Data Submission Guide

Integrated Healthcare Association (IHA)
Data Submission Guide

Version: 4.0 (MY 2020)
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Welcome!

First things first: Welcome to data submissions for the Integrated Healthcare Association (IHA).

Based in Oakland, California, the nonprofit Integrated Healthcare Association convenes diverse stakeholders – including physicians, hospitals, health systems, purchasers, and health plans – that are committed to high-value, integrated care. Together we strive to improve healthcare quality and affordability for patients across California and the nation.

Your organization has, and will continue to play, a critical part in IHA's efforts, providing the foundational data needed to enhance understanding of the use, cost, quality, and delivery of healthcare across California. We're glad you're a part of this exciting initiative – and we're here to help.

Onpoint Health Data has been leading the way in doing this type of work for nearly 20 years, helping launch statewide all-payer claims databases (APCDs) and other data-collection initiatives across the country in support of healthcare reform. We are a nonprofit company committed to a singular mission: Advancing informed decision making by providing independent and reliable health data services.

We will work closely with you to help explain IHA's submission requirements and how to meet them as efficiently as possible. This IHA Data Submission Guide (DSG) is the place to start. In the following pages, we will outline the process from start to finish, walking you through each step of working with Onpoint CDM (Claims Data Manager), our data integration solution for commercial, Medicaid, and Medicare submissions alike.

For new data submitters, this is the place to familiarize yourself with the technical requirements of IHA data submissions, including information on how data fields should be prepared, how to protect and transmit data, and who to contact when questions arise. For data submitters already familiar with Onpoint, these pages will provide a helpful refresher on coding specifications and program milestones. Whether new or veteran, welcome!

We're Here to Help.

Meeting reporting requirements can sometimes seem like a complicated process. Onpoint is here to help. Our Operations staff are trained, experienced, and ready to work with you. If you have a question, we will help find the answer.

How to Reach Onpoint

Onpoint's data operations specialists are available to answer your questions regarding the mechanics of IHA data submissions, including the use of Onpoint's SFTP submission tools and technical issues regarding the population, intent, or contents of submitted fields. We can be reached using the information below.

IHA Data Operations Team
207-623-2555 (Eastern Time)

iha-support@onpointhealthdata.org

www.onpointhealthdata.org

How to Reach Integrated Healthcare Association (IHA)

For program-related questions, please contact:

Marci Scott, Client Success Manager

510-281-5617 (Pacific Time)

mscott@iha.org

www.iha.org

Step 1. Registering with Onpoint (For New Submitters Only)

To satisfy the first step of IHA program participation, new IHA data submitters must register their organization with Onpoint CDM prior to data submission and provide the following information for reference and downstream validation purposes:

- Reporting organization and individual contact information for all collected file types
- Covered lives, claims volume, and incurred claims' value estimates

To get started, log in to Onpoint CDM and click on the "New Registrant" link.

Please note that even if you already submit data to Onpoint for another client, you will still need to register for IHA's data collection efforts. To keep things simple, we will extend your authorizations appropriately, enabling you to use your existing Onpoint CDM credentials for IHA submissions. After registration, each of your organization's newly identified contacts will receive an email confirming their assigned username and password. For more information, please reach out to us via email or telephone (iha-support@onpointhealthdata.org | 207-623-2555).

Step 2. Sending Data to Onpoint

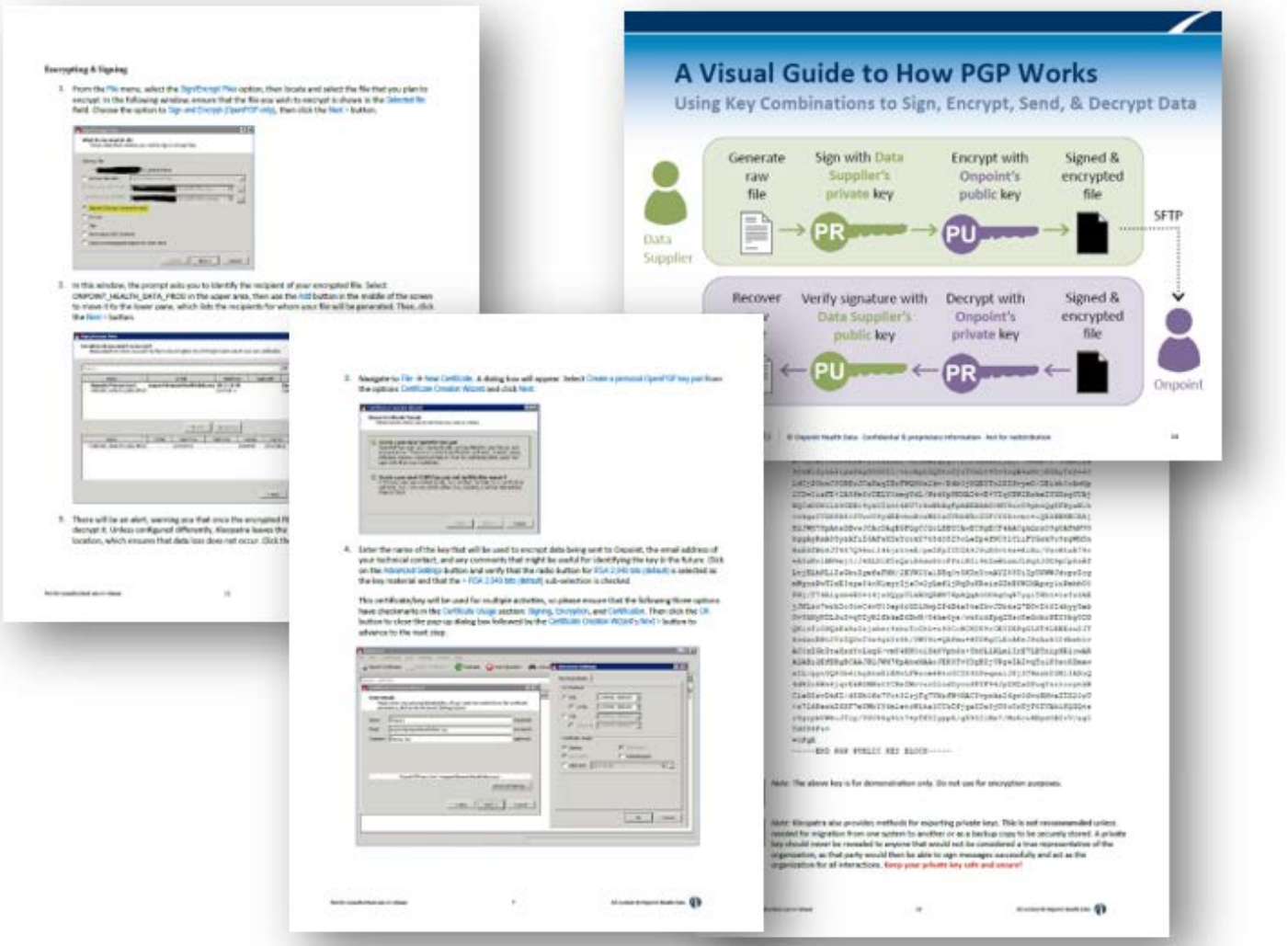
Setting Up for Secure Transfers via SFTP

IHA data submissions will be accepted only through secure file transfer protocol (SFTP) with PGP encryption. To facilitate this process, Onpoint leverages a managed file transfer application for secure file transfer and receipt. Our SFTP server is accessible from a wide range of SFTP client utilities and open-source solutions (e.g., WinSCP, FileZilla, etc.) as well as through a Hypertext Transfer Protocol Secure (HTTPS) (https://sftp.onpointhealthdata.org).

Please note that use of the online CDM portal requires establishing a password that expires regularly for security reasons. We highly recommend establishing connectivity with our systems using an SSH key, which eliminates the password requirement.

SFTP data exchanges with Onpoint must be both encrypted using the OpenPGP standard and signed by the sender prior to transfer to ensure file integrity. Onpoint's SFTP server accepts files of any size and offers users an approach that can be fully scripted on their end to facilitate automation. For a thorough walk-through of the SFTP process, including step-by-step instructions for installing and configuring standard software, please log in to Onpoint CDM and access the Documentation component, where you will find downloadable user guides and other support documentation (Figure 1).

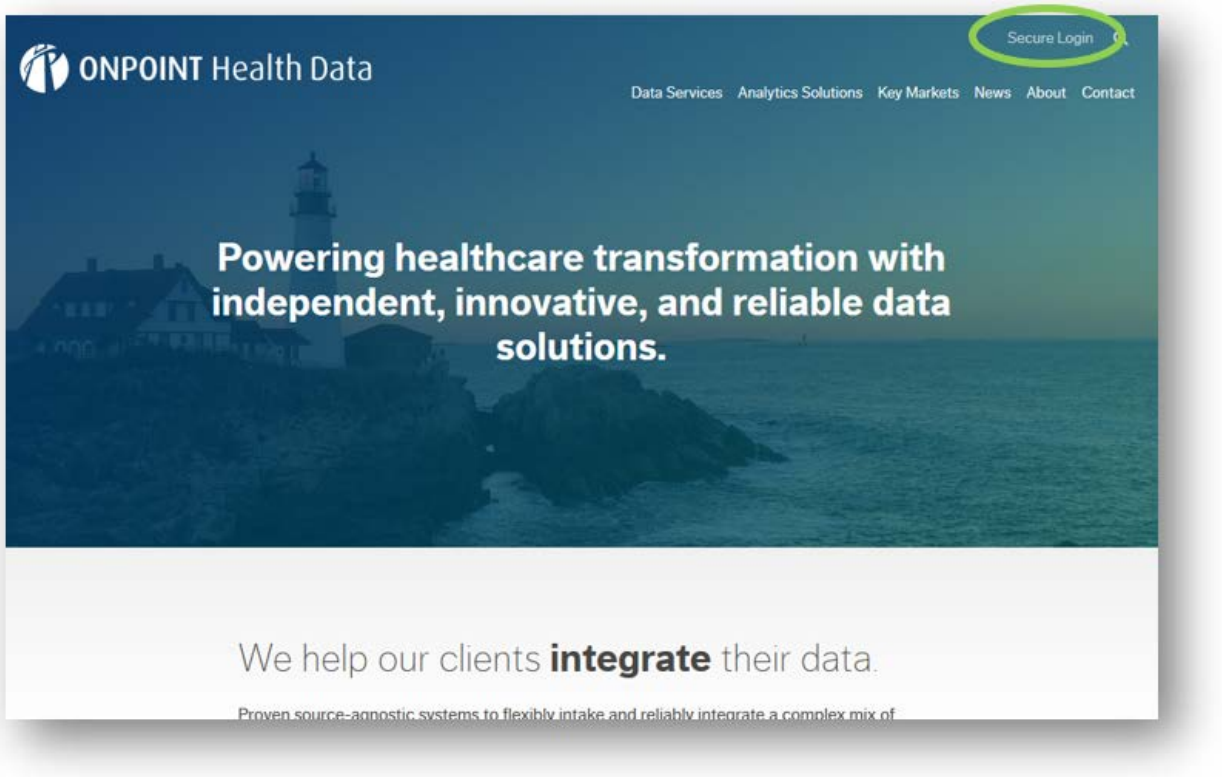
Figure 1. SFTP & PGP Support Documentation (Example)



Step 3. Monitoring Your Submissions

Once you begin supplying data to Onpoint, you can use your credentials to access Onpoint CDM's secure reporting portal, which provides end-to-end visibility on your files' progress. Credentialed users can log in to Onpoint CDM anytime to monitor the status of their submissions, including up-to-date reporting on stage, status, reasons for file failure, and resubmission deadlines. Gaining access begins at the Onpoint CDM home page. Simply click the Secure Login option from our home page's upper-right corner and follow the prompts to access Onpoint CDM's online portal (Figure 2).

Figure 2. Secure Login Location on Onpoint's Home Page



The time from receipt of a data submission by Onpoint CDM to notification of success or failure (due to quality checks) depends on a number of variables, including system load, file size, and data type. Upon receipt, data submissions are decrypted and inspected for quality and compliance with fundamental submission requirements. Pre-load checks that are conducted prior to allowing a submitted file to proceed to data quality review include assessments of whether:

1. The file contains one header record and one trailer record, both of which are formatted correctly
2. The correct number of fields appears in each record
3. The number of data records matches the count in the header record
4. The data type is valid
5. The length and format of submitted Social Security numbers are valid
6. Each file's last record element (i.e., Record Type) is populated correctly (i.e., ME for eligibility, MC for medical claims, PC for pharmacy claims, TC for cost, LR for lab results, and MI for member identifier)

7. For eligibility data, the reported year (ME004) and month (ME005) in the eligibility file are within the period beginning and period ending values cited in the header record
8. For claims data, the incurred date is within the period beginning and period ending values cited in the header record

Supporting Data Submitters

Onpoint CDM includes complex and customized data quality validations and thresholds to ensure that collected data will meet IHA's downstream reporting and research needs. Onpoint CDM's data quality validations can be a rigorous test for some data submitters, which is why we will always work hand in hand with your technical staff to understand and meet the established data layouts, completeness thresholds, quality validations, and compliance processes.

Onpoint's data operations specialists do not simply fail a submission and abandon submitters to resolve issues on their own; we help you find the solutions that both you and IHA need. Our ultimate goal is to arrive at a solution that is efficient and programmable for the submitter without compromising the timeliness and quality of the submitted data.

Onpoint CDM includes automated alerts and hands-on support – on the phone, by email, via webinars, etc. – to help resolve any issues as soon as they arise. We tackle these issues through two key tools: submission tracking and status updates.

Submission Tracking & Status Updates

Throughout the entire data flow, Onpoint CDM monitors each of the submissions from start to finish – and enables data submitters to do the same. Onpoint CDM provides credentialed users with a series of tracking tools, including an updated log of each submission's status, completeness reports, and validation reports. The User Guide for the Onpoint CDM User Interface outlines the essentials of how to track submissions and provides detailed descriptions of each stage of the process (Table 1).

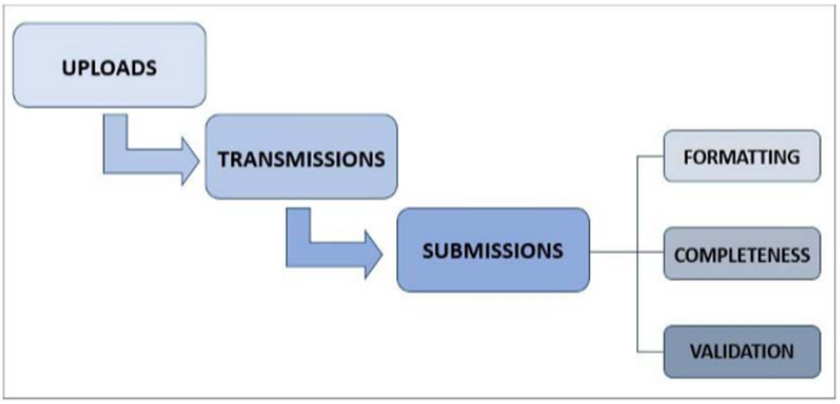
Table 1. Understanding Onpoint CDM's Submission Stage & Status Flags

Stage	Status	Description	Action
Formatting	Review	File has encountered errors when reviewing standard file-level structure and formatting.	Manual review by submitter and Onpoint's Operations team to determine whether the file's errors can be passed with a variance or if a resubmission is required.
	Fail	File has definitively failed the standard file-level structure and formatting quality checks.	Resubmission required.
	Pass	File has passed the standard file-level structure and formatting quality checks.	No action required.
Metric Calculation	Fail	File has encountered errors when calculating metrics for subsequent quality reporting.	Manual review by Onpoint's Operations team.
Completeness	Review	File has encountered element-level discrepancies between achieved completeness and validity results and expected error thresholds.	Manual review by submitter and Onpoint's Operations team to determine whether the file's errors can be passed with a variance or if a resubmission is required.
	Fail	File has definitively failed the completeness and validity quality checks.	Resubmission required.
	Pass	File has passed the completeness and validity quality checks.	No action required.

Stage	Status	Description	Action
Validation	Review	File has encountered cross-element discrepancies between achieved validation results and expected error thresholds.	Manual review by submitter and Onpoint's Operations team to determine whether the file's errors can be passed with a variance or if a resubmission is required.
	Fail	File has definitively failed the validation quality checks.	Resubmission required.
	Pass	File has passed the validation quality checks.	No action required.
No Data	Review	New file is attempting to replace a "No Data Submission" exclusion for an overlapping reporting period.	Manual review by Onpoint's Operations team to either reject or pass the new file's replacement of an existing "No Data Submission" exclusion.
	Fail	New file that attempted to replace a "No Data Submission" exclusion for an overlapping reporting period has been rejected by Onpoint's Operations team.	Existing "No Data Submission" exclusion remains in place for the reporting period in question.
	Pass	New file that attempted to replace a "No Data Submission" exclusion for an overlapping reporting period has been approved by Onpoint's Operations team.	New file replaces previous "No Data Submission" exclusion for the reporting period in question.
Replace	Review	New file is attempting to replace an existing file in Validation/Pass for an overlapping reporting period.	Manual review by Onpoint's Operations team to either reject or pass the new file's replacement of an existing file already in Validation/Pass.
	Fail	New file that attempted to replace an existing file in Validation/Pass for an overlapping reporting period has been rejected by Onpoint's Operations team.	Existing file in Validation/Pass remains in place for the reporting period in question.
	Pass	New file that attempted to replace an existing file in Validation/Pass for an overlapping reporting period has been approved by Onpoint's Operations team.	New file replaces previously accepted file in Validation/Pass for the reporting period in question.

Figure 3 below illustrates the chronological flow of events to reach Validation/Pass:

Figure 3. Process Flow Diagram



When your submission successfully passes all phases – or at any failure prior to final acceptance – Onpoint will send you an email alert. Submissions that fail any completeness check trigger an auto-generated failure notice, which is created instantly at the time of failure and refers data submitters to an online report documenting the failure. Submissions that fail a data quality check trigger a review by Onpoint's data operations team, who notify the submitter, identify the data problem, provide examples of the records failing the validation, and enumerate the necessary next steps. For more complex problems, our operations staff also work with data submitters to suggest the probable cause and propose a possible fix. This process generally takes less than 48 hours following file processing.

All failure notices alert submitters to any required resubmission and include details regarding the data type, data period, and due date. Resubmission due dates are tracked by Onpoint CDM, which captures information to identify the data submitter, the submission, the date due, the date received, the date entered, the submission stage, the submission status, and any additional comments, allowing our Operations staff to track and report on compliance and resubmissions.

Requesting a Variance from the Collection Standards

Throughout the course of capturing data, it may be necessary to make exceptions to IHA's completeness thresholds – most commonly when a data submitter's system does not collect a required element or has special considerations based on the specific population that they serve. When these situations arise, Onpoint CDM enables data submitters to request a variance using the Variance component, which triggers review by Onpoint staff when warranted. Approved variances have a built-in expiration date, requiring data submitters to reapply and justify any continuing exception on a regular basis. Please visit Onpoint CDM's Documentation component for a detailed user guide that outlines all steps of the variance-request process.

Please note: Fields highlighted in yellow in IHA's data file layouts indicate key fields that are crucial to the calculation of measures. If the completeness threshold is not met on a highlighted field, it will be flagged for escalation and will require discussion with Onpoint and IHA before a variance can be approved.

Best Practices for Submitting Your Variance Requests

1. **Adjust Threshold Requests by 0.01% Below the Achieved Result**

   If you failed a threshold for an achieved result that is lower than the expected, request a variance that is 0.01% below your achieved. If you failed a threshold for an achieved result that is higher than the expected, request a variance that is 0.01% above your achieved.

2. **Request Variance in the Earliest Reporting Period**

   If the same validation fails over multiple reporting periods in a file, request a variance in the earliest reporting period that will meet the needs of the achieved result furthest from the expected in your file.

   For example, if the population of the Submitter-Specific Rendering Provider ID field is not meeting the expected threshold of 99.50% for January - March 2020:

   1. Enter your variance request only under the first reporting period for which the validation fails. Extend your "Reporting Period End Date" to the last reporting period for which the validation fails or the last reporting period to which you expect this variance request to apply.
   2. To select the adjusted lower threshold percentage for your single variance request, select the achieved result that measures farthest from the expected across all failed reporting periods. For example, the following achieved results for the Submitter-Specific Rendering Provider ID field did not meet the 99.50% expected threshold:
      - 2020-01: 97.77%
      - 2020-02: 97.78%
      - 2020-03: 97.72%

3. You would want to use March's achieved result (entering a variance of 0.01% below that value—97.71%) as the variance request for the January reporting period and manually update the "Reporting Period End Date" to be 3/31/2020, since March's achieved result was farthest from the expected threshold of 99.50%. Doing so will apply more inclusively across all failed reporting periods.

Step 4. Review & Affirm Validation Report

Once your production files achieve Validation/Pass status in the CDM, Onpoint will generate validation reports for your review. The validation reports provide opportunities for submitters to review their submissions, validate the data fields critical to measure results generation, catch errors to prevent late resubmissions, and allow for the timely delivery of results to IHA participants.

Please return completed validation reports to Onpoint within **5 business days of receipt**. We recommend that submitters review their validation reports as thoroughly as possible with internal stakeholders and experts. Each row in the report must be affirmed for a validation report to be considered complete. It is crucial that you review these values carefully, as errors caught after validation reports have been signed off can cause critical impediments to the IHA results timeline.

Onpoint welcomes all ideas about metrics that could be helpful to include in validation reports. Please reach out to iha-support@onpointhealthdata.org with your suggestions.

Key Steps to Complete Your Validation Report

1. On the "About" tab, complete the name, email address, phone number, and review date sections.
2. Confirm that the validation report was generated for the correct file submission by checking the file submission ID noted in the report.
3. Compare all results to BOTH your completed prior year validation report results, which will be provided with all current year validation reports, and your internal data source results. For example, validate that the distinct member counts provided in the validation report align with results from previous measurement years, as well as your plan's internal data and understanding.
4. Check the list of physician organizations and accountable care organizations to ensure its completeness.
5. Consider any missing populations and how they could affect your results.
6. Indicate 'Y' if you affirm the data or 'N' if you do not affirm.
7. For all denied metrics, provide notes and additional context to support Onpoint's research into the discrepancy. More details and specifics about how you reached any internal data results will help Onpoint resolve discrepancies more quickly.

About Your IHA Submissions

Use of Data

Data submitted to Onpoint will be used to support the generation of measure results for Appropriate Resource Use (ARU), Total Cost of Care (TCOC), and clinical quality measures for both the California Regional Health Care Cost & Quality Atlas (Atlas) and the Align. Measure. Perform. (AMP) programs (Table 2). Detailed measure set information can be found in the AMP Common Measure Set.

Table 2. Overview of IHA's Atlas & AMP Programs

Program	Measurement & Population	Use of Data
California Regional Health Care Cost & Quality Atlas (Atlas)	Region, product, and payer reporting for all California members	• Public reporting via Atlas webtool • Industry insights • Research
AMP Commercial HMO	Physician organization reporting for California commercial HMO and POS members	• Benchmarking • California Office of Patient Advocate (OPA) Report Card • Health plan incentive payments • Physician organization recognition awards
AMP Medicare Advantage	Physician organization reporting for California Medicare Advantage members	• Benchmarking • California Office of the Patient Advocate Report Card • Physician organization recognition awards • Health plan incentive payments (optional)
AMP Medi-Cal Managed Care	Physician organization and Federally Qualified Health Center reporting for California Medi-Cal Managed Care members	• Benchmarking • Health plan incentive payments (optional)
AMP Commercial ACO	Accountable Care Organization reporting for California members	• Benchmarking • Health plan incentive payments (optional)

To support the Atlas and AMP program results, health plans are asked to submit six files. These six files will be linked by member and used to generate the reported performance measure results:

1. Eligibility
2. Medical Claims
3. Pharmacy Claims
4. Cost
5. Lab Results
6. Member Identifier

Please submit data for all California members. If you have any questions or concerns about a specific population, please contact IHA at amp@iha.org.

Data Submission Timelines

The timeline below outlines the MY 2020 data submission deadlines for each stage of the process and for each file type.

Activity	Eligibility	Medical Claims	Pharmacy Claims	Member Identifier	Cost	Lab Results
Q1 2020 Data Submission	4/30/20	4/30/20*	4/30/20*			
Q2 2020 Data Submission	7/31/20	7/31/20	7/31/20			
Q3 2020 Data Submission	10/31/20	10/31/20	10/31/20			
Q4 2020 Data Submission	1/31/21	1/31/21	1/31/21			

Activity	Eligibility	Medical Claims	Pharmacy Claims	Member Identifier	Cost	Lab Results
Q1 2021 Data Submission	4/30/21	4/30/21	4/30/21			
Annual File Submission				4/30/21	5/31/21	6/30/21

* Note that if the final MY 2019 medical claims file or pharmacy claims file includes services rendered in 2020 and paid in Q1 2020, the health plan does not need to resubmit the Q1 2020 claims files for MY2020.

  Also, please continue to send all claims (e.g. adjudicated, paid), regardless of date of service, with your Q1 2021 data submission.

General File Specifications & Basic Formatting Rules

The following section includes overarching information regarding the data that should be submitted. Please see the detailed layouts documentation for additional guidance and field-level specifications.

All Files

This section outlines the submission requirements across all 6 required file types. Please see the detailed file layouts documentation for additional guidance and field-level specifications.

1. **Membership Information for Duration of Contract**

   To generate IHA AMP's all-plan aggregated results for each physician organization, Onpoint requests all membership information for the duration of the health plan-physician organization contract. For example, if your plan had a contract with a physician organization for 6 months, your plan would submit all member eligibility and claims information for the relevant insurance type, product code, and duration of the contract. The appropriate physician organization should be linked to each member's enrollment and claims data for that particular physician organization.

2. **Members Belonging to Non-Consent Physician Organizations**

   Submit member eligibility and claims information for all of your California members, including those that belong to the "non-consent" physician organizations that do not have a participation agreement with IHA and therefore do not participate in IHA AMP program. Doing so helps ensure comprehensive data for Atlas and other strategic initiatives.

   When submitting data for members belonging to non-consent POs, please be sure to leave the PO ID field blank. For a list of non-consent POs, please refer to your plan's PO and ACO ID Masters.

Eligibility File

This section outlines the requirements for eligibility file submission. Please see the detailed data file layouts documentation for additional guidance and field-level specifications.

1. **Eligible Members**

   Include all members who were enrolled for at least one day during the submission period; no continuous enrollment criteria apply.

2. **Enrollment Data**

   The eligibility file should include all enrollment records that cover any portion of the period from January 1, 2020, through December 31, 2020. There are no continuous enrollment criteria. All California members enrolled for any portion of the measurement year should be included.

Medical Claims

This section outlines requirements for medical claims data submission. Please see the detailed data file layouts documentation for additional guidance and field-level specifications.

1. **Eligible Claims**

   Include all members who reside in California and have claims paid in the submission period; no continuous enrollment criteria apply.

2. **Paid Dates and Service Dates**

   Submitters are required to provide data on a paid date logic basis. Using a paid date logic allows for more flexibility for submitters, enables submission frequency to be increased, supports adjustments in lookback to meet program and analytic needs, and provides better data for quality measures that allow lookback for services. Paid Dates (MC017) should be from January 1, 2020 onward; do not limit claims based on date of service. For plans providing historical data, please work with Onpoint and IHA to confirm payment dates and dates of service to include.

3. **Remittance Date**

   When BPR04 (X12 transaction set) is "NON" for nonpayment, plans should report the remittance date in the Paid Date (MC017) field instead. Plans should be consistent in how they populate MC017.

4. **Denied Claims**

   Fully denied claims should be excluded from the submission.

5. **Claims Adjustments**

   Submit all adjustments, including reversals, denials, new payments, and final versions of the claims. If a claim has been fully or partially paid and reported in your submission but then fully reversed or denied, that reversal also should be reported. Please refer to the example below:

Payer Claim Control Number (MC004)	Line Counter (MC005)	Version Number (MC005A)	Charge Amount (MC062)
Claim #1	1	0	100
Claim #1	1	1	-100
Claim #1 (final version)	1	2	150

   In the case above, the version number would be expected to be incremented sequentially for each subsequent version.

   Onpoint uses all adjustments to add up all records to calculate final costs. Please be reassured that Onpoint has robust logic to determine the final disposition of a claim from all claims versions and remove duplicate claims.

6. **Inpatient Stays Spanning Calendar Years**

   Some inpatient stays span two calendar years and are composed of multiple claims. The plan should include claims only when the Paid Dates (MC017) is in or after 2020.

Pharmacy Claims

This section outlines requirements for pharmacy claims data submission. Please see the detailed data file layouts documentation for additional guidance and field-level specifications.

1. **Eligible Claims**

   Include all members who reside in California and have claims paid in the submission period; no continuous enrollment criteria apply.

2. **Paid Dates and Prescription Fill Dates**

   Paid Dates (PC017) should be on or after January 1, 2020 onward; do not limit claims based on prescription fill dates. For plans providing historical data, please work with Onpoint and IHA to confirm payment dates and dates of service to include.

Cost

This section outlines requirements for cost data submission. Please see the detailed data file layouts documentation for additional guidance and field-level specifications.

1. **Eligible Members**

   Include all members with medical benefits who were enrolled for at least one day during the measurement year that are included in the eligibility file; no continuous enrollment criteria apply.

2. **Separate Member Cost by Eligibility Details**

   There may be multiple rows in the cost file for a single member. Each new row represents a change in the eligibility details for the member, specifically, a change to the enrolled PO and/or attributed ACO, or change to the Insurance Type/Product Code the member is enrolled in. The rows together should represent, without duplication, the member's complete eligibility for the year.

   The costs included in each row should represent the costs for that eligibility detail and be mutually exclusive. Summing across all rows for a member would represent the total cost for that member.

   For example, if a member was in a PO all year but attributed to an ACO for part of the year, plans should provide two mutually exclusive records. Calculating a members' total PO costs for the year would require summing both records. See Table 3 for an example excerpt from the member identifier file in below:

Table 3. Example Excerpt from the Member Identifier File

Plan	Member ID	Product Code	PO ID	ACO ID	Month
Health Plan A	1234	HM	9876543	ABCDEF	Jan
Health Plan A	1234	HM	9876543	ABCDEF	Feb
Health Plan A	1234	HM	9876543	ABCDEF	Mar
Health Plan A	1234	HM	9876543	ZZ	Apr
Health Plan A	1234	HM	9876543	ZZ	May
Health Plan A	1234	HM	9876543	ZZ	Jun
Health Plan A	1234	HM	9876543	ABCDEF	Jul
Health Plan A	1234	HM	9876543	ABCDEF	Aug
Health Plan A	1234	HM	9876543	ABCDEF	Sep
Health Plan A	1234	HM	9876543	ZZ	Oct
Health Plan A	1234	HM	9876543	ZZ	Nov
Health Plan A	1234	HM	9876543	ZZ	Dec

The cost file should reflect the below:

Plan	Member ID	Product Code	PO ID	ACO ID	Month
Health Plan A	1234	HM	9876543	ABCDEF	600
Health Plan A	1234	HM	9876543	ZZ	600

3. **Claims Run-Out Period**

   For each reporting period, please include three months of run-out (e.g., for all costs with dates of service in 2020, please report paid dates on or between January 1, 2020, and March 31, 2021).

4. **Hierarchy of Costs**

   The hierarchy column in the cost file layout indicates the order in which costs should be bucketed into different cost categories. Cost categories are mutually exclusive; once a cost is bucketed into a category, it should not be included in subsequent categories. Please note that the hierarchy **does not apply to Plan Paid Amount (TC028) and Member Paid Amount (TC029).** These two amounts break down total cost a different way and are redundant with the service category costs. These two amounts should sum to the total cost, just as all the service categories should sum to the total cost.

   The cost hierarchy can be visualized as show below in Figure 4:

Figure 4. Cost Hierarchy Visualization

Overall Total Cost of Care (TC007)

Field ID	Field Name	Hierarchy
TC027	Behavioral Health Cost	1
TC008	**Total Inpatient Facility Cost**	**TC009 + TC010 + TC011**
TC009	Inpatient Facility Cost (Maternity)	2
TC010	Inpatient Facility Cost (Newborn)	3
TC011	Inpatient Facility Cost (Non-Maternity)	4
TC012	**Total Outpatient Facility Cost**	**TC013 + TC014 + TC015 + TC016**
TC013	Outpatient Facility Cost (Hospital)	7
TC014	Outpatient Facility Cost (ASC)	5
TC015	Outpatient Facility Cost (ED)	6
TC016	Outpatient Facility Cost (Other)	8
TC017	FFS Cost (Other Facility)	9
TC018	FFS Cost (Professional)	10
TC019	**Total Pharmacy FFS Cost**	**TC020 + TC021**
TC020	Pharmacy Cost (Specialty)	11
TC021	Pharmacy Cost (Other)	12
TC022	**Total Capitation Cost**	**TC023 + TC024 + TC025**
TC023	Capitation Cost (Global)	13
TC024	Capitation Cost (Professional)	14
TC025	Capitation Cost (Facility)	15
TC026	Other Cost	16
TC028	Plan Paid Amount	N/A
TC029	Member Paid Amount	N/A

5. **Report Both Capitation & Fee for Service (FFS)**

   Include both capitation and FFS costs in the cost file. TC008–TC021 are for FFS. Any capitation should be reported in TC022–TC025.

6. **Report Both Plan Paid & Member Cost-Sharing**

   Please include member cost-sharing (i.e., copayments, deductibles, coinsurance) in the calculated costs. Given the differences in systems, plans may establish their own approaches to

calculate (in the case of claims) and estimate (in the case of encounters) the member cost-sharing. Please contact Onpoint and IHA if you wish to discuss possible approaches.

7. **Reporting 0 vs. Null**

   Cost should only be populated with 0 if it is a true 0 (i.e., the member had no costs for that category during the measurement period). If there were costs for the member, but the plan is not providing the cost breakdowns, then those fields should be reported as null.

8. **Service Category Exclusions**

   The health plan should exclude any costs related to the following service categories: mental health, chemical dependency, dental, vision, chiropractic, and acupuncture.

   Exclude these costs whether they are included in the PO's capitation agreement or paid for by the health plan. If any of the excluded costs listed above are included under capitation, the plan should adjust out the costs for these services using their own method and provide documentation of the methodology.

   Also, exclude AMP quality incentive payments.

9. **Drug Rebates**

   Plans should include drug rebates in their pharmacy costs where appropriate.

10. **Included Services**

    The cost amount should include all professional, facility (inpatient and outpatient), pharmacy, and other costs (e.g., DME) for services provided to the members. It should also include the following payments made to POs that are not directly related to delivery of services to individuals:

    - Capital infusions
    - Capitation administrative fees
    - Capitation deductions and adjustments
    - Capitation floors and guarantees
    - Non-AMP incentive payments (e.g., outpatient surgery redirects)
    - Shared-risk payments
    - Special case rates for particular populations (e.g., patients with HIV/AIDS)
    - Stop-loss provisions
    - Non-claim payments (other)

    Please note: The fixed costs listed above -- especially those not attributable to a particular member -- may be divided up and attributed to individual members on a pro-rated basis, using the number of days (or months) that a member was enrolled.

11. **Inpatient Stays Spanning Calendar Years**

    Some inpatient stays span two calendar years and are composed of multiple claims. As indicated in the medical claims file specifications, the plan should only include costs for claims when the end date is within the measurement year. Claims associated with a stay that spans years, but for which the end date is in the calendar year before or after the measurement year, should not be included. Please see the examples and supporting table below.

    Example 1: When calculating the costs for MY 2020, the plan should include the costs related only to Claim 2. Please include the entire cost related to Claim 2 (i.e., not just the costs for

services on January 1 and 2). The costs related to Claim 1 should not be included in the MY 2020 cost file submission; they should have been captured already in the MY 2018 cost data submission.

Example 1	Example 1
Claim 1 ● Start Date: December 20, 2019 ● End Date: December 27, 2019	**Claim 2** ● Start Date: December 25, 2019 ● End Date: January 2, 2020

Note that, although this approach divides the inpatient stay (and has the effect of shortening the length of stay), it aligns the data included in the ARU and TCOC measures and, therefore, is the preferred approach.

Example 2: Only the costs associated with Claim 1 should be included in the MY 2020 cost calculations. The utilization/days and costs related to Claim 2 will be captured in the MY 2021 cost submission next year.

Also, do not include financial adjustments made more than three months after the end of the measurement year (i.e., March 31, 2021, for MY 2020).

Example 2	Example 2
Claim 1 ● Start Date: December 20, 2020 ● End Date: December 27, 2020	**Claim 2** ● Start Date: December 25, 2020 ● End Date: January 2, 2021

Lab Results

This section outlines requirements for lab results data submission. Please see the detailed data file layouts documentation for additional guidance and field-level specifications.

1. **Eligible Members**

   Include all members who reside in California and have claims paid in the submission period; no continuous enrollment criteria apply.

2. **HbA1c Test Results**

   Include only HbA1C test results in the lab results file.

Member Identifier File

This section outlines requirements for member identifier file submission collected on an annual basis. For context, the member identifier file was introduced in MY 2019 and contains a subset of 9 fields from the eligibility file. The eligibility file will be used to identify continuous enrollment, while the member identifier file serves as the final source of truth for assigning members to a physician organization (PO) or accountable care organization (ACO) at the end of each measurement year. If there are significant membership differences between the annual member identifier file and the quarterly eligibility and claims submissions or significant differences in eligibility or claims from quarter to quarter, you may need to resubmit and replace your data.

Plans should include one record per member per month. Note that the Submitter-Specific Unique Member ID (MI004) and Insurance Type / Product Code (MI005) fields should align with the values submitted for the same member in the associated eligibility file and cost file.

Please see the detailed data file layouts documentation for additional guidance and field-level specifications.

1. **Eligible Members**

   Include all California members who were enrolled for at least one day during the measurement year; no continuous enrollment criteria apply.

2. **Organization Identifiers to be Included**

   For AMP reporting purposes, the identifiers for all contracted POs and all contracted ACOs that your health plan confirmed with IHA during the Participation Confirmation Period (previously "Intentions") must be included in the submission. Please refer to your health plan's PO Master and ACO Master for a detailed list of organizations to include in reporting. Please note that the ACO ID will also be used to bucket members in the Atlas.

3. **Risk Type**

   For AMP and Atlas reporting purposes, please include the risk type associated with the PO and/or ACO the member is attributed to each month. For PPO members not attributed to an ACO, the risk type will be '5' (no capitation, fee-for-service only).

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