DISCOUNT DATA SPECIFICATIONS

The Uniform Discount and Data Specification (UDS) workgroup was created to develop a standardized data specification in order to simplify the data development process for carriers. The workgroup is only focused on what data elements should be included in the submission. No discussion of use is permitted at any UDS meeting. Any discussion about data use should take place directly between data submitters and data receivers.

Time Period

- Include all medical claims incurred **7/1/2023-12/31/2024 and paid through 2/28/2025.** Please note that for Inpatient claims, admission date should be considered the incurred date.

Data Content

- Include Group claims only
  - Private exchange business should be included
- Include all claims from all providers except as noted in exclusions below
  - Include claims for both contracted and non-contracted providers
  - Include high-cost claims - do not exclude any claim because of high dollar amounts
  - Include all claims for services covered under medical benefits, regardless of the discount percentage amount
  - Include claims that are paid through networks that your organization rents if these rental networks are normally part of the product offering you make to your customers
  - Include all other provider payments not already included in the claims data in the Other Provider Payments portion of Appendix A. All types of payments that are applicable to medical coverage that would not be included in a self-insured admin fee should be captured. These types of payments should be included both if they are passed back to the employer or are not directly passed back to the employer. These payments should be included both if they relate to self-insured or fully insured business. Examples of these payments (but not an exclusive list) include: withholds, pay for performance payments, risk settlements, bonus payments, pre-payments, provider incentives due to risk sharing arrangements, care collaboration fees, and provider fees to fund administrative functions.
  - Include Minnesota provider tax payments in both the 'Eligible Billed $' and 'Allowed $' fields.
- All adjudication adjustments for a claim should be applied to that claim before the claim is summarized
- Exclude the following:
  - Claims for members age 65 or older where age is measured as the difference between the date of service and member's birth date rounded down to the integer
  - All Medicare Supplement, Medicare Advantage and Individual claims
  - All Medicare and Medicaid claims
  - All claims with COB where your organization is the secondary payer
  - All mail order prescription drug, retail prescription drug, dental and vision hardware claims not covered under medical benefits
  - Payments for interest expense, regulatory fees and prompt pay penalties

- Claims paid through custom network arrangements established for specific customers that are not generally available to other groups
    - In these instances, only claims paid through the custom network arrangements for those specific customer and provider combinations should be excluded.
    - Further, if a customer has a custom network with a provider for only a subset of services, only the subset of claims paid under the custom network for those specific customer + provider combinations for which the custom network arrangement applies should be excluded.
    - Additionally, the custom network must be in place at the time of the incurred experience period defined in the Time Period at the beginning of these specifications.
- Claim lines that include ineligible services and related charges as defined below in "Data Layout"
- All capitation paid as well as any claim lines and/or encounter data associated with or paid through capitated arrangements
- All surcharges and covered life assessments such as NYCHRA
- All network access fees including access fees for rental networks
- All members in the following group types:
    - Prison groups (prisoners, not prison employees)
    - Railroad groups
- All denied and pended claims and claim lines.
- All claims for medical provider customers that have an SIC code of 8062
    - Only applies to customers with a physician group that accounts for at least 5% of professional spend or an acute care hospital.
- All claims incurred at an Indian Health Services (IHS) facility. IHS facilities should be identified by either Place of Service code (05-08) or by the list in Appendix N.

DATA AGGREGATION METHODOLOGY

All terminology shown in italics will be further defined in the "Data Layout" section of this document

1. Data should be separated into one of the following three groups based on type of service:
   A. Inpatient Facility (facility charges only; does not include associated professional charges)
   B. Outpatient Facility (facility charges only; does not include associated professional charges)
   C. Professional and Other services (including professional charges associated with facility claims)

2. Service lines should be summarized into an **Event**. An Event is defined according to the type of service it is associated with:
   A. Inpatient Facility Event = Admission
      - If a patient is transferred to a different facility, a new admission record should be created
   B. Outpatient Facility Event = "Case" or "Procedure"
      - Determining whether an Outpatient Event should be reported as either a Case or Procedure is based on the Revenue Codes and logic shown in Appendix C of this document
      - If the Event type is a Case, make sure the Case includes all service lines incurred in a facility by the claimant in one day
      - If the Event type is not "Case" and there are multiple dates of service on the claim, assume all claim lines are incurred on the minimum service date (i.e., first day of service) listed on the claim
   C. Professional and Other Services Event = "Procedure"

   For Inpatient and Outpatient Facility Events, there are situations where Emergency Room visits turn into Inpatient Admissions. In addition, it is also possible that an Emergency Room visit could have an Outpatient Surgery related to it. As such, a hierarchy to define types of Events is needed:
      - If any portion of an Event occurs in an Inpatient setting, then the claim and all charges associated with it should be classified as Inpatient
      - If an Event is not an Inpatient Admission and has any Revenue Codes that indicate Emergency Room services, it should be classified as an Emergency Room case
      - If an Event is not an Inpatient Admission or Emergency Room case and has any Revenue Codes that indicate Outpatient Surgery, the entire claim shall be considered Outpatient Surgery

   When summarizing service lines associated with admissions and cases to the Event level, a claim identification number or similar field should be used to identify all service lines that should be included in the Event.

3. Each Event should be assigned a *Hierarchical Pricing Code, Network Status Indicator* and *Pay as Billed Provider Indicator* as defined below in the "Data Layout" section

4. Each Inpatient Event should also be assigned a *Catastrophic Indicator* based on the Total *Allowed Amount* level of the Event. If the Total *Allowed Amount* for the Inpatient Event equals or exceeds $150,000, the Event is considered a catastrophic claim. There are two categories of catastrophic claims: one for claims with Total Allowed Amounts between $150,000.00 and $299,999.99 and a second for claims equal to or exceeding $300,000.

5. Events are then aggregated as specified in the layout and output in different records according to "Group By" categories specified in Appendix A of this document

Specific instructions on how to categorize Events as well as a list of fields and definitions are provided below.

DATA SUBMISSION TIMING

Organizations providing data understand that in order for the data to be of the best value, it must be submitted in a timely fashion when compared to the service period. With this in mind, all organizations submitting data should do so by the end of September of the following year (i.e., September 30, 2025 for this submission).

DATA LAYOUT

DATA SUBMISSION FILE FORMATS

Files should be submitted in text format. All fields requested in this document are summarized in Appendix A.

FIELD DEFINITIONS

The information presented in this section applies to all types of claims (Inpatient, Outpatient and Professional/Other). After this section, there is a definition and instruction section that addresses additional instructions and fields by claim type (Inpatient, Outpatient and Professional/Other claims).

All indicators in the data should be mutually exclusive. That is, when aggregating amounts on any given field, the sum of data for charge and utilization fields will be the actual total for that field (i.e., no double counting).

Organization Name

Name of organization providing data.

Service Period

Dates of service represented by data submission in format MMDDYY-MMDDYY. First date should be the start date and second date should be end date. As an example, for the CY2024 data submission, this field would be populated as **070123-123124**. If period is not equal to 18 months, it should be disclosed on the actuarial certification.

3 Digit Patient Zip Code

All of the records in this data submission should include the patient's residential 3-digit Zip Code. If the patient's residential zip code is not available, the zip code of the employee to which the member is related should be used. If there is no patient or employee zip code available, a dummy zip code of "ZZZ" should be submitted.

Product Indicator

The "Product Indicator" will be used to identify and differentiate submitted data for each product a carrier would potentially offer an employer group. Data should be aggregated separately for each unique product a carrier wishes to submit for evaluation.

Positions 1 through 3 of the Product Indicator should indicate the product type (PPO, HMO, POS, EPO, TRA) and positions 4 and 5 should be used as a suffix (e.g., 01, 02, 03) in case a carrier submits more than one product of the given type. Please note that no formal naming convention is prescribed for the remaining positions in this submission. This should allow carriers flexibility in providing product indicators that most appropriately reflect their product portfolio. It is expected that each carrier will provide a translation table or key for the "Product Indicator" field in their data submission. The format under which a carrier should submit this information is provided as Appendix G of this document. This key should allow users to easily identify products. It is recommended that both the product's marketing name and description be supplied along with the "Product Indicator" on this key.

For purpose of illustration, examples of characteristics that could cause reimbursement to vary among products are shown below. This is neither an all-inclusive list nor are the items shown intended to be addressed by all carriers. Also, there are other examples that may require product differentiation. As stated above, it is expected that each carrier will appropriately identify key characteristics that differentiate products in their portfolio and provide Product Indicators reflecting these differences.

- Product type: PPO vs. Open Access POS vs. Gatekeeper POS vs. EPO etc.
- Group's Funding Arrangement: Fully Insured vs. Self-Insured
- Multiple Networks available in the same area
- Product with Multiple In-Network Benefit Levels vs. Open Access PPO
- New Business vs Existing Business

Please note above that unique products should be identified based on three factors:

- Network size
- Provider contracts
- Benefit Tiers (1 vs 2+ tiers)

Products that differ in any of these three areas should be submitted under different Product Indicators.

6-Month Indicator

The "6-month Indicator" will be used to identify the half year in which the submitted data was incurred. The table below shows the values that should be entered in the column and the corresponding dates for the submission.

6-month Indicator	Time Period for CY2024 Submission
H1	July 2023 – December 2023
H2	January 2024 – June 2024
H3	July 2024 – December 2024

Hierarchical Pricing Code

The Hierarchical Pricing Codes listed below serve as a replacement for the Benefit/Contract Status indicator from prior submissions. This list is meant to encompass different pricing arrangements that may be in place. As evident in the name, the list is hierarchical meaning if an arrangement can be categorized under Code 1, then it should be categorized as such; otherwise, move on to Code 2.

Code	Description	Notes
1	Direct Carrier Contract	This is defined as a written contract between the carrier and the provider, which covers these services at that provider for this network. If a carrier does not have any direct carrier contracts in a geographic area and instead rents a network, the primary rental network can be categorized in code 1. Any additional/supplemental wrap networks should be considered code 3.
2	Claims subject to surprise billing rules	All claims subject to surprise billing rules should be included, regardless of how the payment amount was determined (QPA-level, through arbitration, or other methods). This includes both the federal surprise billing rules (https://www.federalregister.gov/documents/2022/08/26/2022-18202/requirements-related-to-surprise-billing), and state-specific surprise billing rules. Only claims subject to these surprise billing rules should be included in pricing code 2.
3	Third Party Wrap Network	A Third Party Wrap Network is a third party that the carrier contracts with, where the third party has direct provider contracts.
	Individual Claim Negotiation	This is an isolated negotiated price for a claim, which would not necessarily apply to any other claims incurred at this provider. This would include claims negotiated either internally or by a third party; claims negotiated either on a one-off basis or a batch all at the same time qualify to be in this bucket.
5	Reference Based Pricing Schedule	This is when the carrier or a third-party pays the claim using a Reference pricing table (e.g. Data iSight, FAIR Health, % of Medicare).
6	Percentage of billed Charges	Claims paid at 100% of billed charges belong in this bucket.
7	All Others	

There may be some facility admissions where the Hierarchical Pricing Code for a facility changes during the admission. In these cases, the admission should be classified with the Hierarchical Pricing Code in effect for the facility on the first day of the admission.

Network Status Indicator

This indicator, set to either "I" for "In-Network" or "O" for "Out-of-Network", corresponds to the method of adjudication of member benefits.

Noncontracted Savings Indicator for Negotiated Savings with Noncontracted Providers

Default value is "N". The Noncontracted Savings Indicator should be set to "Y" for claims where:

- A carrier is able to negotiate a contracted savings with the noncontracted provider and
- The provider cannot balance bill the member for the contracted savings.

Please note that all claims submitted should be coded with an indicator for this field and that this field should not be left blank.

Arrangement Indicator

The "Arrangement Indicator" groups data based on Funding Arrangement between Fully Insured and Self-insured groups.

Pay as Billed Provider Indicator

Claims that a carrier requests be considered for Pay as Billed status should be indicated with a "Y" in this field. Carriers should be prepared to substantiate this classification **at the provider level** with proof that the provider either routinely files claims with Submitted Charges = Allowed Charges or the provider does not file Submitted Charges. If the overall discount for a provider is greater than 2.0%, the claims filed by that provider may not be classified as Pay as Billed. Explanation for all claims coded as "Pay as Billed" should be provided in the actuarial certification provided with the data.

Eligible billed charges are not allowed to be adjusted for pay as billed claims, except in the following instance: If a carrier and/or data submitter separately receives a report of billed charges at the claim level from providers who routinely file claims on a pay as billed basis, the separately reported billed charges may be submitted as Actual eligible billed dollars. In those instances, the Pay as Billed Indicator should be 'N'.

Financial Data

The definitions provided below are intended to standardize terminology as it relates to this claim charge data submission for Provider Reimbursement Analysis.

Submitted Charges	All charges submitted by the provider for payment
Ineligible Charges	Sometimes referred to as "Non-covered Charges". These are charges not covered due to denial of services, claim duplication, medical policy, ineligible members or the plan of benefits. Detailed descriptions of types of Submitted Charges that are considered Ineligible are provided below.
Eligible Billed Charges	Sometimes referred to as "Covered Charges". Eligible Billed Charges = (Submitted Charges less Ineligible Charges) before application of fee schedules, contractual reimbursement provisions, and R&C cutbacks
Negotiated Savings	Sometimes referred to as "Provider Discount". Savings resulting from fee schedules or contractual reimbursement provisions. Reductions that could result in member balance billing should not be included as Negotiated Savings
Reasonable & Customary Cutback Amount	Any difference between Submitted Charges and Allowed Amount that is not accounted for in Ineligible Charges.
Allowed Amount	Allowed Amount = (Eligible Billed Charges less Negotiated Savings resulting from fee schedules or contractual reimbursement provisions, OR R&C cutbacks) prior to member cost sharing.
Paid Amount	Sometimes referred to as “Plan Paid Amount”. This is the Allowed Amount reduced for member cost sharing. It represents the actual amount paid by the health plan.
Member Cost Sharing	This is the portion of the Allowed amount that is the member’s responsibility to pay. This includes deductibles, copays, and coinsurance. Member cost sharing, as defined here, should reflect the appropriate balance billing arrangement.

Allowed Amount =

Submitted Charges
Minus
Ineligible Charges
Minus
(Negotiated Savings
OR
R&C cutbacks (if applicable))

Paid Amount =

Allowed Amount
Minus
Member Cost Sharing Amounts

Ineligible Charges
These are charges for services ***not*** considered eligible for payment under the plan. Examples include:

- Duplicate bills
- Pending or denied claims
- A type of service that is not covered by the plan of benefits:
  - For example, if cosmetic surgery is not covered under the plan and a claim is submitted that includes cosmetic procedures, the charges for these procedures would be considered ineligible charges
  - Claim lines with the non-covered cosmetic procedure above would be excluded from this data submission
- Services incurred in excess of plan limits
  - For example, if the plan imposes a 40 visit annual limit on outpatient mental health visits and a claim is submitted for a 41st visit, the charges for this visit would be considered ineligible
  - Another example is a plan that covers up to 5 inpatient days for a certain diagnosis and a claim is submitted for 6 days, the charges for the 6th day would be considered ineligible
  - The visits/days and associated charges not covered in the examples above would be excluded from all Claim data in this data submission
  - Should only exclude services that are not covered due to the plan limit
- Claims denied due to medical management/medical necessity decisions such as length of stay cutbacks and medical claim review
- Pre-Existing Condition Exclusions

As illustrated in the examples above, all claim lines, units and Submitted Charges associated with Ineligible Charges should be excluded prior to summarizing data into the Events described above in "Data Aggregation Methodology".

All claim lines and related Submitted Charges for services which are covered by a plan but are "bundled" through business rules/edits in a carrier's claim processing system should be included as Eligible Billed Charges. These amounts should not be treated as denied claims.

Actual, Adjusted and Projected Data
In order to provide accurate historical information as well as projections for future periods, data is to be provided in three categories as outlined below. Please note that values should be provided for all actual, adjusted and projected fields regardless of whether a carrier is making adjustments or projections. To aid users of the data, two fields are provided that should be used to indicate if adjusted data different than actual is submitted or if projected data different than adjusted is submitted:

- The field "AdjCopyof Actual" should be coded as "Y" for all records if Adjusted is always a copy of Actual. If Adjusted is always or sometimes different than Actual, this field should be populated as "N" for all records.
- The field "ProCopyof Adj" should be coded as "Y" for all records if Projected is always a copy of Adjusted. If Projected is always or sometimes different than Adjusted, this field should be populated as "N" for all records.

Retroactive recoveries (such as fraud, waste, and abuse programs) which are received after the ending paid date of the Time Period are not permitted to be included in Actual, Adjusted, or Projected data fields.

Neither Actual, Adjusted, or Projected data can reflect expected changes in provider mix for any reason, including, but not limited to, the following:

- Providers who were out of the network in at least part of the Time Period, but will be joining the network at a later date
- Providers who have significantly different discounts than others in the area

Specifically prohibited are the following:

- Modifying data to estimate claims shifting between providers
- Removing claims at any provider simply due to abnormal discounts

A - **Actual**: Historical claims incurred and paid in the requested time period with no adjustments. All data submissions require an actuarial certification that confirms that no adjustments have been made to the historical data included in the "*Actual*" fields. "*Actual"* data should be reported for all utilization data (admissions, days, cases and procedures) and financial data (Eligible Billed Charges, Negotiated Savings and Allowed Amount).

B - **Adjusted**: "*Adjusted"* data is historical data that has been changed or modified to more accurately reflect a carrier's actual discounts. Examples of when the "*Adjusted*" fields might be used:

- A carrier has access to a new network in a specific area due to acquisition or merger
- A carrier changes rental network partners used in an area
- A carrier has little or no experience in a new product and uses "*Actual Allowed Amount"* data from an established product with "adjustments" for provider contract differences to represent the new product's "*Adjusted Allowed Amount"*
- A carrier cannot explicitly remove access fees from their data and instead uses an assumption/adjustment method to remove access fees

It is expected that a product for which "*Adjusted Allowed Amount"* data is provided would be based on the "*Actual Allowed Amount"* data of a similar product or network. In the case of new networks from acquisition/merger or changes in rental network partners, it is possible that the "*Adjusted"* data is simply "*Actual"* data from the new network (before merger or selection as a partner) to be substituted for the carriers *"Actual"* data.

For all claim types, "*Adjusted"* data should be reported for all utilization data (admissions, days, cases and procedures) and financial data (Eligible Billed Charges, Negotiated Savings, Allowed Amount, and Paid Amount), even if only one of the fields is affected by the network change. All methods used to create *"Adjusted"* data should be disclosed in the Actuarial Certification (Appendix I) and the impact of these adjustments should be itemized in the Appendix I Supplement - Adjustment Impact Schedule (see excel file with Appendices).

When reflecting adjusted data for items in the list above:

- Only adjustments for discounts can be made; no adjustments for additional cost of care savings or other points can be made
- (M&A Only): The discount for any single provider cannot be adjusted higher than the highest discount of the merged companies
- (Rental Partner Change Only): the rental partner agreement must be executed and effective by no later than six months after the end of the incurred period
- (M&A or Rental Partner Changes): Once the merger and/or rental partner change is in place for the entire historical experience period, adjustments can no longer be made

C – **Projected**: Includes any adjustments to the data file that are based on finalized future changes to provider discounts for which historical data is not representative of future discount results based on finalized contract changes. The most common reason for supplying "*Projected*" data is recognition of recent changes in provider discounts that have yet to be recognized in the "*Actual"* or *"Adjusted"* data provided. Projections should also be used to recognize the impact of contractual fee escalators and/or multi-year guarantees a carrier has with providers. Appendix H gives other examples of situations where *"Projected"* data would be submitted. Carriers should only project discounts for providers for whom a change in discount will occur.

"Projected" data is different from *"Adjusted"* data as "*Adjusted"* data is intended to reflect the same time period as *"Actual"* data while *"Projected"* data is intended to reflect claims in a future period.

The following presents additional guidance around submission of *"Projected"* data:

- Appendix H must be completed and submitted for all geographic areas where *"Projected"* data is provided.
- **In all cases, "*Projected*" data should only be provided for contracts or changes that have been negotiated and finalized. Projections should not be based on negotiation targets or situations that are "likely" to occur.**
- Projections should be submitted for any 3-digit zip code where a change will occur and should include all known changes in that 3 digit zip code, not just discount improvements. Both discount improvements and deterioration should be reflected in *"Projected"* data.
- Discount changes in any 3-digit zip code should be calculated such that the overall *"Projected Discount"* for that zip code reflects the percentage of claims serviced by providers affected by the event justifying the projection
    - "*Projected Discounts*" should only be calculated for providers affected by the event justifying the projection
    - Provider specific *"Actual/Adjusted Discounts"* should be used for claims serviced by providers that are not affected by the event justifying the projection
    - The overall "*Projected Discount*" for a 3-digit zip code should represent a blend of the "*Projected Discount*" for providers affected by the event justifying the projection and the *"Actual/Adjusted Discounts"* of those providers not affected by the event
    - The discount changes submitted on Appendix H should reflect the discount change over all providers and claims in the 3-digit zip code.
    - An example of this calculation is shown on page 14.

For each data submission, the timeframe of the submission and effective dates of claims that drive the "*Projected*" data must be recognized. For this data submission, a projection period of **1/1/2025 – 12/31/2025** should be used**.** All "*Projected*" changes that are effective after **1/1/2025** should be pro-rated for the number of months it will impact discounts in **2025**. In this way, the projected discount will represent the expected discount over the period **1/1/2025-12/31/2025**. Only contracts executed by March 31, 2025 (3 months after the ending incurred date for this submission) for future effective dates should be considered for projections.

"*Projected*" amounts should only differ from the "*Actual*"/"*Adjusted*" data it is based upon for *Negotiated Savings* and *Allowed Amounts*. While "*Projected*" fields for all utilization (admissions, days, cases and procedures) and Eligible Billed Charge data should not differ from the "*Actual*"/"*Adjusted*" data, we require that "*Projected"* amounts for all fields be provided to ensure that the intended discount amount is determined.

"*Projected*" *Allowed Amounts* should be calculated such that the discount off of **1/1/2024-12/31/2024** *Eligible Billed Charges* is the discount that is expected to be achieved in the prospective period **(1/1/2025-12/31/2025).** In order to complete this calculation, a standardized billed charge trend should be used. The billed charge trends for this data submission are included in Appendix B. These trends should be assumed for all discount projections regardless of geographical area. Milliman has also provided appropriate caveats and disclosures for the use of these billed charge trends that should be communicated to field staff.

An illustration of how the projection should be calculated and reported is shown on the next page using a projection period of **1/1/2025 – 12/31/2025** and a historical period of **1/1/2024 – 12/31/2024**. **Please note that data outside of CY2024 (i.e. H1 – July 2023 to December 2023) should not be projected and therefore all projected columns should be populated with $0.** In addition to this example, two examples of how the Expected Change in Allowed Amount and Discount Projection are calculated for contracts where all or a portion of the reimbursement is based on a Percentage of Billed Charge method are also provided below.

Projections when Reimbursed as Percentage of Billed Charges - Example 1
A provider is reimbursed at 50% of billed charges for OP services. No change in the percentage of charges reimbursed for OP Services occurs in the projection period (it remains 50%). While the percentage of billed charges does not change, the amount reimbursed will increase by the same rate as billed charges. In this situation, the Expected Change in Allowed Amount is expected to increase by the prescribed billed trend of 4.0%.

Projections when Reimbursed as Percentage of Billed Charges - Example 2
A provider is reimbursed 50% of billed charges for OP services. A contract change occurs where OP services are now reimbursed at 52% of billed charges. The Expected Change in the Negotiated Savings Amount should be calculated as:

((1 + Prescribed Billed Trend)
Multiplied by
(1 - New Percentage of Billed Charge Reimbursement)
Divided by
(1 - Prior Percentage of Billed Charge Reimbursement))
Minus 1

OR

(1.065 * (1 - 0.52) / (1 - 0.50)) – 1 = **1.8%**

Illustration of Projected Data Submission

		(A)	(B)	(C)
		Actual 1/24 - 12/24		
3-digit Zip Code		**Actual Eligible Billed**	**Actual Allowed**	**Actual Discount**
AAA	Inpatient - Hospital 1	400	200	50.0%
AAA	Outpatient - Hospital 1	375	180	52.0%
AAA	Inpatient - Hospital 2	210	141	32.9%
AAA	Outpatient - Hospital 2	230	125	45.7%
AAA	Inpatient - Hospital 3	50	35	30.0%
AAA	Outpatient - Hospital 3	60	42	30.0%
AAA	Inpatient Total	660	376	43.0%
AAA	Outpatient Total	665	347	47.8%
Formulas				1- (B)/(A)

Example: ***Three hospitals service all facility claims in 3-digit zip code AAA***
Hospital 1 signed a new contract for 0% Inpatient increase effective 1/1/2024, Outpatient is reimbursed at % of charges and is not changing
Hospital 2 has a multi-year guarantee that requires an 11.0% increase to both Inpatient and Outpatient reimbursement on 1/1/2025
Hospital 3 is reimbursed as a % of charges and has no change from 2024 to 2025

Key data and calculation of 1/1/2025 - 12/31/2025 projected is as follows:

Projection needed for:	(D) Actual Discount	(E) Expected Change in Allowed Amounts 1/25 - 12/25	(F) Prescribed Billed Charge Trend	(G) Projected Discount 1/25 - 12/25
Inpatient - Hospital 1	50.0%	**0.0%**	**4.0%**	51.9%
Inpatient - Hospital 2	32.9%	**11.0%**	**4.0%**	28.3%
Outpatient - Hospital 2	45.7%	**11.0%**	**4.5%**	42.3%
Formulas	**(C) above**	**Carrier determines**	**Prescribed in Data Specifications**	**1 - ((1 - D) x (1 + E)/(1 + F)**

		(H)	(I)	(J)
		Calculation of Projected Amounts		
	Actual or Projected	**Eligible Billed**	**Allowed**	**Discount**
Inpatient - Hospital 1	**Projected**	**400**	**192**	**51.9%**
Outpatient - Hospital 1	Actual	375	180	52.0%
Inpatient - Hospital 2	**Projected**	**210**	**150**	**28.3%**
Outpatient - Hospital 2	**Projected**	**230**	**133**	**42.3%**
Inpatient - Hospital 3	Actual	50	35	30.0%
Outpatient - Hospital 3	Actual	60	42	30.0%
Total Inpatient		660	378	42.8%
Total Outpatient		665	355	46.7%
Formulas		from (A)	(1 - (J)) x (H)	from (G) if expect a change, otherwise from

Populate Projected Allowed Amount fields for affected areas and types of service so that 1/25 - 12/25 expected discount is achieved
Please note that for purposes of Projected data submission, you should make no changes to Eligible Billed Charges

		(K)	(L)	(M)
		Projected 1/25 - 12/25		
Area		**Projected Eligible Billed**	**Projected Allowed**	**Projected Discount**
AAA	Inpatient	660	***378***	42.8%
AAA	Outpatient	665	***355***	46.7%
Formulas		from (A)	from (I)	from (J)

Key Observations
Projected Eligible Billed Charges = Actual Eligible Billed Charges
Projected Allowed Amount Calculated so that Projected Allowed Amount divided by Historical Eligible Billed Charges equal Projected Discount in (G) above

FIELDS FOR INPATIENT FACILITY CLAIMS

- All admissions and claims, including high cost claims, should be included
- When coding inpatient facility claims, use coding system MS-DRG v41.1
- Data should be included for all discharges, including due to death of the patient
- This is for facility claims only. No professional fees associated with facility services should be included
- Include data for all inpatient facility types (hospital, rehabilitation center, skilled nursing facility and mental health hospitals)
- Exclude utilization and charge data for any unpaid, non-covered days associated with ineligible charges as defined below
- Incurred dates for Inpatient Claims should be represented by the date of admission.
- There may be some admissions where the Hierarchical Pricing Code for a facility changes during the admission. In these cases, the admission should be classified with the Hierarchical Pricing Code in effect for the facility on the first day of the admission.

Catastrophic Indicator

Indicator set to "0" for Inpatient Events (admissions) with between $150,000 and $299,999.99 of total *Actual Allowed Amount*. The indicator should be set to "1" for Inpatient Events (admissions) with total *Actual Allowed Amount* equal to or exceeding $300,000. Utilization and claim charges submitted with a Catastrophic Indicator = "0" or "1" should include all utilization and claim amounts associated with the Inpatient Event, not just excess portion of the Inpatient Event that exceeds the high cost threshold.

As an example, if a 25 covered day inpatient event with $300,000 in Actual Allowed amounts occur, the entire claim ($300,000 in Actual Allowed amount and all 25 covered days) should be summarized into one event and included with a catastrophic indicator of "1".

All charges and utilization for claims coded with a Catastrophic Indicator of "0" or "1" should be excluded from the aggregation of non-catastrophic claims (Catastrophic Indicator = "N") so that double counting is avoided.

DRG

Based on the discharge DRG. For this submission, use coding system MS-DRG v41.1. Carriers should ensure one DRG version is used for all inpatient data and should not submit data with a mix of DRG versions.

If a carrier must submit data based on a version other than MS-DRG v41.1, it is important that the carrier ensure that all inpatient claims are based on this alternate version and that there is not a mix of data where some claims are coded as MS-DRG v41.1.

DRG Version Indicator

Indicates DRG version submitted in the data. Appendix J shows coding to be used for this field. This field should be coded for all records submitted in the Inpatient claims data file.

MDC

Use standard MDC definitions. Include data for all MDCs. Some claims can be mapped to more than one MDC. Admissions at Skilled Nursing Facilities should be coded as MDC 95. For all admissions where the MDC is unknown or ungroupable, MDC 99 should be used.

Number of Admissions

If a patient is transferred to a different facility, a new admission record should be created. Please ensure that your admission counts are net of any reversals (negative adjustments). Reversals should offset admission counts and financial data in your dataset and should not be counted as additional admissions.

# of Covered Days

Total number of covered inpatient days related to the admissions defined above. All non-covered days should be excluded from the day count. For claims where the admission and discharge date are the same, Number of Covered days should be set to 1. There should be no IP claims with 0 days. Please ensure that your day counts are net of any reversals (negative adjustments). Reversals should offset day counts and financial data in your dataset and should not be counted as additional days.

FIELDS FOR OUTPATIENT FACILITY CLAIMS

For Inpatient and Outpatient Facility Events, there are situations where Emergency Room visits turn into Inpatient Admissions. In addition, it is also possible that an Emergency Room visit could have an Outpatient Surgery related to it. As such, a hierarchy to define types of Events is needed. Please refer to page 2 of this document for classification of facility events into Inpatient and Outpatient categories.

- All claims should be included
- This is for facility claims only. No professional fees associated with facility services should be included.
- If a carrier is unable to separate the facility and professional components of a claim, all lines of the claim should be included as Outpatient Facility events (use Appendix C to determine if the event type should be summarized into a Case or included by Procedure). For these events, a modifier of "GF" (Global Fee) should be used to indicate that the facility and professional components of the claim are both included in Outpatient Facility.
- Carriers should use the actuarial certification to disclose the number of Outpatient Facility events and associated Eligible Billed charges where the following occur:
    - Facility and professional utilization and/or charges cannot be separated and
    - a CPT Code Modifier of "GF" is not used (see definition of CPT Code Modifier below)
- Include data for all outpatient facility types (hospital, independent/freestanding labs and centers, ambulatory surgery centers, rehabilitation center, and mental health hospitals)
- Any Professional claims with Revenue Codes and/or CPT/HCPCS codes in the ranges defined as "Ancillary" Outpatient Facility claims (see Appendix C) should be excluded from Professional claims and included as Outpatient Facility "Ancillary" claims
- For claim lines coded with Revenue Codes 960-989, the following criteria should be used to determine if the claim line should be included in Outpatient Facility or Professional claims:

  - If the claim line has a Revenue Code between 960 and 989 **AND** has a CPT/HCPCS code coded on the claim line, the claim line should be included as a Professional claim and the CPT/HCPCS code should be reported as prescribed for Professional claims
  - Otherwise, the claim should be categorized as an Outpatient Facility claims
- Exclude utilization and charge data for any unpaid, non-covered services associated with ineligible charges as defined above

For the most part, Outpatient Facility Claims use the same definitions as Inpatient Facility Claims. Several Inpatient Facility Claim fields are not collected for Outpatient Facility Claims. They are: Catastrophic Indicator, DRG, MDC, Number of Admissions and Number of Covered Days.

Outpatient Facility Claim fields that are different than fields for other claim types and their related definitions are as follows:

Outpatient Type of Service

There are seven types of services for outpatient facility claims. Appendix C defines the types of services for outpatient facility claims and also describes how to count the number of services for each category.

CPT Code and CPT Code Modifiers

For Radiology and Pathology services, there are situations where a service will have both a Revenue Code and CPT code. In order to ensure consistent collection and treatment of data among carriers, this data submission requires that the combination of CPT Code and Modifier (as defined in Appendix E of this document) be submitted as aggregation variables for any Outpatient Facility Radiology or Pathology services coded with both a Revenue Code and CPT code.

Number of Services

The requested counting methods for each Outpatient Type of Service are shown in Appendix C. Please ensure that your numbers of service counts are net of any reversals (negative adjustments). Reversals should offset service counts and financial data in your dataset and should not be counted as additional services.

FIELDS FOR PROFESSIONAL CLAIMS

- All claims should be included
- This is for professional claims only. For claims where there is a facility (technical) and professional component, only the professional component should be included.
- If a carrier is unable to separate the facility and professional components of a claim, all lines of the claim should be included as Outpatient Facility events (see page 9 for coding of these claims)
- Any Professional claims with Revenue Codes and/or CPT/HCPCS codes in the ranges defined as "Ancillary" Outpatient Facility claims should be excluded from Professional claims and included as Outpatient Facility "Ancillary" claims (see Appendix C for these codes)
- For claim lines coded with Revenue Codes 960-989, the following criteria should be used to determine if the claim line should be included in Outpatient Facility or Professional claims:

  - If the claim line has a Revenue Code between 960 and 989 **AND** has a CPT/HCPCS code coded on the claim line, the claim line should be included as a Professional claim
  - Otherwise, the claim should be categorized as an Outpatient Facility claims
- Exclude utilization and charge data for any unpaid, non-covered services associated with ineligible charges as defined above

For Professional claims, data for 300 specific CPT/HCPCS codes has been requested. Codes not specified in this list of 300 should be grouped into ranges based on the first character of the code. Appendix D outlines the requested codes and ranges.

In addition, data by modifier associated with specified and grouped CPT/HCPCS codes has been requested. Appendix D shows the modifiers by CPT code range that should be submitted. As carriers may have homegrown modifiers or CPT/HCPCS codes, it is required that each carrier affirm that they have been diligent in researching homegrown codes and mapping them appropriately into the CPT/HCPCS and modifier combinations requested.

Where fields have similar names, Professional Claims use the same definitions as Outpatient Facility Claims. Professional Claim fields that are different than fields for other claim types and their related definitions are as follows:

CPT Code

Appendix D of this document includes both the 320 specified codes as well as the grouping of codes not specified.

CPT Code Modifier

Defined in Appendix E. Modifiers to be submitted for Professional claims vary by code range as shown in Appendix D

Number of Procedures

For all codes, code ranges and modifier combinations, the number of procedures equals the number of claim lines that the code and modifier combination occur. Please ensure that your procedure counts are net of any reversals (negative adjustments). Reversals should offset procedures and financial data in your dataset and should not be counted as additional claim lines.

FIELDS FOR OTHER PROVIDER PAYMENTS

- The information presented in this section applies to the Other Provider Payments data file as shown in Appendix A.
- All other provider payments paid to providers during the requested time period from all sources above the amounts reported in the Claims Data files. This amount is intended to capture ALL additional payments to providers that are not already included in the Claims Data file, except for those amounts excluded in the Data Content section. Other provider payments are to be included if paid during the requested time period. The Other Provider Payment amounts should be split into the two categories described below.
- Please elaborate on the methodology used to gather and assign Other Provider Payment amounts in the Data Certification.

Other Provider Payment Type

Carriers should identify which type of service the Other Provider Payments payment covered. For example: Inpatient Facility, Outpatient Facility, or Professional. If the carrier believes other values are needed please define the additional Other Provider Payments Types used in the Data Certification.

Other Provider Payment $ - Direct

Should include all other provider payments that are applicable to medical coverage and directly charged back to the employer. Examples of these payments (but not an exclusive list) include: withholds, pay for performance payments, risk settlements, bonus payments, pre-payments, provider incentives due to risk sharing arrangements, care collaboration fees, unit cost escalator buy-downs, and provider fees to fund administrative functions.

Other Provider Payment $ - Indirect

Should include all other provider payments that are applicable to medical coverage and not directly charged back to the employer. Examples of these payments (but not an exclusive list) include: withholds, pay for performance payments, risk settlements, bonus payments, pre-payments, provider incentives due to risk sharing arrangements, care collaboration fees, unit cost escalator buy-downs, and provider fees to fund administrative functions.

Appendix A – Detailed Data Layout
INPATIENT FACILITY CLAIMS

File should be provided in tab-delimited format

	Field	Notes/Sample Values	Aggregation Function
		REQUIRED FIELDS	
1	Organization Name	Name of organization providing data	Group by
2	Service Period	Dates of service represented by data submission in format MMDDYY-MMDDYY. First date should be the start date and second date should be end date. As an example, for the CY2024 data submission, this field would be populated as **070123-123124**. If period is not equal to 18 months, it should be disclosed on the actuarial certification	Group by
3	3 Digit Patient ZIP Code	Use patient's residential zip code. If the patient's zip code is not available, use employee zip code. If neither the patient or employee zip code are available, zip code should be set to "ZZZ"	Group by
4	Product Indicator	See page 5 for instructions	Group by
5	6-month Indicator	See page 6 for instructions	Group by
6	Hierarchical Pricing Code	See pages 6 and 7 for instructions	Group by
7	Network Status Indicator	See page 8 for instructions	Group by
8	Noncontracted Savings Indicator	"Y" if Negotiated Savings for Noncontracted Providers that cannot be balanced billed to member	Group by
9	Arrangement Indicator	F - Fully-insured S - Self-insured See page 8 for instructions.	Group by
10	Pay as Billed Provider Indicator	Y= Claims carrier requests to be considered Pay as Billed N= Other	Group by
11	Catastrophic Indicator	0 = IP Event with total Allowed amount between $150,000 and $299,999.99 1 = IP Event with total Allowed amount equal to or more than $300,000 N = All other IP events	Group by
12	Diagnosis Related Groups (DRG)	Based on discharge DRG. Use coding system MS-DRG v41.1	Group by
13	DRG Version Indicator	Indicates the DRG version submitted in the data. Should be populated with a value for all records. See Appendix J for coding instructions.	Group by
14	Major Diagnostic Category (MDC)	Report data for all MDCs. Should be based on DRG submitted	Group by
15	***Actual*** Data Filler	Indicates beginning of "Actual" financial fields. Fill field with "AC"	
16	***Actual*** Number of Admissions	If a patient is transferred to a different facility, a new admission record should be created. Please ensure that your admission counts are net of any reversals (negative adjustments). Reversals should offset admission counts and financial data in your dataset and should not be counted as additional admissions.	Sum

17	***Actual*** Number of Covered Days	Total number of covered inpatient days related to the admissions defined above. All non-covered days should be excluded from the day count. For claims where the admission and discharge date are the same, Number of Covered days should be set to 1. There should be no IP claims with 0 days. Please ensure that your day counts are net of any reversals (negative adjustments). Reversals should offset day counts and financial data in your dataset and should not be counted as additional days.	Sum
18	***Actual*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	Sum
19	***Actual*** Negotiated Savings $	Savings due to negotiated discount	Sum
20	***Actual*** Allowed $	Total plan approved amount prior to member cost-sharing, net of R&C cutbacks.	Sum
21	***Actual*** Paid $	Sometimes referred to as "Plan Paid Amount". This is the Allowed Amount reduced for member cost sharing. It represents the actual amount paid by the health plan.	Sum
22	***Filler 1***	Future Use	
23	***Filler 2***	Future Use	
24	***Filler 3***	Future Use	
25	***AdjCopyofActual***	If Adjusted is a copy of Actual data, code as "Y". Otherwise code as "N".	Group by
26	***Adjusted*** Data Filler	Indicates beginning of "Adjusted" financial fields. Fill field with "AD"	
27	***Adjusted*** Number of Admissions	If a patient is transferred to a different facility, a new admission record should be created. Please ensure that your admission counts are net of any reversals (negative adjustments). Reversals should offset admission counts and financial data in your dataset and should not be counted as additional admissions.	Sum
28	***Adjusted*** Number of Covered Days	Total number of covered inpatient days related to the admissions defined above. All non-covered days should be excluded from the day count. For claims where the admission and discharge date are the same, Number of Covered days should be set to 1. There should be no IP claims with 0 days. Please ensure that your day counts are net of any reversals (negative adjustments). Reversals should offset day counts and financial data in your dataset and should not be counted as additional days.	Sum
29	***Adjusted*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	Sum
30	***Adjusted*** Negotiated Savings $	Savings due to negotiated discount	Sum
31	***Adjusted*** Allowed $	Total plan approved amount prior to member cost-sharing, net of R&C cutbacks.	Sum
32	***Adjusted*** Paid $	Sometimes referred to as "Plan Paid Amount". This is the Allowed Amount reduced for member cost sharing. It represents the actual amount paid by the health plan.	Sum
33	***Filler 5***	Future Use	
34	***Filler 6***	Future Use	
35	***Filler 7***	Future Use	
36	***ProCopyofAdj***	If Projected is a copy of Adjusted data, code as "Y". Otherwise code as "N".	Group by

37	***Projected*** Data Filler	Indicates beginning of "Projected" financial fields. Fill field with "PR"	
38	***Projected*** Number of Admissions	If a patient is transferred to a different facility, a new admission record should be created. Please ensure that your admission counts are net of any reversals (negative adjustments). Reversals should offset admission counts and financial data in your dataset and should not be counted as additional admissions.	Sum
39	***Projected*** Number of Covered Days	Total number of covered inpatient days related to the admissions defined above. All non-covered days should be excluded from the day count. For claims where the admission and discharge date are the same, Number of Covered days should be set to 1. There should be no IP claims with 0 days. Please ensure that your day counts are net of any reversals (negative adjustments). Reversals should offset day counts and financial data in your dataset and should not be counted as additional days.	Sum
40	***Projected*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	Sum
41	***Projected*** Negotiated Savings $	Savings due to negotiated discount	Sum
42	***Projected*** Allowed $	Total plan approved amount prior to member cost-sharing, net of R&C cutbacks.	Sum
43	***Filler 8***	Future Use	
44	***Filler 9***	Future Use	
45	***Filler 10***	Future Use	
46	***Filler 11***	Future Use	
47	***Filler 12***	Future Use	
48	***Filler 13***	Future Use	

Appendix A – Detailed Data Layout
OUTPATIENT FACILITY CLAIMS

File should be provided in tab-delimited format

	Field	Notes/Sample Values	Aggregation Function
		REQUIRED FIELDS	
1	Organization Name	Name of organization providing data	Group by
2	Service Period	Dates of service represented by data submission in format MMDDYY-MMDDYY. First date should be the start date and second date should be end date. As an example, for the CY2024 data submission, this field would be populated as **070123-123124**. If period is not equal to 18 months, it should be disclosed on the actuarial certification	Group by
3	3 Digit Patient ZIP Code	Use patient's residential zip code. If the patient's zip code is not available, use employee zip code. If neither the patient or employee zip code are available, zip code should be set to "ZZZ"	Group by
4	Product Indicator	See page 5 for instructions	Group by
5	6-month Indicator	See page 6 for instructions	Group by
6	Hierarchical Pricing Code	See pages 6 and 7 for instructions	Group by
7	Network Status Indicator	See page 8 for instructions	Group by
8	Noncontracted Savings Indicator	"Y" if Negotiated Savings for Noncontracted Providers that cannot be balanced billed to member	Group by
9	Arrangement Indicator	F - Fully-insured S - Self-insured See page 8 for instructions.	Group by
10	Pay as Billed Provider Indicator	Y= Claims carrier requests to be considered Pay as Billed N= Other	Group by
11	Outpatient Type of Service	See Appendix C for definitions	Group by
12	CPT Code	For Radiology or Pathology claims with a Revenue Code and CPT code, claims should be aggregated on each CPT code and Modifier combination as described in Appendix E	Group by
13	CPT Code Modifier	For Radiology or Pathology claims with a Revenue Code and CPT code, claims should be aggregated on each CPT code and Modifier combination as described in Appendix E	Group by
14	***Actual*** Data Filler	Indicates beginning of "Actual" financial fields. Fill field with "AC"	
15	***Actual*** Number of Services	Number of Cases or Number of Services – depends on Outpatient Type of Service – see Appendix C for instructions. Please ensure that your numbers of service counts are net of any reversals (negative adjustments). Reversals should offset service counts and financial data in your dataset and should not be counted as additional services.	Sum
16	***Actual*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	Sum
17	***Actual*** Negotiated Savings $	Savings due to negotiated discount	Sum
18	***Actual*** Allowed $	Total plan approved amount prior to member cost-sharing, net of R&C cutbacks.	Sum

19	***Actual*** Paid $	Sometimes referred to as "Plan Paid Amount". This is the Allowed Amount reduced for member cost sharing. It represents the actual amount paid by the health plan.	
20	***Filler 1***	Future Use	
21	***Filler 2***	Future Use	
22	***Filler 3***	Future Use	
23	***AdjCopyofActual***	If Adjusted is a copy of Actual data, code as "Y". Otherwise code as "N".	Group by
24	***Adjusted*** Data Filler	Indicates beginning of "Adjusted" financial fields. Fill field with "AD"	
25	***Adjusted*** Number of Services	Number of Cases or Number of Services – depends on Outpatient Type of Service – see Appendix C for instructions. Please ensure that your numbers of service counts are net of any reversals (negative adjustments). Reversals should offset service counts and financial data in your dataset and should not be counted as additional services.	Sum
26	***Adjusted*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	Sum
27	***Adjusted*** Negotiated Savings $	Savings due to negotiated discount	Sum
28	***Adjusted*** Allowed $	Total plan approved amount prior to member cost-sharing, net of R&C cutbacks.	Sum
29	***Adjusted*** Paid $	Sometimes referred to as "Plan Paid Amount". This is the Allowed Amount reduced for member cost sharing. It represents the actual amount paid by the health plan.	Sum
30	***Filler 5***	Future Use	
31	***Filler 6***	Future Use	
32	***Filler 7***	Future Use	
33	***ProCopyofAdj***	If Projected is a copy of Adjusted data, code as "Y". Otherwise code as "N".	
34	***Projected*** Data Filler	Indicates beginning of "Projected" financial fields. Fill field with "PR"	Group by
35	***Projected*** Number of Services	Number of Cases or Number of Services – depends on Outpatient Type of Service – see Appendix C for instructions. Please ensure that your numbers of service counts are net of any reversals (negative adjustments). Reversals should offset service counts and financial data in your dataset and should not be counted as additional services.	Sum
36	***Projected*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	Sum
37	***Projected*** Negotiated Savings $	Savings due to negotiated discount	Sum
38	***Projected*** Allowed $	Total plan approved amount prior to member cost-sharing, net of R&C cutbacks.	Sum
39	***Filler 8***	Future Use	
40	***Filler 9***	Future Use	
41	***Filler 10***	Future Use	
42	***Filler 11***	Future Use	
43	***Filler 12***	Future Use	
44	***Filler 13***	Future Use	

Appendix A – Detailed Data Layout
PROFESSIONAL CLAIMS

File should be provided in tab-delimited format

	Field	Notes/Sample Values	Aggregation Function
	REQUIRED FIELDS		
1	Organization Name	Name of organization providing data	Group by
2	Service Period	Dates of service represented by data submission in format MMDDYY-MMDDYY. First date should be the start date and second date should be end date. As an example, for the CY2024 data submission, this field would be populated as **070123-123124**. If period is not equal to 18 months, it should be disclosed on the actuarial certification	Group by
3	3 Digit Patient ZIP Code	Use patient's residential zip code. If the patient's zip code is not available, use employee zip code. If neither the patient or employee zip code are available, zip code should be set to "ZZZ"	Group by
4	Product Indicator	See page 5 for instructions	Group by
5	6-month Indicator	See page 6 for instructions	Group by
6	Hierarchical Pricing Code	See pages 6 and 7 for instructions	Group by
7	Network Status Indicator	See page 8 for instructions	Group by
8	Noncontracted Savings Indicator	"Y" if Negotiated Savings for Noncontracted Providers that cannot be balanced billed to member	Group by
9	Arrangement Indicator	F - Fully-insured S - Self-insured See page 8 for instructions.	Group by
10	Pay as Billed Provider Indicator	Y= Claims carrier requests to be considered Pay as Billed N= Other	Group by
11	CPT Code	See Appendix D for a list of CPT/HCPCS codes and modifiers	Group by
12	CPT Code Modifier	See Appendix D for a list of CPT/HCPCS codes and modifiers	Group by
13	***Actual*** Data Filler	Indicates beginning of "Actual" financial fields. Fill field with "AC"	
14	***Actual*** Number of Procedures	Number of Cases or Number of Procedures. Please ensure that your procedure counts are net of any reversals (negative adjustments). Reversals should offset procedures and financial data in your dataset and should not be counted as additional claim lines.	Sum
15	***Actual*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	Sum
16	***Actual*** Negotiated Savings $	Savings due to negotiated discount	Sum
17	***Actual*** Allowed $	Total plan approved amount prior to member cost-sharing, net of R&C cutbacks.	Sum
18	***Actual*** Paid $	Sometimes referred to as "Plan Paid Amount". This is the Allowed Amount reduced for member cost sharing. It represents the actual amount paid by the health plan.	
19	***Filler 1***	Future Use	
20	***Filler 2***	Future Use	
21	***Filler 3***	Future Use	
22	***AdjCopyofActual***	If Adjusted is a copy of Actual data, code as "Y". Otherwise code as "N".	Group by
23	***Adjusted*** Data Filler	Indicates beginning of "Adjusted" financial fields. Fill field with "AD"	

Appendix A – Detailed Data Layout
PROFESSIONAL CLAIMS

File should be provided in tab-delimited format

	Field	Notes/Sample Values	Aggregation Function
24	***Adjusted*** Number of Procedures	Number of Procedures. Please ensure that your procedure counts are net of any reversals (negative adjustments). Reversals should offset procedures and financial data in your dataset and should not be counted as additional claim lines.	Sum
25	***Adjusted*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	Sum
26	***Adjusted*** Negotiated Savings $	Savings due to negotiated discount	Sum
27	***Adjusted*** Allowed $	Total plan approved amount prior to member cost-sharing, net of R&C cutbacks.	Sum
28	***Adjusted*** Paid $	Sometimes referred to as "Plan Paid Amount". This is the Allowed Amount reduced for member cost sharing. It represents the actual amount paid by the health plan.	Sum
29	***Filler 5***	Future Use	
30	***Filler 6***	Future Use	
31	***Filler 7***	Future Use	
32	***ProCopyofAdj***	If Projected is a copy of Adjusted data, code as "Y". Otherwise code as "N".	Group by
33	***Projected*** Data Filler	Indicates beginning of "Projected" financial fields. Fill field with "PR"	
34	***Projected*** Number of Procedures	Number of Procedures. Please ensure that your procedure counts are net of any reversals (negative adjustments). Reversals should offset procedures and financial data in your dataset and should not be counted as additional claim lines.	Sum
35	***Projected*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	Sum
36	***Projected*** Negotiated Savings $	Savings due to negotiated discount	Sum
37	***Projected*** Allowed $	Total plan approved amount prior to member cost-sharing, net of R&C cutbacks.	Sum
38	***Filler 8***	Future Use	
39	***Filler 9***	Future Use	
40	***Filler 10***	Future Use	
41	***Filler 11***	Future Use	
42	***Filler 12***	Future Use	
43	***Filler 13***	Future Use	

Appendix A – Detailed Data Layout
OTHER PROVIDER PAYMENTS

	Field	Notes/Sample Values	Aggregation Function
REQUIRED FIELDS			
1	Organization Name	Name of organization providing data	Group by
2	Service Period	Dates of service represented by data submission in format MMDDYY-MMDDYY. First date should be the start date and second date should be end date. As an example, for the CY2024 data submission, this field would be populated as **070123-123124**. If period is not equal to 18 months, it should be disclosed on the actuarial certification	Group by
3	3 Digit Patient ZIP Code	Use patient's residential zip code. If the patient's zip code is not available, use employee zip code. If neither the patient or employee zip code are available, zip code should be set to "ZZZ"	Group by
4	Product Indicator	See page 5 for instructions	Group by
5	Other Provider Payment Type	"I" for Inpatient, "O" for Outpatient and "P" for Professional If other values are used, define them in the Data Certification	Group by
6	***Actual*** Other Provider Payment $ - Direct	Total amount paid to providers from all sources and directly charged back to the employer above the amounts reported in the claims data file, subject to exclusions.	Sum
7	***Actual*** Other Provider Payment $ - Indirect	Total amount paid to providers from all sources not directly charged back to the employer above the amounts reported in the claims data file, subject to exclusions.	Sum
8	***Adjusted*** Other Provider Payment $ - Direct	Total amount paid to providers from all sources and directly charged back to the employer above the amounts reported in the claims data file, subject to exclusions.	Sum
9	***Adjusted*** Other Provider Payment $ - Indirect	Total amount paid to providers from all sources not directly charged back to the employer above the amounts reported in the claims data file, subject to exclusions.	Sum
10	***Projected*** Other Provider Payment $ - Direct	Total amount paid to providers from all sources and directly charged back to the employer above the amounts reported in the claims data file, subject to exclusions.	Sum
11	***Projected*** Other Provider Payment $ - Indirect	Total amount paid to providers from all sources not directly charged back to the employer above the amounts reported in the claims data file, subject to exclusions.	Sum
12	Filler 1		
13	Filler 2		
14	Filler 3		

Appendix B – Billed Trends to Use in Projections

Billed Charge Trend Estimates from Milliman

Milliman has agreed to provide billed charge trend estimates that must be used by carriers who wish to submit projected discounts in their discount data submissions. The estimates are based on billed charge increases observed in national claims data.

Milliman will provide separate national billed charge trends for Inpatient, Outpatient and Professional claims in each UDS version.

The estimates are established solely for the purpose of standardizing the billed charge trends and must be used by carriers in discount projections. There are some cautions to the use of this data:

- No adjustments have been made to these estimates for future Claims or contingencies. As such, these billed trend charge estimates are not intended to be the basis of any financial projections or guarantees (including premiums, discount guarantees, etc.) where the projection of billed charges is needed
- We realize that billed charges and billed charge trends within a geographic area can vary significantly from national charges and trends. Since the trend estimates provided by Milliman will be at a national level, the estimates provided may not be appropriate for a specific state or geographic area

The current billed charge levels required to be used are shown in the table below:

Service Category	Billed Trend
IP	4.0%
OP	4.5%
Prof	3.5%

Appendix C - Outpatient Facility Type of Service Codes

FOR CLAIM LINES CODED WITH REVENUE CODES 960-989, see Page 16 for instructions

Type of Service	Code	Notes
Emergency Room	ER	Revenue Codes 450-459, 981 If a claim has any ER revenue code, all outpatient facility charges for the claim should be classified as ER. Charges for ER visits resulting in an inpatient admission should be included with inpatient charges All claims lines related to an ER Claim should be summarized to the Case level. The "Number of Services" reported should be the number of ER Cases (summarized at the claim identification number level)
Surgery	SR	Revenue Codes 360-369, 490-499, 963, 964, 975 If a claim is not classified as ER, and has a surgery revenue code, then all facility charges for that claim should be classified as surgery All claims lines related to an Outpatient Surgery Claim should be summarized to the Case level. The "Number of Services" reported should be the number of Outpatient Surgery Cases (summarized at the claim identification number level)
Radiology	XR	Revenue Codes 320-359, 400-409, 610-619, 972-974 If the carrier is unable to separate the facility and professional components of a claim, all lines of the claim should be included as Outpatient Facility. For these events, a modifier of "GF" (Global Fee) should be used to indicate that the facility and professional components of the claim are both included in the Outpatient facility. CPT/HCPCS codes 70000-79999 should be submitted per Appendix E. Include all claim lines with a Radiology revenue code. For claim lines reported with both a Radiology Revenue Code and a CPT code, the CPT code and modifier as described in Appendix E should be submitted. The "Number of Services" reported should be the number of services/claim lines with the Radiology Revenue Codes shown above
Pathology	LB	Revenue Codes 300-319, 921, 923, 925, 971 If the carrier is unable to separate the facility and professional components of a claim, all lines of the claim should be included as Outpatient Facility. For these events, a modifier of "GF" (Global Fee) should be used to indicate that the facility and professional components of the claim are both included in the Outpatient facility. CPT/HCPCS codes 36415-36419 and 80000-89999 should be submitted per Appendix E. Include all claim lines with a Pathology revenue code. For claim lines reported with both a Pathology Revenue Code and a CPT code, the CPT code and modifier as described in Appendix E should be submitted. The "Number of Services" reported should be the number of services/claim lines with the Pathology Revenue Codes shown above
Specialty Rx	RX	Include claim lines with HCPCS code that begins with J The "Number of Services" reported should be the number of services/claim lines with the HCPCS shown above

Ancillary	AC	All claims (whether Outpatient or Professional) with Revenue Codes and/or CPT/HCPCS Codes in the following ranges. Please make sure to exclude these claim lines from Professional claims. **Revenue Codes:** Ambulance: 540 – 549 DME: 290-299, 946-947 Home Health: 235, 550-608, 640-662, 984, 989 **CPT/HCPCS Codes** CPT–4 Codes 99500–99602; HCPCS Codes G0151–G0156, G0248–G0250, S5035–S5116, S5121–S5126, S5135–S5151, S5180–S5181, S5497–S5502, S5517–S5523, S9122–S9131, S9200–S9379, S9395, S9420–S9425, S9490–S9526, S9535–S9810, T1000–T1005, T1019–T1022, T1030–T1031, T1502, T2022–T2023, T2042–T2046 HCPCS Codes A4206–A4640, A4653, A4930–A5511, A6550–A7527, A9190–A9300, B4034–C1004, C1008, C1063, C1068–C1071, C1075–C1078, C1103, C1105, C1109, C1115–C1116, C1118–C1121, C1123–C1154, C1156–C1163, C1170–C1172, C1175–C1177, C1179–C1184, C1302–C1303, C1306–C1311, C1315–C1318, C1321–C1324, C1336–C1337, C1351–C1359, C1363–C1364, C1721–C1773, C1776–C1779, C1781–C1788, C1816–C1817, C1881–C1900, C2614, C2618–C2621, C2626–C2630, C2700–C3004, C3800–C3801, C4000–C4607, C8501, C8505–C8513, C8518–C8521, C8724–C8777, C9007–C9010, E0100–E8002, K0001–K0116, K0138–K0411, K0419–K0439, K0452–K0547, K0549–L4398, S1001–S1016, S1030–S1040, S5016–S5021, S5025, S5503, S5560–S5571, S8055, S8095–S8105, S8120–S8490, S8999–S9007, V2600–V2615, V5336 HCPCS Codes A0021–A0999, Q3019–Q3020, S0209–S0215, T2001–T2007, T2049 HCPCS Codes C1005–1007, C1780, C1789, C1813–C1815, C1818, C2622, C3400–C3510, C3851, C6050–C6210, C8514–C8516, C8530, C8534, K0440–K0451, L5000–L9900, Q1001–Q1005, V2623–V2632 The "Number of Services" reported should be the number of services/claim lines associated with the Revenue Codes and/or CPT/HCPCS codes shown above
Other	ZZ	A facility claim that is not an Inpatient claim and has a Revenue code that is not indicated in any of the categories above The "Number of Services" reported should be the number of services/claim lines associated with ZZ claims

Appendix D – Requested Professional CPT and HCPCS Procedure Codes

The requested codes are included on worksheet 'Appendix D' in the file "20250109_DDS Appendices_Dates 07012023-12312024.xlsx". Please contact Zach Lamers (zach.lamers@milliman.com) or Josh Reinstein (josh.reinstein@milliman.com) if you need this file.

If a code is not listed in the file referenced above, group the data using the first character of the CPT/HCPCS code followed by 4 X's. As an example, if a code begins with T, create a grouping TXXXX for all claim lines with these codes.

Appendix E –Modifiers to be Submitted by CPT Code Range

CPT Code Range	Modifiers to be Submitted	Note
10000 – 69999	• Bilateral Procedures (50) • Multiple Procedures (51) • Reduced Services (52) • Assistant Surgeon (AS) • Anesthesiologist (AN) • Primary Surgeon, Uncoded, Other or Unknown (ZZ)	**These modifiers apply to the submission of Professional claims only.** Based on standard coding of CPT Modifiers, Bilateral Procedure are coded with Modifier 50, Multiple Procedures are coded with Modifier 51, Reduced Services are coded with Modifier 52, Anesthesia by a surgeon is typically coded with Modifier 47 and Assistant Surgeon is typically coded with Modifier 80, 81 or 82. Carriers must affirm that they have been diligent in identifying any homegrown modifiers used in their claim processing. All homegrown codes must be mapped to the 3 codes shown (AS, AN, ZZ)
Radiology 70000 – 79999 Pathology 80000 – 89999	• Bilateral Procedure (50) • Multiple Procedures (51) • Reduced Services (52) • Global Fee (GF) • Technical Component (TC) • Professional Component (PC) • Uncoded, Other or Unknown (ZZ)	**These modifier rules apply to the submission of both Outpatient Facility and Professional claims.** Based on standard coding of CPT Modifiers, the Technical Component is typically coded as Modifier "TC" and the Professional Component is typically coded as Modifier "26". Global Fee (GF) modifiers must be identified by the carrier Modifiers 26 or PC should not appear in Outpatient Facility data as these indicate the Professional services. Likewise, modifiers TC and GF should not appear in Professional data as these modifiers indicate Outpatient facility charges. Carriers must affirm that they have been diligent in identifying any homegrown modifiers used in their claim processing. All homegrown codes must be mapped to the 4 codes shown (GF, TC, PC, ZZ)
All other codes	• None submitted	Modifiers for CPT codes not falling into the specific ranges noted in the categories above should not be submitted

Appendix F – Control Total/Reconciliation

The schedule included on worksheet 'Appendix F' in the file "20250109_DDS Appendices_Dates 07012023-12312024.xlsx" should be provided for each product for which a "Product Indicator" is provided. Please contact Zach Lamers (zach.lamers@milliman.com) or Josh Reinstein (josh.reinstein@milliman.com) if you need this file.

Appendix G - Product Key

Product Name and Description	Product Indicator
Open Choice	PPO01Choice
Open Choice Plus	PPO02ChoicePlus
Managed Options	POS01Options
Gatekeeper Plus	POS02GKPlus

* Positions 1 through 3 should indicate product type (HMO, EPO, PPO, POS, TRA)
Positions 4 through 5 should be used to differentiate offerings within product type
Positions 6 through 15 should be used to indicate product name

Appendix H – Projection Documentation

PLEASE REFER TO PAGE 12 FOR INSTRUCTIONS ON COMPLETING THIS FORM

		1/25-12/25 Projected Discount Change* (+) means discount improvement (-) means discount deterioration				Annual Trend Applied to Eligible Billed Charges			% of Area Eligible Billed Charges Affected by Change				
Three Digit ZIP(s)	Product Indicator	IP	OP	Prof	Change to Total Discount	IP	OP	Prof	IP	OP	Prof	Total	Discount Improvement Plan Details
AXY	PPO01	2.00%	2.00%	0.00%	1.00%	4.00%	4.50%	0.00%	50.00%	41.00%	0.00%	22.75%	Renegotiated key facility contracts
AZY	PPO01	1.00%	1.00%	2.00%	1.50%	4.00%	4.50%	3.50%	15.00%	20.00%	100.00%	52.55%	Renegotiated key facility contracts Introduce New Physician Fee Schedule
VCX	POS01	0.00%	0.00%	4.00%	2.00%	0.00%	0.00%	3.50%	0.00%	0.00%	75.00%	33.75%	Introduce New Physician Fee Schedule

All projections and reasons for projections should be thoroughly explained in the Actuarial Certification (Appendix I)

* Changes should reflect absolute change in discount
(e.g., if discount expected to improve from 55% to 57%, Change in Discount is 2%; if discount expected to deteriorate from 63% to 60%, Change in Discount is -3%)
Change in discount should reflect expected changes in both Allowed Amount and Eligible Billed
Allowed amount should only be trended at 0% if carrier has a signed contract stating that Allowed amounts will remain unchanged

Common Discount Change Plan Detail Reason Types
Non-Par Hospital Contracting
Free Standing Surgical Centers Contracting
Change Stop Loss Provisions
Introduce New Physician Fee Schedule
Reduce Existing Physician Fee Schedule
Provider acquired by another provider
Par hospital re-contracting
Addition or loss of major hospital(s) in a location
Addition or loss of major group practice(s) in a location
Renegotiated major contract changes with existing network providers
Recognize negotiated escalators in multi-year contracts
This is not intended to be an exhaustive list. Please add other descriptive types as needed.

Appendix I
Disclosure of Compliance with Data Standards

In certifying your compliance with the "Disclosure Items" below, please be sure to be specific and disclose any portion of your submission that deviates from the request. Please do not answer "Yes" to a statement unless your organization is compliant with the statement for 100% of your submission. All deviations, regardless of perceived size, must be disclosed.

Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
1	Data is reported by member 3-digit zip code. Data has not been combined for multiple three-digit zip codes			
2	For each product submitted, data includes 18 months of claims, incurred 7/1/2023-12/31/2024 and paid through 2/28/2025.			
3	All indicators in the data are mutually exclusive so that when amounts for charge and utilization fields are summed, the result is the actual total for that field.			
4	Data is submitted in the format outlined in Appendix A			
5	Data includes all claims (other than those exclusions outlined on page 1) regardless of provider contracting status, claim dollar amount or discount percentage			
6	Data excludes all surcharges and covered life assessments (e.g., NYCHRA in New York)			

Appendix I
Disclosure of Compliance with Data Standards

In certifying your compliance with the "Disclosure Items" below, please be sure to be specific and disclose any portion of your submission that deviates from the request. Please do not answer "Yes" to a statement unless your organization is compliant with the statement for 100% of your submission. All deviations, regardless of perceived size, must be disclosed.

Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
7	Access fees are excluded from all claims. If access fees could not be removed explicitly, please submit data as "Adjusted" and provide your methodology in the box requesting explanation of Adjusted data below			
8	Minnesota provider tax payments have been included in both the 'Eligible Billed $' and 'Allowed $' fields.			
9	Data has been assembled as outlined on pages 3 and 4 ("Data Aggregation Methodology")			
10	A product indicator for each product submitted has been provided And Appendix G has been included with the submission			
11	Hierarchical Pricing Code has been submitted			
12	MDC and DRG have been provided for all inpatient claims			
13	DRG data has been submitted under coding system MS-DRGv41.1 and DRG Indicator Field has been coded properly in your data submission			

Appendix I
Disclosure of Compliance with Data Standards

In certifying your compliance with the "Disclosure Items" below, please be sure to be specific and disclose any portion of your submission that deviates from the request. Please do not answer "Yes" to a statement unless your organization is compliant with the statement for 100% of your submission. All deviations, regardless of perceived size, must be disclosed.

Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
14	For a covered admission where the admission and discharge date are equal, the number of covered days is set to 1. There are no IP Admissions with 0 days			
15	Days and billed charges associated with non-covered days during a hospital admission have been excluded from the data submission			
16	Reversals offset submitted data for admissions, days, OP Services, procedures and dollar amount fields and are not treated as additional utilization/dollar amounts			
17	Financial data has been submitted as defined on page 9 for Eligible Billed Charges, Negotiated Savings, Allowed Amount and Paid Amount			
18	Eligible Billed Charges are equal to the Billed Charge on the claim and have not been adjusted to reflect the Allowed Amount on the claim.			

Appendix I
Disclosure of Compliance with Data Standards

In certifying your compliance with the "Disclosure Items" below, please be sure to be specific and disclose any portion of your submission that deviates from the request. Please do not answer "Yes" to a statement unless your organization is compliant with the statement for 100% of your submission. All deviations, regardless of perceived size, must be disclosed.

Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
19	Ineligible billed charges (as defined on pages 9 and 10) have been excluded and Eligible Billed Charges = Submitted Charges – Ineligible Charges for all claims			
20	All financial and utilization data labeled as "Actual" represents historical claims without adjustment			
21	All Other Provider Payments and Capitation/Settlements are included in Appendix A in the Other Provider Payments data.			
22	"Adjusted" data and "Projected" data have been explained in the space provided below and Appendix H has been submitted for "Projected" data			

Appendix I
Disclosure of Compliance with Data Standards

In certifying your compliance with the "Disclosure Items" below, please be sure to be specific and disclose any portion of your submission that deviates from the request. Please do not answer "Yes" to a statement unless your organization is compliant with the statement for 100% of your submission. All deviations, regardless of perceived size, must be disclosed.

Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
23	Contract changes included in "Projected" data were signed prior to the "cutoff" date of March 31, 2025			
24	The impact of newly signed contracts effective in a future time are only included in "Projected" data and are not included in "Adjusted" data			
25	Outpatient events for which facility and professional claims cannot be separated have been indicated with a modifier of "GF". If unable to label claims with modifier of "GF", please provide the total utilization and eligible billed charges for Outpatient events where facility and professional claims cannot be separated			
26	Ancillary claims as defined in Appendix C have been included in Outpatient Facility claims and excluded from Professional claims			
27	All homegrown modifier codes have been mapped to comply with modifier definitions shown in Appendix E			

Appendix I
Disclosure of Compliance with Data Standards

In certifying your compliance with the "Disclosure Items" below, please be sure to be specific and disclose any portion of your submission that deviates from the request. Please do not answer "Yes" to a statement unless your organization is compliant with the statement for 100% of your submission. All deviations, regardless of perceived size, must be disclosed.

Item #	Disclosure Item	Response (Yes/No)	PROPRIETARY If Response is "No", please provide a description of the deviation from this standard	NON-PROPRIETARY If Response is "No", please provide a description of the deviation from this standard
28	Appendix F has been completed for all products submitted. Total Submitted Charges represent all fee for service claims for a product after the criteria for inclusion/exclusion on page 1 is applied			
29	Has this submission kept separate the data for benefit plans with in-network only and in-network/out-of-network benefits?			
30	The Arrangement Indicator field was populated using the definition found on page 8.			
31	All Other Provider Payments and Capitation/Settlements in Appendix A are based on paid amounts in the incurred Time Period			
32	All Other Provider Payments and Capitation/Settlements are included in Appendix A for both direct and indirect payments.			

Please provide a description of the process used to identify claims that have a Pay-as-Billed Indicator of "Y"

Please provide explanation and the methodology used to calculate any "Adjusted" claim or utilization data included in this data submission. Explanation should be provided by geographic area. Examples of reasons to provide "Adjusted" data can be found on pages 11 and 12 of this document. Carriers reporting adjustments must also complete the Appendix I – Data Supplement Schedule. Please label each adjustment with ProductID and Title of the Adjustment so it can be cross referenced to the Data Supplement Schedule.

Please provide explanation and the methodology used to calculate any "Projected" claim or utilization data included in this data submission. Explanation should be provided by geographic area. Please address the level at which the projected discounts were calculated and applied (3 digit zip code or MSA). Appendix H should also be provided for each geographic area where "Projected" data is submitted

Please disclose any assumptions used to compile the data in the Other Provider Payments table in Appendix A. Please disclose any other deviations from the specification. Please provide a definition of any custom values in the Other Provider Payment Type field. Please provide an explanation for changes in Other Provider Payment totals for Adjusted and Projected data.

Please disclose the amount of claims by Type of Service that were excluded for medical provider customers. In addition, please provide a list of zip codes where more than 5% of total claims in that zip code were excluded.

Please provide an explanation of any Medical Management/Medical Necessity language included in your provider contracts. In addition, please provide the percentage of claims, on an Eligible Billed basis, that are impacted by this language.

Please disclose the Eligible Billed and Allowed amounts of claims incurred outside of the United States. Only include claims for members who live in the United States and are included in the submission. The summary should be grouped by 3-Digit Patient Zip Code.

Please describe any alternative criteria used to identify and exclude claims for medical provider customers other than the criteria listed on pages 1 and 2

Please describe the methodology used to report the COVID-related codes listed in Appendix D

Please describe the methodology used to identify ZIPs where a proxy network was appropriate to use

If IHS facility claims were excluded in accordance with Appendix N, describe the methodology used to identify IHS facilities for exclusion (based on TIN, NPI, Name, etc.), the volume of billed charges that this exclusion represents, as well as a summary of these excluded dollars separately for ER/Non-ER services at the 3-digit zip level.

If any arrangements were categorized under the Hierarchical Pricing Code "5", please describe the Referenced Based Pricing table source used.

For any claims that fall under Hierarchical Pricing Codes 3, 4, 5 or 6, please describe any programs in place to mitigate member balance billing.

Are only claims paid through custom network arrangements excluded as part of the custom network exclusion? (Y/N)

Please disclose and explain how you applied the custom network arrangement exclusions.

Please disclose and explain any other deviations from this data specification that have not been addressed above

Please describe any adjustments, outside of any adjustments already described above, that you make to prepare and adjust your UDS data or recommend changes to data (actuals or adjusted) submitted to UDS.

Please disclose whether you are relying on third party entities to prepare, adjust your UDS data or recommend changes to data (actuals or adjusted) submitted to UDS. (Y/N)

Please describe the nature of these third party adjustments to prepare, adjust your UDS data or recommend changes to data (actuals or adjusted) submitted to UDS.

Please disclose any reliance you have made on other parties in completing this data submission as well as any other areas of concerns you may have as they relate to guidance offered under Actuarial Standard of Practice (ASOP) #23, Data Quality

By signing below, I certify that I have reviewed the data submitted. Based on my thorough review, I believe it presents a fair and accurate representation of the provider reimbursement arrangements of this organization, as reflected in book-of-business claims data. Except as disclosed above, we have followed the procedures outlined in this document to fulfill the data request.

Carrier Name

Signature of Actuary | Printed Name

Title | Date

Appendix J – DRG Version Coding

The DRG Version Identifier is a 4 character field with format V### where:

V: Grouper Version Type Code
- A: CMS (Medicare grouper)
- B: All Payor (sometimes called "New York" grouper)
- C: All Payor Refined (APR grouper)
- D-J: reserved for future use
- K-Z: Other (to be specified in the actuarial certification)

###: Version number (e.g., "A270" is the Medicare grouper effective 10/1/2009)
The first two digits relate to the DRG version number (for example, MS-DRG v36 is coded as 36).
The last digit is a placeholder as sometimes there are corrections released during a year. If a correction is released, the last digit would change from '0' to the correction number of the DRG release used (i.e., A271)

Appendix K – Servicing Provider State

The table below should be created for the following markets.

1. Atlanta, GA (zips 300-303, 311)
2. Fairfield, CT (066, 068, 069)
3. State of Maryland (206-219)
4. Newark, NJ (070-073)
5. Riverside-San Bernardino, CA (922-925)
6. San Angelo-Midland, TX (768, 769, 797)

The zip codes listed above are in reference to the patient zip code, not the provider zip code. Claims should be included for all patients who reside in one of the requested zip codes and are included in the UDS submission.

	Field	Notes/Sample Values	Aggregation Function
REQUIRED FIELDS			
1	Organization Name	Name of organization providing data	Group by
2	Service Period	Dates of service represented by data submission in format MMDDYY-MMDDYY. First date should be the start date and second date should be end date. As an example, for the CY2024 data submission, this field would be populated as **070123-123124**. If period is not equal to 18 months, it should be disclosed on the actuarial certification	Group by
3	3 Digit Patient ZIP Code	Use patient's residential zip code. If the patient's zip code is not available, use employee zip code. If neither the patient or employee zip code are available, zip code should be set to "ZZZ"	Group by
4	3 Digit Service Provider ZIP Code	Use zip code where the service was provided, not the billing zip code. If the provider's zip code is not available, zip code should be set to "ZZZ"	Group by
5	***Actual*** Eligible Billed $	Submitted charges after ineligible charges are removed, but before the savings due to negotiated discounts are taken.	Sum

Appendix L – Indian Health Services (IHS) Provider List

A list of applicable providers is included on worksheet 'Appendix L' in the file "20250109_DDS Appendices_Dates 07012023-12312024.xlsx". Please contact Zach Lamers (zach.lamers@milliman.com) or Josh Reinstein (josh.reinstein@milliman.com) if you need this file.

Change Log

1) Changes from Calendar Year 2021 Specification v1 to Calendar Year 2021 Specification v2

a) Version and Date in Header Changed to Version CY2021.2 and April 27, 2022 (all pages)
b) Updated DRG version to v38.1
   i) Pages 14, 20, 40
c) Updated name of Excel file with Appendices D, N, and O
   i) Pages 34, 53, 54

2) Changes from Calendar Year 2021 Specification to Mid-Year 2022 Specification

a) Deleted list of changes from Calendar Year 2019 Specification to Mid-Year 2020 Specification
b) Version and Date in Header Changed to Version MY2022.1 and February 28, 2023 (all pages)
c) Updated incurred date from 1/1/2021-12/31/2021 and paid through 2/29/2022 to 7/1/2021-6/30/2022 and paid through 8/31/2022
   i) Page 1, 40
d) Updated Incurred date from 010121-123121 to 070121-063022
   i) Page 4, 20, 23, 27, 29, 31, 52
e) Updated Incurred date from 1/1/2021-12/31/2021 to 7/1/2021-6/30/2022
   i) Page 11
f) Projected Data Submission Dates
   i) Page 11 – change from "Only contracts executed by March 31, 2022..." to "Only contracts executed by September 30, 2022…"
   ii) Page 44 – change from "date of March 31, 2022" to "date of September 30, 2022".
g) Updated Projected period from 1/1/2022-12/31/2022 to 1/1/2023-12/31/2023
   i) Page 10, 11
h) Changed "calendar year 2021" to "mid-year 2022"
   i) Page 4, 20, 23, 27, 29, 31, 52
i) Updated dates in Appendix H
   i) Page 39
j) Updated dates referenced in discount projection examples
   i) Page 13
k) Added an additional box within Appendix I addressing proxy network usage
   i) Page 49
l) Updated name of Excel file with Appendices D, N, and O
   i) Pages 34, 55, 56
m) Added an additional box within Appendix I addressing IHS facility exclusion
   i) Page 48
n) Added three additional boxes within Appendix I addressing third party adjustments and reliance
   i) Page 49

3) Changes from Mid-Year 2022 Specification to Calendar Year 2022 Specification

a) Deleted list of changes from Mid-Year 2020 Specification to Calendar Year 2020 Specification
b) Version and Date in Header Changed to Version CY2022.1 and May 31, 2023 (all pages)
c) Updated incurred date from "7/1/2021-6/30/2022 and paid through 8/31/2022" to "1/1/2022-12/31/2022 and paid through 2/28/2023"
   i) Page 1, 39

d) Updated Incurred date from "070121-063022" to "010122-123122"
   i) Page 4, 20, 23, 26, 28, 30, 53
e) Updated Incurred date from "7/1/2021-6/30/2022" to "1/1/2022-12/31/2022"
   i) Pages 11
f) Projected Data Submission Dates
   i) Page 11 – change from "Only contracts executed by September 30, 2022…" to "Only contracts executed by March 31, 2023..."
   ii) Page 43 – change from "date of September 30, 2022" to "date of March 31, 2023".
g) Changed "mid-year 2022" to "calendar year 2022"
   i) Page 4, 20, 23, 26, 28, 30, 53
h) Updated DRG version to v39.1
   i) Pages 14, 20, 40
i) Reviewed Billed Charge trends in Appendix B.
   i) No change to IP trend
   ii) OP trend changed from 6.5% to 4.5%
      (1) Pages 13, 31
   iii) Prof trend changed from 4.0% to 3.5%
      (1) Page 31
j) Updated Appendix H
   i) Page 38
k) Updated name of Excel file with Appendices D, N, and O
   i) Pages 34, 55, 56
l) Added Zach Lamers info
   i) Pages 34, 55, 56
m) Updated specification listed in Excel file with Appendices D, N, and O
   i) Row 2
n) Added facilities to Appendix N
   i) Rows 57-68
o) Added Specialty Rx category to Appendix C
   i) Pages 16, 32
p) Add 6-month Indicator to tables
   i) Pages 5, 20, 23, 26, 28, 30

4) Changes from Calendar Year 2022 Specification to Calendar-Year 2023 Specification

a) Deleted list of changes from Calendar Year 2020 Specification to Mid-Year 2021 Specification
b) Version and Date in Header Changed to Version CY2023.1 and March 27, 2024 (all pages)
c) Updated incurred date from 1/1/2022-12/31/2022 and paid through 2/28/2023 to 7/1/2022-12/31/2023 and paid through 2/29/2024
   i) Page 1, 36
d) Updated Incurred date from 010122-123122 to 070122-123123
   i) Page 4, 20, 23, 25, 27, 51
e) Updated Incurred date from 1/1/2022-12/31/2022 to 7/1/2022-6/30/2023
   i) Page 12
f) Projected Data Submission Dates
   i) Page 12 – change from "Only contracts executed by March 31, 2023..." to "Only contracts executed by March 31, 2024…"

ii) Page 41 – change from "date of March 31, 2024" to "date of March 31, 2025".

g) Updated Projected period from 1/1/2024-12/31/2024 to 1/1/2025-12/31/2025
   i) Page 13
h) Changed "calendar year 2023 data" to "calendar-year 2024 data" or "CY2024 data submission"
   i) Page 4, 20, 23, 25, 27, 51
i) Updated dates in Appendix H
   i) Page 35
j) Updated dates referenced in discount projection examples
   i) Page 14
k) Added wording to indicate that all projected columns and values for data outside of the calendar year (i.e. July 2022 – December 2022) should be set at $0. This replaced wording for how to project non calendar-year data.
   i) Page 13
l) Removed any reference to the "Virtual Service Indicator" or "COVID Indicator", including the complete removal of Appendices M and O
m) Updated name of Excel file with Appendices D, F, and M (renamed with the removal of the above)
   i) Pages 31, 33, 52
n) Added additional wording under custom network arrangement exclusions
   i) Page 2
   ii) Appendix I – Page 46
o) Added wording to reference Appendix I Supplemental file
   i) Page 10
   ii) Appendix I – Page 42
p) Added additional wording on M&A and Rental partners
   i) Page 10
q) Removed any reference to the Benefit/Contract Status Indicator and replaced it with the new "Hierarchical Pricing Codes" and "Network Status Indicator"
   i) Pages 3, 5, 6 and 15
   ii) Completely removed the Non-IC table from Appendix A
   iii) Various other places throughout the specification
   iv) Appendix I – Added free-form boxes on pages 45 and 46
r) Updated Appendix F to reflect the addition for the Appendix I Supplement control totals
s) Adjusted the 6-Month Indicator and corresponding time periods for the addition of "H3" and the new 18-month data submission.
   i) Page 5
t) Removal of any reference to Group Size within the Arrangement/Group Size Indicator previously in the specifications, now strictly Arrangement Indicator

5) Changes from Calendar Year 2023 Specification v1 to Calendar Year 2023 Specification v2

a) Removal of Appendix K altogether and renaming of subsequent appendices given this removal
b) Updated version numbers and dates throughout
c) Updated page reference at the top of Appendix C to Page 16 from Page 14
d) Updated wording under Bucket 2 for the Pricing Code Hierarchy on Page 6

6) Changes from Calendar Year 2023 Specification v2 to Calendar Year 2023 Specification v3

a) Version and Date in Header Changed to Version CY2023.3 and August 16, 2024 (all pages)
b) Updated wording under Bucket 2 for the Pricing Code Hierarchy
    i) Page 6
c) Updated name of Excel file with Appendices D, F, and M (renamed with the removal of the above)
    i) Pages 32, 34, 52

7) Changes from Calendar Year 2023 Specification to Calendar Year 2024 Specification

a) Deleted list of changes from Mid-Year 2021 Specification to Calendar Year 2021 Specification
b) Version and Date in Header Changed to Version CY2024.1 and January 9, 2025 (all pages)
c) Updated incurred date from 7/1/2022-12/31/2023 and paid through 2/28/2024 to 7/1/2023-12/31/2024 and paid through 2/28/2025
    i) Page 1, 37
d) Updated Incurred date from 070122-123123 to 070123-123124
    i) Page 4, 21, 24, 26, 28, 51
e) Updated Incurred date from 1/1/2023-12/31/2023 to 1/1/2024-12/31/2024
    i) Page 13
f) Projected Data Submission Dates
    i) Page 13 – change from "Only contracts executed by March 31, 2024..." to "Only contracts executed by March 31, 2025…"
    ii) Page 41 – change from "date of March 31, 2024" to "date of March 31, 2025".
g) Updated Projected period from 1/1/2024-12/31/2024 to 1/1/2025-12/31/2025
    i) Page 13
h) Changed "CY2023 data submission" to "CY2024 data submission"
    i) Page 4, 21, 24, 26, 28, 51
i) Updated dates in Appendix H
    i) Page 36
j) Updated dates referenced in discount projection examples
    i) Page 15
k) Updated date reference indicating all projected columns and values for data outside of the calendar year (i.e. July 2023 – December 2023) should be set at $0.
    i) Page 14
l) Added wording around data submission timing after group discussion
    i) Page 4
m) Updated name of Excel file with Appendices D, F, and M
    i) Pages 32, 34, 52
n) Updated the DRG Version from v39.1 to v41.1 consistent with the latest available
    i) Pages 16, 21, 38
o) Various page reference updates throughout the document and Appendix I
p) Updated Appendix F for the following:
    i) To include a footnote within each section to address the inclusion of Reasonable and Customary Cutback Amounts for clarity on sources of difference between billed and allowed even though it is no longer in the detailed layout.
    ii) Revised the Appendix I – Data Supplement Reconciliation section to be more straightforward and intuitive
q) Updated Appendix I Supplement for the following:

   i) Removing columns referencing Reasonable and Customary Cutback Amounts (previously columns N and O for "R&C (Applies to Non-Contracted)" and "Change in R&C" respectively)
   ii) Added text boxes showing instructions as well as the definition of "Adjusted" data pulled from the specifications
r) Revised language at end of Appendix I
   i) Page 49 – Changed "…procedures outlined by in this…" to "…procedures outlined in this.."