Oregon Health Authority All Payer All Claims (APAC)

CCO Frequently Asked Questions for Claims Reporting

Submission

1. Has APAC received additional Medicaid information beyond the standard file layouts in the past? How is that data reported?

APAC will continue receiving supplemental data from OHA (Medicaid) for all Medicaid members. CCOs are not required to provide data outside the standard file layouts.

2. What is the deadline for the first required claims submission?

The first round of required claims data is due by May 1, 2025. The data will cover enrollments and services from January 1, 2025, to March 31, 2025. If data files cannot pass validations by that time, an extension should be requested.

3. How will CCOs be separated from other reporting entities for submission?

For entities with both commercial and Medicaid lines of business, a new division will be created to track Medicaid submissions separately for commercial activities.

4. What files are required for submission?

CCOs must submit the standard 'carrier' set of files, excluding the Premiums file (Appendix F). Dental files should be submitted separately.

5. When can we test files for structural issues?

Files can be tested for structural issues between March 3 and May 1, 2025. Detailed instructions will be provided by the end of February. The files do not need to be complete but should work together as a set.

6. Can we request an extension for submission?

Extensions are available for CCOs who cannot pass validations by the first submission deadline (May 1 for submission and May 15 for validation

clearance). Extensions must be requested on a file-by-file basis but approved as a file set.

7. How do we request an exemption for validation failures?

Exemptions can be requested for each rule failure after the data fails the validation rule in the portal. If you have questions about how to request a exemption request in the APAC Data Submission and Quality Portal, please reach out to the APAC team.

8. Who do we reach out to for help if we have questions?

- HSRI for technical support: apachelp@hsri.org
- APAC for general questions: APAC.Admin@odhsoha.oregon.gov

- **Enrollment File**

9. What should CCOs report for ME001 Payer Type?

For CCOs, the appropriate code for all members is "D" for Medicaid.

10. How do CCOs identify ME003 product code from Medicaid PERC codes?

The following priority order should be used to determine the correct product code:

- If PERC starts with Z, U, or is CX, use product code **CHP**.
- If PERC is one of the following: J1, J2, 1Y,1W, W0, W1, W2, W3, W4, Y0, Y1, Y2, Y3, OR Y4, use product code **MRB**.
- If PERC is 3, B3, 4 or D4, use product code **MD**.
- If Medicare A or B, use product code **MDE**.
- If any other PERC codes, use product code **MLI**.

11. What do CCOs report for Subscriber ID (ME007), last name (ME101), first name (ME102) and middle name (ME103)?

Each Medicaid member is considered independently eligible and should be reported as the subscriber, regardless of age or family relationship.

12. What do CCOs report for ME009D OMIP flag?

This field is outdated. Report as "0" until it is discontinued, at which point it should be reported as blank.

13. What do CCOs report for ME009E HKC flag?

This field is also outdated. Report as "0" until the field is discontinued, at which point it should be reported as blank.

14. What do CCOs report for Member ID (ME010)?

Report the Medicaid ID for the Member ID. This will allow APAC to easily link to services outside the CCO contracts.

15. What do CCOs report for ME012 Relationship code?

Since all Medicaid members are independently covered, the relationship code for each should be reported as "18" (Self).

Medical Claims File

16. What should CCOs report for patient payments (MC064, MC066 and MC067)?

Actual patient/member payments should be reported in each field. While APAC understands that Medicaid members generally do not have out-of-pocket costs, co-pay, co-insurance, and deductible amounts should be reported as "0.00" and not left blank.

17. Should CCOs report vision benefits?

APAC does not currently collect vision benefits. However, medical conditions related to the eyes should be reported. For example, the purchase of eyeglasses should not be reported, but the treatment for glaucoma should be.

18. Should CCOs report lab charges?

Yes, charges for laboratory services should be included in the claims data. However, test results should not be reported.

Pharmacy Claims File

19. What if we don't know the pharmacy providing services?

APAC expects the payer, including CCOs, to know the name, city, state, and zip code of pharmacies being paid for services. If the pharmacy name is

unknown but the pharmacy NPI is available, NPPES can be used to find the required information before submission.

20. What should CCOs report for co-pay, coinsurance, and deductible (PC040-042)?

Actual patient/member payments should be reported in each field. Similar to Medical and dental claims, APAC understands that Medicaid members typically do not have out-of-pocket costs. Therefore, co-pay, co-insurance, and deductible amounts should be reported as "0.00" and not left blank, in line with the file format.

Dental Claims File

21. What should CCOs report for prepaid amount, co-pay, coinsurance, and deductible (DC064-067)?

Actual patient/member payments should be reported in each field. Similar to Medical and Pharmacy claims, APAC understands Medicaid members generally do not have any out-of-pocket costs. However, in keeping with the file format, co-pay, co-insurance, and deductible should be reported as "0.00" and not left blank.

Control Totals

22. What do the control files do?

Control files are used to verify that the files submitted contain the expected information from the payer. There are two types of control files:

- The first file confirms the size of the data files by row count and total dollar amounts. It includes one row for each type of file submitted.
- The second file is specific to member counts and contains a count of members who had coverage on the first day of the month. Every member should appear in the Enrollment file, but if their coverage began after the first day of the month, they will not be included in the control total for that month.

23. Do dental files have separate control files?

Yes, the dental file set includes separate control files that track both the dental enrollment and dental claims file.

24. The example in the file layout shows a row for the Premium file. What should CCOs do with that?

CCOs can either omit the row for Premium control totals since the Premium files are not submitted or report the row count as zero.