Prescription Drug Rebate Data Submission Manual

10 CCR 2505-5

August 2023

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 Prescription Drug Rebates on a program established by the Massachusetts Center for Healthcare Information and

Analysis (CHIA). The instructions in this document include language from a 2018 Data Specification Manual to payers about requirements for submitting data on drug rebates. We wish to express our thanks to CHIA 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.

Prescription drug rebate is defined as aggregated information regarding the total amount of any prescription drug rebates and other pharmaceutical manufacturer compensation or price concessions, including Value Based Purchasing (VBP) arrangements, paid by pharmaceutical manufacturers to a payer or their Pharmacy Benefit Manager(s) (PBM). PBM Contract Information is a supplement to the drug rebate file and describes the contractual arrangement a payer has with its PBM.

This Data Submission Manual provides technical details to assist payers in reporting and filing prescription drug rebate data and PBM contract data. **CIVHC recommends that payers coordinate efforts to complete the drug rebate file between the department responsible for managing agreements with Pharmacy Benefit Managers or drug manufacturers and the department responsible submitting monthly files to the APCD** to ensure that details, such as Insurance Product Type and prescription drug expenditures, are accurate.

2. Why Collect Drug Rebate Data?

The goal for collecting drug rebate data is to measure the effect of prescription drug rebates and other compensation on pharmacy spending and spending growth. The purpose of collecting PBM contract information is to understand the role of the PBM in managing the pharmacy benefit and negotiating drug manufacturer rebates and other compensation, which are important when analyzing the total impact of rebates and other compensation in offsetting expenditures for prescription drugs.

3. File Submission Instructions and Schedule

Payers should submit Drug Rebate information according to the following schedule:

Alternative Payment Model and Drug Rebate Data Submission Schedule	
Date	**Files Due**
July 3, 2023	• Waiver request due (if applicable)
July 175, 2023	• Test files of data for 2020 due
September 1, 2023	• Final files for three calendar years, 2020, 2021 and 2022

For the 2023 submission year, files will be submitted either via Excel (.xlsx, .xls, or .csv) or text format (.txt). Please see the chart below for specific instructions for each file type and links to Excel templates, if applicable. The **APM** file types associated with this manual are highlighted in **orange** below for your convenience.

Annual File Submission Format by File Type		
File Type	**Format**	**Link to Template**
AM: Alternative Payment Model	.txt	N/A
CT: APM Control Total	.txt	N/A

Annual File Submission Format by File Type		
AC: APM Contract (formerly 2nd tab in CT file)	Excel	AC File Template
DR: Drug Rebate	**.txt**	**N/A**
PB: PBM Contract (formerly 2nd tab in DR file)	**Excel**	**PB File Template**
PD: Prescription Drug Affordability Board	Excel	PD File Template
VB: Value-Based Pharmacy Contract	Excel	VB File Template

Naming conventions should follow the template:

TESTorPROD_PayerID_SubmissionYearDueFileTypeVersionNumber.FileExtension

For example, the following naming conventions will be used for testing and production in 2023:

TEST_0000_**2023**DRv01.txt
PROD_0000_**2023**DRv02.txt
TEST_0000_**2023**PBv01.txt
PROD_0000_**2023**PBv02.txt

4. Waivers

CIVHC will work collaboratively with payers to ensure that required drug rebate data are submitted in a manner that satisfies the intent of the Data Submission Guide 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 for file exemptions under certain circumstances. Data submitters should submit a waiver request for the **Drug Rebate** filing if the organization meets one of the following criteria:

1) Payer does not provide prescription drug benefits (e.g. payer only provides medical benefits, payer only provides dental benefits, etc.)
2) Payer only provides supplemental insurance (e.g. Medicare Supplemental policies only)
3) Payer does not receive any rebates or other compensation from drug manufacturers/PBMs

Data submitters should submit a waiver request for the **PBM Contract** filing if the organization meets one of the following criteria:

1) Payer does not provide prescription drug benefits (e.g. payer only provides medical benefits, payer only provides dental benefits, etc.)
2) Payer only provides supplemental insurance (e.g. Medicare Supplemental policies only)
3) Payer does not receive any rebates or other compensation from drug manufacturers/PBMs
4) Payer does not use a separate PBM to manage pharmacy benefits
5) Payer itself is a PBM.

If you believe your organization is not obligated to submit a **Drug Rebate** or **PBM Contract** file, but your circumstances do not fall under the listed items above, please contact CIVHC.

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

5. Changes to the Drug Rebate Submission Manual

The following are changes to this Drug Rebate Data Submission Manual, which were adopted following the Data Submission Guide v14 Rule Hearing on November 29, 2022.

- DR005 – Clarification added to description.
- DR008 – DR015 – Clarification added to description

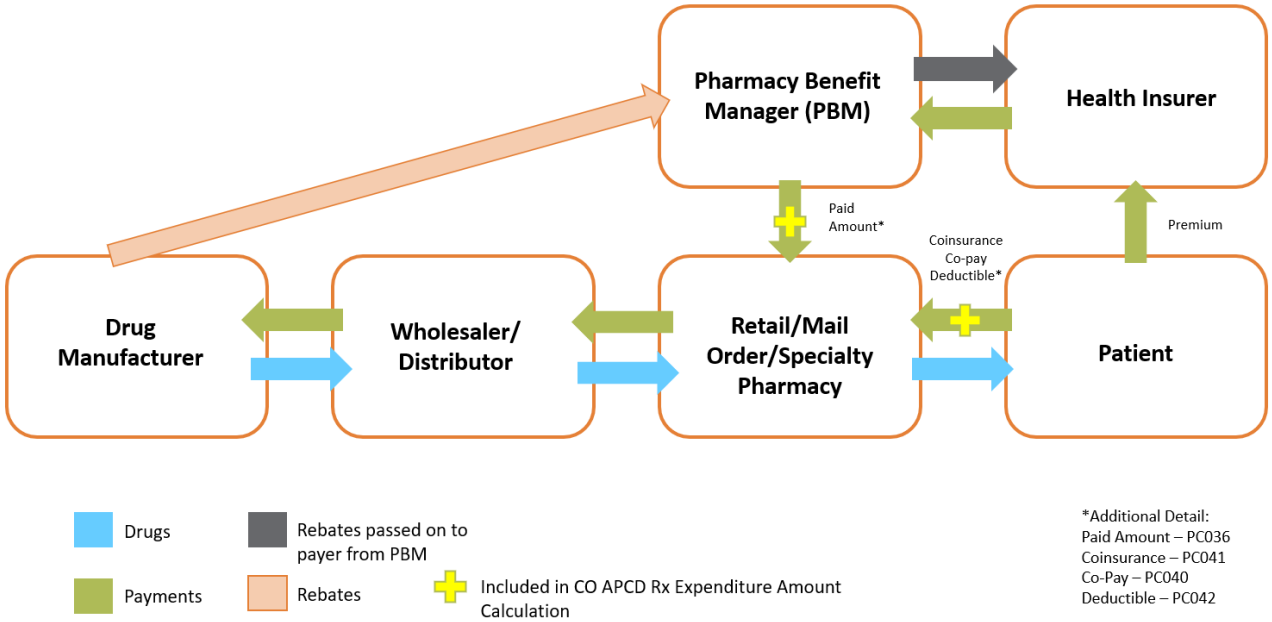
6. Data Submission of Prescription Drug Rebate Details

The submission of drug Rebate data involves the completion of two files:

- The first file, 'DR,' captures data related to pharmacy expenditures and rebates received from drug manufacturers.
- The second file, 'PB', captures summary information about a payer's contract with its PBM.

When reporting rebates, payers should report the total rebates and other compensation **received from the PBM**. If a payer does not utilize a PBM, then the carrier should report the total rebates and other compensation received directly from drug manufacturers.

This diagram provides a simplified illustration of the prescription drug supply chain and the flow of drugs, payments and rebates. It is a useful guide for describing drug rebate file reporting requirements. Payers with PBMs should report the total amount represented by the ***gray*** line. If the submitter is a PBM, then it should report the total amount represented by the ***orange*** line.



DRUG REBATE DATA SPECIFICATIONS

Below is a description of each field in the Drug Rebate filing.

Payer Code (DR001): The CIVHC-assigned organization ID for the payer or carrier submitting the file.

Payer Name (DR002): The name of the payer or carrier submitting the file.

Insurance Category (DR003): The insurance category being reported, according to Table B.1.A. Insurance Type of the Data Submission Guide, displayed below. Payers shall submit drug rebate information for all insurance categories for which they have business. Payers reporting under the "99 Other" category will be asked to identify the type of insurance reflected in this category.

Code	Insurance Type Code Description
12	Preferred Provider Organization (PPO) - Commercial
13	Point of Service (POS) - Commercial
15	Indemnity Insurance - Commercial
16	Health Maintenance Organization (HMO) Medicare Advantage
17	Dental Maintenance Organization (DMO)
18	Vision Insurance
DN	Dental
HM	Health Maintenance Organization - Commercial
19	Prescription Drug Only Insurance – Commercial
EP	Exclusive Provider Organization (EPO) - Commercial
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MD	Medicare Part D
MP	Medicare Primary
QM	Qualified Medicare Beneficiary
TV	Title V
99	Other
SP	Medicare Supplemental (Medi-gap) plan
CP	Medicaid CHIP
MS	Medicaid Fee for service
MM	Medicaid Managed care
CS	Commercial Supplemental plan
ME	Medicare Advantage Preferred Provider Organization (PPO)
ML	Medicare Advantage Indemnity Plan
MO	Medicare Advantage Point of Service (POS) Plan

Calendar Year (DR004): The payer must enter the calendar year for which the drug rebate data will be reported. Prescription drug rebate data should be reported based on drug fill date.

Drug Manufacturer NDC/NHRIC Labeler Code (DR005): The first five digits in the 11-digit national drug code (NDC) format that is assigned to the manufacturer by the Food & Drug Administration (FDA). Labeler code can be found on the FDA website. https://www.fda.gov/industry/structured-product-labeling-resources/ndcnhric-labeler-codes.

Labeler Code Firm (Manufacturer)Name (DR006): Firm (manufacturer) name associated with NDC/NHRIC labeler code.

Therapeutic Class (DR007): Grouping of drugs with similar pharmacologic, therapeutic, and/or chemical characteristics in a 4-tier hierarchy (https://www.ashp.org/products-and-services/database-licensing-and-integration/ahfs-therapeutic-classification?loginreturnUrl=SSOCheckOnly). CIVHC will only collect and report on **Hierarchy 1** drug classifications using the American Hospital Formulary Service for Therapeutic Drug Class. Please submit the Class Number code of Hierarchy 1 (e.g., 28:00). Leave the field blank if there is no available drug class for a reported NDC.

Total Pharmacy Expenditure Amount (DR008):

Instruction also applicable to:
- Pharmacy Expenditure Amount for Specialty Drugs (DR009),
- Pharmacy Expenditure Amount for Non-Specialty Brand Drugs (DR0010), and
- Pharmacy Expenditure Amount for Non-specialty Generic Drugs (DR011)

The sum of all incurred claim allowed payment amounts to pharmacies for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit in a given calendar year. This amount shall include member cost sharing amounts. This shall include all incurred claims for individuals included in the member population regardless of where the prescription drugs are dispensed (i.e., includes claims from in-state and out-of-state providers). Claims should be attributed to a calendar year based on the date of fill. Pharmacy Expenditure amounts should include a count of all paid prescriptions. Do not count claims that have been fully reversed. Additionally, do not count reversal versions of claims.

The allowed paid amount is equal to the total payment amounts to a pharmacy including all payer paid amounts, pharmacy benefit manager (PBM) paid amounts, and member cost sharing. This amount shall include direct drug costs and exclude non-claim costs. Importantly, this amount shall not reflect prescription drug rebates in any way (i.e., the reported amount must not be reduced by prescription drug rebates).

The expenditure amount is the sum of:
Copay (PC040) +
Coinsurance (PC041) +
Deductible (PC042) +
Payer portion (plan paid, PC036)

Pharmacy Expenditure Amount: Specialty Drugs (DR009): A drug defined as a specialty drug by the payer or under the terms of a payer's contract with its PBM. Specialty drug expenditure and rebate amounts should be mutually exclusive from non-specialty brand drug and non-specialty generic drug expenditure and rebate amounts.

Pharmacy Expenditure Amount: Non-Specialty Brand Drugs (DR0010): A drug defined as a non-specialty brand drug by the payer or under the terms of a payer's contract with its PBM. Non-specialty brand drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty generic drug expenditure and rebate amounts.

Pharmacy Expenditure Amount: Non-Specialty Generic Drugs (DR011): A drug defined as a non-specialty generic drug by the payer or under the terms of a payer's contract with its PBM. Non-specialty generic drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty brand drug expenditure and rebate amounts.

Total Prescription Drug Rebate/Other Compensation Amount (DR012):

Instruction also applicable to:

- **Rebate/Other Compensation Amounts for Specialty Drugs (DR013),**
- **Rebate/Other Compensation Amounts for Non-specialty Brand Drugs (DR014), and**
- **Rebate/Other Compensation Amounts for Non-specialty Generic Drugs (DR015)**

Total rebates, and other price concessions (including concessions from price protection and hold harmless contract clauses) provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, excluding manufacturer-provided fair market value bona fide service fees. This amount shall include PBM rebate guarantee amounts as well as any additional rebate amounts transferred by the PBM in addition to the rebate guarantee amounts. This amount shall include the total amount of prescription drug rebates and price concessions provided by pharmaceutical manufacturers, regardless of whether they are conferred to the payer directly by the manufacturer, a PBM, or any other entity. In addition, this amount shall include the total amount of prescription drug rebates and price concessions provided by pharmaceutical manufacturers, regardless of whether they are conferred to the payer through regular aggregate payments, on a claim-by-claim basis at the point-of-sale, as part of retrospective financial reconciliations (including reconciliations that also reflect other contractual arrangements), or by any other method.

> Rebates: "Rebates" will include price concessions, price discounts, or discounts of any sort that reduce payments, a partial refund of payments or any reductions to the ultimate amount paid; a performance based financial reward; a financial reward for inclusion of a drug in a preferred drug list or formulary or preferred formulary position; market share incentive payments and rewards; credits; remuneration or payments for the provision of utilization or claim data to manufacturers for rebating, marketing, outcomes insights, or any other purpose; rebates, regardless of how categorized, and all Other Compensation to carriers, their PBMs, rebate aggregators, subsidiaries, any affiliated holding and/or parent company or within the parent organization, and all other organizational affiliates. The rebate terms of the reduction must be fixed and disclosed in writing to the payer.
>
> Compensation: "All Other Compensation" includes, but is not limited to, all remuneration from the manufacturer to pay for services, actions, activities or trade or fees for an item or service as part of an arms-length transaction; educational grants or other commissions; manufacturer administrative fees; and administrative management fees.

Prescription Drug Rebate/Other Compensation Amount: Specialty Drugs (DR013): Rebates specific to specialty drugs.

Prescription Drug Rebate/Other Compensation Amount: Non-Specialty Brand Drugs (DR014): Rebates specific to non-specialty drugs brand drugs.

Prescription Drug Rebate/Other Compensation Amount: Non-Specialty Generic Drugs (DR015): Rebates specific to non-specialty generic drugs.

Total Count of Prescriptions Filled (DR016):

Instruction also applicable to:

- **Count of Prescriptions Filled for Specialty Drugs (DR017),**
- **Count of Prescriptions Filled for Non-specialty Brand Drugs (DR018), and**
- **Count of Prescriptions Filled for Non-specialty Generic Drugs (DR019)**

The distinct count of all incurred claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit in a given calendar year. This shall include all incurred claims for individuals included in the member population regardless of where the prescription drugs are dispensed (i.e., includes claims from in-state and out-of-state providers). Claims should be attributed to a calendar year based on the date of fill. Prescription counts should include a count of all *paid prescriptions.* Do not count claims that have been fully reversed. Additionally, do not count reversal versions of claims.

Count of Prescriptions Filled: Specialty Drugs (DR017): Prescription counts specific to specialty drugs.

Count of Prescriptions Filled: Non-Specialty Brand Drugs (DR018): Prescription counts specific to non-specialty drugs brand drugs.

Count of Prescriptions Filled: Non-Specialty Generic Drugs (DR019): Prescription counts specific to non-specialty generic drugs.

Comments (DR020): Use this field to provide additional information or describe any caveats regarding data in the Drug Rebate submission.

Record Type (DR999): Record type identifier: DR

7. Data Submission of PBM Contract Information

The PBM Contract Information file captures information about the contractual arrangement a payer has with its PBM. Some Drug Rebate submitters are not required to submit the PBM Contract file. Please see the waiver instructions in Section 4 of this document for further details.

PBM CONTRACT DATA SPECIFICATIONS

The payer is expected to record prescription drug rebate data in the Prescription Drug Rebate Submission DSG 13 Excel template. Below is a description of each field.

Payer Code (PB001): The CIVHC-assigned organization ID for the payer or carrier submitting the file.

Payer Name (PB002): The name of the payer or carrier submitting the file.

Pharmacy Benefit Manager Name (PB003): The name of a pharmacy benefit manager (PBM) that provided any of the following services in a given insurance category and calendar year: claims processing, drug formulary management, or manufacturer drug rebate contracting.

Insurance Product Type Code (PB004): The insurance category being reported, according to Table B.1.A. Insurance Type of the Data Submission Guide, displayed below. Payers shall submit PBM Contract information for all insurance categories for which they have business. Payers reporting under the "99 Other" category will be asked to identify the type of insurance reflected in this category.

Code	Insurance Type Code Description
12	Preferred Provider Organization (PPO) - Commercial
13	Point of Service (POS) - Commercial
15	Indemnity Insurance - Commercial
16	Health Maintenance Organization (HMO) Medicare Advantage
17	Dental Maintenance Organization (DMO)
18	Vision Insurance
DN	Dental
HM	Health Maintenance Organization - Commercial
19	Prescription Drug Only Insurance – Commercial
EP	Exclusive Provider Organization (EPO) - Commercial
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MD	Medicare Part D
MP	Medicare Primary
QM	Qualified Medicare Beneficiary
TV	Title V
99	Other
SP	Medicare Supplemental (Medi-gap) plan
CP	Medicaid CHIP

Calendar Year (PB005): The payer must report the calendar year for which the PBM Contract information is reported. On or after January 1 and on or before December 31 for a given year.

Drug Formulary Management (PB006): Payers should identify whether an individual PBM organization performed all, some, or none of the drug formulary management for its pharmacy benefit within a given insurance category and calendar year. Payers should input one of three possible entries: "All", "Some", or "None". If multiple PBMs provided a drug formulary management services within a given insurance category and calendar year, payers should include a separate observation for each PBM and enter "Some" for drug formulary management in each observation.

Manufacturer Drug Rebate Contracting (PB007): Payers should identify whether an individual PBM organization performed all, some, or none of the manufacturer drug rebate contracting for its pharmacy benefit within a given insurance category and calendar year. Payers should input one of three possible entries: "All", "Some", or "None". If multiple PBMs provided contracting services within a given insurance product type code and calendar year, payers should include a separate observation for each PBM and enter "Some" for manufacturer drug rebate contracting in each observation.

Percent Rebate Passed to Carrier (PB008): Payers should identify the percentage of total rebates and other compensation the PBM passed on to the carrier from the Drug Manufacturer. This element should be expressed in decimal form. For example, if a PBM passed on 80% of the rebates to the carrier, **0.80** should be reported in this field.

Comments (PB009): Payers may use this field to provide additional information or describe any caveats pertaining to the PBM Contract Information.

8a. Drug Rebate File Content

Submitted to CIVHC via SFTP in .txt file format.

Drug Rebate File Header Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	DR
HD002	Payer Code	varchar	4	Distributed by CIVHC
HD003	Payer Name	varchar	75	Distributed by CIVHC
HD004	Beginning Month	date	6	CCYYMM (Example: 200801)
HD005	Ending Month	date	6	CCYYMM (Example: 200812)
HD006	Record count	int	10	Total number of records submitted in the Drug Rebate file, excluding header and trailer records

Drug Rebate File Trailer Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	DR
TR002	Payer Code	varchar	4	Distributed by CIVHC
TR003	Payer Name	varchar	75	Distributed by CIVHC
TR004	Beginning Month	date	6	CCYYMM (Example: 200801)
TR005	Ending Month	date	6	CCYYMM (Example: 200812)
TR006	Extraction Date	date	8	CCYYMMDD

Drug Rebate File Contents

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
DR001	Payer Code	varchar	8	Distributed by CIVHC	R
DR002	Payer Name	varchar	30	Distributed by CIVHC	R
DR003	Insurance Type Code/Product	char	2	See Lookup Table B-1. A	R
DR004	Calendar Year	Year	4	4-digit Year for the most recent calendar year time period reported in this submission	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
DR005	Drug Manufacturer NDC/NHRIC Labeler Code	varchar	5	The first four or five digits in the 11-digit national drug code (NDC) format that is assigned to the manufacturer by the Food & Drug Administration (FDA). Include leading zero's Labeler code can be found on the FDA website. https://www.fda.gov/industry/structured-product-labeling-resources/ndcnhric-labeler-codes	R
DR006	Labeler Code Firm Name	varchar	200	Firm name associated with NDC/NHRIC labeler	R
DR007	Therapeutic Class	varchar	70	Therapeutic class of drug	R
DR008	Total Pharmacy Expenditure Amount	Numeric	15	The sum of all incurred claim allowed payment amounts to pharmacies for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit in a given calendar year. This amount shall include member cost sharing amounts. This shall also include all incurred claims for individuals included in the member population regardless of where the prescription drugs are dispensed (i.e., includes claims from in-state and out-of-state providers). Claims should be attributed to a calendar year based on the date of fill. (allowed amount should include direct drug costs and exclude non-claim costs. This amount will not reflect prescription drug rebates in any way) Two explicit decimal places (e.g., 200.00).	R
DR009	Pharmacy Expenditure Amount: Specialty Drugs	Numeric	15	The total expenditure for a specialty drug. Specialty drug expenditure and rebate amounts should be mutually exclusive from non-specialty brand drug and non-specialty generic drug expenditure and rebate amounts. Drug defined as a specialty drug under the terms of a payer's contract with its PBM.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				Two explicit decimal places (e.g., 200.00).	
DR0010	Pharmacy Expenditure Amount: Non-Specialty Brand Drugs	Numeric	15	The total expenditure for Non-Specialty Brand Drugs. Non-specialty brand drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty generic drug expenditure and rebate amounts. A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	R
DR011	Pharmacy Expenditure Amount: Non-Specialty Generic Drugs	Numeric	15	The total expenditure for Non-Specialty Generic Drugs. Non-specialty generic drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty brand drug expenditure and rebate amounts. A drug defined as a non-specialty generic drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	R
DR012	Total Prescription Drug Rebate/Other Compensation Amount	Numeric	15	Total rebates, and other price concessions (including concessions from price protection and hold harmless contract clauses) provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, excluding manufacturer-provided, fair market value, bona fide service fees. Two explicit decimal places (e.g., 200.00).	R
DR013	Prescription Drug Rebate/Other Compensation Amount: Specialty Drugs	Numeric	15	Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts for all specialty drugs. Specialty drug expenditure and rebate amounts should be mutually exclusive from non-specialty brand drug and non-specialty generic drug expenditure and rebate amounts.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				Drug defined as a specialty drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	
DR014	Prescription Drug Rebate/Other Compensation Amount: Non-Specialty Brand Drugs	Numeric	15	Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts for all Non-Specialty Brand Drugs. Non-specialty brand drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty generic drug expenditure and rebate amounts. A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	R
DR015	Prescription Drug Rebate/Other Compensation Amount: Non-Specialty Generic Drugs	Numeric	15	Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts for all Non-Specialty Generic Drugs. Non-specialty generic drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty brand drug expenditure and rebate amounts. A drug defined as a non-specialty generic drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	R
DR016	Total Count of Prescriptions Filled	int	15	Total count of all prescriptions filled by members.	R
DR017	Count of Prescriptions Filled: Specialty Drugs	int	15	Total count of all specialty prescriptions filled by members. A drug defined as a specialty drug under the terms of a payer's contract with its PBM.	R
DR018	Count of Prescriptions Filled: Non-Specialty Brand Drugs	int	15	Total count of all non-specialty brand prescriptions filled by members.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM.	
DR019	Count of Prescriptions Filled: Non-Specialty Generic Drugs	int	15	Total count of all non-specialty generic prescriptions filled by members. A drug defined as a non-specialty generic drug under the terms of a payer's contract with its PBM.	R
DR020	Comments	varchar	1000	Use this field to provide additional information or describe any caveats regarding data in the Drug Rebate submission.	O
DR999	Record Type	char	2	DR	R

8b. PBM Contract Information Content

Submitted to CIVHC via SFTP in Excel file format. Please populate the template for submission.

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PB001	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC	R
PB002	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC	R
PB003	Pharmacy Benefit Manager Name	varchar	N/A – Excel file	The name of a pharmacy benefit manager (PBM) that provided any of the following services in a given insurance category and calendar year: claims processing, drug formulary management, or manufacturer drug rebate contracting.	R
PB004	Insurance Product Type code	char	N/A – Excel file	See lookup table B.1.A Payers shall report for all insurance categories for which they have business.	R
PB005	Calendar Year	year	N/A – Excel file	4-digit year for the calendar year time period reported in this submission	R
PB006	Drug Formulary Management?	varchar	N/A – Excel file	Identify whether an individual PBM organization performed all, some, or none of the drug formulary management for its pharmacy benefit within a given insurance category and year. Three possible responses: All, Some, None	R
PB007	Manufacturer Drug Rebate Contracting?	varchar	N/A – Excel file	Identify whether an individual PBM organization performed all, some, or none of the manufacturer drug rebate contracting for its pharmacy benefit within a given insurance category and year. Three possible responses: All, Some, None	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PB008	Percent Rebate Passed to Carrier	decimal	N/A – Excel file	Identify the percentage of total rebates and other compensation that is passed through to the carrier from the PBM. This field should be in decimal format.	R
PB009	Comments	varchar	N/A – Excel file	Use this field to provide additional information or describe any caveats regarding data in the PBM Contract submission	O

Appendix A: Waiver Instructions and Form

CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

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 file exemptions for their Alternative Payment Model (APM) and Drug Rebate files. This policy is intended to recognize the special circumstances for each payer (see section 4 of the Data Submission Manuals) and document their exempt status for APM or Drug Rebate submissions.

Data submitters may request a one-year waiver from submitting required file types.

For waivers of a particular file type:

- The year for which the file exemption is requested.
- The file type for which the file exemption is requested.
- An explanation as to why the data submitter is unable to submit the file.
- 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. Please submit all documentation electronically to **submissions@civhc.org**. Questions may also be directed to **submissions@civhc.org**.

*Please note, this section will be updated with instructions on how to submit waivers via the Portal. Submitters may elect to submit waivers via instructions above, or via Portal for the 2023 Annual Submissions

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

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

Data File Name (AM, CT, DR, etc)	Detailed description of reason

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

Submitted by: _____

Name Title Date

_____

Signature

Appendix B: Sample Files

a. Prescription Drug Rebate File

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DR|0|Example Insurance Company|201901|202112|12
DR001|DR002|DR003|DR004|DR005|DR006|DR007|DR008|DR009|DR010|DR011|DR012|DR013|DR014|DR015|DR016|DR017|DR018|DR019|DR020|DR999
0|Example Insurance Company|12|2019|11111|DrugMakrz|8:00|3090635.52|405112.5|1215337.51|1470185.51|37087626.12|20769070.63|14093297.93|2225257.57|810225|97227|332192|380805||DR
0|Example Insurance Company|12|2019|11111|DrugMakrz|4:00|344464.32|1246.51|253950.02|89267.79|8421620.22|4716107.32|3200215.68|505297.21|249300|29916|102213|117171||DR
0|Example Insurance Company|12|2019|11111|DrugMakrz|38:00|39833.11|17866.5|19599.53|2367.08|1314491.64|736115.32|499506.82|78869.5|35733|4287|14650|16794||DR
0|Example Insurance Company|12|2019|11111|DrugMakrz|36:00|388471.14|65441.25|196323.75|126706.14|4273182.54|2392982.22|1623809.37|256390.95|130882|15705|53661|61514||DR
0|Example Insurance Company|12|2019|22222|AstroPharm|96:00|2840510.5|486135.01|1309659.04|1044716.45|48288677.65|27041659.48|18349697.51|2897320.66|972270|116672|398630|456966||DR
0|Example Insurance Company|12|2019|22222|AstroPharm|10:00|213819.86|14958.03|190890.05|7971.78|3484417.8|1951273.97|1324078.76|209065.07|299160|35899|122655|140605||DR
0|Example Insurance Company|12|2019|33333|Atlantis Drug|56:00|49595.91|21439.81|21502.26|6653.84|843129.28|472152.4|320389.13|50587.76|42879|5145|17580|20153||DR
0|Example Insurance Company|HN|2019|11111|DrugMakrz|52:00|485856.45|78529.52|282082.57|125244.36|5830276.32|3264954.74|2215505|349816.58|157059|18847|64394|73817||DR
0|Example Insurance Company|HN|2019|11111|DrugMakrz|48:00|2772856.36|583362.18|1252697.94|936796.24|69321404.5|38819986.52|26342133.71|4159284.27|1166724|140006|478356|548360||DR
0|Example Insurance Company|HN|2019|22222|AstroPharm|80:00|24237492.01|179496.01|22263870.82|1794125.18|11762126.88|6586791.05|4469608.21|705727.61|358992|43079|147186|168726||DR
0|Example Insurance Company|HN|2019|33333|Atlantis Drug|28:00|2704619.76|25727.76|1982324.44|696567.56|1628017.08|911689.56|618646.49|97681.02|51455|6174|21096|24184||DR
0|Example Insurance Company|HN|2019|33333|Atlantis Drug|40:00|46854897.4|94235.4|34593662.25|12166999.75|8989472.32|5034104.5|3415999.48|539368.34|188470|22616|77273|88581||DR
DR|0|Example Insurance Company|201901|202112|20220901
```

Link: TBD

Link: TBD

b. PBM Contract Information File

PB001	PB002	PB003	PB004	PB005	PB006	PB007	PB008	PB009
Payer Code	Payer Name	Pharmacy Benefit Manager Name	Insurance Product Type Code	Calendar Year	Drug Formulary Management?	Manufacturer Drug Rebate Contracting?	Percent Rebate Passed to Carrier	Comments
0000	Example Insurance Company	Drugs R Us	12	2018	All	Some	0.80	
0000	Example Insurance Company	Drugs R Us	13	2018	All	Some	0.80	
0000	Example Insurance Company	Drugs R Us	15	2018	All	Some	0.80	
0000	Example Insurance Company	Best Rx	MM	2018	None	Some	1.00	
0000	Example Insurance Company	Drugs R Us	12	2019	All	Some	0.85	
0000	Example Insurance Company	Drugs R Us	13	2019	All	Some	0.85	
0000	Example Insurance Company	Drugs R Us	15	2019	All	Some	0.85	
0000	Example Insurance Company	Best Rx	MM	2019	None	Some	1.00	
0000	Example Insurance Company	Drugs R Us	12	2020	All	Some	0.87	
0000	Example Insurance Company	Drugs R Us	13	2020	All	Some	0.87	
0000	Example Insurance Company	Drugs R Us	15	2020	All	Some	0.87	
0000	Example Insurance Company	Best Rx	MM	2020	None	Some	1.00	

Link: **PBM Blank File (PB)**

Link: **PBM Scenario File (PB)**

Appendix C: Frequently Asked Questions

1) When is each file due?

Test files for Alternative Payment Models, Drug Rebate and Control Totals are due by June 16, 2023. Test files should include data for calendar year 2020.

Final production files are due by September 01, 2023. Production files must be submitted with data for three previous calendar years – 2020, 2021, 2022.

2) How should the files be submitted and named?

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

TESTorPROD_PayerID_SubmissionYearDueFileTypeVersionNumber.FileExtension

Naming conventions should follow the template:

TESTorPROD_PayerID_SubmissionYearDueFileTypeVersionNumber.FileExtension

For example, the following naming conventions will be used for testing and production in 2023:

TEST_0000_2023DRv01.txt
PROD_0000_2023PBv02.xlsx
TEST_0000_2023DRv01.txt
PROD_0000_2023PBv02.xlsx

3) What is the objective for collecting Drug Rebate data?

The drug rebate data will allow CIVHC to report the impact of drug rebates on trends in total costs of care and in prescription drug costs in Colorado.

CIVHC does not plan to report this data by payer/submitter.

4) My organization submits under multiple CIVHC-assigned payer codes. How should I handle this in the Drug Rebate file?

You may submit this information in one file. However, be sure to enter each assigned payer code (DR001) and enter requested information for each code separately. Please note that the Alternative Payment Model (APM) files should be submitted separately for each payer code.

5) What is the timeframe of the payments included in the Drug Rebate files?

Fill dates corresponding to each of the three most recent calendar years (2020, 2021 and 2022) should be reported in these files.

6) What is the process for requesting waivers to the Drug Rebate 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 instruction file submitted by your organization. CIVHC will provide this document to you for your records.

Please submit these waiver documents no later than July 3, 2023.

*Please note, this section will be updated with instructions on how to submit waivers via the Portal. Submitters may elect to submit waivers via the current method, or via Portal for the 2023 Annual Submissions.

7) 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. However, we will compare total allowed amounts and other comparable elements in these files to aggregated CO APCD data to ensure the numbers are in the same ballpark.

8) In the Drug Rebate file, what date should be used as the basis for reporting pharmacy expenditures?

Payers should base these records on fill date.

9) What payment amounts should be included in the payment fields (DR008-DR011)?

The sum of all incurred claim *allowed payment amounts* to pharmacies for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit in a given calendar year should be included in these fields. This amount shall include member cost sharing amounts. This shall include all incurred claims for individuals included in the member population regardless of where the prescription drugs are dispensed (i.e., includes claims from in-state and out-of-state providers). Please refer to the Data Submission Guide (DSG) or Manual for a complete definition.

10) How do you define specialty drugs (DR009 and DR013)?

Specialty drugs are defined based on the payer's definition. CIVHC will NOT provide a list of what we consider specialty drugs.

11) My organization is unable to break out the drug expenditure and rebate amount by specialty, brand, and generic drugs (DR009-DR011, DR013-DR015). How should I populate these fields?

Please contact CIVHC with the details of what you are unable to submit. CIVHC will work with you to develop modified data specifications that accommodate your data limitations and allow CIVHC to fulfill its statutory obligations.

12) How is Total Prescription Drug Rebate Amount (DR012) defined? Does it include prior year dollars included from any retro-active payments?

CIVHC uses the definition refined under DSG 14 for rebates and other compensation. Payers should report only rebate amounts that are associated with payments for prescriptions filled during the reported calendar year. Payers should report retroactive payments in the calendar year when the associated prescriptions were filled.

"Rebates" will include price concessions, price discounts, or discounts of any sort that reduce payments, a partial refund of payments or any reductions to the ultimate amount paid; a performance based financial reward; a financial reward for inclusion of a drug in a preferred drug list or formulary or

preferred formulary position; market share incentive payments and rewards; credits; remuneration or payments for the provision of utilization or claim data to manufacturers for rebating, marketing, outcomes insights, or any other purpose; rebates, regardless of how categorized, and all Other Compensation to carriers, their PBMs, rebate aggregators, subsidiaries, any affiliated holding and/or parent company or within the parent organization, and all other organizational affiliates. The rebate terms of the reduction must be fixed and disclosed in writing to the payer.

"All Other Compensation" includes, but is not limited to, all remuneration from the manufacturer to pay for services, actions, activities or trade or fees for an item or service as part of an arms-length transaction; educational grants or other commissions; manufacturer administrative fees; and administrative management fees.

13) What should I include in Comments (DR020)?

This cell should be used if a payer cannot fully complete the Drug Rebate file to the specifications outlined in the DSG. The payer should enter an explanation of how their submission differs from the specifications.

14) What should be included in Record Type (DR999)?

Please populate each record in the Drug Rebate file with "DR". This is for administrative purposes.

15) My organization is a PBM, but the PBM Contract tab asks about a payer's relationship with a PBM. How should I approach this section of the Drug Rebate filing?

As a PBM, you are not required to complete the contract information file.

Appendix D: SFTP Submission Instructions

CO APCD New File Types

Submitter Instructions

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

1. File Transmission

Data submissions will be made via SFTP. Each submitting entity should have an existing SFTP connection with NORC at the University of Chicago to submit other data types to the Colorado APCD. Payers should coordinate internally to share the existing connection information. All files transferred via SFTP will be automatically linked to the payer's account based on the file name. It is important that the files be named per a standard naming convention outlined in CIVHC's Data Submission Guide to ensure that the file type and submission periods can properly be discerned.

Many tools exist for Secure File Transfer Protocol. FileZilla and WinSCP are two examples. Please refer to your program's documentation for help with setup, if needed.

Connection Information for the SFTP Server:

- Server Name: transfer.norc.org
- User: the account name issued via secure download
- Password: the SFTP password issued via secure download
- Annual Test files in .txt format (DR)
    - [root]/incoming/AnnTxtProdPortal
- Annual Test files in .xlsx format (PB)
    - [root]/incoming/AnnExcelProdPortal
- Annual Prod files in .txt format (DR)
    - [root]/incoming/AnnTxtProdPortal
- Annual Prod files in .xlsx format (PB)
    - [root]/incoming/AnnExcelProdPortal

You will NOT receive an automated email notification once the file has been received. If you have questions about whether your file has been received please contact the Help Desk (civhchelp@hsri.org).

2. File Format

Files should be submitted in Excel format (.xlsx, .xls, .txt, or .csv) through the SFTP server. While these files do not contain sensitive data they are still required to be compressed and encrypted since they are being opened and validated in the submitter portal. If your organization requires the encryption of files before transmission you can do so with a commercially available, payer-approved file compression and encryption software such as WinZip or 7-Zip. Files should be compressed and encrypted in 256-bit AES. The password can be obtained through the CO APCD Portal. If you do not have access to the portal please coordinate internally at your organization to obtain this information. PGP encryption will not be supported for these file types.

Appendix E: CO APCD Data Submission Guide Version 14 Testing Instructions

Last Updated: May 9, 2022

Introduction

This document contains your instructions to begin testing MP, ME, MC, and PC files in the data submission guide version 14 format for the Colorado APCD.

Data Submission Guide Version 14 Overall Implementation Timeline

DSG 14 Timeline	
Task	**Due Date**
Payer Connect Calls	Bimonthly
Request for DSG feedback (monthly and annual files)	Ongoing
Initial Payer feedback due	8/1/2022
CIVHC distribute updated DSG 14 draft based on stakeholder feedback	8/31/2022
CIVHC File Rule Packet with HCPF	10/7/2022
Public Review Meeting	11/8/2022
Executive Director Hearing	11/29/2022
Rule Effective	1/30/2023
Annual Override Reset	2/28/2023
Monthly Data Files (ME, MC, PC, MP) Testing and Implementation	
Submitter testing of DSG v14 in Test Portal	May – June 2023
April 2023 due in DSG v13 in Production Portal	6/1/2023
April 2023 Submissions Must be in a Status of Validation Passed	6/15/2023
At least one BETA test file submitted to Test Portal	6/16/2023
DSG v14 Production Portal Go Live. Submitted files will be held and processed on 6/27/2023	6/23/2023 – 6/26/2023
May 2023 Submissions Due in DSG v14 – no less than 120 days after Rule Effective Date	7/3/2023
May 2023 Submissions Must be in a Status of Validation Passed	7/17/2023
Annual Data File (AM, CT, DR, AC, VB, PD, PB) Testing and Implementation	
Test files with 2020, 2021, 2022 data due	7/17/2023
Production files with 2020 – 2022 data due	9/1/2023
PLEASE NOTE: If you are onboarding to the CO APCD follow the timeline discussed with CIVHC and HSRI.	
Timeline updated 12/16/2022	

Testing Requirements

5/29/2023 - 6/26/2023

- Transmit properly named, compressed, and encrypted files via SFTP to the appropriate directory (see details below).
    - Submit at least one of each expected ME, MC, PC, MP file type for January 2023 paid dates by **June 16th**.
    - During this testing period you have the opportunity to test annual file submissions, however, test files are not required to be submitted and passing all intake validations until July 17th.
- Review all validation results and resolve all structural and failure-level validation issues by resubmission.

Please note we have made updates to the Test SFTP folder directories:

- Monthly Claims Test Files (ME, MC, PC, MP) should be transmitted to: [root]/incoming/MthlyTestPortal
- Annual Files in .txt format (AM, CT, DR) should be transmitted to: [root]/incoming/AnnTxtProdPortal
- Annual Files in .xlsx format (VB, AC, PB, PD) should be transmitted to: root]/incoming/AnnExcelProdPortal

Overview of Testing Steps

1. **Prepare January 2023 files in DSG v14 Format:** Properly name files "TEST" according to the file naming convention outlined in DSG v14. Submit each file type typically required to submit.
2. **Compression and Encryption of File(s):** Compress and encrypt your data files using the same method as used in production (256-bit AES or PGP).
3. **Transfer of Compressed and Encrypted File(s) via SFTP:** Transfer the compressed and encrypted files via the SFTP server transfer.norc.org. **See above details for new test folder directories**.
4. **Portal Login:** Login to the CO APCD Test Portal: https://coapcd-test.norc.org. All production portal (https://coapcd.norc.org) user account credentials have been copied to the test portal for use. If you do not have an account or have issues logging into the Test Portal, please contact the Help Desk (civhchelp@hsri.org).
5. **Review and Resolve Validation Issues:** After receiving a notification email, login and review validation issues. Resolve structural and failure-level validation issues.

Step 1: Prepare January 2023 files in DSG v14 Format.

Payers must submit each file type typically required.

Name **monthly claims files** according to the file naming convention outlined in DSG v14:

TEST_PayerID_PeriodEndingDateFileTypeVersionNumber.txt

- TEST: "TEST" for test files
- Payer ID: This is the four-digit payer ID assigned to each submitter
- Period Ending Date: Expressed as CCYYMM (Ex: 202301 indicates a January 2023 end date).

- File Type: Member Eligibility (ME), Medical Claims (MC), Pharmacy Claims (PC), Provider (MP)
- Version number: This is used to differentiate multiple submissions of the same file. This will be important if a file needs to be resubmitted to resolve an issue such as a validation failure. The letter "v" should be used, followed by two digits, starting with v01. You must include the leading zero. Original submissions of all files should be labeled v01. The Portal will not accept files that have the same name as an existing file.
- File extension (.txt)
- *Example: TEST_0000_202301MEv01.txt*

Name **annual files** according to the file naming convention outlined in DSG v14:

TEST_PayerID_SubmissionYearDueFileTypeVersionNumber.txt

- TEST: "TEST" for test files
- Payer ID: This is the four-digit payer ID assigned to each submitter
- Submission year due, expressed as CCYY (four-digit calendar year).
- File Type - APM File (AM), Control Total (CT), APM Contract Supplement (AC), Drug Rebate (DR), PBM Contract Supplement (PB), PDAB (PD), Value Based Purchasing Contract (VB)
- Version number: Used to differentiate multiple submissions of the same file. This is important when a file must be resubmitted to resolve an issue, such as a validation failure. The letter v should be used, followed by two digits, starting with v01. Please include the leading zero. Original submissions of all files should be labeled v01. The Portal will not accept files that have the same name as an existing file.
- File extension (.xlsx for PD, PB, AC and VB files, .txt for AM, CT, and DR files)
- *Example: TEST_0000_2020AMv01.txt*

Step 2: Compression and Encryption of File(s)

Data Preparation

To ensure the security of personally identifiable information and personal health information, and to reduce file transmission times, we require submitters to compress and encrypt all files before submission. Compress and encrypt your data files using the same method as used in production (256-bit AES or PGP).

Step 3: Transfer of Compressed and Encrypted File(s) via SFTP

Data submissions will be made via SFTP.

All files transferred via SFTP will be automatically associated with the submitter account based on the file name. It is important that the files be named per the standard naming convention outlined in CIVHC's Data Submission Guide Version 14 to ensure that the file type and submission periods can properly be discerned.

Please note we have made updates to the Test SFTP folder directories:

- Monthly Claims Test Files (ME, MC, PC, MP) should be transmitted to: [root]/incoming/MthlyTestPortal

- Annual Files in .txt format (AM, CT, DR) should be transmitted to: [root]/incoming/AnnTxtProdPortal
- Annual Files in .xlsx format (VB, AC, PB, PD) should be transmitted to: [root]/incoming/AnnExcelProdPortal

Many tools exist for Secure File Transfer Protocol. FileZilla and WinSCP are two examples. Please refer to your program's documentation for help with setup, if needed.

Connection Information for the SFTP Server:

- **Server Name: transfer.norc.org**
- **Folder Name: see above**
- **User: Same as production**
- **Password: Same as production**

Step 4: Portal Login

You will receive an email notifying you of the file status once the validation is complete. At that time, login to the Test Portal to track the progress of your file. Any user who has an account with the CO APCD Production Portal will be able to use their existing username and password to login to the CO APCD Test Portal here: https://coapcd-test.norc.org. If you have any issues logging in, contact the CIVHC Help Desk.

Step 5: Submission Notification, Review and Resolve Validation Issues

As part of this testing period, we expect you to review the validation results and resolve structural and failure level validation issues by resubmitting a corrected file. The override functionality will be disabled for profile, ad hoc, and exemption level validation issues. Continue reading for details.

Once a file has been submitted via SFTP you will receive a notification that is has been received and is being processed. Files will then be evaluated against a set of data validations before they can proceed for further quality assurance checks. You will receive an email notifying you of the file status once the validation is complete. The validations and validation issues will all be viewable within the Test Portal. Login to the Test Portal and navigate to the **Submissions menu** to track the progress of your file. When files complete processing, they will display a Status of "Error", "Failed", or "Validation Passed".

Processing typically takes under an hour, but we guarantee it will happen within 24 hours. If your submission does not reach one of these statuses within 24 hours and/or you do not receive an email, please contact the Help Desk so that we can investigate. If the validation failed, you would then log in to the Test Portal to view details of the validation results.

Files with a "Validation Failed" status mean your file has failed one or more data intake validations. When this is the case, you will need to click on "Details" to see what the specific issues are. This will take you to a list of issues in the file.

- **Structural Level Validation Issues**: If there are issues with an Issue Type of "Structural", you will need to resolve these before moving on to other issues. Most structural issues cannot be overridden. Structural issues tend to involve file structure and formatting of fields such as too many characters or are in direct conflict with the specification in the Data Submission Guide. You can see additional information about a validation by clicking on "Details". For most structural validations, you will see a message indicating that the error needs correction in the file and will thus need resubmission.

- **Failure Level Validation Issues**: Issues of type "Failure" cannot be overridden. They typically involve an intrinsic issue with the format of the data and will need to be fixed and resubmitted.
- **Profile Level Validation Issues**: Issues of type "Profile" represent validations that vary by book of business and can be overridden with a clear explanation of why you consider the data of sufficient quality. Subsequent failures on the same validation rule will be automatically overridden for the remainder of the calendar year once a Profile override has been established.
- **Exemption Level Validation Issues**: Issues of type "Exemption" can be overridden but require approval from CIVHC. Requesting an override for these issues will require you to supply a time for which you believe you will need the exemption. All overrides are reset yearly, so if you need an exemption past December of a given year, you will need to submit a new request the following year, if your data continues to fail the validation.
- **Ad Hoc Level Validation Issues**: Issues of type "Ad Hoc" may be overridden without the need for CIVHC approval. However, unlike Profile overrides, Ad Hoc overrides will not persist for subsequent failures on the same validation rule such that submitters will need to provide an explanation whenever criteria for such a rule are not met.

Files with a "Validation Passed" status have passed our data intake validations.

Feedback and Questions

If you encounter any issues during testing, please contact the CIVHC Help Desk at civhchelp@hsri.org.

Resources

CO APCD User Manual: https://coapcd-test.norc.org/Home/UserManual

CO APCD Frequently Asked Questions: https://coapcd-test.norc.org/Home/FAQ