail (type and max/min length), % filled field frequency default thresholds; and data quality checks with maximum and minimum default thresholds. After the files are evaluated in a much shorter period of time, the FFQC will send tabular, color-coded audit results via email that outline the outcomes of all phases of the data verification process. Milliman will also provide support through a ticketing system to allow health care claims processors to submit any questions or issues that may arise during the FFQC process.

If files are not accepted due to a “catastrophic” (structural) failure, the files will need to be corrected and resubmitted. If the failure(s) are not ‘catastrophic”, health care claims processors can submit directly from the automated tables threshold exception (adjustment) requests resulting from non-catastrophic data completeness and quality failures. Threshold exceptions existing under the current system will be nullified and will need to be re-established under the new FFQC. As is currently the case, all 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.

It is anticipated that the FFQC will be implemented in August. Milliman will provide health care claims processors with a demonstration and training of the new system during the month of July. You will be provided the details of the FFQC demonstration and training via a separate mailing.

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 March, 2015, 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, 2015.

Carve-Outs

In the June, 2014 newsletter a large amount of information was provided regarding "carve outs" (the practice of a carrier contracting with a TPA or PBM to provide pharmacy, dental, and/or behavioral health/substance abuse services for the carrier's members). As stated previously, "carve outs" can create a number of problems when creating a claims database, including 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.

In June of last year the NHID and the DHHS asked that Milliman contact all health care claims processors submitting data for the NH CHIS to reinforce and clarify one section of the existing Chapter Ins 4000 rules that addresses carved out services. 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 have interpreted 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.

Under the proposed rule revisions, NHID and DHHS have maintained these requirements, but they have now been moved to Section Ins 4005.01 (c) and read as follows:

> (c) When more than one entity is involved in the administration of a policy, data shall be submitted in accordance with the following:
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> (1) A carrier shall be responsible for submitting the claims data on policies that it has written;
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> (2) A third-party administrator shall be responsible for submitting claims data on self-insured plans that it administers;
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> (3) Each carrier and third-party administrator shall submit all health care claims processed by any subcontractor on its behalf, including but not limited to claims related to pharmacy services, dental services, and behavioral health, mental health and substance abuse treatment services;
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> (4) Each carrier and third-party administrator shall ensure that the subcontractor is not submitting duplicate claims to the department or its designee if the subcontractor falls under the definition of a carrier, meets the requirements of this section, and is required to submit data as a separate entity; and
>
> (5) Each carrier and third-party administrator shall ensure that member and subscriber identifiers in any files processed by subcontracts are consistent with member and subscriber identifiers in the medical and pharmacy claims files and the member eligibility files.

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

Establishment of Regularly Scheduled Calls with Major Health Care Claims Processors

In an effort to foster better communications between the State of NH/Milliman and the health care claims processors and to identify and resolve issues with data submissions, the State of NH will would like to schedule meetings on a periodic basis with the major (high volume) health care claims processors. Those data submitters deemed to be “major” will be contacted by Milliman on behalf of the State of NH to discuss and establish a schedule (frequency, times) and a list of participants.