CDM Registration – CT APCD

REGISTRATION FORM FOR THE CONNECTICUT ALL-PAYER CLAIMS DATABASE (CT APCD)

Welcome to the CT APCD Registration Form

Welcome to the downloadable version of the registration form for the Connecticut All-Payer Claims Database (CT APCD). Thank you in advance for taking the time to complete this form in its entirety. Please note that this form should be used only to help you collect the necessary information to complete the online version, which can be found at the following URL: https://ct-registration.onpointhealthdata.org/

About the Process

The rules and regulations governing the Connecticut All-Payer Claims Database (APCD) – Public Act 13-247, sections 138(a)(8) and (9) and section 144(b)(3)(A) – require each reporting entity (i.e., any insurer, third-party administrator (TPA), pharmacy benefits manager (PBM), or carve-out payer) to register annually with Onpoint Health Data, the state's contracted data integration and analytics vendor. Annual registration (and re-registration) is due by October 31.

As noted in the Connecticut APCD Policies & Procedures, data related to the following types of policies shall be excluded from the files submitted by reporting entities: hospital confinement indemnity coverage; disability income protection coverage; accident only coverage; long-term care coverage; specified accident coverage; Medicare supplement coverage; specified disease coverage; TRICARE Supplemental Coverage; travel health coverage; and single service ancillary coverage, with the exception of dental and prescription drug coverage.

Furthermore, reporting entities that have fewer than 3,000 members enrolled in plans not otherwise excluded from the files listed above are exempt from the data submission requirements set forth in the Connecticut APCD Policies & Procedures for the following calendar year. Nonetheless, Public Act 13-247 requires all reporting entities to comply with the requirement for annual registration regardless of whether they are required to submit data to the Connecticut APCD.

The following pages will guide you through the registration process conducted on behalf of AccessHealth Connecticut:

- Reporting organization and individual contact information for all collected file types
- Third-party administrator (TPA), pharmacy benefits manager (PBM), and mental health carve-out identification
- Covered lives, claims volume, and paid claims' value estimates

For more information, please reach out to us via telephone or email (207-623-2555 | ahct-support@onpointhealthdata.org). When ready, please complete your organization's registration form online.

Part I: Organization Information

Registrant *Please provide the following information regarding the person responsible for completing this form.*	
First Name*	
Last Name*	
Email*	
Phone*	
Extension	
Organization Name*	
Job Title	
Address Line 1*	
Address Line 2	
City*	
State/Province*	
Postal Code*	
Country*	

Organization Information *Please provide the following information regarding the type of organization that you represent.*	
Organization Name*	
Submitter Code	
Type of Insurer*	☐ Insurance Company ☐ Third-Party Administrator ☐ Pharmacy Benefits Manager ☐ Government Provider
NAIC Number(s)	
FEIN Number(s)*	
Address Line 1*	
Address Line 2	
City*	
State/Province*	
Postal Code*	
Country*	

Medical Coverage Estimates

For reporting relevant to this data collection initiative, please provide estimates for your organization's overall book of business and individual lines of business based on an average, single month.*

Note: Grand total values may not be the sum of the detailed categories, as the provided list of individual lines of business is not exclusive; if individual lines of business categories are not applicable, please enter a value of '0' (zero).

	Covered Lives	Claim Volume	Claim Value (USD)
Grand Total*			$
Small Employer Health Insurance Plans*			$
Exchange Plans*			$
Self-Insured ERISA Plans*			$
Self-Insured Non-ERISA Plans*			$
Medicare FFS*			$
Medicare Part C*			$
Medicare Supplemental*			$
Medicaid FFS*			$
Medicaid Managed Care*			$

Pharmacy Coverage Estimates

For reporting relevant to this data collection initiative, please provide estimates for your organization's overall book of business and individual lines of business based on an average, single month.*

Note: Grand total values may not be the sum of the detailed categories, as the provided list of individual lines of business is not exclusive; if individual lines of business categories are not applicable, please enter a value of '0' (zero).

	Covered Lives	Claim Volume	Claim Value (USD)
Grand Total*			$
Small Employer Health Insurance Plans*			$
Exchange Plans*			$
Self-Insured ERISA Plans*			$
Self-Insured Non-ERISA Plans*			$
Medicare FFS*			$
Medicare Part C*			$
Medicare Part D*			$
Medicare Supplemental*			$
Medicaid FFS*			$
Medicaid Managed Care*			$

Dental Coverage Estimates

For reporting relevant to this data collection initiative, please provide estimates for your organization's overall book of business and individual lines of business based on an average, single month.*

Note: Grand total values may not be the sum of the detailed categories, as the provided list of individual lines of business is not exclusive; if individual lines of business categories are not applicable, please enter a value of '0' (zero).

	Covered Lives	Claim Volume	Claim Value (USD)
Grand Total*			$
Small Employer Health Insurance Plans*			$
Exchange Plans*			$
Self-Insured ERISA Plans*			$
Self-Insured Non-ERISA Plans*			$
Medicare FFS*			$
Medicare Part C*			$
Medicare Supplemental*			$
Medicaid FFS*			$
Medicaid Managed Care*			$

Part II: Qualifier Question

Qualifier	
Please indicate whether the insurer you represent expects to provide coverage to 3,000 or more members as of November 1 of the current year. For purposes of the Connecticut APCD, members include:* • Connecticut residents • Students enrolled in a student plan at a Connecticut college or university • Individuals covered by a health plan issued in Connecticut in the individual or small-group market (except to the extent that such health plan is grandfathered from the risk-adjustment requirements of Section 1343 of the federal Patient Protection and Affordable Care Act) regardless of their state of residence	☐ Yes ☐ No

NO	Thank you for participating in the **Connecticut All-Payer Claims Database (APCD)** registration process. Your response to the registration qualifier indicates that you are not subject to the Connecticut APCD regulations requiring data submission. Connecticut APCD representatives will contact you directly in the case of a discrepancy or question regarding your registration status. In the meantime, if you have any questions about the Connecticut APCD's data collection initiative, please contact Onpoint Health Data via email or telephone (ahct-support@onpointhealthdata.org | 207-623-2555). **Action: Please do not complete the following sections of this form.**
YES	Thank you for participating in the registration process for the **Connecticut All-Payer Claims Database (APCD)**. Your response to the registration qualifier indicates that you are subject to the Connecticut APCD regulations requiring data submission. Please continue to the next section of this registration form when ready. **Action: Please complete the following sections of this form.**

Part III: Contacts Information

Program Compliance Lead *Please provide the following information regarding the person responsible for program compliance.*	
Select Contact*	☐ Registrant ☐ New Contact

If **NEW CONTACT**, please complete the following information for this contact:*	
First Name*	
Last Name*	
Email*	
Phone*	
Extension	
Organization Name*	
Job Title	
Address Line 1*	
Address Line 2	
City*	
State/Province*	
Postal Code*	
Country*	

SFTP Connectivity Lead *Please provide the following information regarding the person responsible for establishing connectivity with Onpoint's SFTP server.*	
Select Contact*	☐ Registrant ☐ Program Compliance Lead ☐ New Contact

If **NEW CONTACT**, please complete the following information for this contact:*	
First Name*	
Last Name*	
Email*	
Phone*	
Extension	
Organization Name*	
Job Title	
Address Line 1*	
Address Line 2	
City*	
State/Province*	
Postal Code*	
Country*	

Enrollment Submissions Lead *Please provide the following information regarding the person responsible for enrollment submissions.*	
Select Contact*	☐ Registrant ☐ Program Compliance Lead ☐ SFTP Connectivity Lead ☐ New Contact ☐ Not Applicable

If **NEW CONTACT**, please complete the following information for this contact:*	
First Name*	
Last Name*	
Email*	
Phone*	
Extension	
Organization Name*	
Job Title	
Address Line 1*	
Address Line 2	
City*	
State/Province*	
Postal Code*	
Country*	

Medical Claims Lead *Please provide the following information regarding the person responsible for medical claims submissions.*	
Select Contact*	☐ Registrant ☐ Program Compliance Lead ☐ SFTP Connectivity Lead ☐ Enrollment Submissions Lead ☐ New Contact ☐ Not Applicable

If **NEW CONTACT**, please complete the following information for this contact:*	
First Name*	
Last Name*	
Email*	
Phone*	
Extension	
Organization Name*	
Job Title	
Address Line 1*	
Address Line 2	
City*	
State/Province*	
Postal Code*	
Country*	

Pharmacy Claims Lead *Please provide the following information regarding the person responsible for pharmacy claims submissions.*	
Select Contact*	☐ Registrant ☐ Program Compliance Lead ☐ SFTP Connectivity Lead ☐ Enrollment Submissions Lead ☐ Medical Claims Lead ☐ New Contact ☐ Not Applicable

If **NEW CONTACT**, please complete the following information for this contact:*	
First Name*	
Last Name*	
Email*	
Phone*	
Extension	
Organization Name*	
Job Title	
Address Line 1*	
Address Line 2	
City*	
State/Province*	
Postal Code*	
Country*	

Dental Claims Lead *Please provide the following information regarding the person responsible for dental claims submissions.*	
Select Contact*	☐ Registrant ☐ Program Compliance Lead ☐ SFTP Connectivity Lead ☐ Enrollment Submissions Lead ☐ Medical Claims Lead ☐ Pharmacy Claims Lead ☐ New Contact ☐ Not Applicable

If **NEW CONTACT**, please complete the following information for this contact:*	
First Name*	
Last Name*	
Email*	
Phone*	
Extension	
Organization Name*	
Job Title	
Address Line 1*	
Address Line 2	
City*	
State/Province*	
Postal Code*	
Country*	

Part IV: Claims Information

Use of a TPA *Note: Please only answer the following questions if you indicated that your organization will be submitting **MEDICAL CLAIMS**.** *	
Does your organization plan to work with a third-party administrator to administer medical benefits?	☐ Yes ☐ No

If **YES**, please answer the following questions:	
TPA Organization Name*	
Which organization will be submitting data to Onpoint? *	☐ The TPA ☐ The Insurer

Use of a PBM *Note: Please only answer the following questions if you indicated that your organization will be submitting **PHARMACY CLAIMS**.** *	
Does your organization plan to work with a pharmacy benefits manager to administer pharmacy benefits?	☐ Yes ☐ No

If **YES**, please answer the following questions:	
PBM Organization Name*	
Which organization will be submitting data to Onpoint? *	☐ The PBM ☐ The Insurer

Use of a Mental Health Carve-Out Payer	
Does your organization plan to work with a mental health carve-out payer to administer mental health benefits?*	☐ Yes ☐ No

If **YES**, please answer the following questions:	
Mental Health Carve-Out Payer Organization Name*	
Which organization will be submitting data to Onpoint? *	☐ The Mental Health Carve-Out Payer ☐ The Insurer

Submission Schedule *Please indicate your planned schedule for regular submissions:*	
Select Submission Frequency	☐ Monthly

Comments *Please provide any comments that would be helpful for Onpoint's Data Operations team as they process your information and data submissions.*

Thank You!

Thank you for completing the downloadable version of the **Connecticut All-Payer Claims Database** registration form.

Your next step? Visit the online version of the CT APCD registration form at the following URL: https://ct-registration.onpointhealthdata.org/

Now that you've pre-gathered all of your organization's information, the online version should take you no more than 10 minutes to complete. As always, please let us know if you have any questions along the way via telephone or email (207-623-2555 | ahct-support@onpointhealthdata.org).

We look forward to working with you!