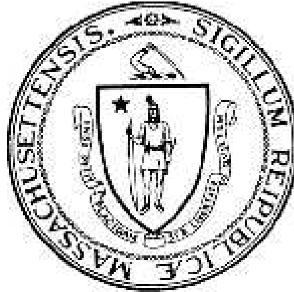

The Commonwealth of Massachusetts

Center for Health Information and Analysis

The Massachusetts All-Payer Claims Database Benefit Plan Control Total File Submission Guide

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February 2017

Charles Baker, Governor
Commonwealth of Massachusetts

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Center for Health Information and Analysis

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MA APCD Benefit Plan Control Total File Submission Guide

Revision History

Date	Version	Description	Author
6/7/13	**1.0**	First Draft	**K. Hines**
6/20/13	**3.1**	Final Version	**K. Hines**
10/30/2014	**4.0**	Administrative Bulletin 14-08	**K. Hines**
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2/2016	**5.0**	Update Cover Sheet, CHIA website and address	**K. Hines**
2/2016	**5.0**	Update APCD Version Number – HD009 – to 5.0	**K. Hines**
2/17	**6.0**	Initial 6.0 Updates	**K. Hines**

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Introduction

Access to timely, accurate, and relevant data is essential to improving quality, mitigating costs, and promoting transparency and efficiency in the health care delivery system. A valuable source of data can be found in health care claims. Using its broad statutory authority to collect, store and maintain health care information in a payer and provider claims database pursuant to M.G.L. c. 12C, the Center for Health Information and Analysis (CHIA) has adopted regulations to collect medical, pharmacy, and dental claims as well as provider, product, and member eligibility information derived from fully-insured, self-insured (where allowed), Medicare, Medicaid and Supplemental Policy data which CHIA stores in a comprehensive All Payer Claims Database (APCD). CHIA serves as the Commonwealth's primary hub for health care data and a primary source of health care analytics that support policy development. In cooperation with the Health Connector and in support of administrative simplification, this document intends to provide further clarifications on the Benefit Plan Control Total File, which was required in the April 2013 Supplemental Filing and became part of the standard MA APCD data submission starting November, 2013. The Benefit Plan Control Total File is only required to be submitted for Risk Adjustment Covered Plans (RACPs), i.e., those benefit plans that are subject to risk adjustment.

Risk adjustment is a permanent risk mitigation program under the provision of the Patient Protection and Accountable Care Act (ACA). The Massachusetts Commonwealth Health Insurance Connector Authority (Health Connector) is the designated administrator of the Commonwealth's risk adjustment program. In the Massachusetts Notice of Benefit and Payment Parameters published in April, 2013, the Health Connector announced that it will work with CHIA to use the MA APCD for risk adjustment data collection. CHIA, in collaboration with the Health Connector, has amended the MA APCD data submission requirements through a number of official publications since Fall 2012, with the intent of collecting all necessary data for the Health Connector to conduct risk adjustment calculations.

To facilitate communication and collaboration, CHIA maintains a dedicated MA APCD website (http://www.chiamass.gov/apcd-information-for-data-submitters/) with resources including the submission and release regulations, Administrative Bulletins, the technical submission guide with examples, and support documentation. These resources will be periodically updated with materials and the CHIA staff will continue to work with all affected submitters to ensure full compliance with the regulation.

We welcome your ongoing suggestions for revising reporting requirements that facilitate our shared goal of administrative simplification. If you have any questions regarding the regulations or technical specifications we encourage you to utilize the online resources and reach out to our staff for any further questions.

Thank you for your partnership with CHIA on the MA APCD.

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Deleted: Using its broad authority to collect health care data ("without limitation") under M.G.L. c. 118G, § 6 and 6A, the Center for Health Information and Analysis (CHIA) has adopted regulations to create a comprehensive all payer claims database (APCD) with medical, pharmacy, and dental claims as well as provider, product, member eligibility and benefit plan control total information derived from fully-insured, self-insured, Medicare, Medicaid and Supplemental Policy data.

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Moved up [1]: In cooperation with the Health Connector and in support of administrative simplification, this document intends to provide further clarifications on the Benefit Plan Control Total File, which was required in the April 2013 Supplemental Filing and will be part of the standard MA APCD data submission starting November, 2013. The Benefit Plan Control Total File is only required to be submitted for Risk Adjustment Covered Plans (RACPs), i.e., those benefit plans that are subject to risk adjustment. ¶

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957 CMR 8.00: APCD and Case Mix Data Submission

957 CMR 8.00 governs the reporting requirements regarding health care data and information that health care Payers and Hospitals must submit pursuant to M.G.L. c. 12C in connection with the APCD and the Acute Hospital Case Mix and Charge Data Databases. The regulation establishes the data submission requirements for the health care claims data and health plan information that Payers must submit. and the procedures and timeframe for submitting such health care data and information. CHIA collects data essential for the continued monitoring of health care cost trends, minimizes the duplication of data submissions by payers to state entities, and promotes administrative simplification among state entities in Massachusetts.

Except as specifically provided otherwise by CHIA or under Chapter 12C, claims data collected by CHIA for the APCD is not a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66. No public disclosure of any health plan information or data shall be made unless specifically authorized under 957 CMR 5.00. CHIA developed the data release procedures defined in CHIA regulations to ensure that the release of data is in the public interest, as well as consistent with Federal and State patient privacy and data security laws.

Patient Identifying Information

No patient identifying information may be included in any fields not specifically instructed as such within the element name, description and submission guideline outlined in this document. Patient identifying information includes name, address, social security number and similar information by which the identity of a patient can be readily determined.

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MA APCD Benefit Plan Control Total File Submission Guide

Acronyms Frequently Used

APCD – All-Payer Claims Database

AV – Actuarial Value

AWSS - Aliens with Special Status

CHIA – Center for Health Information and Analysis

CSO – Computer Services Organization

DBA – Delegated Benefit Administrator

DBM – Dental Benefit Manager

DOI – Division of Insurance

GIC – Group Insurance Commission

ID – Identification; Identifier

MA APCD – Massachusetts' All-Payer Claims Database

Non-AWSS - Non-Aliens with Special Status

PBM – Pharmacy Benefit Manager

QA – Quality Assurance

RA – Risk Adjustment; Risk Adjuster

RACP – Risk Adjustment Covered Plan

TME / RP – Total Medical Expense / Relative Pricing

TPA – Third Party Administrator

The File Types:

DC – Dental Claims

MC – Medical Claims

ME – Member Eligibility

PC – Pharmacy Claims

PR – Product File

PV – Provider File

BP – Benefit Plan Control Total File

SD – Supplemental Diagnosis Code File (Connector Risk Adjustment plans only)

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Benefit Plan Control Total File for Risk Adjustment Covered Plans (RACPs)

In connection with the Massachusetts Risk Adjustment program, a **Benefit Plan Control Total File (BP)** has been added to the MA APCD. All submitters participating in the **Massachusetts Risk Adjustment** program are required to submit a Benefit Plan Control Total File for their Risk Adjustment Covered Plans (RACPs). The Benefit Plan Control Total File requires data for all RACPs offered in Massachusetts. Submitters are not required to submit Benefit Plan Control Total File data for their Non-RACP plans.

Failures to correctly identify benefit plans subject to risk adjustment and errors in file submissions will impact the integrity of the Commonwealth's risk adjustment program. It not only affects the data submitter's own risk adjustment funds transfer, premium development, and medical loss ratio calculations, etc., it also affects all other carriers with RACP plans.

The Benefit Plan Control Total file (BP) shall be submitted monthly to capture the attributes necessary for linking to the monthly Eligibility and Claims Files. It should contain records for each RACP offered by the Issuer.

The BP Detail Records are defined as one record per RACP Benefit Plan, per Month, for each Claim Type (Medical and Pharmacy). The MA APCD elements that have been added for this file are detailed below in **File Guidelines and Layout**.

Below are additional details and clarifications:

Specification Question	Clarification	Rationale
What is the frequency of submission?	BP files must be submitted monthly for all RACP Benefit Plans.	CHIA requires monthly files to capture the attributes necessary for linking RACPs and RACP Control Totals to the Medical Claim, Pharmacy Claim, and Member Eligibility Files coming in on the same schedule.

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Specification Question	Clarification	Rationale
What is the format of the file?	Each submission must start with a Header Record and end with a Trailer Record to define the contents of the data within the submission. Each Detail Record must contain elements in an asterisk delimited format.	The Header and Trailer Records help to determine period-specific editing and create an intake control for quality. The asterisk is an inherited symbol from previous filings that submitters had already coded their systems to compile for previous version of the MA APCD.
What does each row in a file represent?	Each row, or Detail Record, contains the information for a unique **Benefit Plan Contract ID** and **Claim Type** (Medical or Pharmacy), within the Submission Period.	CHIA recognizes that information at this detailed level is necessary for aggregation and reporting for the Risk Adjustment Methodology.
How are the control totals used?	CHIA and the Health Connector expect the control totals to tie out to the monthly medical, pharmacy and eligibility submission by benefit plan. So, for example, in the October 2014 Benefit Plan file, the dollars and claim lines associated with Benefit Plan X would closely match the sum of the dollars and claim lines for that benefit plan found in the October 2014 Medical Claim file as being paid in October 2014. CHIA and the Health Connector will perform analysis to validate this match.	CHIA recognizes that information at this detailed level is necessary for aggregation and reporting for the Risk Adjustment Methodology.

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Types of Data collected in Benefit Plan Control Total File

Non-Massachusetts Resident

CHIA requires that payers submitting claims and encounter data on behalf of an employer group submit claims and encounter data for employees who reside outside of Massachusetts.

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CHIA requires data submission for employees that are based in Massachusetts whether the employer is based in MA or the employer has a site in Massachusetts that employs individuals. This requirement is for all payers that are licensed by the MA Division of Insurance, are involved in the MA Health Connector's Risk Adjustment Program, or are required by contract with the Group Insurance Commission to submit paid claims and encounter data for all Massachusetts residents, and all members of a Massachusetts employer group including those who reside outside of Massachusetts.

For payers reporting to the MA Division of Insurance, CHIA requires data submission for all members where the "situs" of the insurance contract or product is Massachusetts regardless of residence or employer (or the location of the employer that signed the contract is in Massachusetts).

Submitter-Assigned Identifiers

CHIA requires various Submitter-assigned identifiers for linking to the other files. Some examples of these elements include the Benefit Plan Contract ID (BP001 and ME128). These elements will be used by CHIA and the Health Connector to link members across different files, conduct all risk adjustment calculations and reporting to carriers. Failure to provide the proper identifiers will result in inaccurate risk adjustment funds transfers for the data submitter as well as all others subject to risk adjustment.

Control Total Data

CHIA requires control total data at the RACP level for claims and eligible members. The claim counts, member counts and dollar amounts should align to the detail claims submitted to the MA APCD, for the same reporting month.

Risk Adjustment Covered Plan

The Patient Protection and Affordable Care Act's (ACA's) Risk Adjustment program is intended to encourage insurers to compete based on their plans' value and efficiency rather than by attracting healthier enrollees by transferring funds from plans with lower-risk enrollees to plans with higher-risk enrollees. States operating an exchange have the option to either establish their own State-run Risk Adjustment program or allow the Federal government to run the program. Massachusetts operates its own Risk Adjustment program, which will end in 2017.

The Risk Adjustment program does not apply to all plans. As such, this section clarifies which plans are subject to the Risk Adjustment program. The Federal Risk Adjustment program applies to plans in the

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individual and small group insurance markets, both inside and outside of the exchanges, with some exceptions, including:

- Grandfathered health plans;
- HIPAA excepted benefits;
- Student health plans; and
- Plans not yet subject to the ACA's market reforms or essential health benefit requirements.[1]

A State risk adjustment methodology could (subject to Federal approval) take a different approach to applicability—either by including plans that are exempt under the Federal methodology or by excluding additional plans. The Commonwealth is not contemplating making any modifications to applicability in this regard.

Guidance Regarding Reporting Risk Adjustment Covered Plans (RACPs) for State-Subsidized Coverage for 2013 Benefit Plans

As of January 1st 2014, the subsidized coverage programs in Massachusetts began to transition in accordance with the Affordable Care Act to a different structure. Many of those that were covered under the Commonwealth Care program and Medical Security program moved into the merged market plans- many of which are Risk Adjustment Covered Plans.

To support quarterly reporting, we asked that carriers manually populate a few data elements for the **Commonwealth Care Program** and **Medical Security Program** for the period between the effective date of this notice and January 1, 2014. This allows the Health Connector to identify members currently on subsidized insurance and their corresponding plan AV. It will help ensure a smooth operation in quarterly risk adjustment reports to carriers, which as of April, 2014 are based on rolling 12-month data. Below we provide specific instructions for coding both the Benefit Plan Contract ID and AV for the Commonwealth Care and Medical Security Program members.

We ask that carriers who participate in the Commonwealth Care and Medical Security Programs use the values in Table 1 below to report Benefit Contract Plan ID for Commonwealth Care and Medical Security Program members (ME128 and BP001) and AV (ME120 and BP003) for these same members.

[1] For more information, please see the *Commonwealth of Massachusetts Notice of Benefit and Payment Parameters 2014*, available at https://www.mahealthconnector.org/wp-content/uploads/reports-and-publications/Risk_Adjustment/MANoticeofBenefitPaymentParameters.pdf.

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The Code of Federal Regulations ("CFR"), as amended in the HHS Notice of Benefit and Payment Parameters, Final Rule ("Final Notice"), defines a "risk adjustment plan" as:¶
Any health insurance coverage offered in the individual or small group market with the exception of grandfathered health plans, group health insurance coverage described in § 146.145(c) of this subchapter [excepted benefits in the group market], individual health insurance coverage described in § 148.220 of this subchapter [excepted benefits in the individual or non-group market], and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.¶
Thus, the regulatory text creates three explicit exemptions from the risk adjustment program:¶
<#>Grandfathered health plans;¶
<#>HIPAA excepted benefits; and¶
<#>Other plans specified in the Federally-certified risk adjustment methodology (whether created by HHS or a state)¶
The preamble to the Final Notice expands on this concept, stating that, at least under the Federal methodology, student health plans and plans not subject to the health insurance "market reforms and essential health benefit package requirements" would not be subject to risk adjustment charges and would not receive risk adjustment payments.[10] The Final Notice also makes it clear, in the context of small group coverage, that enrollees in a risk adjustment covered plan must be assigned to the applicable risk pool in the State in which the employer's policy was filed and approved (see 45 CFR 153.360).¶ ... [1]

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Deleted: [9] 45 CFR 153.20, as amended in Final Notice, 78 FR 15525

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[11] "For a number of plans, such as student health plans and plans not subject to the market ref ... [2]

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Table 1: Benefit Plan Contract ID and corresponding Actuarial Value for Commonwealth Care and Medical Security coverage programs

Commonwealth Care

Benefit Plan Contract Type	FPL (%)	Commonwealth Care Benefit Plan Contract ID	Actuarial Value (using the Federal AV Calculator)
Non-AWSS Plan Type 1	0% - 100%	CN100	0.9962
Non-AWSS Plan Type 2a	100.1% - 150%	CN210	0.9503
Non-AWSS Plan Type 2b	150.1% - 200%	CN220	0.9503
Non-AWSS Plan Type 3a	200.1% - 250%	CN310	0.9253
Non-AWSS Plan Type 3b	250.1% - 300%	CN320	0.9253
AWSS Plan Type 1	0% - 100%	CA100	0.9962
AWSS Plan Type 2a	100.1% - 150%	CA210	0.9503
AWSS Plan Type 2b	150.1% - 200%	CA220	0.9503
AWSS Plan Type 3a	200.1% - 250%	CA310	0.9253
AWSS Plan Type 3b	250.1% - 300%	CA320	0.9253

Medical Security Plan (MSP)

Benefit Plan Contract Type	FPL (%)	Medical Security Plan Benefit Plan Contract ID	Actuarial Value (using the Federal AV Calculator)
Non-AWSS Plan Type 1	0% - 100%	MN100	0.9962
Non-AWSS Plan Type 2a	100.1% - 150%	MN210	0.9503
Non-AWSS Plan Type 2b	150.1% - 200%	MN220	0.9503
Non-AWSS Plan Type 3a	200.1% - 250%	MN310	0.9253
Non-AWSS Plan Type 3b	250.1% - 300%	MN320	0.9253
AWSS Plan Type 1	0% - 100%	MA100	0.9962
AWSS Plan Type 2a	100.1% - 150%	MA210	0.9503
AWSS Plan Type 2b	150.1% - 200%	MA220	0.9503
AWSS Plan Type 3a	200.1% - 250%	MA310	0.9253
AWSS Plan Type 3b	250.1% - 300%	MA320	0.9253

Please note: AWSS indicates Aliens with Special Status; Non-AWSS indicates Non-Aliens with Special Status.

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Since the Commonwealth Care program extension ended in early 2015, carriers with applicable QHPs in ConnectorCare are expected to use the following Benefit Plan IDs and corresponding Actuarial Values. Carriers covering American Indian/American Native tribal members shall indicate 100% Actuarial Value (ME120) in the Member Eligibility File for these members.

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			Actuarial Value (after Federal and State CSR)	
ConnectorCare Plan Type	FPL (%)	ConnectorCare Benefit Plan Contract ID	Non American Indian/American Native	American Indian/American Native
Plan 1	0-100%	CC100	99.6%	100%
Plan 2A	100.1-150%	CC210	95.0%	100%
Plan 2B	150.1-200%	CC220	95.0%	100%
Plan 3A	200.1-250%	CC310	92.5%	100%
Plan 3B	250.1-300%	CC320	92.5%	100%

Additional Information

For additional information regarding the Massachusetts Alternative Risk Adjustment Program, please refer to the Massachusetts Notice of Benefit and Payment Parameters for the 2014 Benefit Year on the Health Connector's website:

https://www.mahealthconnector.org/ .

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File Guideline and Layout

Legend

1. File: Identifies the file per element as well as the Header and Trailer Records that repeat on all MA APCD File Types. Headers and Trailers are Mandatory as a whole, with just a few elements allowing situational reporting.
2. Col: Identifies the column the data resides in when reported
3. Elmt: This is the number of the element in regards to the file type
4. Data Element Name: Provides identification of basic data required
5. Date Modified: Identifies the last date that an element was adjusted
6. Type: Defines the data as Decimal, Integer, Numeric or Text. Additional information provided for identification, e.g., Date Period – Integer
7. Type Description: Used to group like-items together for quick identification
8. Format / Length: Defines both the reporting length and element min/max requirements. See below:
    a. char[n] – this is a fixed length element of [n] characters, cannot report below or above [n]. This can be any type of data, but is governed by the type listed for the element, Text vs. Numeric.
    b. varchar[n] – this is a variable length field of max [n] characters, cannot report above [n]. This can be any type of data, but is governed by the type listed for the element, Text vs. Numeric.
    c. int[n] – this is a fixed type and length element of [n] for numeric reporting only. This cannot be anything but numeric with no decimal points or leading zeros.

    The plus/minus symbol (±) in front on any of the Formats above indicate that a negative can be submitted in the element under specific conditions.

    Example: When the Claim Line Type (MC138) = V (void) or B (backout) then certain claim values can be negative.
9. Description: Short description that defines the data expected in the element
10. Element Submission Guideline: Provides detailed information regarding the data required as well as constraints, exceptions and examples.
11. Condition: Provides the condition for reporting the given data
12. %: Provides the base percentage that the MA APCD is expecting in volume of data in regards to condition requirements.

13. Cat: Provides the category or tiering of elements and reporting margins where applicable. 'A' level fields must meet their APCD threshold percentage in order for a file to pass. The other categories (B, C, Z) are also monitored but will not cause a file to fail. Header and Trailer Mandatory element errors will cause a file to drop. Where elements have a conditional requirement, percentages are applied to the number of records that meet the condition.

    HM = Mandatory Header element; HS = Situational Header element; HO = Optional Header element; A0 = Data is required to be valid per Conditions and must meet threshold percent with 0% variation; A1= Data is required to be valid per Conditions and must meet threshold percent with no more than 1% variation; A2 = Data is required to be valid per Conditions and must meet threshold percent with no more than 2% variation; B and C = Data is requested and errors are reported, but will not cause a file to fail; Z = Data is not required; TM = Mandatory Trailer element; TS = Situational Trailer element; TO = Optional Trailer element.

Elements that are highlighted indicate that a MA APCD lookup table is present and contains valid values expected in the element. In very few cases, there is a combination of a MA APCD lookup table and an External Code Source or Carrier Defined Table, these maintain the highlight.

It is important to note that Type, Format/Length, Condition, Threshold and Category are considered as a suite of requirements that the intake edits are built around to insure compliance, continuity and quality. This insures that the data can be standardized at other levels for greater understanding of healthcare utilization.

File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
	1	HD001	Type of File	5/9/13	Text	ID Record	char[2]	Defines the file type and data expected.	Report **BP** here. Indicates that the data within this file is expected to be BENEFIT PLAN-based. This must match the File Type reported in TR001.	Mandatory	100%	HM
	2	HD002	Submitter	5/9/13	Integer	ID OrgID	varchar[6]	Header Submitter / Carrier ID defined by CHIA	Report the CHIA defined, unique Submitter ID here. TR002 must match the Submitter ID reported here.	Mandatory	100%	HM
	3	HD003	Period Beginning Date	5/9/13	Date Period - Integer	Century Year Month - CCYYMM	Int[6]	Header Period Start Date	Report the Year and Month of the reported submission period in CCYYMM format. This date period must be repeated in HD004, TR005 and TR006. This same date must be selected in the upload application for successful transfer.	Mandatory	100%	HM

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File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
BP	4	HD004	Period Ending Date	5/9/13	Date Period - Integer	Century Year Month - CCYYMM	Int[6]	Header Period End Date	Report the Year and Month of the reported submission period in CCYYMM format. This date period must be repeated in HD003, TR005 and TR006. This same date must be selected in the upload application for successful transfer.	Mandatory	100%	HM
BP	5	HD005	APCD Version Number	2/2016	Decimal – Numeric	ID Version	Char[3]	Submission Guide Version	Report the version number as presented on the APCD Benefit Plan File Submission Guide in 0.0 Format. Sets the intake control for editing elements. Version must be accurate or file will drop. **EXAMPLE:** 3.0 = Version 3.0	Mandatory	100%	HM
								Code	**Description**			
								3.0	Version 3.0; required for reporting periods as of October 2013; No longer valid as of May 2015.			
								4.0	Version 4.0 required for reporting periods October 2013 onward; No longer valid as of August 2016.			
								5.0	Version 5.0; required for reporting periods October 2013 onward as of August 2016; no longer valid as of August 2017.			
								6.0	Version 6.0; required for reporting periods October 2013 onward as of August 2017			
BP	6	HD006	Comments	5/9/13	Text	Free Text	varchar[80]	Header Carrier Comments	May be used to document the submission by assigning a filename, system source, compile identifier, etc.	Optional	0%	HO

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File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
BP	1	BP001	Benefit Plan Contract ID	5/9/13	Text	Unique Benefit Plan ID	varchar[30]	Benefit Plan ID	The Benefit Plan Contract ID is the issuer generated unique ID number for *each* benefit plan for which the issuer sets a premium in the Massachusetts merged (non-group/small group) market. This identifier is used to link this Benefit Plan line with its attributes to eligibility lines using APCD Member Eligibility file data element ME128 (Benefit Plan Contract ID).	All	100%	A0
BP	2	BP002	Benefit Plan Name	5/9/13	Text	Name Contract	varchar[70]	Submitter defined benefit plan name	A benefit plan refers to the health insurance services covered by a health insurance contract or "plan" and the financial terms of such coverage, including cost sharing and limitation of amounts of services. Risk scores are calculated at the benefit plan level by geographic rating area. Report a unique name for every RACP Benefit Plan in a Carrier's system. For Benefit Plans with identical names, it is required that the Submitter add a refining 'element' to create unique Benefit Plan Names that align to unique Benefit Plan Contract ID Numbers. This refining element can be numeric, alpha or alpha-numeric. Report every RACP Benefit Plan offered by the Issuer regardless of the number of members enrolled in a particular month.	All	100%	A0

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File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
BP	3	BP003	Actuarial Value	5/9/13	Decimal	Numeric	varchar[6]	Actuarial value for the benefit plan	Calculate using the Federal AV Calculator for the risk adjustment covered plan. Report the Actuarial Value of this plan as of the 15th of the month. Format to be used is 0.000. For example, an AV of 88.27689% should be reported as 0.8828.	All	100%	A0
BP	4	BP004	Claim Type Qualifier	5/9/13	Lookup Table - Integer	tlkpSupplementClaimType	int[1]	Claim Type Identifier Code	Report the value that defines the claim type for the control totals in BP005 – BP007. EXAMPLE: 1 = Medical Claim Reporting	All	100%	A0
								Value	***Description***			
								1	Medical Claim Reporting			
								2	Pharmacy Claim Reporting			
BP	5	BP005	Monthly Claims Paid Number for the Benefit Plan	10/30/14	Quantity - Integer	Counter	varchar[15]	Total Number of Claims Paid	Report the total number of claim lines that correspond to the Benefit Plan Contract ID in BP001 and Monthly Net Dollars Paid in BP006 for the month reported in HD003. (Note that not all will be "paid" claim lines). Use Claims Paid Date MC089 or PC063. If no claims were paid for this BP Contract ID, report 0. Do not use a 1000 separator (commas).	All	100%	A0

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File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
BP	6	BP006	Monthly Net Dollars Paid for the Benefit Plan	10/30/14	Integer	Currency	varchar[15]	Total Paid Amount	Report the monthly aggregate Total Plan Paid Amount that corresponds to the Benefit Plan Contract ID in BP001 and the Claim Type in BP004 for the month reported in HD003. For the medical claims, the Paid Amount is MC063 and for pharmacy claims the Paid Amount is PC036. Calculate the total based on Paid Date (MC089 or PC063). Include fee-for-service equivalent paid amount for services that have been carved out. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	100%	A0
BP	7	BP007	Total Monthly Eligible Members by Benefit Plan ID Period Date	10/30/14	Quantity - Integer	Numeric	varchar[15]	Total Eligible Members	Number of eligible members enrolled on the 15th of the month reported in HD003 for the Benefit Plan Contract ID reported in BP001, including billable and non-billable members.	All	100%	A0
BP	8	BP008	Benefit Plan Start Date	10/30/14	Full Date-Integer	Century Year Month Date – CCYYMMDD	Int[8]	Benefit Plan Start Date	Report the first date that this Benefit Plan is active in CCYYMMDD Format.	All	100%	A0
BP	9	BP009	Benefit Plan End Date	10/30/14	Full Date – Integer	Century Year Month Date – CCYYMMDD	Int[8]	Benefit Plan End Date	Report the last date that this Benefit Plan is active in CCYYMMDD Format. If product is still active do not report any value here.	All	100%	B
BP	1	TR001	Type of File	5/9/13	Text	ID File	char[2]	Validates the file type defined in HD001.	Report **BP** here. Indicates that the data within this file is expected to be BENEFIT PLAN-based. This must match the File Type reported in HD001.	Mandatory	100%	TM

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File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
BP	2	TR002	Submitter	5/9/13	Integer	ID Submitter	varchar[6]	Trailer Submitter / Carrier ID defined by CHIA	Report the Unique Submitter ID as defined by CHIA here. This must match the Submitter ID reported in HD002.	Mandatory	100%	TM
BP	3	TR003	Record Count	5/9/13	Integer	Numeric	varchar[10]	Trailer Record Count	Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters.	Mandatory	100%	TM
BP	4	TR004	Date Processed	5/9/13	Integer	Century Year Month Day– CCYYMMDD	int[8]	Trailer Processed Date	Report the full date that the submission was compiled by the submitter in CCYYMMDD Format.	Mandatory	100%	TM
BP	5	TR005	Period Beginning Date	5/9/13	Date Period - Integer	Century Year Month - CCYYMM	Int[6]	Trailer Period Start Date	Report the Year and Month of the reported submission period in CCYYMM format. This date period must be repeated in HD003, HD004 and TR006. This same date must be selected in the upload application for successful transfer.	Mandatory	100%	HM
BP	6	TR006	Period Ending Date	5/9/13	Date Period - Integer	Century Year Month - CCYYMM	Int[6]	Trailer Period End Date	Report the Year and Month of the reported submission period in CCYYMM format. This date period must be repeated in HD003, HD004, and TR005. This same date must be selected in the upload application for successful transfer.	Mandatory	100%	HM

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The Code of Federal Regulations ("CFR"), as amended in the HHS Notice of Benefit and Payment Parameters, Final Rule ("Final Notice"), defines a "risk adjustment plan" as:

> Any health insurance coverage offered in the individual or small group market with the exception of grandfathered health plans, group health insurance coverage described in § 146.145(c) of this subchapter [excepted benefits in the group market], individual health insurance coverage described in § 148.220 of this subchapter [excepted benefits in the individual or non-group market], and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.

Thus, the regulatory text creates three explicit exemptions from the risk adjustment program:

Grandfathered health plans;

HIPAA excepted benefits; and

Other plans specified in the Federally-certified risk adjustment methodology (whether created by HHS or a state)

The preamble to the Final Notice expands on this concept, stating that, at least under the Federal methodology, student health plans and plans not subject to the health insurance "market reforms and essential health benefit package requirements" would not be subject to risk adjustment charges and would not receive risk adjustment payments. [10] The Final Notice also makes it clear, in the context of small group coverage, that enrollees in a risk adjustment covered plan must be assigned to the applicable risk pool in the State in which the employer's policy was filed and approved (see 45 CFR 153.360).

Combining the regulatory text and the preamble language of the Final Notice, the following types of plans thus appear to be exempt from risk adjustment under the Federal rules:

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[10] 78 FR 15418-19.

[11] "For a number of plans, such as student health plans and plans not subject to the market reform rules, we will not transfer payments under the HHS risk adjustment methodology. However, as discussed above, we believe that States should have the flexibility to submit a methodology that transfers funds between these types of plans (either in their own risk pool or with the other metal levels).." 78 FR 15435.

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Guidance Regarding Reporting RACP for State-Subsidized Coverage for 2013 Benefit Plans

For eligibility periods through June 30, 2014, Commonwealth Care and Medical Security plans should be treated on your submissions as RACP plans (RACP value of 3 in ME126). Starting January 1 2014, in

accordance with the ACA, subsidized coverage programs in Massachusetts will be structured very differently to those provided today. Many of those currently covered under the **Commonwealth Care program and Medical Security program** will move into the merged market plans (many of which will be RACPs). To support quarterly reporting to carriers, we are asking that carriers manually populate a few data elements for the **Commonwealth Care Program and Medical Security Program** for the period between the effective date of this notice and July 1, 2014.

This will allow the Health Connector to identify members currently on subsidized insurance and their corresponding plan Actuarial Value (AV). It will help ensure a smooth operation in quarterly risk adjustment reports to carriers, which will be based on rolling 12-month data starting in April, 2014. Below we provide specific instructions for coding both the Benefit Plan Contract ID and AV for the Commonwealth Care and Medical Security Program members.