Alternative Payment Model Data Submission Manual

10 CCR 2505-5

April 15, 2019

CIVHC

CENTER FOR IMPROVING
VALUE IN HEALTH CARE

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Note: The Center for Improving Value in Health Care (CIVHC) is basing its approach to collecting information about Alternative Payment Models (APM) on a program established by the Oregon Health Authority (OHA). The instructions in this document include language from a 2018 memorandum from the OHA to payers about requirements for submitting data on APMs. We wish to express our thanks to OHA for their generous assistance in the creation of this document.

1. Introduction

In October 2018 and in accordance with Code of Colorado Regulation 10 CCR 2505-5, the Department of Health Care Policy and Financing (HCPF) changed the rules governing the All Payer Claims Database (APCD) Data Submission Guide (DSG) to require the Center for Improving Value in Health Care (CIVHC) to collect data on alternative payment models and prescription drug rebate information from public and private payers.

Alternative payment models (APM) are defined as payments made to providers outside traditional fee-for-service model. This includes: Pay for Performance Payment/Penalty, Shared Savings/Risk, Global Budget, Limited Budget, Capitation, Bundled/Episode-Based, Integrated Delivery System, Patient-Centered Primary Care/Medical Home, Other non-fee-for-service and Total fee-for-service.

The first submission, which is a test file of APM data for 2016, is due from payers in July 2019. Final files for each of three calendar years from 2016-2018 are due by September 30, 2019.

This Data Submission Manual provide instructions to assist payers in reporting APM data.

2. Why Collect APM Data?

The goal for collecting APM data is to track progress in the transition from fee-for-service to value-based reimbursement and, ultimately, to evaluate the impact of APMs on quality and cost of care.

There are a growing number and variety of APMs and we currently lack the ability to track spending and the number of patients receiving care under these models. Collecting data on APMs will enable researchers, policy makers, health plans, providers and other stakeholders to establish baseline information regarding current spending levels and the number of patients receiving health care under APMs (vs. traditional fee-for-service) and track changes over time.

Information on APMs also help to identify the types of APMs that are most effective in reducing costs and improving quality, informing the development of policy solutions to improve the value of health care.

3. File Submission Instructions and Schedule

Payers can access CIVHC's APM data submission Excel file from the CIVHC website here and should submit APM information according to the following schedule:

Alternative Payment Model and Drug Rebate Data Submission Schedule	
Date	**Files Due**
July 1, 2019	• Test files of data for 2016
September 1, 2019	• Waiver request due (if applicable)
September 30, 2019	• Final files for each of three calendar years: 2016, 2017 and 2018.

Files should be submitted in Excel format (.xlsx, .xls, or .csv) through the SFTP server.

Naming conventions should follow the template:

TESTorPROD_PayerID_SubmissionYearDueFileTypeVersionNumber.xlsx

For example, the following naming conventions will be used for testing and production in 2019:

TEST_0000_2019AMv01. xlsx

PROD_0000_2019CTv02. xlsx

4. Waivers

CIVHC will work collaboratively with payers to ensure that required APM data submissions achieve the intent of the rules. These rules have been put in place to deliver a high quality, reliable source of data for Colorado.

CIVHC will consider requests from data submitters to provide summarized data or file exemptions for their APM files. The purpose of permitting submission of summarized data is to enable a payer to materially comply with the data submission guide requirements while gaining time to develop the capability to overcome their limitations in providing required detailed data. This policy is intended to recognize the limitations of some payers and also maintain the utility of the overall APM data set.

Please see Appendix A for instructions for filing a waiver and waiver form.

5. Data Submission of APM Details – General Rules

The submission of APM data involves the completion of two files. The first captures details of each APM and the second provides a control total or summary of APM details.

The following are general rules for completing the first file. The content of the APM data submission files are displayed in pages 10-12. A sample of a completed file is included in Appendix B. Rules for completing the control total file can be found in section 6.

Level of Reporting APM Information

In accordance with Code of Colorado Regulation 10 CCR 2505-5, payers must report APM information at the billing provider level. Payers should only include information for members for which they are the primary payer, and exclude any paid claims for which it was the secondary or tertiary payer.

Payers should include only information pertaining to policies sold in the state of Colorado. For example, if an individual lives in Wyoming but has commercial coverage through their employer based in Colorado, information for this individual would be included. Conversely, if a Colorado resident works in Wyoming and has commercial coverage through their employer, their data would not be included.

All claims and non-claims payments shall be reported for each billing provider or organization and payment arrangement type. Reported payment should be based on allowed amounts, i.e. provider payment and any patient cost sharing amounts.

If a large APM-related payment is sent to the financial parent of a health system (e.g., Independent Practice Association), the payer should attempt to report the portion of payments that were distributed to its billing providers. If a payer is unable to report at this level of granularity, then please contact CIVHC.

If, in addition to the large APM-related payment to the financial parent, additional payments were made to the individual providers, then those additional provider payments should be reported as well. In this way, CIVHC will be able to sum all of the payments to calculate the total dollars paid by each payer.

Types of Payments

Reported payments for medical care or contracts should include:

- Payments made on a fee-for-service basis for medical services performed during the APM Submission Performance Period;

- Global and capitation type payments for contracts that fully or partially span the APM Submission Performance Period;
- Salary expenditures for Integrated Delivery Systems (IDS) which correspond to the provision of care during the APM Submission Performance Period;
- Payments related to performance incentives or penalties for contracts that fully or partially span the APM Submission Performance Period;
- Shared savings and risk for contracts that fully or partially span the APM Submission Performance Period;
- Infrastructure payments; and
- Patient-Centered Primary Care Home (PCPCH) or other type of patient-centered medical home (PCMH) recognition for the APM Submission Performance Period.

Lines of Business Included

Payers should submit APM data for commercial, Medicaid, Medicare Advantage and self-insured plans not subject to ERISA lines of business. Payers can voluntarily submit APM data for ERISA self-insured plans.

If the payer is providing information for self-insured plans, CIVHC requests that the payer report this information using a separate tab labeled "[Payer Code]_SF" in the submitted Excel file. Please direct any questions to CIVHC.

Payers are not required to submit APM data for these lines of business: prescription drugs only, dental benefits only.

Performance Period

The performance period for the APM submission calendar year should include payments for the entire calendar year. For an APM submission for 2016, for example, payments for the period January 1 – December 31, 2016 would be included. This performance period would be documented as AM007 (Performance Period Start Date) = 20160101 and AM008 (Performance Period End Date) = 20161231.

When payments occur during contract periods that fall partly outside of the APM submission calendar year, report the payments in full for the actual contract start and end dates and record the actual contract start and end dates in AM007 and AM008, respectively. CIVHC will prorate the payments (and associated member months, when applicable) for the time within the APM submission calendar year.

Reporting Payments

The APM data files are meant to capture all payments, not just alternative payments. For example, both fee-for-service and "other" are included as required payment arrangement categories for reporting. Therefore, if the only payment made to a billing provider was under a FFS arrangement, then AM010 and AM012 (claims payments) should be populated with the payment amounts and AM011 and AM013 (non-claims payments) should both reflect $0. Only in instances where there is no payment at all made to a particular billing provider or organization for contracts during the reporting period, should they be omitted from the file.

The data collection files include four payment categories; two that pertain to primary care payments and two that pertain to total payments. The two primary care payment categories are subsets of the total payment categories. Total Primary Care Claims Payments (AM010) is a subset of the value input for Total Claims Payments (AM012) and Total Primary Care Non-Claims Payments (AM011) is a subset of the value input for Total Non-Claims Payments (AM013).

In cases where payments include primary care and non-primary care, payments should be apportioned to the primary care payment categories (AM010 and AM011) to reflect the amounts attributable to primary care only.

CIVHC will add the values in AM010 and AM011 to arrive at the total dollars paid for primary care services/contracts during the APM performance period. Similarly, CIVHC will add the values in AM012 and AM013 to arrive at the total dollars paid for healthcare services/contracts during the APM performance period.

Defining Primary Care

Primary care payments are defined as payments made to a primary care provider for a primary care service, according to these definitions:

1. **Primary Care Provider**: Any providers that practice within one of the state's designated Patient Centered Primary Care Home (PCPCH) practices or any providers that have one of the taxonomy codes below, and
2. **Primary Care Service:** Services listed in the table of procedure codes shown below.

Primary Care Provider Taxonomy

Taxonomy code	Description
261QF0400X	Federally Qualified Health Center
261QP2300X	Primary care clinic
261QR1300X	Rural Health Center
207Q00000X	Physician, family medicine
207R00000X	Physician, general internal medicine
175F00000X	Naturopathic medicine
208000000X	Physician, pediatrics
2084P0800X	Physician, general psychiatry
2084P0804X	Physician, child and adolescent psychiatry
207V00000X	Physician, obstetrics and gynecology
207VG0400X	Physician, gynecology
208D00000X	Physician, general practice
363L00000X	Nurse practitioner
363LA2200X	Nurse practitioner, adult health
363LF0000X	Nurse practitioner, family
363LP0200X	Nurse practitioner, pediatrics
363LP0808X	Nurse practitioner, psychiatric
363LP2300X	Nurse practitioner, primary care
363LW0102X	Nurse practitioner, women's health
363LX0001X	Nurse practitioner, obstetrics and gynecology
363A00000X	Physician's assistant
363AM0700X	Physician's assistant, medical
207RG0300X	Physician, geriatric medicine

Taxonomy code	Description
175L00000X	Homeopathic medicine
2083P0500X	Physician, preventive medicine
364S00000X	Certified clinical nurse specialist
163W00000X	Nurse, non-practitioner

Primary Care Services

CPT Codes	Description
99201-99205	Office or outpatient visit for a new patient
99211-99215	Office or outpatient visit for an established patient
99241-99245	Office or other outpatient consultations
99341-99345	Home visit for a new patient
99347-99350	Home visit for an established patient
99381-99385	Preventive medicine initial evaluation
99391-99395	Preventive medicine periodic reevaluation
99401-99404	Preventive medicine counsel and/or risk reduction intervention
99411-99412	Group prev. medicine counsel and/or risk reduction intervention
99420	Administration and interpretation of health risk assessments
99429	Unlisted preventive medicine service
59400	Routine obstetric care incl. vaginal delivery
59510	Routine obstetric care incl. cesarean delivery
59610	Routine obstetric care incl. VBAC delivery
59618	Routine obs. care incl. attempted VBAC
90460-90461	Immunization through age 18, including provider consult
90471-90472	Immunization by injection
90473-90474	Immunization by oral or intranasal route
99386-99387	Initial preventive medicine evaluation
99396-99397	Periodic preventive medicine reevaluation
G0402	Welcome to Medicare visit
G0438-G4039	Annual wellness visit

T1015	Clinic visit, all-inclusive
Primary ICD-10 Code	**Description**
Z00	Encounter for general exam without complaint
Z000	Encounter for general adult medical examination
Z0000	Encounter for general adult medical exam without abnormal findings
Z0001	Encounter for general adult exam with abnormal findings
Z001	Encounter for newborn, infant and child health examinations
Z0011	Newborn health examination
Z00110	Health examination for newborn under 8 days old
Z00111	Health examination for newborn 8 to 28 days old
Z0012	Encounter for routine child health examination
Z00121	Encounter for routine child health exam with abnormal findings
Z00129	Encounter for routing child health exam without abnormal findings
Z008	Encounter for other general examination
Z014	Encounter for gynecological examination
Z0141	Encounter for routing gynecological examination
Z01411	Encounter for gynecological exam, general, routing with abnormal findings
Z01419	Encounter for gynecologic exam, general, routing without abnormal findings

Calculating Member Months

Reporting member months is required for certain types of payment arrangements (e.g. global budget, limited budget, and capitated payments). When required, payers should include the total number of members (represented in member months) that participated in the reported APM.

Note that a given member could receive services from multiple providers in the same reporting period, all of whom received payments under a global budget, limited budget or capitated payment. When this occurs, the sum of all member months associated with alternative payment arrangements will exceed the actual total of unique member months. The control total file is intended eliminate the duplication of member months (see section 6).

APM Categories

For payment model assignment, payers will classify payment models for physician groups and members based on the mutually exclusive payment method allocation hierarchy:

Code	Value	Definition/Example
PP	Pay for Performance /Payment Penalty	Annual payments or penalties made to a billing provider for performance against non-financial goals (quality and utilization metrics) during reporting year.
SH	Shared Savings /Shared Risk	Annual payments or penalties made to the billing provider for performance against spending targets during reporting year.
GB	Global Budget	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for either a: • Comprehensive set of services for a broadly defined population • Defined set of services, where certain benefits such as BH or Rx are carved out and not part of the budget Must, at a minimum, include physician services and IP/OP hospital services.
LB	Limited Budget	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for a non-comprehensive set of services to be delivered by a single provider organization (e.g. capitated primary care or oncology services)
CU	Capitation – Unspecified	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for a set of services for a defined population, for which it cannot be determined if the arrangement is a global budget or limited budget arrangement.
BU	Bundled/Episode-Based	Payments made to a billing provider where a set budget was set for a defined episode of care for a specific condition (e.g. knee replacement) delivered by providers across multiple provider types
ID	Integrated Delivery System	One or more legal entities encompassing financing and delivery of a full-spectrum of healthcare services under a mutually exclusive contract agreement. Resources and decision-making rights are shared across entities, and reimbursement is not dependent on services provided.
PC	Patient-Centered Primary Care Home / Patient-Centered Medical Home	Payment for recognition as a Patient-Centered Primary Care Home (PCPCH) or other type of Patient-Centered Medical Home (PCMH), including recognition under a proprietary PCMH initiative. Only reported for payments exclusively for PCPCH or other PCMH recognition. FFS, pay-for-performance, shared savings, and capitation payments made for members in a PCPCH or other PCMH should be reported under those payment arrangement categories.
OT	Other, Non-FFS	All other payments made to a billing provider which are not based on a FFS model, including payments for health information technology structural changes; payments or expenses for supplemental staff or supplemental activities integrated into the practice, such as practice coaches, patient educators, or patient navigators; and other infrastructure payments.
FS	FFS	Payments made to a billing provider under a traditional fee-for-service model, where each service rendered to a patient is separately reimbursed. FFS includes: Diagnosis Related Groups (DRGs), per-

Code	Value	Definition/Example
		diem payments, fixed procedure code-based fee schedule (e.g. Medicare's Ambulatory Payment Classifications (APCs), claims-based payments adjusted by performance measures, and discounted charges-based payments.

The type of APM to which a provider organization and a member should be attributed is determined by the contractual arrangement between the payer and the provider organization. For example, for a member whose managing physician group is under a global payment contract, the dollar amount associated with this member should be classified as global payments (GB) in the payment arrangement category column (AM006) even though the payer utilizes a FFS payment mechanism to reimburse providers at the transactional level and then conducts a financial settlement against the spending target at the end of the year. The payment amount associated with the FFS payment mechanism should be recorded under the total claims payments fields and the financial settlement against the spending target should be recorded under the total non-claims payments fields. The same logic applies to limited budget or bundled payment arrangements.

6. Data Submission of APM Control Totals – General Rules

The submission of APM data involves the completion of two files. The first captures details of each APM and the second provides a control total or summary of APM details.

The following are general rules for completing the second, control total file. The content of the APM data submission files are displayed in page 13. A sample of a completed file is included in Appendix C.

The control total file captures information summarizing the payer's detailed APM data in the first file. The control total file requires payers to report the sum of non-duplicated member months overall and for APMs and the sum of non-duplicated payments for the four categories of payments: primary care claims, primary care non-claims, total claims and total non-claims.

7a. APM Data Submission File Content and Dictionary

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM001	Billing Provider Number	Varchar	N/A – Excel file	Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. This number should align with billing provider numbers in the MC file.	R
AM002	National Billing Provider ID	Varchar	N/A – Excel file	National Provider ID	R
AM003	Billing Provider Tax ID	Varchar	N/A – Excel file	Tax ID of billing provider. Do not code punctuation.	R
AM004	Billing Provider Last Name or Organization Name	Varchar	N/A – Excel file	Full name of provider billing organization or last name of individual billing provider.	R
AM005	Billing Provider Entity	Char	N/A – Excel file	F = Facility G = Provider group I = IPA P = Practitioner	R
AM006	Payment Arrangement Category	Text	N/A – Excel file	See look up table, above. Payment arrangement type reported. If there is more than one payment arrangement type with a billing provider/organization, then separately report each payment arrangement type.	R
AM007	Performance Period Start Date	Date	N/A – Excel file	Effective date of performance period for reported Insurance Line of Business and Payment Arrangement Type. CCYYMMDD If varying performance periods apply to a billing provider or organization (for a particular line of business and payment arrangement type), report results on separate lines.	R
AM008	Performance Period End Date	Date	N/A – Excel file	End date of performance period for reported Insurance Line of Business and Payment. Arrangement Type. CCYYMMDD. If varying performance periods apply to a billing provider or organization (for a particular line of business and payment arrangement type), report results on separate lines.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM009	Member Months	INT	N/A – Excel file	Total number of members in reported stratification that participate in the reported payment arrangement, expressed in months of membership No decimal places; round to nearest integer. Example: 12345	R
AM010	Total Primary Care Claims Payments	Numeric	N/A – Excel file	Sum of all associated claims payments, including patient cost-sharing amounts that pertain to primary care. Primary Care Services are to be identified based on Provider Taxonomy Codes listed in Lookup Table B.1.K and Procedure and Diagnosis Codes listed in Lookup Table B.1.L. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter O if no primary care claims payments made. This value should never exceed the amount of Total Claims Payments (AM010).	R
AM011	Total Primary Care Non-Claims Payments	Numeric	N/A – Excel file	Sum of all associated non-claims payments that pertain to primary care. Primary Care Services are to be identified based on Provider Taxonomy Codes listed in Lookup Table B.1.K and Procedure and Diagnosis Codes listed in Lookup Table B.1.L. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter O if no primary care non-claims payments made. This value should never exceed the amount of Total Non-Claims Payments (AM011).	R
AM012	Total Claims Payments	Numeric	N/A – Excel file	Sum of all associated claims payments, including patient cost-sharing amounts Two explicit decimal places (e.g., 200.00). Enter negative	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				number if the billing provider or organization has to pay the mandatory reporter. Enter O if no claims payments made	
AM013	Total Non-Claims Payments	Numeric	N/A – Excel file	Sum of all associated non-claims payments Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter O if no non- claims payments made	R
AM014	Billing Provider Office Street Address	Varchar	N/A – Excel file	Physical address	R
AM015	Billing Provider Office City	Varchar	N/A – Excel file	Physical address	R
AM016	Billing Provider Office State	Char	N/A – Excel file	Physical address - Use postal service standard 2 letter abbreviations.	R
AM017	Billing Provider Office Zip	Varchar	N/A – Excel file	Physical address - Minimum 5-digit code.	R
AM018	Billing Provider DEA Number	Varchar	N/A – Excel file		TH
AM019	Billing Provider NPI	Varchar	N/A – Excel file		TH
AM020	Billing Provider State License Number	Varchar	N/A – Excel file	Prefix with two-character state of licensure with no punctuation. Example COLL12345	TH
AM021	Billing Provider office Address	Varchar	N/A – Excel file	Physical address - Suite number, floor number, Unit number, etc.	O
AM022	Billing Provider Office phone number	Varchar	N/A – Excel file	Provider Office number: Telephone number where provider delivers health care services.	O
AM023	Record Type	Char	N/A – Excel file	AM	R

7b. APM Data Submission Control Total File and Dictionary

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
CT001	Payer Code	Varchar	N/A – Excel file	The CIVHC-assigned organization ID for the payer or carrier submitting the file	R
CT002	Payer Name	Varchar	N/A – Excel file	The CIVHC-assigned name of the payer or carrier submitting the file.	R
CT003	Submitted File	Text	N/A – Excel file	File name of the APM file	R
CT004	Data Rows	Numeric	N/A – Excel file	Number of rows in the submitted file	R
CT005	All Member Months	Numeric	N/A – Excel file	Total enrollment, summed from the APM data submission file	R
CT006	Alternative Arrangement Months	Numeric	N/A – Excel file	Total enrollment in alternative payment models, summed from the APM data submission file	R
CT007	Total Primary Care Claims Payments	Numeric	N/A – Excel file	Sum of total primary care claims payments from the APM data submission file	R
CT008	Total Primary Care Non-Claims Payments	Numeric	N/A – Excel file	Sum of total primary care non-claims payments from the APM data submission file	R
CT009	Total Claims Payments	Numeric	N/A – Excel file	Sum of total claims payments from the APM data submission file	R
CT010	Total Non-Claims Payments	Numeric	N/A – Excel file	Sum of total non-claims payments from the APM data submission file	R
CT011	Record Type	Varchar	N/A – Excel file	CT	R

INSTRUCTIONS TO REQUEST A DATA SUBMISSION WAIVER for the COLORADO ALL PAYER CLAIMS DATABASE – APM AND DRUG REBATE FILES

CIVHC will work collaboratively with APCD data submitters to ensure that required submissions achieve the intent of the rules. These rules have been put in place to deliver a high quality, reliable source of health care data for Colorado. The APCD Program will engage in a Continuous Quality Improvement (CQI) process intended to achieve ever higher levels of data quality and completeness as the APCD Program evolves.

Consistent with the CQI process, the APCD will consider requests from data submitters to provide summarized data or file exemptions for their Alternative Payment Model (APM) and Drug Rebate files. The purpose of permitting submission of summarized data is to enable a data submitter to materially comply with the data submission guide requirements while gaining time to develop the capability to overcome their limitations in providing required detailed data. This policy is intended to recognize the limitations of some submitters and also maintain the utility of the overall data set.

Data submitters may request a one year waiver for a file type or a one year relief from submitting required details for a data element. If the latter, the request should include the following information for each data element.

For waivers of a particular data element:

- The year for which the summarized data/file exemption is requested.
- The specific field(s) including number and description for which the submitter is requesting to provide summarized data, if the request involves a specific field.
- The data submitter's proposal for providing summarized data for each field, if applicable.
- An explanation as to why the data submitter is unable to submit the file or provide requested details for those same fields, including the conditions or factors affecting the data submitter's ability to comply.
- A description of the process the data submitter will follow to develop the capability to achieve the established requirements in the future, including milestones for completion.
- An original signed certification by the organization's Chief Information Officer or Regulatory Compliance Office that includes the above information and asserts that the data submitter cannot meet the requirements because the requested information is not available and cannot be derived from the data submitter's information systems.

A template for the request for waiver is attached for your convenience. Please attach additional pages of narrative as needed to provide a full explanation of the reasons that the data submitter cannot comply and the plans for improving compliance over the term of the waiver. Please submit all documentation electronically to **submissions@civhc.org**. Questions may also be directed to **submissions@civhc.org**.

Colorado APCD Data Variance Submission Request for [Year]:_____

Name of Submitter:	Date Submitted:
Contact Name, Email and Phone:	

The following information should be included for each file type. Include data element if applicable; attach additional pages of narrative as needed to explain the request and describe the plan to improve compliance if applicable.

Data File Name	Data Element Number (if applicable	Data Element Name (if applicable)	Detailed description of reason

Certification: On behalf of _____, I certify that this data submitter cannot submit the files listed or meet the required threshold because the required information is not available and cannot be derived from the data submitter's information systems.

Submitted by: _____

Name Title Date

Appendix B: Sample of Completed APM Detailed Data File

AM001	AM002	AM003	AM004	AM005	AM006	AM007	AM008	AM009	AM010	AM011	AM012	AM013	AM014	AM015	AM016	AM017	AM018	AM019	AM020	AM021	AM022	AM023
Billing Provider Number	National Billing Provider ID	Billing Provider Tax ID	Billing Provider Last Name or Organization Name	Billing Provider Entity	Payment Arrangement Category	Performance Period Start Date	Performance Period End Date	Member Months	Total Primary Care Claims Payments	Total Primary Care Non-Claims Payments	Total Claims Payments	Total Non-Claims Payments	Billing Provider Office Street Address	Billing Provider Office City	Billing Provider Office State	Billing Provider Office Zip	Billing Provider DEA Number	Billing Provider NPI	Billing Provider State License Number	Billing Provider office address	Billing Provider Office phone number	Record Type
1111111	10101010	1234567	Example Billing Organization	F	FS	20160101	20161231	3467	$ 4,160.00	$ -	$ 33,280.00	$ -	111 Example Street	Example	CO	80000	13579	10101010	99999	Ste 111	1111111111	AM
1111111	10101010	1234567	Example Billing Organization	G	FS	20160101	20161231	5653	$ 2,830.00	$ -	$ 22,640.00	$ -	111 Example Street	Example	CO	80000	13579	10101010	99999	Ste 111	1111111111	AM
1111111	10101010	1234567	Example Billing Organization	P	PP	20160101	20161231	1539	$ -	$ 767,608.00	$ -	$ 6,140,864.00	111 Example Street	Example	CO	80000	13579	10101010	99999	Ste 111	1111111111	AM
1111111	10101010	1234567	Example Billing Organization	F	PP	20160101	20161231	1954	$ -	$ 361,521.00	$ -	$ 2,169,126.00	111 Example Street	Example	CO	80000	13579	10101010	99999	Ste 111	1111111111	AM
1111111	10101010	1234567	Example Billing Organization	F	FS	20170101	20171231	3045	$ 4,568.00	$ -	$ 22,840.00	$ -	111 Example Street	Example	CO	80000	13579	10101010	99999	Ste 111	1111111111	AM
1111111	10101010	1234567	Example Billing Organization	G	FS	20170101	20171231	8522	$ 12,783.00	$ -	$102,264.00	$ -	111 Example Street	Example	CO	80000	13579	10101010	99999	Ste 111	1111111111	AM
1111111	10101010	1234567	Example Billing Organization	P	PP	20170101	20171231	1062	$ -	$ 728,758.00	$ -	$ 7,287,580.00	111 Example Street	Example	CO	80000	13579	10101010	99999	Ste 111	1111111111	AM
1111111	10101010	1234567	Example Billing Organization	F	PP	20170101	20171231	7171	$ -	$ 273,983.00	$ -	$ 1,317,881.00	111 Example Street	Example	CO	80000	13579	10101010	99999	Ste 111	1111111111	AM
1111111	10101010	1234567	Example Billing Organization	F	FS	20170101	20171231	3153	$ 10,931.00	$ -	$ 54,955.00	$ -	111 Example Street	Example	CO	80000	13579	10101010	99999	Ste 111	1111111111	AM
1111111	10101010	1234567	Example Billing Organization	G	FS	20170101	20171231	9584	$ 7,667.00	$ -	$ 46,002.00	$ -	111 Example Street	Example	CO	80000	13579	10101010	99999	Ste 111	1111111111	AM
1111111	10101010	1234567	Example Billing Organization	P	PP	20170101	20171231	2057	$ -	$ 713,922.00	$ -	$ 7,139,220.00	111 Example Street	Example	CO	80000	13579	10101010	99999	Ste 111	1111111111	AM
1111111	10101010	1234567	Example Billing Organization	F	PP	20170101	20171231	3324	$ -	$ 330,386.00	$ -	$ 6,332,702.00	111 Example Street	Example	CO	80000	13579	10101010	99999	Ste 111	1111111111	AM
22222	20202020	2345678	Example Billing Organization 2	I	GB	20160101	20161231	7268	$ -	$ 160,372.00	$ -	$ 1,603,720.00	222 Example Stree	Example	CO	80001	24680	20202020	88888	Ste 222	2222222222	AM
22222	20202020	2345678	Example Billing Organization 2	G	PC	20160101	20161231	5457	$ -	$ 580,536.00	$ -	$ 4,644,768.00	222 Example Stree	Example	CO	80001	24680	20202020	88888	Ste 222	2222222222	AM
22222	20202020	2345678	Example Billing Organization 2	I	GB	20160101	20161231	2171	$ -	$ 430,757.00	$ -	$ 2,584,542.00	222 Example Stree	Example	CO	80001	24680	20202020	88888	Ste 222	2222222222	AM
22222	20202020	2345678	Example Billing Organization 2	G	PC	20160101	20161231	8376	$ -	$ 345,233.00	$ -	$ 7,561,864.00	222 Example Stree	Example	CO	80001	24680	20202020	88888	Ste 222	2222222222	AM
22222	20202020	2345678	Example Billing Organization 2	I	GB	20170101	20171231	2384	$ -	$ 667,385.00	$ -	$ 4,007,310.00	222 Example Stree	Example	CO	80001	24680	20202020	88888	Ste 222	2222222222	AM
22222	20202020	2345678	Example Billing Organization 2	G	PC	20170101	20171231	9683	$ -	$ 517,885.00	$ -	$ 5,178,850.00	222 Example Stree	Example	CO	80001	24680	20202020	88888	Ste 222	2222222222	AM
22222	20202020	2345678	Example Billing Organization 2	I	GB	20170101	20171231	2794	$ -	$ 463,541.00	$ -	$ 3,708,328.00	222 Example Stree	Example	CO	80001	24680	20202020	88888	Ste 222	2222222222	AM
22222	20202020	2345678	Example Billing Organization 2	G	PC	20170101	20171231	5545	$ -	$ 194,185.00	$ -	$ 1,747,665.00	222 Example Stree	Example	CO	80001	24680	20202020	88888	Ste 222	2222222222	AM
22222	20202020	2345678	Example Billing Organization 2	I	GB	20180101	20181231	3656	$ -	$ 437,222.00	$ -	$ 4,372,220.00	222 Example Stree	Example	CO	80001	24680	20202020	88888	Ste 222	2222222222	AM
22222	20202020	2345678	Example Billing Organization 2	G	PC	20180101	20181231	1086	$ -	$ 31,345.00	$ -	$ 188,070.00	222 Example Stree	Example	CO	80001	24680	20202020	88888	Ste 222	2222222222	AM
22222	20202020	2345678	Example Billing Organization 2	I	GB	20180101	20181231	4291	$ -	$ 487,522.00	$ -	$ 3,900,176.00	222 Example Stree	Example	CO	80001	24680	20202020	88888	Ste 222	2222222222	AM
22222	20202020	2345678	Example Billing Organization 2	G	PC	20180101	20181231	7895	$ -	$ 578,716.00	$ -	$ 4,051,012.00	222 Example Stree	Example	CO	80001	24680	20202020	88888	Ste 233	2222222222	AM

Appendix C: Sample of Completed APM Control Total File

CT001	CT002	CT003	CT004	CT005	CT006	CT007	CT008	CT009	CT010	CT011
Payer Code	Payer Name	Submitted File	Data Rows	All Member Months	Alternative Arrangement Months	Total Primary Care Claims Payments	Total Primary Care Non-Claims Payments	Total Claims Payments	Total Non-Claims Payments	Record Type
1111	Example Insurance Company	PROD_20152017AMv01.xlsx	24	30638	40945	$33,084.00	$ 8,805,499.00	$ 177,041.00	$ 67,276,638.00	CT

Appendix D: Frequently Asked Questions

1) **When is each file due?**

   Test files for Alternative Payment Models, Drug Rebate and Control Totals are due by July 1, 2019. Test files should include data for calendar year 2016.

   Final production files are due by September 30, 2019. Production files must be submitted with data for three previous calendar years – 2016, 2017, 2018.

2) **How should the files be submitted and named?**

   Files should be submitted in Excel format (.xlsx, .xls, or .csv) through the SFTP server. Naming conventions should follow the template:

   TESTorPROD_PayerID_SubmissionYearDueFileTypeVersionNumber.xlsx

   For example, the following naming conventions will be used for testing and production in 2019:
   TEST_0000_2019AMv01. xlsx
   PROD_0000_2019CTv02. xlsx

3) **What is the objective of the Alternative Payment Model (APM) files?**

   The overarching goal of the APM file is to gain a better understanding of how payments to providers in Colorado are shifting from traditional fee-for-service (FFS) to alternative payment models that pay incentives to providers for delivering high quality, cost-effective care.

   There are a growing number and variety of APMs being tested and we currently lack the ability to track spending and the number of patients receiving care under these models. Including data on APMs in the CO APCD would enable researchers, policy makers, health plans, providers and other stakeholders to establish baseline information regarding current spending levels and the number of patients receiving care under APMs (vs. traditional FFS) and track changes over time. This information may also help to identify the types of APMs that are most effective in reducing costs and improving quality, informing the development of policy solutions to improve the value of health care.

   The APM file captures detailed information about each provider and the dollars the provider receives under each payment model.

4) **What is the objective of the Control Total (CT) files?**

   The Control Total file supplements the APM file by collecting summary information about the distribution of payments under various payment models. It is used to confirm that the APM file from each submitter was received and loaded correctly. It is also used to understand the market share of APM payments in Colorado via de-duplicated member months.

5) My organization submits claims data under multiple CIVHC-assigned payer codes. How should I handle this?

For the APM and Control Total files, please submit separate files for each payer code. If you are unable to report these data by payer code, please contact CIVHC. We will work with you to develop modified data specifications that accommodate your data limitations and allow CIVHC to fulfill its statutory obligations. Please note that these instructions for the APM file differ from instructions related to the Drug Rebate file.

6) What is the timeframe of the payments included in the APM and Control Total files?

These files require information for each of the three most recent calendar years (2018, 2017 and 2016).

Payments include:

- Payments made on a fee-for-service basis for medical/dental services *performed* during the file submission period;
- The following types of contract payments that fully or partially span the provision of services during the file submission period*:
    a. PP: Pay for performance;
    b. SH: Shared savings payments;
    c. GB: Global budget payments;
    d. LB: Limited budget payments;
    e. CU: Capitation payments;
    f. BU: Bundled/episode-based payments;
    g. ID: Integrated delivery system payments;
    h. PC: Foundational payments for infrastructure and operations, which includes payments associated with the Patient Centered Primary Care Home program;
    i. OT: All other Non-FFS payments.

* Payers should report the details of all payments that span any part of the submission period and should include the start and end date of the contract in the data submission.

When contracts fall partly outside of the submission period ("performance period") and payments cannot be exclusively attributed to the submission period, the payment shall still be reported, in full, along with the contract period start and end dates. For example, for a contract period of July 2015 through June 2016, your organization would submit the following start and end dates in the file with a submission period of 2016-2018:

Performance Period Start Date (AM007): 20150701
Performance Period End Date (AM008): 20160630

CIVHC will prorate these payments (and associated member months where applicable) for the submission period.

7) **What is the process for requesting waivers and exceptions to the APM file submission requirements?**

Please complete the form on page two of Appendix A, "Data Submission Waiver Instructions - APM and Drug Rebate Files" and email it to **submissions@civhc.org**. CIVHC will review the document and provide comments, if necessary. CIVHC will then complete the Data Submission Waiver Agreement and combine this with the completed file submitted by your organization. CIVHC will provide this document to you for your records.

Please submit these waiver documents no later than September 1, 2019.

8) **Will you be joining these files to the other claims files (MC, PC, ME, MP) that we submit to the APCD?**

No, we will not join these files to the data in the APCD. CIVHC understands that the data collected in the APM file are based on different inclusion criteria than the data in the APCD files, so it is not expected that the numbers will be equal. However, we will compare the paid amounts and member months in these files to ensure the numbers are in the same ball park.

9) **Who is obligated to submit the APM and Control Total files?**

Payers that submit data to the CO APCD and reimburse providers under any Alternative Payment model are required to submit APM and Control Total files.

10) **What level of reporting is required for the APM files?**

All payments to billing providers and large provider organizations (e.g., IPAs) must be reflected only once such that the sum of your organization's payments to a single entity accurately reflects the total payments made to that entity spanning that performance period.

11) **What is the difference between the data reported in the APM files and the data reported in the other claims files (eligibility, claims, provider, etc)?**

Data reported in the APM files should include payment amounts and member months based on the location of the contract recipient, not based on the member. Other claims files are submitted only for Colorado residents, regardless of provider location.

For example, if an individual resides in Wyoming but has commercial coverage through their private employer based in Denver, Colorado, information for this individual would be included in the APM Files but not in the other APCD claims files. Conversely, if a Colorado resident works in Wyoming and has insurance coverage through their employer, their data would be in included in the other APCD claims files, but not in the APM Files.

12) **How should member months (AM009) be calculated?**

Population of the member months field (AM009) is only required when reporting certain types of payment arrangements such as population-based payments. When required, your organization should include the total number of members (represented in member months) that participated in the reported APM. This will require identifying the number of members (monthly) served under the payment arrangement model for each billing provider or contract ID. For example, a

global budget payment (Payment Model = GB) paid for a member for January through December would count as 12-member months. If your organization covers a person for even one day of the month, even if it's the 1st or the 31st, then this counts as a member month.

CIVHC understands that a given member could be reflected across multiple billing providers. For example, if the same individual received services from multiple providers in the same reporting period, all of whom received non-claims payments, then the membership should be reflected in each row corresponding to the member's providers.

13) Should we be reporting information (NPI, tax ID, entity type) for the entity/organization a payment is actually sent to or the providers within that organization that receive the payment? For example, if a large payment is sent to the financial parent of a health system, should we report what is sent to the financial parent, or should we figure out how the financial parent distributed this payment to its providers?

Payers should provide the most granular payment data available. In the example given where the financial parent receives a large payment for all of their providers, your organization shall provide detailed information about how that financial parent disbursed the large payment to the various provider groups it contains. If you are unable to achieve this level or granularity, please contact CIVHC.

CIVHC desires a unique ID for each recipient of these funds. The typical unique ID is the billing provider ID, but we understand that there are certain instances where this level of granularity is unavailable. If this is the case for your organization, please notify CIVHC. We will work with you to develop modified data specifications that accommodate your limitations and allow CIVHC to fulfill its statutory obligations.

14) What if a single payment under a Billing Provider ID consists of several different components? For example, what if a payment includes a FFS portion plus a bonus payment for meeting performance and quality goals?

In instances when a single contract consists of several components (but is paid out in a single check), your organization should separate these payments and report them on separate lines. In the above example, your organization would report the amount of the payment that was FFS and the amount that was a pay-for-performance bonus; these data would be entered as two separate rows in the submission with the same Billing Provider ID.

Additionally, if your organization has a contract that is based on FFS and includes shared savings and shared risk, the Payer would report the amount of FFS payments on one row, and the amount for any shared savings or shared risk payments on another row.

15) How are the different "payment" variables (AM010-AM013) defined?

There are four payment variables in the APM file; two that relate to primary care payments and two that relate to total payments. The two primary care payment elements (AM010 and AM011) should be subsets of the total payment elements (AM012 and AM013), respectively. Total Primary Care Claims Payments (AM010) should be a subset of the value input for Total Claims Payments (AM012) and Total Primary Care Non-Claims Payments (AM011) should be a subset of the value input for Total Non-Claims Payments (AM013).

16) When would a negative or zero-dollar payment be reported?

Negative payments should be reported when your organization receives money from a contracted entity, as opposed to paying money out. For example, a payment a contracted entity makes to your organization under a shared risk payment arrangement.

There may also be instances in which your organization should enter $0 for a given payment to convey important details about that contract. For example, if your organization has a shared savings arrangement with a FFS base but at the end of the contract period the provider did not achieve the threshold necessary to receive shared savings payments, you should enter the payment amounts for FFS and enter $0 in another row for Alternative Payment Models with Shared Savings (code SH). This conveys that your organization had a shared savings payment arrangement with the provider, instead of a traditional FFS arrangement, but that the threshold for the Shared Savings payment was not met.

17) What should be reported in instances when a certain billing provider ID does not have any alternative payment model contracts? For example, what if a provider only receives payments under a FFS arrangement? How should we report the total payments made to this provider?

The APM file is meant to capture all payments, not just alternative payments. For example, both fee-for-service and alternative payment methodologies are included in the APM file as required payment models for reporting. Therefore, if the only payment made to one or more Billing Provider IDs was under a FFS arrangement, then the claims payments fields (AM010 and AM012) should be populated with the payment amounts and non-claims payments fields (AM011 and AM113) should reflect $0. Only in instances where there is no payment at all made to a particular billing provider or organization for contracts during the reporting period should they be omitted from the APM file.

18) What is the definition of primary care for reporting elements AM010 and AM011?

CIVHC is using the definition established by the Department of Human Services and Oregon Health Authority in their Alternative Payment Model collection. Primary care payments are defined as payments made to a primary care provider for a primary care service.

a. **Primary Care Provider**: Any providers that practice within one of the state's designated Patient Centered Primary Care Home (PCPCH) practices or any providers that have one of the taxonomy codes below, and
b. **Primary Care Service**: Who billed for or rendered any of the services listed in the table of procedure codes shown below. The sum of payments made for the services listed below equal the sum of primary care payments. Note: costs associated with services provided in hospital and ambulatory surgical center settings do not count toward primary care spending.

Primary Care Provider Taxonomy Table (condition a):

Taxonomy code	Description
261QF0400X	Federally Qualified Health Center

Taxonomy code	Description
261QP2300X	Primary care clinic
261QR1300X	Rural Health Center
207Q00000X	Physician, family medicine
207R00000X	Physician, general internal medicine
175F00000X	Naturopathic medicine
208000000X	Physician, pediatrics
2084P0800X	Physician, general psychiatry
2084P0804X	Physician, child and adolescent psychiatry
207V00000X	Physician, obstetrics and gynecology
207VG0400X	Physician, gynecology
208D00000X	Physician, general practice
363L00000X	Nurse practitioner
363LA2200X	Nurse practitioner, adult health
363LF0000X	Nurse practitioner, family
363LP0200X	Nurse practitioner, pediatrics
363LP0808X	Nurse practitioner, psychiatric
363LP2300X	Nurse practitioner, primary care
363LW0102X	Nurse practitioner, women's health
363LX0001X	Nurse practitioner, obstetrics and gynecology
363A00000X	Physician's assistant
363AM0700X	Physician's assistant, medical
207RG0300X	Physician, geriatric medicine
175L00000X	Homeopathic medicine
2083P0500X	Physician, preventive medicine
364S00000X	Certified clinical nurse specialist
163W00000X	Nurse, non-practitioner

Primary Care Service Table (condition b)

CPT Codes	Description
99201-99205	Office or outpatient visit for a new patient
99211-99215	Office or outpatient visit for an established patient
99241-99245	Office or other outpatient consultations
99341-99345	Home visit for a new patient
99347-99350	Home visit for an established patient
99381-99385	Preventive medicine initial evaluation

CPT Codes	Description
99391-99395	Preventive medicine periodic reevaluation
99401-99404	Preventive medicine counsel and/or risk reduction intervention
99411-99412	Group prev. medicine counsel and/or risk reduction intervention
99420	Administration and interpretation of health risk assessments
99429	Unlisted preventive medicine service
59400	Routine obstetric care incl. vaginal delivery
59510	Routine obstetric care incl. cesarean delivery
59610	Routine obstetric care incl. VBAC delivery
59618	Routine obs. care incl. attempted VBAC
90460-90461	Immunization through age 18, including provider consult
90471-90472	Immunization by injection
90473-90474	Immunization by oral or intranasal route
99386-99387	Initial preventive medicine evaluation
99396-99397	Periodic preventive medicine reevaluation
G0402	Welcome to Medicare visit
G0438-G4039	Annual wellness visit
T1015	Clinic visit, all-inclusive
Primary ICD-10 Code	**Description**
Z00	Encounter for general exam without complaint
Z000	Encounter for general adult medical examination
Z0000	Encounter for general adult medical exam without abnormal findings
Z0001	Encounter for general adult exam with abnormal findings
Z001	Encounter for newborn, infant and child health examinations
Z0011	Newborn health examination
Z00110	Health examination for newborn under 8 days old
Z00111	Health examination for newborn 8 to 28 days old
Z0012	Encounter for routine child health examination
Z00121	Encounter for routine child health exam with abnormal findings
Z00129	Encounter for routing child health exam without abnormal findings
Z008	Encounter for other general examination
Z014	Encounter for gynecological examination
Z0141	Encounter for routing gynecological examination
Z01411	Encounter for gynecological exam, general, routing with abnormal findings

CPT Codes	Description
Z01419	Encounter for gynecologic exam, general, routing without abnormal findings

19) What should be included in Record Type (AM023)?

Please populate each record in the APM file with "AM". This is for administrative purposes.

20) What should be included in Record Type (CT011)?

Please populate each record in the Control Total file with "CT". This is for administrative purposes.