CIVHC

CENTER FOR IMPROVING
VALUE IN HEALTH CARE

Member Capitation File

Data Submission Manual | April 2025

Navigation

Introduction

In October 2018 and in accordance with Colorado Regulation 10 CCR 2505-5 1.200, the Department of Health Care Policy and Financing (HCPF) changed the rules governing the Colorado All Payer Claims Database (CO APCD) Data Submission Guide (DSG) to require the Center for Improving Value in Health Care (CIVHC) to collect data on Alternative Payment Models (APMs) and prescription drug rebate information from public and private payers. 10 CCR 2505-5 1.200 provides the following definition:

> "Alternative Payment Model (APM) file" means a detailed file that captures payments made to providers outside of the traditional fee-for-service model. This includes: Foundation Payments for Infrastructure and Operations, Pay for Reporting, Pay for Performance, Shared Savings, Shared Savings and Downside Risk, Risk Based Payments NOT Linked to Quality, Condition-Specific Population-Based Payment, Comprehensive Population-Based Payment, Integrated Finance and Delivery Systems, and Capitated Payments NOT Linked to Quality. APM files are submitted according to the requirements contained in the submission guide.

In 2022, as part of the initiative to develop submission standards, APCD-Council and NAHDO focused on developing a standard for collecting non-claims payments (NCP) data not captured by the All-Payer Claims Database (APCD) Common Data Layout (APCD-CDL™). This effort aimed to provide a standardized data collection tool, enabling comparisons of NCP data across states and programs while reducing the burden of data submission. The NCP Data Layout™ seeks to improve efficiency, reduce administrative costs, and improve accuracy.

In an effort to align the CO APCD with the NCP and to ensure the completeness of non-claim payment collection, CIVHC introduced the Member Capitation file (CF). This file accommodates data on payments made by a payer to a provider for member-attributable services under a capitation arrangement. The programs include primary care, professional, facility, behavioral health, global, laboratory, radiology and/or payments to integrated, comprehensive payment and delivery systems.

The first submission, which is a test file of CF data for 2022-2024, is due from payers by **July 1st, 2025**. CIVHC acknowledges that not all claim systems will have 2024 data by July 1st, 2025, for TEST submission due to run-outs. Payers should contact CIVHC if they experience this issue with the TEST file. Final files for calendar years 2022-2024 are due by **September 1st, 2025.**

This Data Submission Manual provides instructions to assist payers in reporting CF data.

Why Collect APMs and Capitation Data?

The goal of collecting APMs and Capitation 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 Capitation, and we currently lack the ability to track spending and the number of patients receiving care under these models. Collecting data on APMs and Capitation 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 and Capitation (vs. traditional fee-for-service) and track changes over time. Information on APMs also helps 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.

File Submission Instructions and Schedule

Payers should submit CF information according to the following schedule:

Alternative Payment Model and Drug Rebate Data Submission Schedule	
Date	**Files Due**
April 1, 2025	• Waiver request due (if applicable)
July 1, 2025	• Test files with calendar years of 2022-2024 due *
August 1, 2025	• Deadline to update CF contact list in portal
September 1, 2025	• Production files with calendar years of 2022-2024 due **

*CIVHC acknowledges that not all claim systems will have 2024 data by July 1st, 2025, for TEST submission due to run-outs. Payers should contact CIVHC if they experience this issue with their TEST file(s).

** Since this is the first year CO APCD collects Member Capitation data, there will not be level 2 validation and attestation processes.

For the 2025 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.

Annual File Submission Format by File Type		
File Type	**Format**	**Link to Template**
AM: Alternative Payment Model	.txt	**AM File Template** (TBD)
CT: APM Control Total	.txt	**CT File Template** (TBD)
AC: APM Contract (formerly 2nd tab in CT file)	Excel	**AC File Template** (TBD)
DR: Drug Rebate	.txt	**DR File Template** (TBD)
PB: PBM Contract (formerly 2nd tab in DR file)	Excel	**PB File Template** (TBD)
PD: Prescription Drug Affordability Board	Excel	**PD File Template** (TBD)
VB: Value-Based Pharmacy Contract	Excel	**VB File Template** (TBD)

Annual File Submission Format by File Type		
CF: Member Capitation File	.txt	CF File Template (TBD)

Naming conventions should follow the template:

TESTorPROD_PayerID_SubmissionYearDueFileTypeVersionNumber.FileExtension

For example, the following naming conventions will be used for testing and production in 2025:

TEST_0000_2025CFv01.txt
PROD_0000_2025CTv02.txt
TEST_0000_2025VBv01.xlsx

Waiver for CF Files

CIVHC will work collaboratively with payers to ensure that required CF 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 **CF Filing** if their organization does not provide any of these capitation programs:

1) Primary care capitation
2) Professional capitation
3) Facility capitation
4) Behavioral health capitation
5) Global capitation
6) Payment to integrated, comprehensive payment and delivery systems
7) Laboratory capitation
8) Radiology capitation

If you believe your organization is not obligated to submit a CF file, but your circumstances do not fall under any of the items above, please contact CIVHC.

If you believe you are unable to fully comply with the Data Submission Guide's specifications for the CF filing due to other reasons, please contact CIVHC. Do not submit a waiver form as these circumstances are handled separately.

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

Data Submission of CF– General Rules

The following are general rules for completing the CF file. More detail about the content of the CF data submission files is included in later section of this document. A sample of a completed file is included in Appendix B.

CF File Selection Criteria Summary	
Include	**Exclude**
Payments to health care providers	Payments to vendors, other health plans, community organizations that do not provide healthcare services, or payments received from government entities
All health care providers who received capitated reimbursement for member attributable services.	Providers who did not receive any capitated reimbursement during the performance period
Claims and payments attributed to Colorado residents covered by plans regulated by the Colorado Division of Insurance	
Payments for services rendered January 1, 2022 – December 31, 2024, and paid through June 30, 2025	Payments made on or after July 1, 2025
Commercial, Medicaid, and Medicare Advantage lines of business and self-insured plans not subject to ERISA	Prescription only, dental only, vision only lines of business
If ERISA self-insured data is included in a payer's monthly APCD submissions then it should be included in the CF file as well	

Level of Reporting CF Information

The CF data should be reported at the billing provider TIN level and the member that the capitation arrangement is associated with. For example, if the arrangement is under a primary care capitation program, payers are required to submit the payments made to the assigned primary care practice site for that member. If the member goes to another primary care practice site that shares the same TIN as their assigned one, reported payments should be under the same row.

Reporting Member Information

Payers are required to report the member information such as Carrier Specific Unique Member ID, Last name, First Name, Sex, Date of Birth, and Social Security Number. This information needs to align with the reported data in payer's ME files.

- Carrier Specific Unique Member ID should align with ME010 – Member Number
- Last Name should align with ME104 – Member Last Name
- First Name should align with ME105 – Member First Name
- Sex should align with ME013 – Member Gender
- DOB should align with ME014 - DOB
  SSN should align with ME011 – Member Identification Code

Member Population Included

Payers should include only information pertaining members who reside in the state of Colorado. A Colorado resident is defined as any eligible member whose residence is within the State of Colorado, and all covered dependents. An exception to this is subscribers covered under a student plan. In this case, any student enrolled in a student plan for a Colorado college/university would be considered a Colorado resident regardless of their address of record.

For example, if an individual lives in Wyoming but has commercial coverage through their employer based in Colorado, information for this individual would be NOT be included. Conversely, if a Colorado resident works in Wyoming and has commercial coverage through their employer sponsored plan issued in CO, their data would be included.

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.

The members reported in the CF file should be a sub-set of the members included in the monthly ME files.

CF Payment Categories

As part of DSG v16, the HCP LAN category has been replaced with the Expanded Non-Claims Payment Framework (or Expanded Framework) in an effort to align the CO APCD APM Layout with CDL-NCP. The Expanded Framework is a new method to categorize and collect non-claims payments data, built upon two models HCP-LAN and Milbank. The Milbank approach focuses on identifying the purpose of spending, while the HCP-LAN framework categorizes payments based on the level of risk assumed by a provider. In the absence of a national standard for categorizing non-claims payments, Expanded Framework was created and features more specificity in its categories and subcategories than the Milbank and HCP-LAN frameworks. It also allows for analysis of provider risk by mapping to HCP-LAN categories. For instance, the subcategory, "Population Health and Infrastructure Payments: Practice tTansformation Payments," is cross-referenced with HCP-LAN category, Foundational Payments for Infrastructure and Operations. Another feature of the Expanded Framework is its comprehensive approach to capitation: Category 4, "Capitation and Full Risk Payments," includes "primary care capitation" and "professional capitation," which includes specialty services, among its six subcategories.

Details about the Expanded Framework's categories and sub-categories can be found below.

The applicable categories for the CF file are:

- **D – Capitation and Full Risk Payments which includes the subcategories of**
  - **D1 - Primary Care Capitation**
  - **D2 - Professional Capitation**
  - **D3 - Facility Capitation**
  - **D4 - Behavioral Health Capitation**
  - **D5 - Global Capitation**
  - **D6 - Payments to Integrated, Comprehensive Payment and Delivery Systems.**

#	Non-claims-based Payment Categories and Subcategories	Corresponding HCP-LAN Category
A	**Population Health and Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	2A
A2	Primary care and behavioral health integration	2A
A3	Social care integration	2A
A4	Practice transformation payments	2A
A5	EHR/HIT infrastructure and other data analytics payments	2A
B	**Performance Payments**	
B1	Pay-for-reporting payment	2B
B2	Pay-for-performance payments	2C
C	**Shared Savings Payments and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	3A, 3N
C2	Procedure-related, episode-based payments with risk of recoupments	3B, 3N
C3	Condition-related, episode-based payments with shared savings	3A, 3N

C4	Condition-related, episode-based payments with risk of recoupments	3B, 3N
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A, 3N
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B, 3N
D	**Capitation and Full Risk Payments**	
D1	Primary Care Capitation	4A, 4N
D2	Professional Capitation	4A, 4N
D3	Facility Capitation	4A, 4N
D4	Behavioral Health Capitation	4A, 4N
D5	Global Capitation	4B, 4N
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C, 4N
E	**Other Non-Claims Payments**	

For additional information regarding the Expanded Framework, please go to:

https://www.milbank.org/2024/03/a-new-standard-for-categorizing-and-collecting-non-claims-payment-data/

https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/

Lines of Business Included

Payers should submit CF data for Commercial, Medicaid and Medicare Advantage lines of business and self-insured plans not subject to ERISA. If the payer currently provides information for ERISA self-insured plans in monthly claims submissions, data for these members should be included in the CF submission. Please direct any questions to CIVHC.

Payers are not required to submit CF data for these types of coverage: prescription drug benefits only or vision benefits only.

Below is a detailed list of included and excluded lines of business:

- Lines of business that must be included:
  (A) Medicare (parts C, D, and Dual Special Needs Plans);
  (B) Medicaid;
  (D) Individual;
  (E) Small employer health insurance;
  (F) Large group;
  (G) Associations and trusts;
  (H) Self-insured plans not subject to ERISA
  (I) Self-insured plans subject to ERISA, if data for these members are included in monthly claims submissions
  * Line of Business inclusion might vary for payers due to their system. Payers should adhere to the guideline above unless agreement with CIVHC otherwise.

- Lines of business that should be excluded:
  (A) Accident policy;
  (B) Disability policy;
  (C) Hospital indemnity policy;
  (D) Long-term care insurance;
  (E) Medicare supplemental insurance;
  (F) Specific disease policy;
  (G) Stop loss only policy;
  (H) Student health policy;
  (I) Supplemental insurance that pays deductibles, copays or coinsurance;
  (J) Vision-only insurance;
  (K) Workers compensation;
  (L) Prescription drug only policy;
  (M) Dental-only insurance;

Performance Period

The CF submission performance periods are calendar years and should include capitated payments for member-attributable services incurred during each calendar year. The period start date should be the beginning of the reporting period covered for the contract performance. The period end date should be the end of the reporting period covered for the contract performance.

All three Performance Years included in this year's filing (2022, 2023, 2024) should include all capitated payments paid through June 30, 2025.

When payments occur during contract periods that fall partly outside of the submission calendar year, contact CIVHC to discuss the proper method of reporting these payments.

CF Data Submission File Content and Dictionary

File submitted via .txt format

CF File Header Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	Char	2	CF
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 APM file, excluding header and trailer records
HD007	Med_BH PMPM	int	7	Place holder. Leave field value blank.
HD008	Pharmacy PMPM	int	7	Place holder. Leave field value blank.
HD009	Dental PMPM	int	7	Place holder. Leave field value blank.
HD010	Vision PMPM	int	7	Place holder. Leave field value blank.

CF File Trailer Record

TR001	Record Type	char	2	CF
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

CF File

File submitted via .txt format

Data Element	Name	Type	Max Length	Description/Valid Values
CF001	Payer Code	varchar	8	Distributed by CIVHC
CF002	Reporting Period Start Date	integer	6	YYYYMM. Beginning of reporting period covered for contract performance.
CF003	Reporting Period End Date	integer	6	YYYYMM. End of reporting period covered for contract performance.
CF004	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier/submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's/submitter's files for reporting and aggregation.
CF005	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.
CF006	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name
CF007	Member Middle Initial	varchar	1	The member's middle initial. If the member is the subscriber, report the subscriber's middle initial.

CF008	Member Sex	char	1	Sex of the member. M=Male F=Female U=UNKNOWN Member sex represents biological or administrative sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have access to regarding physical or legal sex (e.g., administrative sex as categorized by X12 values)
CF009	Member Date of Birth	date	8	Date of birth of the member. If the member is the subscriber, report the subscriber's date of birth. YYYYMMDD.
CF010	Member Social Security Number	char	9	The member's Social Security Number. If the member is the subscriber, report the subscriber's Social Security Number. Do not include dashes. Leave blank if not collected.
CF011	Billing Provider ID	varchar	35	Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change.

CF012	Billing Provider NPI	char	10	National Provider Identifier (NPI) for the billing provider as enumerated in the Center for Medicaid and Medicare Services National Plan & Provider Enumeration System (NPPES).
CF013	Billing Provider Tax ID	char	9	Tax ID of the billing provider. Do not code punctuation.
CF014	Billing Provider Last Name or Organization	varchar	60	Full name of provider billing organization or last name of individual billing provider.
CF015	Billing Provider First Name	varchar	35	Individual first name. If provider is a facility or organization, leave blank.
CF016	Insurance/Product Category Code	char	2	See B.1.A Insurance Type for codes. Use the most granular choice available.
CF017	Payment Subcategory	char	2	D1 = Primary care capitation D2 = Professional capitation D3 = Facility Capitation D4 = Behavioral health capitation D5 = Global capitation D6 = Payment to integrated, comprehensive payment and delivery systems D7 = Laboratory capitation D8 = Radiology capitation
CF018	Total Paid Amount	numeric	15	Total of all payments made to a contractor during the Reporting/Performance Period. Two explicit decimal places (e.g., 200.00). This field may contain a negative value.

CF019	Record Type	char	2	Value = CF

Appendix A: Waiver Instructions and Form

Data Submitter Request Form
Waiver of Annual File Submissions

Waiver Submission Tracking	
Annual File Submission Year:	*YYYY*
Data Submitter Code/Name (**one** per form):	*0000 / Entity Name*
Submitter Contact Name:	
Submitter Contact Email:	
Date of Form Submission to CIVHC:	
Date of CIVHC Decision:	Compliance Decision on

The Center for Improving Value in Health Care (CIVHC), in its role as the Colorado All Payer Claims Database (CO APCD) Administrator, will work collaboratively with CO APCD Data Submitters to support their compliance with regulatory submission requirements.

In addition to monthly file submissions, Data Submitters must submit eight (8) more files on an annual basis related to drug rebates and Alternative Payment Models (APMs). These submission requirements are defined in C.R.S. 10-16-1405 and CO APCD governing statute 10 CCR 2505-5-1.200. Details about annual files' structure and content can be found in the Data Submission Guide and related Data Submission Manuals.

To be considered for waiver from the annual file submission requirement for one year, Data Submitters must complete the following:

1. Indicate on pages 2 and 3 of this form which files are requested waived from the annual submission requirement and provide the reason for waiver request.
2. Read the Agreement to Waiver Conditions included in this document.
3. Certify this form with a signature from the organization's authorized signatory (e.g., Chief Information Officer, Regulatory Compliance Officer, etc.) asserting that the Data Submitter cannot meet the submission requirements because the requested information is not available and cannot be derived from the Data Submitter's information systems.
4. **Submit this form to Submissions@CIVHC.org no later than April 1** to be considered for production files due September 1 of the same calendar year.

This form will be returned with CIVHC's decision to the Data Submitter by June 1 of the calendar year in which it is submitted. An approved waiver applies only to the submission year in which it is approved (i.e., a new waiver request must be submitted every calendar year).

Back to Top 020-011.1-FOR 202502 1

Data Submitter Request Form
Waiver of Annual File Submissions

Waiver Request Details

See the CIVHC's Submitter Resources web page for the below files' respective Data Submission Manuals.

The Data Submitter named in this document requests waiver of the annual submission requirement for the following file(s):

Alternative Payment Model (APM) Files	
File Abbreviation and Name	Reason for Waiver Request
☐ AM – APM File[1]	Choose an item.
	CIVHC Decision: ☐ **Approved** ☐ **Denied**
☐ CT – APM Control Total[1]	Choose an item.
	CIVHC Decision: ☐ **Approved** ☐ **Denied**
☐ AC – APM Contract Information[1]	Choose an item.
	CIVHC Decision: ☐ **Approved** ☐ **Denied**
Drug Rebate (DR) Files	
File Abbreviation and Name	Reason for Waiver Request
☐ DR – Drug Rebate Data[1]	Choose an item.
	CIVHC Decision: ☐ **Approved** ☐ **Denied**
☐ PB – PBM Contract Information[1]	Choose an item.
	CIVHC Decision: ☐ **Approved** ☐ **Denied**
☐ PD – PDAB Collection Information[2][3]	Choose an item.
	CIVHC Decision: ☐ **Approved** ☐ **Denied**

[1] Annual submission requires the three (3) calendar years preceding the reporting year (e.g, the 2025 submission will include files for 2022, 2023, and 2024 reporting years).
[2] Submission is required under C.R.S. 10-16-1405: "Each carrier and each pharmacy benefit management firm acting on behalf of a carrier shall report to the all-payer health claims database."
[3] Annual submission requires one (1) calendar year preceding the submission year (e.g., the 2025 submission will include the 2024 reporting year).

Back to Top 020-011.1-FOR 202502 2

Data Submitter Request Form
Waiver of Annual File Submissions

☐ VB – VBPC Collection Information[4]	Choose an item. **CIVHC Decision:** ☐ **Approved** ☐ **Denied**
Other Files	
File Abbreviation and Name	Reason for Waiver Request
☐ CF – Member Capitation Collection Information[1]	Payer does not contract with any of the following capitated programs: Primary Care Capitation Professional Capitation Facility Capitation Behavioral Health Capitation Global Capitation Payment to Integrated Comprehensive Payment and Delivery Systems Laboratory Capitation Radiology Capitation **CIVHC Decision:** ☐ **Approved** ☐ **Denied**
Additional Comments from Data Submitter (Optional)	
Additional Comments from CIVHC (Optional)	

[4] Annual submission requires the four (4) calendar years preceding the submission year (e.g, the 2025 submission will include files for 2021, 2022, 2023, and 2024 reporting years).

Data Submitter Request Form

Waiver of Annual File Submissions

Agreement to Waiver Conditions

1. This Agreement to Waiver Conditions ("Agreement") is made and entered as of the date of the last signature obtained below (the "Effective Date") by and between CIVHC, in its capacity as the CO APCD Administrator, and the submitting entity named in this document ("Data Submitter").

2. The Data Submitter requests, and CIVHC hereby grants, waiver from the annual submission requirement of the file(s) selected by the Data Submitter under *Waiver Request Details* ("Waiver") and marked with CIVHC Decision "Approved."

3. The Data Submitter acknowledges and agrees that the Waiver granted under this Agreement will remain in effect only through **SELECT DATE**, or until such time as the Data Submitter is reasonably able to submit the required annual files in accordance with the Data Submission Guide ("DSG"), whichever is earlier.

4. The Data Submitter acknowledges and agrees that the Waiver granted under this Agreement is temporary in nature, effective only for the term described in the previous provision and granted based on current systematic issues or limitations that, according to CIVHC's understanding and under CIVHC's sole discretion, prevent the Data Submitter from complying with the DSG.

5. The granting of any Waiver, under this Agreement or otherwise, provides no guarantee of the approval or granting by CIVHC of any future request for Waiver from the Data Submitter.

6. As a condition of being granted this Waiver, the Data Submitter agrees that it will act in a reasonable and diligent manner to correct the systematic issues or limitations that prevent it from complying with the DSG as soon as reasonably possible.

7. By signing this Agreement, the Data Submitter certifies that it cannot currently meet the DSG's requirements because (a) the required data is not reasonably available within Data Submitter's systems, and/or (b) the required data cannot be reasonably derived from data that is available within Data Submitter's systems.

Data Submitter Acknowledgement		CIVHC Acknowledgement	
Signature:		Signature:	
Name:		Name:	
Title:		Title:	
Date:		Date:	

Back to Top 020-011.1-FOR 202502 4

Appendix B: Sample of Completed CF Data File

Please note that this example only contains 15 providers-members. Production files should include 3 years' worth of data and contain all billing providers who received payments from payers.

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CF|0|Example Insurance Company|202201|202412|15||||
CF001|CF002|CF003|CF004|CF005|CF006|CF007|CF008|CF009|CF010|CF011|CF012|CF013|CF014|CF015|CF016|CF017|CF018|CF019
0|202201|202412|12345XYZ|Doe|Jane|A|F|19900102|000000000|Provider1|1234567890|987654321|Great Doctor Office||HM|D2|1000.00|CF
0|202201|202412|XYZ123|Smith|David||M|20001230|000000001|Provider2|0987654321|123456789|Jordan|Michael|16|D1|753951.00|CF
0|202201|202412|ABC123321|Johnston|John|B|U|19600101|000000002|Provider3|1357924680|789456123|Denver Family Medicine||12|D6|12345.00|CF
0|202201|202412|123CBA|Thompson|Alex||M|19540804|000000003|Provider4|0864213579|999999999|Foster|Liam|CP|D5|98712.00|CF
0|202201|202412|CBAABC111|Clark|Nora||F|19400825|000000004|Provider5|5846729031|104839657|Littleton Wellness Clinic||12|D6|5762.00|CF
0|202201|202412|000X78901|Bennett|Leo|C|M|20000615|000000005|Provider6|4713928560|726451983|Advanced Pediatric Group||HM|D5|65341.00|CF
0|202201|202412|APCD98765X|Parker|Maya||F|19460205|000000006|Provider7|5839264710|295764813|Evergreen Health Center||MS|D4|896451.00|CF
0|202201|202412|123ABC123|Reed|Ethan||M|19500723|000000007|Provider8|7390152846|648293107|Ross|Benjamin|CP|D1|159753.00|CF
0|202201|202412|987ID45603|Hunter|Maxwell||M|19901231|000000008|Provider9|6182493750|281657394|Moore|Owen|12|D3|3500.00|CF
0|202201|202412|B00080015|Montgomery|Collin||M|19860524|000000009|Provider10|9057384126|507213846|Rocky Mountain Health Partners||16|D2|7981.50|CF
0|202201|202412|MEMBER123|Wells|Chloe||F|19780630|000000010|Provider11|1328456901|382746159|Summit View Medical Group||HM|D3|74685.00|CF
0|202201|202412|SUBSCRIBER321|Mitchell|Emma||F|19520601|000000011|Provider12|3048562971|104839657|Aspen Grove Medical Associates||EP|D3|56985.45|CF
0|202201|202412|CFFILEID02|Lee|Jackson||U|19720909|000000012|Provider13|2468195730|849302176|Clear Creek Family Care||QM|D2|984561.00|CF
CF|0|Example Insurance Company|202201|202412|20250815
```

Link: CF Detailed Blank File (TBD)

Link: CF Detailed Scenario File (TBD

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	AC001	AC002	AC003	AC004	AC005	AC006	AC007	AC008	AC009	AC010	AC011	AC012	AC013	AC014	AC015
2	**Payer Code**	**Payer Name**	**Contract Type Name**	**Contract Description** -- Description of the alternative payment model contract 3-5 sentences describing the nature of the contract including a summary of services provided, provider reimbursement method, and any other important details related to the purpose and structure of the contract	**Involves both claims and non-claims** C = claims only N = non-claims only B = both claims and non-claims	**Services Covered** N = non-medical activities only S = specific set of medical services M = comprehensive medical services	**Involves measurement of quality** (Y/N)	**Involves measurement of spending targets** (Y/N)	**Payments are prospective or retrospective** PR = prospective w/ retrospective reconciliation PN = prospective w/o retrospective reconciliation RT = retrospective N/A = not applicable	**Payment is population-based** (Y/N)	**Risk to Provider** U = upside only D = downside only B = both upside and downside N/A = not applicable	**Payment model involves quality measurement of drug utilization or spending (Y/N)**	**Provider Type** PC = Primary Care BH = Behavioral Health OT = Other	**Assigned LAN Category**	**Comments**
3	0000	Example Insurance Company	HIT Payments Program	Program provides payments to practices that sign up to modernize their software. After providers sign up, there is a one-time payment issued for software developments.	N	N	N	N	N/A	N	N/A	N	PC, BH, OT	2A	
4	0000	Example Insurance Company	Patient Centered Medical Home	The practice receives a monthly PMPM infrastructure payment in order to provide additional services such as care coordination and health education. Clinical services provided by PCMH practices are reimbursed solely on a fee-for-service basis.	N	N	N	N	PN	Y	N/A	N	PC	2A	
5	0000	Example Insurance Company	Bonus Incentive Program	Program incentivizes primary care doctors to hit certain quality measures. Quality measures include decreasing avoidable ED visits. Provider receives an additional quarterly PMPM bonus payment on top of FFS payments if targets are hit.	B	M	Y	N	RT	Y	N/A	N	PC, BH	2C	*Note that AC005 is submitted as 'B' because this arrangement includes both the non-claims bonus payments and the claims payments used to evaluate performance. Corresponding 2C records should include both claims and non-claims payments in the APM/CT files.*
6	0000	Example Insurance Company	Shared Savings Program	A provider participates in a shared savings arrangement in which the payer will make a retrospective payment to the provider if the actual spending on the provider's attributed population is less than expected spending and the provider performs well on specific HEDIS performance measures during the performance period. This program encompasses all medical services delivered by the participating provider to their attributed population.	B	M	Y	Y	RT	Y	U	N	OT	3A	
7	0000	Example Insurance Company	Musculoskeletal Capitation Program	Program provides PMPM payments to physician practices for treatment of musculoskeletal disorders in lieu of FFS payments. Provider has the responsibility of staying within the budget provided with the PMPM payments. Providers are requried to meet certain quality benchmarks, including selected HEDIS measures, to continue to participate in the program.	N	S	Y	Y	PR	Y	B	N	OT	4B	
8	0000	Example Insurance Company	Primary Care Capitation Program	A primary care provider receives a capitation payment for all primary care services for its attributed members. There is no link to quality in the payment model.	N	S	N	N	PN	Y	B	N	PC	4N	
9															

Appendix C: Expanded Non-claim Payment Framework Category Definitions

#	Non-claims-based Payment Categories and Subcategories	Draft Definition
A	**Population Health and Infrastructure Payments**	**Prospective, non-claims payments paid to healthcare providers or organizations to support specific care delivery goals; not tied to performance metrics. Does not include costs associated with payer personnel, payer information technology systems or other internal payer expenses.**
A1	Care management/care coordination/population health/medication reconciliation	Prospective, non-claims payments paid to healthcare providers or organizations to fund a care manager, care coordinator, or other traditionally non-billing practice team members (e.g., practice coach, patient educator, patient navigator, pharmacist, or nurse care manager) who helps providers organize clinics to function better and helps patients take charge of their health.
A2	Primary care and behavioral health integration	Prospective, non-claims payments paid to healthcare providers or organizations to fund the integration of primary care and behavioral health and related services that are not typically reimbursed through claims (e.g., funding behavioral health services not traditionally covered with a fee-for-service payment when provided in a primary care setting). Examples of these services include a) substance use disorder or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, c) supporting health behavioral change, such as diet and exercise for managing pre-diabetes risk, d) brief interventions with a social worker or other behavioral health clinician not reimbursed via claims.

A3	Social care integration	Prospective, non-claims payments paid to healthcare providers or organizations to support screening for health-related social needs, connections to social services and other interventions to address patients' social needs, such as housing or food insecurity, that are not typically reimbursed through claims.
A4	Practice transformation payments	Prospective, non-claims payments paid to healthcare providers or organizations to support practice transformation which may include care team members not typically reimbursed by claims, technical assistance and training, and analytics.
A5	EHR/HIT infrastructure and other data analytics payments	Prospective, non-claims payments paid to healthcare providers or organizations to support providers in adopting and utilizing health information technology, such as electronic medical records and health information exchanges, software that enables practices to analyze quality and/or costs, and/or the cost of a data analyst to support practices.
B	**Performance Payments**	**Non-claims bonus payments paid to healthcare providers or organizations for reporting data or achieving specific goals for quality, cost reduction, equity, or another performance achievement domain.**
B1	Pay-for-reporting payment	Non-claims bonus payments paid to healthcare providers or organizations for reporting data related to quality, cost reduction, equity, or another performance achievement domain.
B2	Pay-for-performance payments	Non-claims bonus payments paid to healthcare providers or organizations for achieving specific, predefined goals for quality, cost reduction, equity, or another performance achievement domain.
C	**Shared Savings Payments and Recoupments**	**Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. Dollars reported in this category should reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. Recouped dollars should be reported as a negative**

		value. Payments in this category are considered "linked to quality" if the shared savings payment or any other component of the provider's payment was adjusted based on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the shared savings payment, then the shared savings payment would be considered "linked to quality."
C1	Procedure-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for- service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.
C2	Procedure-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a procedure- based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.
C3	Condition-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for- service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.

C4	Condition-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.
C5	Risk for total cost of care (e.g., ACO) with shared savings	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for- service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 40% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 20% if they do not meet minimum savings requirements.
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers with a minimum of 50% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for

		shared savings at a lower rate of 25% if they do not meet minimum shared savings requirements. These models also must put providers at risk for at least 30% losses. Models offering less than this degree of risk are classified as "Risk for total cost of care with shared savings."
D	**Capitation and Full Risk Payments**	**Per capita, non-claims payments paid to healthcare providers or organizations to provide a defined set of services to a designated population of patients over a defined period of time. Payments in this category are considered "linked to quality" if the capitation payment or any other component of the provider's payment was adjusted based on specific, pre-defined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the capitation payment, then the capitation payment would be considered "linked to quality."**
D1	Primary Care Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide primary care services to a designated patient population over a defined period of time. Services are restricted to primary care services performed by primary care teams.
D2	Professional Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide professional services to a designated patient population over a defined period of time. Services typically include primary care clinician, specialty care physician services, and other professional and ancillary services.
D3	Facility Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide inpatient and outpatient facility services to a designated patient population over a defined period of time.
D4	Behavioral Health Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide behavioral health services to a designated patient population over a defined period of time. May include professional, facility, and/or residential services.

D5	Global Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital, and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out.
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	Per capita, non-claims payments paid to healthcare organizations and providers to provide a comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out. This category differs from the global capitation category because the provider organization and the payer organization are a single, integrated entity.
E	**Other Non-Claims Payments**	**Any other payments to a healthcare provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit. It also includes governmental payer grants and shortfall payments to providers (e.g., Disproportionate Share Hospital payments and FQHC wraparound payments).**

Appendix D: Frequently Asked Questions

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

Test files for CF are due by July 1, 2025. Test files should include data for the previous three calendar years – 2022, 2023, 2024. Please note that CIVHC acknowledges that not all claim systems would have 2024 data by July 1st, 2025 for TEST submission due to run-outs. Payers are recommended to reach out to CIVHC if they experience this issue with TEST file.

Final production files are due by September 1, 2025. Production files must be submitted with data for the previous three calendar years – 2022, 2023, 2024.

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

For example, the following naming conventions will be used for testing and production in 2025:

TEST_0000_2025AMv01.txt
PROD_0000_2025CTv02.txt
TEST_0000_2025ACv01.xlsx
PROD_0000_2025ACv02.xlsx

3) **What is the objective of the CF files?**

The overarching goal of the APMs/CF 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/Capitated Payments 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/CF 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 CF file captures detailed information about each provider, members and the dollars the provider receives under a member-attributable service.

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

For the CF file, please submit separate files for each payer code. If you are unable to report the 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 CF file differ from instructions related to the Drug Rebate file.

5) **What is the timeframe of the payments included in the CF file?**

These files require information for each of the three most recent calendar years (2022, 2023 and 2024). The year (CF002 – CF003) signed based on service or incurred date rather than paid date. Include all capitated payments made on or before June 30, 2025.

When contracts fall partly outside of the submission period ("performance period") and payments cannot be exclusively attributed to the submission period, please contact CIVHC to discuss the method of reporting these data.

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

Please complete the form from Appendix A, "Data Submission Waiver Instructions and Forms" 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 April 1, 2025.

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. CIVHC understands that the data collected in the CF 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. Since this is the first year the CF data is collected, CIVHC will not perform level 2 validation. However, a comparison between the CF and APCD data could be a potential validation check point for future submission.

8) **Who is obligated to submit the CF file?**

Payers that submit data to the CO APCD and reimburse providers under any capitated payment model for member-attributable services are required to submit the CF file.

9) What level of reporting is required for the CF file?

All payments to billing providers and large provider organizations (e.g., IPAs) must be reflected only once per member 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.

10) Should we be reporting information (NPI, tax ID, entity type) for the entity/organization where a payment is actually sent to, or from 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 should 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.

11) 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.

12) What should be included in Record Type (CF999)?

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

13) How do I know if my files have been accepted and passed the validation process?

Although you receive automated confirmation emails when you submit monthly files, you will not receive an automated email after submitting your annual CF file. If your file has not been

received in the correct folder by the due date, a representative from CIVHC will send an email requesting immediate submission.

A typical validation process for existing annual files such as APM, Drug Rebates, etc. is as follows: After CIVHC has conducted a check of the validity of the data in your files against the data in the CO APCD, you will receive an email with a list of questions about your file. After all questions have been answered and the remaining issues have been resolved, CIVHC will notify you by email.

Please NOTE that since this is the first year that CIVHC collects CF data, level 2 validation will not be performed. Payers might receive questions from CIVHC regarding the file, however, it should not affect the passing status of the file.

Appendix E: 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.

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).

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 F: CO APCD Data Submission Guide Version 16 Testing Instructions

Member Capitation File

Data Submission Manual | April 2025

Last Updated: April 9, 2025

Introduction

This document contains your instructions to begin testing APM File (AM), Control Total (CT), APM Contract Supplement (AC), Drug Rebate (DR), PBM Contract Supplement (PB), PDAB (PD), Value Based Purchasing Contract (VB), Member Capitation (CF) files in the Data Submission Guide Version 16 format for the Colorado APCD.

Data Submission Guide Version 16 Overall Implementation Timeline

DSG 16 Timeline		
Task	**Due Date**	**Complete**
Payer Connect Calls	Bimonthly	Ongoing
Request for DSG feedback (monthly and annual files)	Ongoing	✓
Initial Payer feedback due	8/1/2024	✓
CIVHC distribute updated DSG 16 draft based on stakeholder feedback	9/1/2024	✓
CIVHC File Rule Packet with HCPF	10/4/2024	✓
Public Review Meeting	10/30/2024	✓
Executive Director Hearing	11/22/2024	✓
Rule Effective	3/1/2025	✓
Annual Override Reset	2/28/2025	✓
Monthly Data Files (ME, MC, PC, MP) Testing and Implementation		
Submitter testing of DSG v16 in Test Portal (ME, MP, MC, PC)	6/2 – 6/20	
April 2025 due in DSG v15 in Production Portal	6/1/2025	
April 2025 Submissions Must be in a Status of Validation Passed	6/15/2025	
Production Portal closed for upgrades. DSGv15 format no longer accepted. Files submitted in DSGv16 format between 6/24 and 6/25 will be processed on 6/26/2025	6/23/2025	
DSG v16 Production Portal Go Live	6/26/2025	
May 2025 Submissions Due in DSG v16 – no less than 120 days after Rule Effective Date	7/1/2025	
May 2025 Submissions Must be in a Status of Validation Passed	7/15/2025	
Annual Data File (AM, CT, DR, AC, VB, PD, PB) Testing and Implementation		
Annual File Submission Waivers Due	4/1/2025	✓
Test files with 2022, 2023, 2024 data due (AM, CT, AC, DR, PB)	7/1/2025	
Test files with 2021, 2022, 2023, 2024 data due (VB)		
Test files with 2024 data due (PD, CF)		
Production files with above reporting data by file type due	9/1/2025	
PLEASE NOTE: If you are onboarding to the CO APCD follow the timeline discussed with CIVHC and HSRI.		
Timeline updated 04/09/2025		

Testing Requirements

7/1/2025 – 7/17/2025

- Transmit properly named, compressed, and encrypted files via SFTP to the appropriate directory (see details below).
- During this testing period you will test annual file submissions, with test files to be submitted and passing all intake validations by July 17th.
- Review all validation results and resolve all structural and failure-level validation issues by resubmission.
- Annual Files in .txt format (AM, CT, DR, CF) 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 the applicable files in DSG v16 Format:** Properly name files "TEST" according to the file naming convention outlined in DSG v16. 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 Production Portal: https://coapcd.norc.org. If you do not have an account or have issues logging into the Prod 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 Annual Files in DSG v16 Format.

Name **annual files** according to the file naming convention outlined in DSG v16: 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), Member Capitation (CF).
- 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, DR and CF files)
- *Example: TEST_0000_2024AMv01.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 16 to ensure that the file type and submission periods can properly be discerned.

- Annual Files in .txt format (AM, CT, DR, CF) 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 it 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 and will move on to the level II data quality validation process.

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