FEHB Program Carrier Letter
All Community-Rated Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter Number 2021-17

Date: November 22, 2021

Fee-for-service [n/a] Experience-rated HMO [n/a] Community-rated HMO [15]

Subject: Claims Data Requirements for All Community-Rated HMOs - except Traditional Community-Rated HMOs

2020 Medical Loss Ratio (MLR) Claims Data Requirement

This letter provides detailed instructions regarding claims data submissions to the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), and applies to any carrier of a community-rated plan that is required to prepare and submit an MLR form to OPM (that is, carriers that are not mandated by their state to use traditional community rating (TCR)).

Carriers of community-rated plans required to prepare and submit an MLR form must submit to the OIG detailed Federal Employees Health Benefits (FEHB) Program claims data used in their 2020 MLR calculation. The data should include FEHB claims incurred during calendar year 2020 and paid through June 30, 2021. **No other claims will be considered, and completion factors should not be applied to this data.** Only FEHB claims associated with benefits covered may be included in the MLR claims. Please read the attached specifications and provide the supporting documentation by **November 30, 2021**. The information may be used for audit and investigative purposes only.

2022 Rate Development Claims Data Requirement

In addition, carriers using an Adjusted Community Rating (ACR) methodology are required to submit the rate development claims data to the OIG. Carriers should use the data layout and specifications included in this letter to meet this requirement. The claims data for the FEHB Program should be downloaded from a central database at the time the rates are developed. The information may be used for audit and investigative purposes only.

Carriers that use an ACR methodology and base their FEHB Program rates on group-specific claims or utilization data are required to submit this data as follows:

- Carriers that submit rates as large carriers and use an ACR methodology to develop the FEHB Program rates for 2022 must submit this data to the OIG by November 30, 2021. Carriers with more than 1,500 FEHB contracts at the time of the rate proposal (by rating area) must file as large carriers.
- Carriers of plans with less than 1,500 FEHB contracts that do not submit rates as large plans are not required to submit this data for those plans. However, while carriers of small plans are not required to submit the data, they are encouraged to do so.

We remind carriers to retain and/or submit their data to avoid the potential for future audit findings.

Questions regarding audit objectives or data requests should be directed to Matthew Knupp, Chief, Community-Rated Audits Group on (724) 741-0739 or at Matthew.Knupp@opm.gov, or to Nekitra Tuell at OIGCRAGCLAIM@opm.gov. Data or file formatting questions should be directed to the Data Management Team at OIGOM-DMG@opm.gov.

Sincerely,

Laurie E. Bodenheimer
Associate Director
Healthcare and Insurance

Attachments

United States Office of Personnel Management

Office of the Inspector General (OIG)

Office of Audits

Community-Rated Audits Group

Claims Data Requirements for All Community-Rated HMOs – Except Traditional Community-Rated HMOs

ACR Claims Data Due Date: November 30, 2021

MLR Claims Data Due Date: November 30, 2021

Instructions for Formatting and Submitting Claims

OIG has a mandatory claims data layout that **must** be used when creating your medical and pharmacy data files. The same layout is used for both the ACR and MLR claims submissions. A copy of this data layout, in Excel, will be provided to all carriers required to comply with this data submission request. Please keep in mind that the data files should include FEHB claims incurred during calendar year 2020, and paid through June 30, 2021, for the MLR submission and the claims data used in the development of the 2022 FEHB Program premium rates for the ACR submission.

New Claims Data File Formatting Changes

- All claim file submissions produced must have a header record added.
- A header record by default is a single record and is the first record before all claims record on the file.
- Specifications of the header record is provided within the Excel document 'Mandatory Claims Layout'. Follow the sample template provided ***exactly*** how the header must appear.
- All elements within the header ***must*** occupy at their specific position(s) on the record.
- When reporting the 'FILE_RECORD_COUNT' be sure that the count represents the claims records only and excludes the header.
- The 'FILE_CONTROL_SUM' and 'FILE_CONTROL_FIELD' work together. Indicate which amount field used to create the summing.
- Two new fields have been added to the end of the Medical and Rx submissions. 'Submission Year' and 'Submission Type' will be used to delineate the claims for the MLR and ACR submission.

Formatting Requirements:

- All Files must be in ASCII format with records of fixed length.
- Amount fields: Must always contain numbers (no special characters like decimal points, slashes, or commas are allowed); must be right-justified with leading zeros, except for the 1st position, which is reserved for the sign.

- Date fields: Must always contain numbers (no special characters like decimal points, dollar signs, slashes, or commas are allowed); and must always contain values in this format: yyyymmdd. The acceptable date paid window (range) is claims incurred during the calendar year, and paid through six months of the following year (June 30), with the exception of 'encounters', please do not split the encounters across years.

Note: All fields listed on the Excel spreadsheet are required. All fields must be populated. If data for any field is unavailable, please include the field, but populate the field as follows:

- If the field is non-monetary or non-numeric, fill the field with spaces
- If the field is monetary or numeric, fill the field with zeros
- If the field is a date field, fill with zeros

If certain mandatory fields are not captured or are unavailable, please contact Nekitra Tuell at OIGCRAGCLAIM@opm.gov prior to the submission. If any required fields are missing and the OIG has not been contacted, your claims submission will be considered incomplete.

Please return Attachment 1 with each data submission. Normally, the data submission files should contain a separate record for ***each line/charge*** that is contained in each claim. For carriers that use a method other than actual, adjudicated claims (e.g., encounters, utilization, etc.), please include the **detailed** experience data you used to determine the contract year 2022 FEHB rates and the 2020 FEHB MLR numerator.

Required Documentation

Claims Data Submission – Claims data is to be provided in an OIG-approved file format as follows:

- Fixed Width Flat File (Text) – All data must be sent as .txt files that is non delimited. No other format/method will be accepted.

Note: The OIG should receive a separate file for medical and pharmaceutical claims.

- All transmitted files have required naming conventions. We will not be able to accept any data files unless the appropriate naming conventions are applied. (See OIG SFTP Transfer Step #7 for further explanation.)
- The file name should not exceed 31 characters.

Attachment 1 – Complete the Media Specification Form (Attachment 1) for each MLR and ACR claims data file submitted.

Data Dictionary – Submit a data dictionary that includes definitions and any applicable code sets for all fields included in your data file. This dictionary should include, but not be limited to the following fields:

- Field # 12 - Patient Relationship Code (Medical File)
- Field # 31 - Place of Service Code (Medical File)
- Field # 33 - Type of Service Code (Medical File)
- Field(s) # 35, 37, 39, 41 - Diagnosis Code - Please provide a list of any non- ICD codes used for these fields (Medical File)
- Field # 57 - Performing Provider Specialty Code (Medical File)
- Field # 59 – Patient Relationship Code (Pharmacy File)

Claims Data Submission Requirements

All Community-Rated carriers that submit FEHB claims data to OPM's OIG must do so using a Secure File Transfer Protocol (SFTP) account. ***Submitting claims data using any other method (i.e., DVD, flash drive, secure mail, FTP), is no longer permitted.***

The OPM/OIG SFTP transfer consists of several steps involving, but not limited to, OPM firewall access, OIG server user ID and password generation, and data compression and encryption. To acquire a SFTP account through OPM/OIG, please follow the steps outlined below.

SFTP File Submission Requirements

- All files should now be transferred to the following directory: /CRAG
- All files transmitted via SFTP are required to be encrypted.
- SFTP server passwords are set to expire after 60 days. Please contact the OIG Helpdesk (OIG-HELPDESK@opm.gov) to reset or create new passwords.
- Please ensure that all files maintain their extensions during PGP encryptions (see Step 7).
- WinZip/csv data files are no longer accepted.
- PKZIP Encryption is no longer accepted.

OIG SFTP Technical Questions:

All SFTP technical questions or issues should be directed to the following individuals:

OIG SFTP Administrators

- Rohit Kapoor, Chief, OPM OIG Information Systems Technology Group, 202-606-1280 or at Rohit.Kapoor@opm.gov
- Jason Cooper, IT Specialist, OPM OIG Information Systems Technology Group, 202-606-9505 or at Jason.Cooper@opm.gov
- OIG Helpdesk at OIG-HELPDESK@opm.gov

OIG SFTP Transfer Steps:

1. **Public IP Address of Internal Server** – To gain access through the OPM Firewall, the carrier must provide the public IP address of the server(s) sending the file to OPM. Once this information is obtained and ready to be given to OPM/OIG, proceed to Step 2.
2. **Initiate Account Set-up** – To request a SFTP account or update an existing FTP account, contact the OIG SFTP Administrators via phone or email (listed above). Provide them with the public IP address of the server(s) sending the file to OPM. This information will be entered into the OPM firewall for access.
3. **Obtain Username and Password** - Once firewall access has been obtained, the OIG SFTP Administrators will work with the carrier's

point of contact to provide a username and password to the SFTP server. SFTP server passwords are set to expire after 60 days. Please contact the OIG Helpdesk (OIG-HELPDESK@opm.gov) to reset or create new passwords.

4. **File Specifications** – ***All transmitted files must be in Binary format based on the agreed-upon fixed length format.***

5. **Select Encryption Software** - The OIG SFTP process requires that all transmitted data be compressed and encrypted. The carrier must use the same software as the OIG. File encryption software performs data compression and data encryption. Coordinate with the OIG SFTP Administrator to determine which software will be used. The OIG SFTP server can accept:
   - PGP (or GPG) Encryption (preferred method), OIG PGP public key will be provided.
   - Please ensure that all files maintain their extensions during PGP encryptions (see Step 7).
6. **File Testing** - Coordinate with the OIG SFTP Administrators to transmit test files. Once testing has been completed, the carrier will be assigned a date and time for the initial data transfer and recurring transmissions. The OIG prefers that the carrier send an email to OIG-HELPDESK@opm.gov and Jason.Cooper@opm.gov each time a test file has been transmitted.
7. **File Naming Conventions** – We request the following naming conventions be placed on the transmitted files:

   Medical Claims
   - CRAG_Medical_MLRCLMS_PlanCode_Y2020.txt.pgp
   - CRAG_Medical_ACRCLMS_PlanCode_Y2022.txt.pgp

   Pharmacy Claims
   - CRAG_Pharmacy_MLRCLMS_PlanCode_Y2020.txt.pgp
   - CRAG_Pharmacy_ACRCLMS_PlanCode_Y2022.txt.pgp

Attachment 1 (separate one for each data file – see below examples)

- CRAG_Attachment 1_MLRMedical_PlanCode_Y2020.pdf.pgp
- CRAG_Attachment 1_ACRMedical_PlanCode_Y2022.pdf.pgp
  (Attachment 1's can also be in a .txt, .xlsx or a .docx format)

Example: CRAG_Attachment 1_MLRMedical_AZ_Y2020.docx.pgp
Example: CRAG_Attachment 1_MLRPharmacy_AZ_Y2020.docx.pgp
Example: CRAG_Attachment 1_ACRMedical_AZ_Y2022.docx.pgp
Example: CRAG_Attachment 1_ACRPharmacy_AZ_Y2022.docx.pgp

Data Dictionary

- CRAG_DataDictionary_PlanCode_Y2020.docx.pgp
  (Data Dictionaries can also be in a .txt, .xlsx or a .pdf format)

For all above naming conventions, PlanCode, 2020, and 2022 mean the following:

a) 2020 & 2022 = the time frame the file covers, ***not*** when it was transmitted; and
b) Plan Code = the two digit alphanumeric code assigned by the FEHB Program. (Example: CRAG_Medical_MLRCLMS_AZ_Y2020)

We will not be able to accept any files unless the appropriate naming convention is applied.

8. **Confirmation Email** – We request that an email be sent after each file/group of files has been transmitted. The purpose is to notify us that a specific file(s) has been transmitted and to provide us with the *file name, the number of records in the file, and the amount paid by the plan (Field name - Insurance Amount Paid) to confirm that the complete file(s)* was received. We request that the following OIG staff members be copied on each transmission email:
   - OIG-Helpdesk (OIG-HELPDESK@opm.gov)
   - Nekitra Tuell (OIGCRAGCLAIM@opm.gov)
   - OIG's Data Management Group (OIGOM-DMG@opm.gov)

Attachment 1
U.S. OPM, Office of the Inspector General, Office of Audits Media Specifications Form

Please Complete and Return for Each Plan Code

Insurance Company or Health Plan Name: _____

Plan Code(s): _____
(Maximum 31-character name)

Medical File Name: _____
(Maximum 31-character name)

Pharmacy File Name: _____
(Maximum 31-character name)

Submission Certification Check List:

Header record present with valid record counts and control amounts.

Valid claims records are ASCII formatted fixed length not delimited.

Providing only two forms of claims data ((1) medical and (1) pharmacy) file for each plan code (if applicable).

Ensure proper year used on file name.

Ensure file used proper naming convention.

Ensure data files are unzipped.

Media Type & Recording Format for both files:

SFTP (All Carriers)

Record Size: Record Count: Amount Control Total: $ (Medical)

Record Size: Record Count: Amount Control Total: $ (Pharmacy)

Signature: _____

Phone: _____

Date: _____

Print Name: _____

Attachment 2
U.S. OPM, Office of the Inspector General, Office of Audits Mandatory Medical & Pharmacy Claim Code Sets

Claim Disposition Status Code – (See Field # 25)

1 Original Claim

2 Adjustment of Original, Adjusted or Split Billed Claim

3 Reversal of Original, Adjusted or Split Billed Claim

4 Void of Original, Adjusted or Split Billed Claim

5 Final Claim All value equal to 5 = Final version of claim at the time of data extract

6 Extension to original facility claim (split bill)

9 Denied Claim

A Refund Request record

B Refund Received record

D Manual Adjustment of Original, Adjusted or Split Billed Claim

Service Unit Code (HIPAA codes) – (See Field # 29)

DA Days

DH Miles (Ambulance)

MA Modalities (Therapeutic Agents) MJ Minutes (Anesthesia, etc.)

MO Month (DME Certification Loop) UN Units (Default Value)

VS Visits

WK Week (DME Certification Loop) YR Year (DME Certification Loop)

blank Unknown – *(Do not add the actual word "blank". Please fill the fields with spaces.)*

Patient Discharge Status Code (UB-04 codes) – (See Field # 49)

00 Unknown or not applicable (not an inpatient facility claim)

01 Discharged/Transferred to Home or self-care (routine discharge)

02 Discharged/Transferred to another short term general hospital for inpatient care

03 Discharged/Transferred to SNF (Skilled Nursing Facility)

04 Discharged/Transferred to ICF (Intermediate Care Facility)

05 Discharged/Transferred to another type of facility (e.g. Cancer Hospital, Children's Hospital) or referred for outpatient services to another facility

06 Discharged/Transferred to Home under care of Home Health Service

07 Left against medical advice or discontinued care

08 Discharged/Transferred to Home under care of Home IV Service [deleted 10/1/2005]

09 Admitted as an inpatient to this hospital (more than 3 days after related outpatient services or admission is unrelated to outpatient services)

20 Died

21 Discharged/Transferred to Court/Law Enforcement [added 10/1/2009]

30 Still a patient or expected to return for Outpatient Services

40 Died at home (Hospice claims only)

41 Died in a medical facility (Hospice claims only)

42 Died at unknown location (Hospice claims only)

43 Discharged/Transferred to Federal Health Care Facility (e.g. DOD, VA) [added 10/1/2003]

50 Discharged/Transferred to Hospice care- Home

51 Discharged/Transferred to Hospice care - Medical Facility

61 Discharged/Transferred to Hospital-based Medicare approved Swing Bed [added 10/1/2001]

62 Discharged/Transferred to Inpatient Rehabilitation Facility or Hospital Rehabilitation Unit [added 10/1/2001]

63 Discharged/Transferred to LTC (Long Term Care) Hospital [added 10/1/2001]

64 Discharged/Transferred to Nursing Facility - Medicaid Certified [added 10/1/2002]

65 Discharged/Transferred to Psychiatric Hospital or Hospital Psychiatric Unit [added 10/1/2003]

66 Discharged/Transferred to CAH (Critical Access Hospital) [effective 1/1/2006]

70 Discharged/Transferred to another type of health care institution not defined elsewhere in the code list [effective 4/1/2008]

71 Discharged/Transferred for Outpatient Services - another Facility [10/1/2001 - 9/30/2003 only]

72 Discharged/Transferred for Outpatient Services - this Facility [10/1/2001 - 9/30/2003 only]

Debarred Provider - Payment Reason Code– (See Field # 60)

C OPM has approved payment. Member is receiving continuing care. D Denied [no payment, after 15 day grace period]

G Claim is within 15 day grace period.

M OPM has approved payment. Member resides in a Medically Underserved Area.

U Claim was paid, unknown reason.

X OPM has approved payment. Other/unspecified reason.

Blank not applicable - not a debarred provider *(Do not add the actual word "blank". Please fill the fields with spaces.)*

Medicare Payment Disposition Code – (See Field # 65)

A Medicare Part A or Medicare Prepaid/Advantage Plan payment

B Medicare Part B or Medicare Prepaid/Advantage Plan payment

C Medicare Part A and Part B payments [ended 12/31/2005]

C Medicare Part D Prescription Drug Coverage payment [effective 1/1/2006]

D all charges applied to Medicare Part B Deductible, no Medicare payment

E Medicare Part A Benefit Period is Exhausted, no Medicare payment

F Not a Medicare Part A or Part B or Medicare Prepaid/Advantage Plan Benefit, no Medicare payment

G all charges applied to Medicare Part A Deductible, no Medicare payment

H Provider is not covered by the Medicare Prepaid/Advantage Plan, no Medicare payment

J Medicare Part A or Part B multi-line pricing; Medicare payment is indicated on another charge line

K No Medicare Part A benefit available, Medicare Part B provided payment

N Not enrolled in the Part of Medicare that would cover this service, no Medicare payment

P Speculative Medicare

U Medicare Part A and/or Part B payment (Unable to distinguish)

X Medicare Part A and/or Part B priced the claim but the carrier is unable to determine why there was no Medicare payment.

blank not enrolled in Medicare *(Do not add the actual word "blank". Please fill the fields with spaces.)*

Carrier - Paid Indicator (HIPAA codes) – (See Fields #66, 68)

16 Medicare Fee-for-Service/Advantage Plan

BL Other BlueCross BlueShield

C1 Other Commercial Care

MA Traditional Medicare (Part A)

MB Traditional Medicare (Part B)

MU Traditional Medicare (Unable to determine whether Part A and/or Part B)

NF No Fault Insurance

SP Speculative

SU Subrogation

WC Workers Compensation

blank this carrier paid as primary *(Do not add the actual word "blank". Please fill the fields with spaces.)*

Pricing Method– (See Fields #71, 72)

4 Percentage of Technical Amount Paid - applied after appropriate savings have been deducted from the Total Covered Charges, but prior to the application of any deductible and/or coinsurance.

5 Dental Fee Schedule Allowance (Rate X the Number of Services)

6 Maximum Allowable Charge (MAC) - deductible and/or coinsurance applied to the MAC Amount.

B Percentage of FEP Allowable Charges - applied after appropriate savings have been deducted from the Total Covered Charges, but prior to the application of any deductible and/or coinsurance.

D Percentage of Total Covered Charges - applied directly to the Total Covered charges prior to the application of appropriate savings, deductible and/or coinsurance.

E Per Diem (Rate X the Number of Days) - deductible and/or coinsurance applied to the lesser of the Per Diem Amount or the Total Covered Charges. Applies only to inpatient claims.

F Medical Fee Schedule Allowance (Rate X the Number of Services)

G Diagnostic Related Group (DRG) Price Amount - deductible and/or coinsurance applied to the lesser of the DRG Amount or the Total Covered Charges. Applies only to inpatient claims.

I Encounter/Capitated Service - the service reported on this charge is considered encounter data as it is covered by a set fee paid to the provider regardless of whether or not services are rendered. No disbursement will occur as a result of this charge.

K Per Diem (Rate X the Number of Days) plus any deductible and/or coinsurance - Deductible and/or coinsurance is calculated on the Per Diem allowance to determine the amount the provider agreed to accept as payment in full. Applies only to inpatient claims.

L Percentage of Total Charges All Services - applied directly to the Total Charges All Services prior to the application of appropriate savings, deductible and/or coinsurance.

M Percentage of Negotiated Allowance - applied after the primary pricing method has been used to reduce the Total Covered Charges, but prior to the application of any other savings, deductible and/or coinsurance amounts.

N Percentage of Amount Paid Special Formula - the Pricing Percentage is applied after any non-covered amount, deductible and/or coinsurance has been deducted from the Billed Charges.

U Unspecified - the specific pricing method is not available.

V Priced by Vendor - such as PPO Provider Network, etc. This should be used if it was priced by a vendor and the carrier doesn’t know what method the vendor used.