CIVHC

CENTER FOR IMPROVING VALUE IN HEALTH CARE

Alternative Payment Models

Data Submission Manual | April 2025

Navigation

Acknowledgement

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

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.

The first submission, which is a test file of APM 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 APM data.

Why Collect APM Data?

The goal of collecting APM data is to track progress in the transition from fee-for-service to value-based reimbursement and, ultimately, to evaluate the impact of APMs on quality and cost of care. There are a growing number and variety of APMs, and we currently lack the ability to track spending and the number of patients receiving care under these models. Collecting data on APMs will enable researchers, policy makers, health plans, providers and other stakeholders to establish baseline information regarding current spending levels and the number of patients receiving health care under APMs (vs. traditional fee-for-service) and track changes over time. Information on APMs also 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 APM 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 APM contact list in portal
September 1, 2025	Production files with calendar years of 2022-2024 due
October 15, 2025	Deadline for all APM files (CT, AM, AC) to pass CIVHC QC Validation
October 31, 2025	Deadline for attestation form to be signed and submitted to CIVHC for APM files

*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).

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. 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	AM File Template
CT: APM Control Total	.txt	CT File Template
AC: APM Contract (formerly 2nd tab in CT file)	Excel	AC File Template
DR: Drug Rebate	.txt	DR File Template
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
CF: Member Capitation File	.txt	CF 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 2025:
TEST_0000_2025AMv01.txt
PROD_0000_2025CTv02.txt
TEST_0000_2025VBv01.xlsx
PROD_0000_2025PBv02.xlsx

Waiver for APM Related Files

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

CIVHC will consider data submitters' requests for waiver from the APM filing submission requirement under certain circumstances. Data submitters should complete a Data Submitter Request Form for Waiver of Annual File Submissions (see Appendix A) for the **APM filing** if their organization meets one of the following criteria:

1) Payer does not provide medical benefits (e.g., payer only provides prescription drug benefits, payer only provides dental benefits, etc.)
2) Payer only provides supplemental insurance (e.g., Medicare Supplemental policies only)
3) Payer only reimburses providers on a Fee-for-Service model

If you believe your organization is not obligated to submit an APM file but one of the three criteria above are not applicable, please contact CIVHC.

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

See Appendix A for instructions for filing a waiver and waiver form.

Changes to APM Data Submission Manual

The following are changes to this APM Data Submission Manual, which were adopted following the DSG v16 Rule Hearing on November 22, 2024:

AM File:

- Addition to the Header portion of the AM file:
    - Med_BH PMPM (HD007), Pharmacy PMPM (HD008), Dental PMPM (HD009), and Vision PMPM (HD010) were added as a place holder to align all file header records for processing purposes

- Update on AM007 – Payment Arrangement Category to align with the Non-Claims Payer Expanded Framework Model
- Addition of the following fields to align with the CDL-NCP layout:
    - AM025 – Contract Number
    - AM026 – Billing Provider First Name
    - AM027 – Payment Subcategory
    - AM028 – Member Count
    - AM029 – Total Member Responsibility Amount
    - AM030 – Total Amount Paid for Behavioral Health
- Correct field reference in descriptions of several fields

CT File:

- Addition to the Header portion of the CT File:
    - Med_BH PMPM (HD007), Pharmacy PMPM (HD008), Dental PMPM (HD009), and Vision PMPM (HD010) were added as a place holder to align all file header records for processing purposes
- Clarifying the case sensitivity requirement for CT003
- Update the CT006 – Payment Arrangement Category to align with the Non-Claims Payer Expanded Framework Model
- Clarifying the calculation for CT019 – Percent of Providers Participating in at least one APM contract
- Addition of the following fields to align with the CDL-NCP layout:
    - CT020 – Payment Subcategory
    - CT021 – Payment Arrangement Category Member Count
    - CT022 – All Member Count
    - CT023 – Total Alternative Arrangement Member Count
    - CT024 – Total Member Responsibility Amount
    - CT025 – Total Amount Paid for Behavioral Health

- Correct field reference in descriptions of several fields

AC File:

- Addition of the following fields to align with the CDL-NCP layout:
    - AC016 – Contract Number
    - AC017 – Contract Type

Data Submission of APM Details – General Rules

The submission of APM data involves the completion of three files:

- **Alternative Payment Model file (AM)**: Captures payment details of each APM, submitted at the billing provider level of granularity. **APM Control Total file (CT)**: Provides a control total, or summary of APM details at a more aggregated level of granularity. **APM Contract Information file (AC)**: Provides high-level, qualitative attributes and details surrounding each type of APM reported in the AM/CT files.

The following are general rules for completing the first file. More detail about the content of the APM data submission files is included in this document. A sample of a completed file is included in Appendix B. Rules for completing the control total file can also be found in this document.

APM 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 reimbursement, including providers who only have fee-for-service arrangements, during the performance period	Providers who did not receive any reimbursement during the performance period
Claims and payments paid as primary	Claims paid as secondary or tertiary payer
Claims and payments attributed to Colorado residents covered by plans regulated by the Colorado Division of Insurance	

APM File Selection Criteria Summary	
Include	Exclude
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 CO APCD submissions, then it should be included in the APM file as well	

A. Level of Reporting APM Information

In accordance with the 10 CCR 2505-5 1.200, payers must report APM information at the billing provider level. All claims and non-claims payments shall be reported for each billing provider or organization and payment arrangement type.

The type of APM to which a provider organization and a member should be attributed is determined by the contractual arrangement between the payer and the provider organization. All payments for services reimbursed under a given arrangement and/or services that are considered when determining incentive payments, including both claims and non-claims expenditures, should be submitted under the same payment arrangement category.

For example, for a physician group with a contract specifying prospective per member per month payment for comprehensive health care services, payments should be classified as a comprehensive population-based payment arrangement (E4) in the payment arrangement category column (AM007). The payment amount should be recorded under the non-claims payments fields (AM014, AM015, AM018, and AM019).

For providers under a procedure-based bundled payment contract who receive FFS payments with a retrospective reconciliation, the payment amount is classified as an APM with Shared Savings and Downside Risk (B3, D3 or F3). The payment amount associated with the FFS payment mechanism should be recorded under the claims payments fields (AM012, AM013, AM016 and AM017) and the financial settlement should be recorded under the non-claims payments fields (AM014, AM015, AM018, and AM019). **Both the claims and non-claims elements to the B3, D3 or F3 arrangement should be reported on the same record.** Please refer to Appendix B for an example on how to correctly submit these types of payments.

For providers under a pay-for-performance contract, include both the incentive payments and all payments for services that are considered when evaluating provider performance, even if the services

are reimbursed on a FFS basis, under B2 (Pay-for-Performance). The claims payments for services are considered B2 and not category X9 (Fee-For-Service) because the care is delivered with the performance incentive in mind and are therefore linked to quality. **Both the claims and non-claims elements to the B2 arrangement should be reported on the same B2 record.**

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

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

The APM file should only include payments to health care providers. It should NOT include payments to vendors, other payers/health plans or payments received from government entities.

B. Reporting Payments

B(i). Payments to Include

The APM data files are meant to capture all payments to providers, not just alternative payments. Fee-for-service is included as a required payment arrangement category for reporting. Therefore, if the only payment made to a billing provider was under a FFS arrangement, then the claims payment fields (AM012, AM013, AM016 and AM017) should be populated with the appropriate payment amounts and non-claims payment fields (AM014, AM015, AM018, and AM019) should all reflect $0. Only in instances where there is no payment at all made to a particular billing provider or organization for contracts during the reporting period, should that billing provider be omitted from the file.

APM claims and non-claims payments should include those for substance use disorder, since these payments will be reported in aggregate and cannot be identified.

B(ii). Calculating Total Payments

Reported total payments should represent the allowed amounts, i.e. carrier payment and any patient cost sharing amounts.

The total allowed amount is the sum of:
Copay (MC065) +
Coinsurance (MC066) +
Deductible (MC067) +
Payer portion (plan paid, MC063)

B(iii). Payment Categories

The data collection files include four payment categories, two that pertain to primary care payments and two that pertain to total payments. The two primary care payment categories are subsets of the total payment categories. Total Primary Care Claims Payments (AM012) is a subset of the value input for Total Claims Payments (AM016). Total Primary Care Non-Claims Payments (AM014) is a subset of the value input for Total Non-Claims Payments (AM018).

All four of the payment values listed above also have an associated Payer Portion field (AM013, AM015, AM017, and AM019). The Payer Portion is a subset of the Total Payment value (e.g., AM013 is a subset of AM012). The claims-based Payer Portion fields (AM013 and AM017) correspond to the data submitted in the Plan Paid field (MC063) on the monthly claims' files. These new fields were requested by the Division of Insurance (DOI) to understand the impacts of their regulations on primary care spend.

Starting under DSG 13, CIVHC will also collect recoupments in the Recoupments from Provider field (AM020). This field is meant to capture any funds going from the provider back to the payer as a result of missed quality metrics, missed spending targets, or APM reconciliation payments. The intent behind collecting recoupments from providers is for stakeholders, specifically the DOI, to understand the extent to which payers must recoup funds from providers.

Note that all other payment fields should be reported *net* of provider recoupments. For example, if a provider received $500 in non-claims payments from a payer in a given year but had to repay $50 to the payer due to missed quality metrics, the payer should report the net $450 in Total Non-Claims Payments (AM018) and report $50 in Recoupments from Provider (AM020).

Two additional payment categories, Total Member Responsibility Amount and Total Amount Paid for Behavioral Health, were added to DSG v16. The Total Member Responsibility Amount can be calculated by summing the Copay amount (MC065), Coinsurance amount (MC066) and Deductible amount (MC067). The Total Amount Paid for Behavioral Health can be calculated using the Taxonomy type of Behavioral Health in the Appendix G: Primary Care Code Sets below.

B(iv). Prospective Payment Flag

Prospective payments refer to any payments made to providers in advance of services rendered. Typically, these are based on predetermined payment amounts for services.

If a provider contract arrangement includes any prospective payments, then the Prospective Payment Flag (AM008) should be populated with 'Y', even when retrospective reconciliation is part of the contract. Population-based payment arrangements (A4, B4, C4, D4, E4, F4) likely include prospective payments, though other payment arrangement types in in other categories might also be considered prospective. If the provider contract does not include any prospective payments, then the flag should be submitted as 'N'. Please direct any specific questions to CIVHC.

C. APM 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 the CDL-NCP

layout. 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, the 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 transformation 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 as well as the corresponding HCP LAN category can be found in the table below. Payers are recommended to use the Xwalk to replace their existing LAN categories with the appropriate Expanded Framework categories and sub-categories in AM007 – Payment Arrangement Category and AM027 – Payment Subcategory. Please direct any questions regarding how to report the new Expanded Framework to CIVHC.

Note: Non-value-based arrangements should continue to be submitted as 3N and 4N in AM007, AM027, CT006, CT020, and AC014, unless specific guidance indicates otherwise. All other submissions should follow the new subcategory instructions.

#	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**	

#	Non-claims-based Payment Categories and Subcategories	Corresponding HCP-LAN Category
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**	
X	**Fee for Service**	
X9	Fee for Service	01
Z	**Member Count**	

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/

D. Member Population Included

Per Colorado regulation 10 CCR 2505-5 1.200, Payers are required to submit data to the CO APCD under the following conditions:

1. The Payer has 1,000 or more Colorado residents covered under a fully insured health plan **OR**

2. The Payer has 100 or more Colorado residents covered under a self-insured employer-sponsored plan not subjected to ERISA.

Once either of the above thresholds has been met, Payers should submit data for all Colorado residents covered under these plans.

Payers should only include information for members for which they are the primary payer and exclude any paid claims for which they are the secondary or tertiary payer.

E. Calculating Member Months

Reporting member months is required for certain types of payment arrangements that are population-based (e.g. APMs with shared savings, comprehensive population-based payments). When required, payers should include the total number of members (represented in member months) that were included in the calculation of the reported APM.

If your organization covers a person for even one day of the month, even if it is the 1st or the 31st, then this counts as a member month.

Note that a given member could be associated with multiple providers in the same reporting period, all of whom received payments under APMs with shared savings and downside risk and condition-specific population-based payments. When this occurs, the sum of all member months associated with alternative payment arrangements will exceed the actual total of unique member months. The control total file is intended to eliminate the duplication of member months (see APM Control Total Section).

F. Lines of Business Included

Payers should submit APM 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 APM submission. **Please direct any questions to CIVHC.**

Payers are not required to submit APM data for the following types of coverage: prescription drugs only, 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 guidelines 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

G. Performance Period

The APM submission performance periods are calendar years and should include payments for services **incurred** during each calendar year. For example, for calendar year 2022, claims payments to a provider should include payments for services incurred between January 1, 2022, and December 31, 2022. Non-claims payments should include payments for contract periods/services during 2022. This performance period should be documented as AM009 (Performance Year) = 2022.

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

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

H. Defining Primary Care

CIVHC uses the definition established by the Colorado Primary Care Payment Reform Collaborative. This definition was operationalized as payments made to a primary care provider for a primary care service. Included in this definition are services delivered by behavioral health providers who practice in an integrated primary care setting.

H(i). Reporting Primary Care Claims Payments

The primary care definition consists of two components that should be summed to produce total primary care payments:

A. Outpatient services delivered by primary care providers (which include OB/GYN providers), defined by a combination of primary care provider taxonomy and primary care CPT-4 procedure codes

B. Outpatient services delivered by behavioral health providers, nurse practitioners and physician assistants, defined by a combination of the "other" provider taxonomy and primary care CPT-4 procedure codes AND billed by a primary care provider (defined by primary care taxonomy)

Include services delivered in an outpatient setting and exclude facility claims and inpatient services.

Component	Setting Requirement		Procedure Requirement		Service Provider Taxonomy Requirement		Billing Provider Taxonomy Requirement
A	Outpatient (defined by place of service codes in *Appendix F, Table 4* **or** FQHC/RHC taxonomy)	+	Primary Care (defined by CPT-4 codes in *Appendix F, Table 3*)	+	Primary Care (defined by taxonomies in *Appendix F, Table 1*)	+	None
B	Outpatient (defined by place of service codes in *Appendix F, Table 4* **or** FQHC/RHC taxonomy)		Primary Care (defined by CPT-4 codes in *Appendix F, Table 3*)		Other Primary Care (defined by taxonomies in *Appendix F, Table 2*)		Primary Care (defined by taxonomies in *Appendix F, Table 1*)

Please note that for CPT-4 procedure codes that describe global services for vaginal or Cesarean deliveries, payments should be multiplied by 60% to approximate the payments for antepartum and postpartum services only. This applies to both total payments and plan payments fields. All delivery CPT-4 codes that should be adjusted are flagged in Appendix F, Table 3.

H(ii). Reporting Primary Care Non-Claims Payments

Include non-claims-based payments for services delivered by:

- Providers with specialties in the primary care taxonomy (Appendix F, Table 1)
- Behavioral health providers with a specified taxonomy (Appendix F, Table 2) that deliver care that is integrated with primary care (i.e., either within the primary care practice or through working relationships that involve close communication and collaboration with primary care providers)

- Payments to Nurse Practitioners and Physician Assistants (Appendix F, Table 2) that deliver primary care or work within a primary care practice

Please reach out to CIVHC if your organization is unable to identify specific service providers within a large contract and need assistance allocating or estimating non-claims primary care expenditures.

Data Submission of APM Control Totals (CT) – General Rules

10 CCR 2505-5 1.200 provides the following definition:

> "Control Total File" means a file that captures aggregated data related to payments made to providers outside of the traditional fee-for-service model. This includes Population Health and Practice Infrastructure Payments, Performance Payments, Payments with Shared Savings and Recoupments, Capitation and Full Risk Payments, Member Count and other non-claim payments. APM files are submitted according to the requirements contained in the submission guide.

The Control Total file is meant to accompany the AM file by eliminating some detailed granularity from the APM file to allow for higher-level analysis.

The following are general rules for completing the Control Total file. Note that several of the instructions listed in the above section can be applied to the Control Total file (i.e., reporting payments, defining primary care, etc.). The contents of the Control Total data submission file and supplement are displayed in this document. A sample of a completed file is included in Appendix C and D.

A. Reporting Member Months in the Control Total File

The Control Total file captures information summarizing the payer's detailed data from the APM file at the year, insurance product type, payment arrangement category, and RAE (if applicable) level of granularity. In other words, the Control Total removes one level of granularity (Billing Provider) from the APM file. This information allows CIVHC to understand payment trends across time and payer type (Medicare, Medicaid, Commercial, Medicare Advantage) without duplicating member months.

Member months expressed in the Control Total file should de-duplicate the member months reported in the APM file.

Three Member Month values should be reported in the Control Total file:

- CT007 (Payment Arrangement Category Member Months),
- CT008 (All Member Months), and
- CT009 (Total Alternative Arrangement Member Months)

Payment Arrangement Category Member Months (CT007) includes the de-duplicated member months for the associated Year (CT004), Insurance Product Type Code (CT005), Payment Arrangement Category (CT006), Payment Sub-category (CT020), and RAE (CT018) if applicable. If any member is attributed to multiple providers within the same payment arrangement category in a given year, then their eligibility

months should only be counted once in the CT007 field. Payers should report '0' under CT007 for non-population-based payment arrangements.

> Example: Suppose an HMO member can be attributed to two providers participating in a comprehensive population-based payment model (category D5) in a given year. This member's 12 eligibility months will be counted under both providers in the member months field (AM009) in the APM file. However, since the Control Total member months field associated with the D5 payment arrangement category should represent the distinct count of member months, the member months from the APM file need to be de-duplicated. Therefore, the member months should be equal to 12, not 24 under APM category D5.

All Member Months (CT008) includes all de-duplicated member months for the associated Year (CT004), Insurance Product Type Code (CT005) and RAE (CT018) if applicable, regardless of payment arrangement type. This field should be all-encompassing of members for which you are the primary medical insurance carrier, regardless of the payment arrangement type and regardless of whether the member used services during the reporting period. **CT008 should repeat for each record associated with a given year, insurance product type code and RAE if applicable.**

Total Alternative Arrangement Member Months (CT009) includes all de-duplicated member months associated with any population-based payment arrangement for the associated Year (CT004), Insurance Product Type Code (CT005) and RAE (CT018) if applicable. Payers should report '0' under CT009 if the given insurance product type/year/RAE if applicable combination does not involve any population-based payment arrangements. **CT009 should repeat for each record associated with a given year, insurance product type code and RAE if applicable.**

> Example: Suppose a PPO member visits two different providers in 2022. One provider is reimbursed under a pay-for-performance arrangement (B2) and the other provider is reimbursed under an APM with shared savings and downside risk (C2). The member months for this member will be counted in both payment arrangement rows in the Control Total file under CT007 but should be counted only once under CT009.

Please refer to Appendix E to find examples of these member months scenarios.

B. Reporting Payments in the Control Total File

Payments should be summed from the APM file and grouped by Year (CT004), Insurance Product Type Code (CT005), Payment Arrangement Category (CT006), Payment Arrangement Subcategory (CT020), RAE (CT018) if applicable and separated into the same categories defined in the APM file (claims vs non-claims and primary care vs total payments). The Payer Portion amounts should be summed up in a similar way. The totals reported in the Control Total file should align with the sum of payments reported in the APM file.

Data Submission of APM Contract Supplement (AC) – General Rules

10 CCR 2505-5 1.200 provides the following definition:

> "APM Contract Supplement file" means a file that captures qualitative information related to alternative arrangements between carriers and providers. It is submitted according to the requirements contained in the submission guide.

The purpose of the Contract Information Supplement is to ensure that the provider arrangements are appropriately classified and that the associated expenditures are submitted correctly in the APM and CT files. This important contextual information helps to validate that organizations are accurately represented in CIVHC's analyses of APM and primary care investment in Colorado.

Each of the data elements represents a question that CIVHC consistently asks payers related to each payment model when assisting them with categorizing payments into the Expanded Non-Claims Payments framework. The addition of the supplemental contract information helps to facilitate these discussions, standardize the information, and streamline this effort. CIVHC does not intend to share this information publicly.

The supplement should include an entry for each type of contract represented in the APM and Control Total files (e.g. episode-based payments for orthopedic procedures or mental health-specific population-based payments). **There does not need to be an entry for each individual provider contract.** Contracts that are entirely fee-for-service also do not need to be included.

Please see the following detailed information surrounding each field in the APM Contract Supplement:

Contract Type Name (AC003) should be populated with the name of the overall contract. Examples include 'Patient Centered Medical Home' and 'Musculoskeletal Capitation Program.'

Contract Description (AC004) should include a description, or summary, of the alternative payment model contract type. It should be 3-5 sentences describing the nature of the contract type including a summary of services provided, provider reimbursement method, and any other important details related to the purpose and structure of the contract type. If a contract type includes a measurement of quality, then the payer should describe the quality measurements.

Involves both claims and non-claims (AC005): Populate this field with the value that best answers the questions, 'how are providers reimbursed under this contract?' and if applicable, 'how is quality evaluated under this contract?' For example, a full capitation program under category 4 with no fee-for-service would be submitted as N (non-claims only). A pay-for-performance contract that includes a bonus payment determined by quality measures which are calculated using claims data would be submitted as B (both claims and non-claims). The value of this field should also correspond with the associated expenditures submitted in the APM file.

Services Covered (AC006): Populate this field with the value that best answers the question, 'what services are providers reimbursed for under this contract?' For example, infrastructure payments would most likely be submitted as N (non-medical services) and an episode-based shared savings program would be submitted with S (specific set of medical services). Multiple values can be submitted if applicable.

Involves measurement of quality (AC007): Populate with 'Y' if quality measure results are used to determine incentive payments, reimbursement, or provider eligibility for the program. If this field is populated with a 'Y,' then the Contract Description field (AC004) should contain details related to the quality measures evaluated for reimbursement.

Involves measurement of spending targets (AC008): Populate with 'Y' if providers are evaluated against medical spending goals or a budget.

Payments are prospective or retrospective (AC009): Populate this field with the value that best answers the question, 'when are providers reimbursed for services under this contract?' Payments that are not for medical services will most likely be submitted as N/A. Arrangements built on a fee-for-service architecture, categories A, B and C will most likely be submitted as RT (retrospective). Category D capitated payments will most likely be either PR (prospective with retrospective reconciliation) or PN (prospective without retrospective reconciliation). Expenditures associated with arrangements described as including prospective payments should be submitted with a Prospective Payment Flag (AM008) = Y in the APM file.

Payment is population-based (AC010): Populate with 'Y' if member months are used to determine provider reimbursement or incentive payments. Arrangements that are described as population-based should include the associated member month information in the APM and CT files.

Risk to Provider (AC011): If the provider assumes risk when providing services then populate with D (downside risk only) or B (upside and downside risk), depending on the arrangement. Populate with U (upside risk only) if the provider does not assume risk and the fee-for-service equivalent for services rendered is guaranteed. Populate with N/A if the arrangement does not cover medical services.

Involves measurement of drug utilization or spending targets (AC012): Populate with 'Y' if providers are evaluated against pharmacy spending goals or a budget.

Provider Type (AC013): Populate with the appropriate provider type for the contract type. Options include Primary Care Provider (PC), Behavioral Health Provider (BH), or OT (Other Provider). If a contract type is arranged with multiple provider types, then list each. For example, if a payer has a particular Pay-for-Performance contract set up with Primary Care providers and Behavioral Health providers where fields AC003 – AC012 apply consistently, submit "PC, BH" in AC013.

Assigned LAN Category (AC014): Populate with the appropriate Expanded Framework categorization (see Appendix F.1 or look up table B.1.J in the DSGv16). All LAN categories that are submitted in the APM and CT files should be represented in the Contract Supplement.

Comments (AC015): Use this field for any additional information or describe any caveats that would be helpful for CIVHC to have a better understanding of the contracts.

Contract Number (AC016): Populate this field with the contract number. This field should align with AM025.

Contract Type (AC017): Populate with the type of contract. Options are 'M' for Medical benefit contract or 'D' for Dental benefit.

The APM Contract file should be submitted using the APM Contract filing template found here. Please direct any questions about this file to CIVHC.

APM Data Submission File Content and Dictionary

File submitted via .txt format

APM File Header Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	Char	2	AM
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.

APM File Trailer Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	AM
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

APM File

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM001	Payer Code	varchar	4	Distributed by CIVHC	R
AM002	Billing Provider Number	varchar	30	Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. This number should align with billing provider numbers in the MC file.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM003	National Billing Provider ID	varchar	20	National Provider ID	R
AM004	Billing Provider Tax ID	varchar	9	Tax ID of billing provider. Do not code punctuation.	R
AM005	Billing Provider Last Name or Organization Name	varchar	128	Full name of provider billing organization or last name of individual billing provider.	R
AM006	Billing Provider Entity	char	1	F = Facility G = Provider group I = IPA P = Practitioner	R
AM007	Payment Arrangement Category	char	1	See look up table B.1.J Payment arrangement type reported. If there is more than one payment arrangement type with a billing provider/organization, then separately report each payment arrangement type.	R
AM008	Prospective Payment Flag	char	1	Y = Payment to provider for services was made prospectively; populate field with 'Y' even when retrospective reconciliation is part of contract N = Payment to provider for services was not made prospectively	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM009	Performance Year	year	4	Effective year of performance period for reported Insurance Product Type Code and Payment Arrangement Type. CCYY format	R
AM010	Insurance Product Type Code	char	2	See lookup table B.1.A	R
AM011	Member Months	int	12	Total number of members in reported stratification attributed to given billing provider that participate in the reported payment arrangement in given year, expressed in months of membership No decimal places; round to nearest integer. Example: 12345	R
AM012	Total Primary Care Claims Payments	numeric	15	Sum of all associated payments tied to a claim, including patient cost-sharing amounts that pertain to primary care. Primary care services are to be identified based on the definition provided in table B.1.K. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care claims payments made. This value should never exceed the amount of Total Claims Payments (AM016).	R
AM013	Payer Portion: Total Primary Care Claims Payments	numeric	15	Payer portion of total primary care payments tied to a claim reported in AM012. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM012.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care claims payments made by payer.	
AM014	Total Primary Care Non-Claims Payments	numeric	15	Sum of all associated non-claims payments that pertain to primary care. Primary care services are to be identified based on the definition provided in table B.1.K. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care non-claims payments made. Amount reported should be net of any provider recoupments. This value should never exceed the amount of Total Non-Claims Payments (AM018).	R
AM015	Payer portion: Total Primary Care Non-Claims Payments	numeric	15	Payer portion of Total Primary Care Non-Claims Payments reported in AM014. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM014. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Amount reported should be net of any provider recoupments.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				Enter 0 if no primary care non-claims payments made by payer.	
AM016	Total Claims Payments	numeric	15	Sum of all associated payments tied to a claim, including patient cost-sharing amounts. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no claims payments made.	R
AM017	Payer Portion: Total Claims Payments	numeric	15	Payer portion of total payments tied to a claim reported in AM016. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM016. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no claims payments made by payer.	R
AM018	Total Non-Claims Payments	numeric	15	Sum of all associated non-claims payments. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Amount reported should be net of any provider recoupments. Enter 0 if no non-claims payments made.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM019	Payer Portion: Total Non-Claims Payments	numeric	15	Payer portion of Total Non-Claims Payments reported in AM018. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM018. Amount reported should be net of any provider recoupments. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no non-claims payments made by payer.	R
AM020	Recoupments from Provider	numeric	15	Any funds that were refunded to carrier from provider as a result of missed quality metrics, missed spending targets, or APM reconciliation payments. Do not report claim reversals or any other recoupments that occurred as a result of accounting errors.	R
AM021	Billing Provider Office City	varchar	30	Physical address – name of city	R
AM022	Billing Provider Office State	char	2	Physical address – name of state. Use postal service standard 2 letter abbreviations.	R
AM023	Billing Provider Office Zip	varchar	11	Physical address - Minimum 5-digit zip code.	R
AM024	RAE Indicator	char	2	Identify which Medicaid Regional Accountable Entity the provider is associated with 1 = RAE Region 1	R for RAE and MCOs

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				2 = RAE Region 2 3 = RAE Region 3 4 = RAE Region 4 5 = RAE Region 5 6 = RAE Region 6 7 = RAE Region 7 8 = RAE Region 8 Leave blank if non-MCO/RAE submitter	
AM025	Contract Number	varchar	80	The unique number identifying a contract between the submitter and the billing provider for the reported payment model. Default to 'FFS' for Fee-for-service payments.	R
AM026	Billing Provider First Name	varchar	35	Individual first name. If provider is a facility or organization, leave blank.	R
AM027	Payment Subcategory	char	2	Report a Payment Subcategory corresponding to the initial character in the Payment Arrangement Category in AM007. See table B.1.J.A	R
AM028	Member Count	int	12	The total number of members enrolled during the reporting period. Report when Payment Category (AM007) = 'B', 'D', or 'Z':	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				1. Category = 'B': Total number of members associated with the incentive payments. 2. Category = 'D': Total number of members associated with the capitated payments reported. 3. Category = 'Z': Total number of months enrolled for members reported in Member Count (members for submitters entire book of business for the year). This record is not expected to have any associated dollar amounts reported.	
AM029	Total Member Responsibility Amount	numeric	15	Total of all member responsibility amounts (copay, coinsurance, and deductibles). Two explicit decimal places (e.g., 200.00). If the value for this field is zero, report as "0.00", not as null. This field may contain a negative value.	R
AM030	Total Amount Paid for Behavioral Health	numeric	15	Total of all payments made to a billing provider for behavioral health services during the Reporting/Performance Period. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Two explicit decimal places (e.g., 200.00). If the value for this field is zero, report as "0.00", not as null. This field may contain a negative value.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM999	Record Type	char	2	AM	R

APM Data Submission Control Total (CT) File and Dictionary

File submitted via .txt format

CT File Header Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	CT
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 Control Total file, excluding header and trailer records
HD007	Med_BH PMPM	int	7	Place holder. Leave field value blank.

Data Element #	Data Element Name	Type	Max Length	Description/valid values
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.

CT File

Trailer Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	CT
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

CT File

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
CT001	Payer Code	varchar	4	Distributed by CIVHC	R
CT002	Payer Name	varchar	75	Distributed by CIVHC	R
CT003	Submitted File	varchar	25	File name of the APM file. Note, please do not include file extension in the corresponding APM file name, i.e., '.txt'. If your organization resubmits AM under v02, the reference in CT003 should also reflect v02. The value should be case sensitive. For example, if the AM file name is *PROD_0000_2024AMv02*, CT003 should be *PROD_0000_2024AMv02* and not *PROD_0000_2024AMV02*.	R
CT004	Performance Year	year	4	Year of reporting, submit in YYYY format	R
CT005	Insurance Product Type Code	char	2	See lookup table B.1.A	R
CT006	Payment Arrangement Category	varchar	2	See look up table B.1.J Payment arrangement type reported.	R
CT007	Payment Arrangement Category Member Months	int	12	Total, de-duplicated member months associated with payment arrangement category identified in CT006 & CT020 and Medicaid Regional Accountable Entity (RAE) identified in CT018, if applicable. No decimal places; round to nearest integer Example: 12345	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				Enrollment should be reported as de-duplicated member months and should only be reported for those members for whom the mandatory reporter was the primary payer	
CT008	All Member Months	int	12	Total enrollment during the previous calendar year, regardless of payment arrangement type. No decimal places; round to nearest integer. Example: 12345 Enrollment should be reported as de-duplicated member months and should only be reported for those members for whom the mandatory reporter was the primary payer. The value in this field will repeat in the Control Total file for each reported year/insurance product type code/RAE (if applicable) combination.	R
CT009	Total Alternative Arrangement Member Months	int	12	Total enrollment in alternative payment arrangements during the previous calendar year. No decimal places; round to nearest integer Example: 12345 Enrollment should be reported as de-duplicated member months and should only be reported for those members for whom the mandatory reporter was the primary payer. The value in this field will repeat in the Control Total file for each reported year/insurance product type code/RAE (if applicable) combination.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
CT010	Sum of Primary Care Claims Payments	numeric	15	Sum of Total Primary Care Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R
CT011	Sum of Payer Portion of Primary Care Claims Payments	numeric	15	Sum of Payer Portion of Total Primary Care Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R
CT012	Sum of Primary Care Non-Claims Payments	numeric	15	Sum of Total Primary Care Non-Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R
CT013	Sum of Payer Portion of Primary Care Non-Claims Payments	numeric	15	Sum of Payer Portion of Total Primary Care Non-Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
CT014	Sum of Claims Payments	numeric	15	Sum of Total Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R
CT015	Sum of Payer Portion of Claims Payments	numeric	15	Sum of Payer Portion of Total Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R
CT016	Sum of Non-Claims Payments	numeric	15	Sum of Total Non-Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R
CT017	Sum of Payer Portion of Non-Claims Payments	numeric	15	Sum of Payer Portion of Total Non-Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
CT018	RAE Indicator	char	2	Identify which Medicaid Regional Accountable Entity the provider is associated with 1 = RAE Region 1 2 = RAE Region 2 3 = RAE Region 3 4 = RAE Region 4 5 = RAE Region 5 6 = RAE Region 6 7 = RAE Region 7 8= RAE Region 8 Leave blank if non-MCO/RAE submitter	R for RAE and MCOs
CT019	Percent of Providers Participating in at Least One APM	numeric	3	Percent of providers under at least one APM contract with the payer. Report the percentage for the Performance Year (CT004) CT019 = (Count of providers that participate in at least one APM contract) / (Count of providers that have at least one claim adjudicated or at least one APM payment during the performance year (CT004)) Two explicit decimal places (e.g., 78.05)	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
CT020	Payment Subcategory	char	2	Report a Payment Subcategory corresponding to the initial character in the Payment Category in CT006. See table B.1.J.A	R
CT021	Payment Arrangement Category Member Count	int	12	Total, de-duplicated member count associated with payment arrangement category identified in CT006 & CT020 and Medicaid Regional Accountable Entity (RAE) identified in CT018, if applicable. No decimal places; round to nearest integer Example: 12345 Count should be reported as de-duplicated member counts and should only be reported for those members for whom the mandatory reporter was the primary payer	
CT022	All Member Count	int	12	Total member count during the previous calendar year, regardless of payment arrangement type. No decimal places; round to nearest integer. Example: 12345 Count should be reported as de-duplicated member counts and should only be reported for those members for whom the mandatory reporter was the primary payer. The value in this field will repeat in the Control Total file for each reported year/insurance product type code/RAE (if applicable) combination.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
CT023	Total Alternative Arrangement Member Count	int	12	Total enrollment in alternative payment arrangements during the previous calendar year. No decimal places; round to nearest integer Example: 12345 Count should be reported as de-duplicated member counts and should only be reported for those members for whom the mandatory reporter was the primary payer. The value in this field will repeat in the Control Total file for each reported year/insurance product type code/RAE (if applicable) combination.	R
CT024	Total Member Responsibility Amount	numeric	15	Total of all member responsibility amounts (copay, coinsurance, and deductibles). Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00). If the value for this field is zero, report as "0.00", not as null. This field may contain a negative value.	R
CT025	Total Amount Paid for Behavioral Health	numeric	15	Total of all payments made to a billing provider for behavioral health services during the Reporting/Performance Period. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				responsibility amounts (copay, coinsurance, and deductibles). Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00). If the value for this field is zero, report as "0.00", not as null. This field may contain a negative value.	
CT999	Record Type	char	2	CT	R

APM Data Submission - APM Contract (AC) File and Dictionary

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
AC001	Payer Code	Varchar	N/A – Excel file	Distributed by CIVHC	R
AC002	Payer Name	Varchar	N/A – Excel file	Distributed by CIVHC	R
AC003	Contract Type Name	Varchar	N/A – Excel file	The unique name of the alternative payment contract type between the payer and providers.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AC004	Contract Description	Varchar	N/A – Excel file	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 If AC007 = "Y", then describe quality metrics associated with arrangement	R
AC005	Involves both claims and non-claims payments	Char	N/A – Excel file	C = Claims only N = Non-Claims only B = Both claims and non-claims	R
AC006	Services Covered	Char	N/A – Excel file	N = Non-medical activities only S = Specific set of medical services M = Comprehensive medical services	R
AC007	Involves measurement of quality	char	N/A – Excel file	Y = Quality measurement N = No quality measurement	R
AC008	Involves measurement of spending targets	char	N/A – Excel file	Y = Spending targets N = No spending targets	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AC009	Payments are prospective or retrospective	char	N/A – Excel file	PR = Prospective with retrospective reconciliation PN = Prospective with no retrospective reconciliation RT = Retrospective N/A = Not Applicable	R
AC010	Payment is population-based	char	N/A – Excel file	Y = Population-Based N = Not Population-Based	R
AC011	Risk to Provider	char	N/A – Excel file	U = Upside Only D = Downside Only B = Both Upside and Downside N/A = Not Applicable	R
AC012	Payment model involves quality measurement of drug utilization or spending	char	N/A – Excel file	Y = Drug spending/utilization targets N = No drug spending/utilization targets	R
AC013	Provider Type	char	N/A – Excel file	PC = Primary care provider BH = Behavioral health provider OT = Other provider	R
AC014	Assigned Payment Category	char	N/A – Excel file	See look up table B.1.J. Payment arrangement type reported.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AC015	Comments	varchar	N/A – Excel file	Use this field to provide additional information or describe any caveats	O
AC016	Contract Number	varchar	80	The unique number identifying a contract between the submitter and the billing provider for the reported payment model as reported in AM025. Default to 'FFS' for Fee-for-service payments (if applicable).	
AC017	Contract Type	char	1	Use this field to indicate whether the payments reported were administered as part of a medical benefits contract or a dental benefits contract. The only valid codes for this field are: M = Medical: Payments made under a medical benefits contract, including all payments made to providers for medical, pharmacy, and dental services incurred under medical stand-alone coverage. D = Dental: Payments made under a dental benefits contract; this should include only payments made to providers for members on dental stand-alone coverage.	R

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).

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:	

Appendix B: Sample of Completed APM Detailed Data File

```
AM|0|Example Insurance Company|202201|202412|14||||
AM001|AM002|AM003|AM004|AM005|AM006|AM007|AM008|AM009|AM010|AM011|AM012|AM013|AM014|AM015|AM016|AM017|AM018|AM019|AM020|AM021|AM022|AM023|AM024|AM025|AM026|AM027|AM028|AM029|AM030|AM999
0|11111|1111111111|111111111|ABC Group|G|X|N|2022|HM|0|0|0|0|0|15706699.86|12879493.89|0|0|0|Denver|CO|80223|1|X12345||X9|0|654.00|0.00|AM
0|22222|2222222222|222222222|XYZ Primary Care Group|G|X|N|2022|HM|0|758783.84|644966.26|0|0|758783.84|622202.75|0|0|0|Monument |CO|80132|2|A654||X9|0|4856.00|741.00|AM
0|22222|2222222222|222222222|XYZ Primary Care Group|G|X|N|2022|12|0|126031.65|107126.9|0|0|126031.65|103345.95|0|0|0|Monument |CO|80132|3|A1V1D||X9|0|84563.00|79864.00|AM
0|33333|3333333333|333333333|Great Doctors Group|G|B|N|2023|16|842|58528165.45|49748940.63|250349.05|225314.15|225108328.6|184588829.5|500394.01|475374.31|500|Denver|CO|80210|4|ABCXYZ||B2|72|64987.00|8654.00|AM
0|44444|4444444444|444444444|Super Great Hospital|F |X|N|2023|12|0|0|0|0|0|44973705.92|36878438.85|0|0|0|Ft Collins|CO|80523|5|987654||X9|0|21648.00|654.00|AM
0|44444|4444444444|444444444|Smith|F |A|Y|2023|12|647|0|0|0|0|0|0|323500.01|307325.01|0|Ft Collins|CO|80523|6|321654987|David|A4|55|0.00|0.00|AM
0|55555|5555555555|555555555|U Get Better Hospital|F|B|N|2023|MM|1289|0|0|0|0|0|0|1000000.01|950000.01|0|Boulder|CO|80301|7|ContractNumber1||B1|110|0.00|0.00|AM
0|66666|6666666666|666666666|Doe|F|A|N|2024|12|0|0|0|0|0|0|0|50000.01|47500.01|0|Sedalia|CO|80135|8|753159ABC|Jane|A2|0|0.00|879654.00|AM
0|77777|7777777777|777777777|Dr Fix It Group|G|C|N|2024|16|4977|0|0|0|0|1493157.01|1224388.75|65000.01|61750.01|0|Pagosa Springs|CO|81147|1|1010CONTRACT||C3|420|354.00|1254.00|AM
0|88888|8888888888|888888888|Sub-par Docs|G|D|Y|2024|12|203260|0|0|0|0|60978135.01|50002070.71|1000000.01|1000000.01|1500000|Denver|CO|80022|2|ContractNumber2||D3|16939|131.00|65468.00|AM
0|99999|9999999999|999999999|Cloud 9 Group|G|C|N|2024|HM|0|0|0|0|0|1346579.01|1104194.79|13498.01|12823.11|0|Limon|CO|80828|3|Cloud9Contract||C3|0|687465.00|6878.00|AM
0|12121|1212121212|121212121|Primary Care Rock Star IPA|I|D|Y|2024|12|849653|0|0|3228584.58|2905726.12|0|0|3228584.58|3067155.35|0|Colorado Springs|CO|80941|4|1800PROVIDER||D5|70805|0.00|0.00|AM
0|23232|2323232323|232323232|Streep|P|D|Y|2024|16|52743|0|0|189000.01|170100.01|0|0|189000.01|179550.01|0|Vail|CO|81658|5|APMCONTRACT|Mery1|D6|4400|0.00|0.00|AM
0|34343|3434343434|343434343|We Love Bones Orthopedic Clinic|G|D|Y|2024|HM|484|0|0|0|0|0|0|160752.01|152714.41|0|Buena Vista|CO|81211|6|XYZABC||D5|45|0.00|9872.00|AM
AM|0|Example Insurance Company|202201|202412|20250815
```

Please note that this example only contains 14 providers. Production files should include 3 years' worth of data and contain all billing providers who received payments from payers.

Link: APM Detailed Blank File (AM)

Link: APM Detailed Scenario File (AM)

Appendix C: Sample of Completed APM Control Total (CT) File

```
CT|0|Example Insurance Company|202201|202412|26||||
CT001|CT002|CT003|CT004|CT005|CT006|CT007|CT008|CT009|CT010|CT011| CT012 | CT013 |CT014|CT015|CT016|CT017|CT018|CT019|CT020|CT021|CT022|CT023|CT024|CT025|CT999
0|Example Insurance Company|PROD_0000_2023AMv01|2022|HM|X|0|12875396|5513496|790472062.00|663996532.10|0.00|0.00|3952360310.00|3359506264.00|0.00|0.00|1|78.05|X9|0|1072950|459458|0.00|0.00|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2022|HM|C|5369485|12875396|5513496|0.00|0.00|25279507.80|24015532.41|0.00|0.00|72227165.15|68615806.89|2|78.05|C2|448|1072950|459458|7222716.52|457438.71|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2022|HM|D|235613|12875396|5513496|0.00|0.00|624272434.60|593058812.80|0.00|0.00|1783635527.00|1694453751.00|3|78.05|D1|19700|1072950|459458|178363552.70|11296358.34|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2022|16|X|0|2397847|20489|147213418.70|123659271.70|0.00|0.00|736067093.60|625657029.60|0.00|0.00|4|78.05|X9|0|199821|1707|0.00|0.00|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2022|16|C|20489|2397847|20489|8360186.40|7022556.58|500678.00|475644.10|41800932.00|35530792.20|500678.00|475644.10|5|78.05|C6|1708|199821|1707|50067.80|3170.96|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2022|12|X|0|2512156|122710|4620476.00|3881199.84|0.00|0.00|10286282.00|8743339.70|0.00|0.00|6|78.05|X9|0|209346|10226|0.00|0.00|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2022|12|B|0|2512156|122710|482645.00|405421.80|20384627.00|19365395.65|666050.10|566142.59|28130785.26|26724246.00|7|78.05|B2|0|209346|10226|2813078.53|178161.64|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2022|12|C|30563|2512156|122710|0.00|0.00|0.00|0.00|102947.00|87504.95|20371.00|19352.45|8|78.05|C1|2550|209346|10226|2037.10|129.02|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2022|12|D|92649|2512156|122710|0.00|0.00|102548.00|97420.60|0.00|0.00|926482.00|880157.90|1|78.05|D6|7720|209346|10226|92648.20|5867.72|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2022|MM|X|0|502379|46987|30843056.33|25908167.31|0.00|0.00|154215281.60|131082989.40|0.00|0.00|2|78.05|X9|0|41865|3916|0.00|0.00|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2022|MM|D|46987|502379|46987|0.00|0.00|5637171.35|5355312.78|0.00|0.00|16106203.86|15300893.67|3|78.05|D1|3916|41865|3916|1610620.39|102005.96|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2023|HM|D|268719|13229763|5364882|0.00|0.00|28831533.31|27389956.64|0.00|0.00|82375809.45|78257018.98|4|62.34|D3|22400|1102480|447074|8237580.95|521713.46|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2023|HM|D|5377420|13229763|5364882|0.00|0.00|625194981.50|593935232.40|0.00|0.00|1786271376.00|1696957807.00|5|62.34|D5|449118|1102480|447074|178627137.60|11313052.05|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2023|MM|X|0|503982|49135|30941470.91|25990835.56|0.00|0.00|154707354.50|131501251.40|0.00|0.00|6|62.34|X9|0|41999|4095|0.00|0.00|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2023|MM|D|49135|503982|49135|0.00|0.00|5894873.36|5600129.69|0.00|0.00|16842495.30|16000370.54|7|62.34|D1|4150|41999|4095|1684249.53|106669.14|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2023|16|X|0|3268894|21638|200690478.20|168580001.70|0.00|0.00|1003452391.00|852934532.50|0.00|0.00|8|62.34|X9|0|272408|1803|0.00|0.00|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2023|16|C|21638|3268894|21638|8513627.40|7151447.02|326798.00|310458.10|42568137.00|36182916.45|326798.00|310458.10|1|62.34|C6|1880|272408|1803|32679.80|2069.72|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2023|12|X|0|62557|0|4502959.21|3782485.73|0.00|0.00|21442662.89|18226263.46|0.00|0.00|2|62.34|X9|0|5213|0|0.00|0.00|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2024|HM|X|0|15663337|3114357|961634911.80|807773325.90|0.00|0.00|4808174559.00|4086948375.00|0.00|0.00|3|83.59|X9|0|1305278|259530|0.00|0.00|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2024|HM|D|301779|15663337|3114357|0.00|0.00|32378623.36|30759692.19|0.00|0.00|92510352.45|87884834.83|4|83.59|D3|25200|1305278|259530|9251035.25|585898.90|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2024|HM|D|6133739|15663337|3114357|0.00|0.00|713126897.40|677470552.50|0.00|0.00|2037505421.00|1935630150.00|5|83.59|D5|511150|1305278|259530|203750542.10|12904201.00|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2024|MM|X|0|505003|52556|31004154.18|26043489.51|0.00|0.00|155020770.90|131767655.30|0.00|0.00|6|83.59|X9|0|42084|4380|0.00|0.00|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2024|MM|D|52556|505003|52556|0.00|0.00|6305300.99|5990035.94|0.00|0.00|18015145.68|17114388.40|7|83.59|D1|4579|42084|4380|1801514.57|114095.92|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2024|16|X|0|3270120|25779|200765747.30|168643227.70|0.00|0.00|1003828736.00|853254425.90|0.00|0.00|8|83.59|X9|0|272510|2148|0.00|0.00|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2024|16|C|25779|3270120|25779|8978926.20|7542298.01|-50978.00|-50978.00|44894631.00|38160436.35|-50978.00|-50978.00|1|83.59|C6|2200|272510|2148|-5097.80|-339.85|CT
0|Example Insurance Company|PROD_0000_2023AMv01|2024|12|X|0|62998|0|4534703.14|3809150.63|0.00|0.00|21593824.46|18354750.79|0.00|0.00|2|83.59|X9|0|5250|0|0.00|0.00|CT
CT|0|Example Insurance Company|202201|202412|20250815
```

Production files should include 3 years' worth of data.

Please note that the totals from the Control Total example and the APM example do not align.

Link: APM Control Total Blank File (CT)

Link: APM Control Total Scenario File (CT)

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Appendix D: Sample of Completed APM Contract (AC) File

AC001	AC002	AC003	AC004	AC005	AC006	AC007	AC008	AC009	AC010	AC011	AC012	AC013	AC014	AC015	AC016	AC017
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	**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**	**Contract Number**	**Contract Type**
0000	Example Insurance Company	0	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			M
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		PCMH123	M
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*	BIP321	M
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	B	M	Y	Y	RT	Y	U	N	OT	3A		SSP852	M
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 required 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		MCP258	M
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		PCCP654	M

Please see DSG 16 Scenario File – AC for a larger view of this file.

Link: APM Contract Blank File (AC)

Link: APM Contract Scenario File (AC)

Appendix E: Control Total (CT) Member Months Reporting

					Values are unique to Performance Year + IPT Code + Payment Arrangement SubCategory + RAE (if applicable)	Values are unique to Performance Year + IPT Code + RAE (if applicable) and consistent across all rows		
					Research Question: What % of members received care under a specific arrangement	Denominator	Research Question: What % of members received care under any alternative arrangement?	
CT004	CT005	CT006	CT018	CT020	CT007	CT008	CT009	
Performance Year	Insurance Product Type Code	Payment Arrangement Category	RAE Indicator	Payment Subcategory	Payment Arrangement Category Member Months	All Member Months	Total Alternative Arrangement Member Months	
2022	HM	X	7	X9	0	12,875,396	5,513,496	Note: CT009 will typically be less than the sum of CT007 -- members that are attributed to multiple LAN categories should only be counted once in CT009. CT009 should never be greater than the sum of CT007 values.
2022	HM	D	7	D1	235,613	12,875,396	5,513,496	
2022	HM	D	7	D5	5,369,485	12,875,396	5,513,496	
2022	16	X	2	X9	0	2,397,847	20,489	Note: CT009 should be populated for FFS (category X) rows. We would also expect that CT009 to be less than CT008.
2022	16	C	2	C6	20,489	2,397,847	20,489	
2022	12	X	1	X9	0	60,981	0	Note: If no members under a specific IPT code are attributed to an alternative arrangement model then CT009 will be zero.

Appendix F.1: Expanded Non-claim Payment Framework Category Definitions

Note: Non-value-based arrangements should continue to be submitted as 3N and 4N in AM007, AM027, CT006, CT020, and AC014, unless specific guidance indicates otherwise.

#	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.

#	Non-claims-based Payment Categories and Subcategories	Draft Definition
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

#	Non-claims-based Payment Categories and Subcategories	Draft Definition
		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

#	Non-claims-based Payment Categories and Subcategories	Draft Definition
		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.

#	Non-claims-based Payment Categories and Subcategories	Draft Definition
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).**

#	Non-claims-based Payment Categories and Subcategories	Draft Definition
X9	**Fee for Service**	
Z9	**Member Count**	

Appendix F.2: Health Care Payment Learning & Action Network (HCP LAN) APM Category Definitions

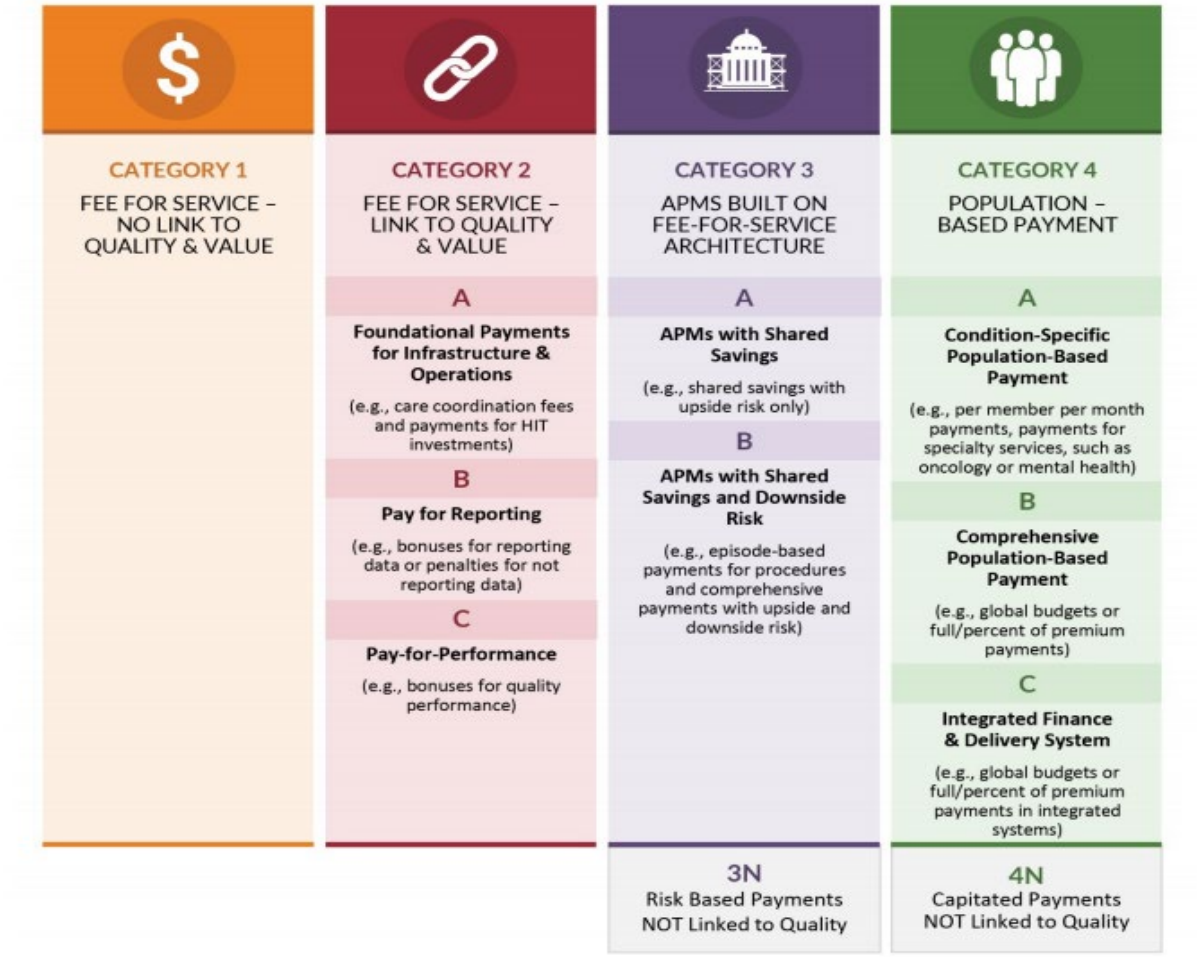
For reference, information regarding the HCP LAN Framework is below. This framework was used to report payment arrangement categories **prior to the 2025 annual submission.**

Note: Non-value-based arrangements should continue to be submitted as 3N and 4N in AM007, AM027, CT006, CT020, and AC014, unless specific guidance indicates otherwise.

For payment model assignments, payers classified payments and member months based on payment arrangement categories defined by the Health Care Payment Learning & Action Network (HCP LAN). The HCP LAN Framework is illustrated below.

The Framework is used to assign payments from payers to health care providers to four Categories, such that movement from Category 1 fee-for-service to Category 4 population-based payments involves increasing provider accountability for both quality and total cost of care.

Health Care Payment Learning & Action Network (HCP LAN) APM



Code	Value	Definition/Example
01	Fee for Service	Payments made on a traditional fee-for-service model, no link to quality and value. These are traditional FFS payments that are not adjusted to account for infrastructure investments, provider reporting of quality data, for provider performance on cost and quality metrics. Diagnosis-related groups (DRGs) that are not linked to quality are in Category 1.
2A	Foundational Payments for Infrastructure and Operations	Payments for infrastructure investments that can improve the quality of patient care. (e.g., payments designated for staffing a care coordination nurse or upgrading to electronic health records).
2B	Pay for Reporting	Payments (incentives or penalties) to report quality measurement results
2C	Pay-for-Performance	Payments (incentives or penalties) based on performance in meeting goals for quality measures (e.g. bonuses for quality performance)
3A	APMs with Shared Savings	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Does not include penalties when cost or utilization targets are not met. (e.g., shared savings with upside risk only)
3B	APMs with Shared Savings and Downside Risk	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Includes penalties representing a portion of the losses that result when a cost or utilization target is not met. (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)
3N	Risk Based Payments NOT Linked to Quality	Payments representing a share of savings generated when a cost or utilization target is met and no quality targets exist (e.g., episode-based payments for procedures without quality measures and targets)
4A	Condition-Specific Population-Based Payment	Payments for the comprehensive treatment of specific conditions (e.g., payments for specialty services, such as oncology or mental health). Bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering only chemotherapy payments. Also, payments that are prospective and population-based and cover all care delivered by particular types of clinicians (e.g., orthopedics).

Code	Value	Definition/Example
4B	Comprehensive Population-Based Payment	Payments that are prospective and population-based, and cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct, (e.g. global budgets or full/percent of premium payments)
4C	Integrated Finance and Delivery System	Payments that also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, while in other cases they consist of delivery systems that offer their own insurance products (e.g. global budgets or full/percent of premium payments in integrated systems)
4N	Capitated Payments NOT Linked to Quality	Payments that are prospective and population-based, but not linked to quality.

For additional information about the HCP LAN APM categories and their definitions, please go to: https://hcp-lan.org/apm-refresh-white-paper/#1466615468036-18abb176-bf37

The type of APM to which a provider organization and a member should be attributed is determined by the contractual arrangement between the payer and the provider organization. All payments associated with a contract, even those that include both fee-for-service and non-claims payments (e.g. 3B APMs with Shared savings and Downside Risk), should be reported on the same APM record. Fee-for-service payments that are used to determine incentive payments (e.g. 2C Pay-for-Performance) should also be included on the APM record. In these situations, both the claims' payments (AM012, AM013, AM016, and AM017) and non-claims payments fields (AM014, AM015, AM018, and AM019) will be populated. Do not report the fee-for-service component of an APM contract separately under Category 1 (Fee For Service). Please refer to Appendix B for an example on how to correctly submit these types of payments.

Appendix G: Primary Care Code Sets

Table 1: Primary Care Provider Taxonomies

Taxonomy Code	Description	Taxonomy Type
261QF0400X	Federally Qualified Health Center	Organization
261QP2300X	Primary care clinic	Organization
261QR1300X	Rural Health Center	Organization
261QC1500X	Community Health	Organization
261QM1000X	Migrant Health	Organization
261QP0904X	Public Health, Federal	Organization
261QS1000X	Student Health	Organization
207Q00000X	Physician, family medicine	Individual
207R00000X	Physician, general internal medicine	Individual
208000000X	Physician, pediatrics	Individual
208D00000X	Physician, general practice	Individual
363LA2200X	Nurse practitioner, adult health	Individual
363LF0000X	Nurse practitioner, family	Individual
363LP0200X	Nurse practitioner, pediatrics	Individual
363LP2300X	Nurse practitioner, primary care	Individual
363LW0102X	Nurse practitioner, women's health	Individual
363AM0700X	Physician's assistant, medical	Individual
207RG0300X	Physician, geriatric medicine, internal medicine	Individual
2083P0500X	Physician, preventive medicine	Individual
364S00000X	Certified clinical nurse specialist	Individual
163W00000X	Nurse, non-practitioner	Individual
207QG0300X	Allopathic & Osteopathic Physicians/Family Medicine, Geriatric Medicine	Individual

Taxonomy Code	Description	Taxonomy Type
207QA0000X	Family Medicine - Adolescent Medicine	Individual
207QA0505X	Family Medicine - Adult Medicine	Individual
207QB0002X	Family Medicine - Obesity Medicine	Individual
207QG0300X	Family Medicine - Geriatric Medicine	Individual
207QS0010X	Family Medicine - Sports Medicine	Individual
207RA0000X	Internal Medicine - Adolescent Medicine	Individual
207RB0002X	Internal Medicine - Obesity Medicine	Individual
207RS0010X	Internal Medicine - Sports Medicine	Individual
2080A0000X	Pediatrics - Adolescent Medicine	Individual
2080B0002X	Pediatrics - Obesity Medicine	Individual
2080S0010X	Pediatrics - Sports Medicine	Individual
363LC1500X	Nurse Practitioner - Community Health	Individual
363LG0600X	Nurse Practitioner - Gerontology	Individual
363LS0200X	Nurse Practitioner - School	Individual
364SA2200X	Clinical Nurse Specialist - Adult Health	Individual
364SC1501X	Clinical Nurse Specialist - Community Health/Public Health	Individual
364SC2300X	Clinical Nurse Specialist - Chronic Health	Individual
364SF0001X	Clinical Nurse Specialist - Family Health	Individual
364SG0600X	Clinical Nurse Specialist - Gerontology	Individual
364SH1100X	Clinical Nurse Specialist - Holistic	Individual
364SP0200X	Clinical Nurse Specialist - Pediatrics	Individual
364SS0200X	Clinical Nurse Specialist - School	Individual
364SW0102X	Clinical Nurse Specialist - Women's Health	Individual

Taxonomy Code	Description	Taxonomy Type
207V00000X	Physician, obstetrics and gynecology	OB/GYN
207VG0400X	Physician, gynecology	OB/GYN
363LX0001X	Nurse practitioner, obstetrics and gynecology	OB/GYN
367A00000X	Physician Assistants & Advanced Practice Nursing Providers/Midwife, Certified Nurse	OB/GYN
207VX0000X	OB/GYN- Obstetrics	OB/GYN

Table 2: Other Primary Care Provider Taxonomies

Taxonomy Code	Description	Taxonomy Type
363L00000X	Nurse practitioner	Nurse Practitioner
363A00000X	Physician's assistant	Physician's Assistant
2084P0800X	Physician, general psychiatry	Behavioral Health
2084P0804X	Physician, child and adolescent psychiatry	Behavioral Health
363LP0808X	Nurse practitioner, psychiatric	Behavioral Health
1041C0700X	Behavioral Health & Social Service Providers/Social Worker, Clinical	Behavioral Health
2084P0805X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Geriatric Psychiatry	Behavioral Health
2084H0002X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Hospice & Palliative Medicine	Behavioral Health
261QM0801X	Ambulatory Health Care Facilities/Clinic/Center, Mental Health- CMHC	Behavioral Health
101Y00000X	Counselor	Behavioral Health

Taxonomy Code	Description	Taxonomy Type
101YA0400X	Counselor - Addiction (SUD)	Behavioral Health
101YM0800X	Counselor - Mental Health (Note: Counselor working in MAT programs in FQHC)	Behavioral Health
101YP1600X	Counselor - Pastoral	Behavioral Health
101YP2500X	Counselor - Professional (Note: Counselor in FQHC)	Behavioral Health
101YS0200X	Counselor - School	Behavioral Health
102L00000X	Psychoanalyst	Behavioral Health
103T00000X	Psychologist (Note: Clinical Psychologist in FQHC)	Behavioral Health
103TA0400X	Psychologist - Addiction	Behavioral Health
103TA0700X	Psychologist - Adult Development and Aging (Note: Clinical Psychologist in FQHC)	Behavioral Health
103TB0200X	Psychologist - Cognitive and Behavioral	Behavioral Health
103TC0700X	Psychologist - Clinical	Behavioral Health
103TC1900X	Psychologist - Counseling	Behavioral Health
103TC2200X	Psychologist - Clinical Child & Adolescent	Behavioral Health
103TE1000X	Psychologist - Educational	Behavioral Health
103TE1100X	Psychologist - Exercise & Sports	Behavioral Health

Taxonomy Code	Description	Taxonomy Type
103TF0000X	Psychologist - Family	Behavioral Health
103TH0004X	Psychologist - Health	Behavioral Health
103TH0100X	Psychologist - Health Service	Behavioral Health
103TM1700X	Psychologist - Men & Masculinity	Behavioral Health
103TM1800X	Psychologist - Mental Retardation & Developmental Disabilities	Behavioral Health
103TP0016X	Psychologist - Prescribing (Medical)	Behavioral Health
103TP0814X	Psychologist - Psychoanalysis	Behavioral Health
103TP2700X	Psychologist - Psychotherapy	Behavioral Health
103TP2701X	Psychologist - Group Psychotherapy	Behavioral Health
103TR0400X	Psychologist - Rehabilitation	Behavioral Health
103TS0200X	Psychologist - School	Behavioral Health
103TW0100X	Psychologist - Women	Behavioral Health
104100000X	Social Worker	Behavioral Health
1041S0200X	Social Worker - School	Behavioral Health
106H00000X	Marriage & Family Therapist (Note: Psychotherapist in FQHC)	Behavioral Health

Table 3: Primary Care Services (CPT-4 Procedure Codes)

Procedure Code	Description
10060	DRAINAGE OF SKIN ABSCESS
10061	DRAINAGE OF SKIN ABSCESS
10080	DRAINAGE OF PILONIDAL CYST
10120	REMOVE FOREIGN BODY
10121	REMOVE FOREIGN BODY
10160	PUNCTURE DRAINAGE OF LESION
11000	DEBRIDE INFECTED SKIN
11055	TRIM SKIN LESION
11056	TRIM SKIN LESIONS 2 TO 4
11100	BIOPSY SKIN LESION
11101	BIOPSY SKIN ADD-ON
11200	REMOVAL OF SKIN TAGS <W/15
11201	REMOVE SKIN TAGS ADD-ON
11300	SHAVE SKIN LESION 0.5 CM/<
11301	SHAVE SKIN LESION 0.6-1.0 CM
11302	SHAVE SKIN LESION 1.1-2.0 CM
11303	SHAVE SKIN LESION >2.0 CM
11305	SHAVE SKIN LESION 0.5 CM/<
11306	SHAVE SKIN LESION 0.6-1.0 CM
11307	SHAVE SKIN LESION 1.1-2.0 CM
11310	SHAVE SKIN LESION 0.5 CM/<

Procedure Code	Description
11311	SHAVE SKIN LESION 0.6-1.0 CM
11400	EXC TR-EXT B9+MARG 0.5 CM<
11401	EXC TR-EXT B9+MARG 0.6-1 CM
11402	EXC TR-EXT B9+MARG 1.1-2 CM
11403	EXC TR-EXT B9+MARG 2.1-3CM
11420	EXC H-F-NK-SP B9+MARG 0.5/<
11421	EXC H-F-NK-SP B9+MARG 0.6-1
11422	EXC H-F-NK-SP B9+MARG 1.1-2
11423	EXC H-F-NK-SP B9+MARG 2.1-3
11720	DEBRIDE NAIL 1-5
11730	REMOVAL OF NAIL PLATE
11750	REMOVAL OF NAIL BED
11765	EXCISION OF NAIL FOLD TOE
11900	INJECT SKIN LESIONS </W 7
11976	REMOVE CONTRACEPTIVE CAPSULE
11980	IMPLANT HORMONE PELLET(S)
11981	INSERT DRUG IMPLANT DEVICE
11982	REMOVE DRUG IMPLANT DEVICE
11983	REMOVE/INSERT DRUG IMPLANT
12001	RPR S/N/AX/GEN/TRNK 2.5CM/<
12042	INTMD RPR N-HF/GENIT2.6-7.5
15839	EXCISE EXCESS SKIN & TISSUE
17000	DESTRUCT PREMALG LESION

Procedure Code	Description
17003	DESTRUCT PREMALG LES 2-14
17004	DESTROY PREMAL LESIONS 15/>
17110	DESTRUCT B9 LESION 1-14
17111	DESTRUCT LESION 15 OR MORE
17250	CHEM CAUT OF GRANLTJ TISSUE
17281	DESTRUCTION OF SKIN LESIONS
17340	CRYOTHERAPY OF SKIN
19000	DRAINAGE OF BREAST LESION
20005	I&D ABSCESS SUBFASCIAL
20520	REMOVAL OF FOREIGN BODY
20550	INJ TENDON SHEATH/LIGAMENT
20551	INJ TENDON ORIGIN/INSERTION
20552	INJ TRIGGER POINT 1/2 MUSCL
20553	INJECT TRIGGER POINTS 3/>
20600	DRAIN/INJ JOINT/BURSA W/O US
20605	DRAIN/INJ JOINT/BURSA W/O US
20610	DRAIN/INJ JOINT/BURSA W/O US
20612	ASPIRATE/INJ GANGLION CYST
36415	ROUTINE VENIPUNCTURE
36416	CAPILLARY BLOOD DRAW
54050	DESTRUCTION PENIS LESION(S)
54056	CRYOSURGERY PENIS LESION(S)
55250	REMOVAL OF SPERM DUCT(S)

Procedure Code	Description
56405	I & D OF VULVA/PERINEUM
56420	DRAINAGE OF GLAND ABSCESS
56501	DESTROY VULVA LESIONS SIM
56515	DESTROY VULVA LESION/S COMPL
56605	BIOPSY OF VULVA/PERINEUM
56606	BIOPSY OF VULVA/PERINEUM
56820	EXAM OF VULVA W/SCOPE
56821	EXAM/BIOPSY OF VULVA W/SCOPE
57061	DESTROY VAG LESIONS SIMPLE
57100	BIOPSY OF VAGINA
57105	BIOPSY OF VAGINA
57135	REMOVE VAGINA LESION
57150	TREAT VAGINA INFECTION
57170	FITTING OF DIAPHRAGM/CAP
57410	PELVIC EXAMINATION
57420	EXAM OF VAGINA W/SCOPE
57421	EXAM/BIOPSY OF VAG W/SCOPE
57452	EXAM OF CERVIX W/SCOPE
57454	BX/CURETT OF CERVIX W/SCOPE
57455	BIOPSY OF CERVIX W/SCOPE
57456	ENDOCERV CURETTAGE W/SCOPE
57500	BIOPSY OF CERVIX
57505	ENDOCERVICAL CURETTAGE

Procedure Code	Description
58100	BIOPSY OF UTERUS LINING
58110	BX DONE W/COLPOSCOPY ADD-ON
58120	DILATION AND CURETTAGE
58300	INSERT INTRAUTERINE DEVICE
58301	REMOVE INTRAUTERINE DEVICE
59025	FETAL NON-STRESS TEST
59200	INSERT CERVICAL DILATOR
59300	EPISIOTOMY OR VAGINAL REPAIR
59400	OBSTETRICAL CARE
59409	OBSTETRICAL CARE
59410	OBSTETRICAL CARE
59412	Vaginal Delivery, Antepartum and Postpartum Care Procedures * **60% of payment**
59414	Under Vaginal Delivery, Antepartum and Postpartum Care Procedures * **60% of payment**
59425	ANTEPARTUM CARE ONLY
59426	ANTEPARTUM CARE ONLY
59430	CARE AFTER DELIVERY
59510	CESAREAN DELIVERY
59514	CESAREAN DELIVERY ONLY
59515	CESAREAN DELIVERY
59515	Cesarean delivery only * **60% of payment**
59610	Routine obstetric care incl. VBAC delivery * **60% of payment**

Procedure Code	Description
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps) * **60% of payment**
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care * **60% of payment**
59618	ATTEMPTED VBAC DELIVERY
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery * **60% of payment**
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care * **60% of payment**
59820	CARE OF MISCARRIAGE
69200	CLEAR OUTER EAR CANAL
69209	REMOVE IMPACTED EAR WAX UNI
69210	REMOVE IMPACTED EAR WAX UNI
76801	OB US < 14 WKS SINGLE FETUS
76802	OB US < 14 WKS ADDL FETUS
76805	OB US >= 14 WKS SNGL FETUS
76810	OB US >= 14 WKS ADDL FETUS
76811	OB US DETAILED SNGL FETUS
76812	OB US DETAILED ADDL FETUS
76813	OB US NUCHAL MEAS 1 GEST
76814	OB US NUCHAL MEAS ADD-ON
76815	OB US LIMITED FETUS(S)
76816	OB US FOLLOW-UP PER FETUS
76817	TRANSVAGINAL US OBSTETRIC
76818	FETAL BIOPHYS PROFILE W/NST

Procedure Code	Description
76819	FETAL BIOPHYS PROFIL W/O NST
90460	IM ADMIN 1ST/ONLY COMPONENT
90461	IM ADMIN EACH ADDL COMPONENT
90471	IMMUNIZATION ADMIN
90472	IMMUNIZATION ADMIN EACH ADD
90473	IMMUNE ADMIN ORAL/NASAL
90474	IMMUNE ADMIN ORAL/NASAL ADDL
90785	PSYTX COMPLEX INTERACTIVE
90791	PSYCH DIAGNOSTIC EVALUATION
90792	PSYCH DIAG EVAL W/MED SRVCS
90832	PSYTX W PT 30 MINUTES
90833	PSYTX W PT W E/M 30 MIN
90834	PSYTX W PT 45 MINUTES
90837	PSYTX W PT 60 MINUTES
90846	FAMILY PSYTX W/O PT 50 MIN
90847	FAMILY PSYTX W/PT 50 MIN
92551	PURE TONE HEARING TEST AIR
92552	PURE TONE AUDIOMETRY AIR
92558	EVOKED AUDITORY TEST QUAL
92567	TYMPANOMETRY
92585	AUDITOR EVOKE POTENT COMPRE
92587	EVOKED AUDITORY TEST LIMITED
92588	EVOKED AUDITORY TST COMPLETE

Procedure Code	Description
94010	BREATHING CAPACITY TEST
94014	PATIENT RECORDED SPIROMETRY
94015	PATIENT RECORDED SPIROMETRY
94016	REVIEW PATIENT SPIROMETRY
94060	EVALUATION OF WHEEZING
94070	EVALUATION OF WHEEZING
94375	RESPIRATORY FLOW VOLUME LOOP
96101	PSYCHO TESTING BY PSYCH/PHYS
96102	PSYCHO TESTING BY TECHNICIAN
96103	PSYCHO TESTING ADMIN BY COMP
96110	DEVELOPMENTAL SCREEN W/SCORE
96111	DEVELOPMENTAL TEST EXTEND
96127	BRIEF EMOTIONAL/BEHAV ASSMT
96150	ASSESS HLTH/BEHAVE INIT
96151	ASSESS HLTH/BEHAVE SUBSEQ
96156	Health behavior assessment or re-assessment
96160	PT-FOCUSED HLTH RISK ASSMT
96161	CAREGIVER HEALTH RISK ASSMT
96372	THER/PROPH/DIAG INJ SC/IM
97802	MEDICAL NUTRITION INDIV IN
97803	MED NUTRITION INDIV SUBSEQ
97804	MEDICAL NUTRITION GROUP
98925	OSTEOPATH MANJ 1-2 REGIONS

Procedure Code	Description
98926	OSTEOPATH MANJ 3-4 REGIONS
98927	OSTEOPATH MANJ 5-6 REGIONS
98928	OSTEOPATH MANJ 7-8 REGIONS
98929	OSTEOPATH MANJ 9-10 REGIONS
98960	SELF-MGMT EDUC & TRAIN 1 PT
98961	SELF-MGMT EDUC/TRAIN 2-4 PT
98962	5-8 patients
98966	HC PRO PHONE CALL 5-10 MIN
98969	ONLINE SERVICE BY HC PRO
99000	SPECIMEN HANDLING OFFICE-LAB
99024	POSTOP FOLLOW-UP VISIT
99050	MEDICAL SERVICES AFTER HRS
99051	MED SERV EVE/WKEND/HOLIDAY
99056	MED SERVICE OUT OF OFFICE
99058	OFFICE EMERGENCY CARE
99071	PATIENT EDUCATION MATERIALS
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity or diabetic instructions)
99173	VISUAL ACUITY SCREEN
99174	OCULAR INSTRUMNT SCREEN BIL
99177	OCULAR INSTRUMNT SCREEN BIL
99188	APP TOPICAL FLUORIDE VARNISH
99201	OFFICE/OUTPATIENT VISIT NEW

Procedure Code	Description
99202	OFFICE/OUTPATIENT VISIT NEW
99203	OFFICE/OUTPATIENT VISIT NEW
99204	OFFICE/OUTPATIENT VISIT NEW
99205	OFFICE/OUTPATIENT VISIT NEW
99211	OFFICE/OUTPATIENT VISIT EST
99212	OFFICE/OUTPATIENT VISIT EST
99213	OFFICE/OUTPATIENT VISIT EST
99214	OFFICE/OUTPATIENT VISIT EST
99215	OFFICE/OUTPATIENT VISIT EST
99334	DOMICIL/R-HOME VISIT EST PAT
99336	DOMICIL/R-HOME VISIT EST PAT
99337	DOMICIL/R-HOME VISIT EST PAT
99339	Individual physician supervision of a patient requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian), and/or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan; and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99340	30 minutes or more
99341	HOME VISIT NEW PATIENT
99342	HOME VISIT NEW PATIENT
99343	HOME VISIT NEW PATIENT
99344	HOME VISIT NEW PATIENT

Procedure Code	Description
99345	HOME VISIT NEW PATIENT
99347	HOME VISIT EST PATIENT
99348	HOME VISIT EST PATIENT
99349	HOME VISIT EST PATIENT
99350	HOME VISIT EST PATIENT
99354	PROLONG E&M/PSYCTX SERV O/P
99355	PROLONG E&M/PSYCTX SERV O/P
99358	PROLONG SERVICE W/O CONTACT
99359	PROLONG SERV W/O CONTACT ADD
99366	TEAM CONF W/PAT BY HC PROF
99367	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician
99368	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
99381	INIT PM E/M NEW PAT INFANT
99382	INIT PM E/M NEW PAT 1-4 YRS
99383	PREV VISIT NEW AGE 5-11
99384	PREV VISIT NEW AGE 12-17
99385	PREV VISIT NEW AGE 18-39
99386	PREV VISIT NEW AGE 40-64
99387	INIT PM E/M NEW PAT 65+ YRS
99391	PER PM REEVAL EST PAT INFANT
99392	PREV VISIT EST AGE 1-4

Procedure Code	Description
99393	PREV VISIT EST AGE 5-11
99394	PREV VISIT EST AGE 12-17
99395	PREV VISIT EST AGE 18-39
99396	PREV VISIT EST AGE 40-64
99397	PER PM REEVAL EST PAT 65+ YR
99401	PREVENTIVE COUNSELING INDIV
99402	PREVENTIVE COUNSELING INDIV
99403	PREVENTIVE COUNSELING INDIV
99404	PREVENTIVE COUNSELING INDIV
99406	BEHAV CHNG SMOKING 3-10 MIN
99407	BEHAV CHNG SMOKING > 10 MIN
99408	AUDIT/DAST 15-30 MIN
99409	Alcohol and/or drug assessment or screening
99411	PREVENTIVE COUNSELING GROUP
99412	PREVENTIVE COUNSELING GROUP
99420	Administration and interpretation of health risk assessments
99421	Online digital evaluation and management service for an established patient for up to 7 days cumulative time during the 7 days, 5-10 minutes
99422	Online digital evaluation and management service for an established patient for up to 7 days cumulative time during the 7 days, 11-20 minutes
99423	Online digital evaluation and management service for an established patient for up to 7 days cumulative time during the 7 days, 21 or more minutes
99429	UNLISTED PREVENTIVE SERVICE
99441	PHONE E/M PHYS/QHP 5-10 MIN

Procedure Code	Description
99442	PHONE E/M PHYS/QHP 11-20 MIN
99443	PHONE E/M PHYS/QHP 21-30 MIN
99444	ONLINE E/M BY PHYS/QHP
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, > 16 minutes
99455	WORK RELATED DISABILITY EXAM
99456	DISABILITY EXAMINATION
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
99458	each additional 20 minutes (List separately in addition to code for primary procedure
99461	INIT NB EM PER DAY NON-FAC
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
99474	separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient
99484	CARE MGMT SVC BHVL HLTH COND
99487	CMPLX CHRON CARE W/O PT VSIT
99489	CMPLX CHRON CARE ADDL 30 MIN

Procedure Code	Description
99490	CHRON CARE MGMT SRVC 20 MIN
99491	Chronic care management services at least 30 minutes
99492	1ST PSYC COLLAB CARE MGMT
99493	SBSQ PSYC COLLAB CARE MGMT
99494	1ST/SBSQ PSYC COLLAB CARE
99495	TRANS CARE MGMT 14 DAY DISCH
99496	TRANS CARE MGMT 7 DAY DISCH
99497	ADVNCD CARE PLAN 30 MIN
99498	ADVNCD CARE PLAN ADDL 30 MIN
0500F	INITIAL PRENATAL CARE VISIT
0501F	PRENATAL FLOW SHEET
0502F	SUBSEQUENT PRENATAL CARE
0503F	POSTPARTUM CARE VISIT
1000F	TOBACCO USE ASSESSED
1031F	SMOKING & 2ND HAND ASSESSED
1032F	PT received Tobacco Cessation Information
1033F	TOBACCO NONSMOKER NOR 2NDHND
1034F	CURRENT TOBACCO SMOKER
1035F	SMOKELESS TOBACCO USER
1036F	TOBACCO NON-USER
1111F	DSCHRG MED/CURRENT MED MERGE
1220F	PT SCREENED FOR DEPRESSION
3016F	PT SCRND UNHLTHY OH USE

Procedure Code	Description
3085F	SUICIDE RISK ASSESSED
3351F	NEG SCRN DEP SYMP BY DEPTOOL
3352F	NO SIG DEP SYMP BY DEP TOOL
3353F	MILD-MOD DEP SYMP BY DEPTOOL
3354F	CLIN SIG DEP SYM BY DEP TOOL
3355F	CLIN SIG DEP SYM BY DEP TOOL
4000F	TOBACCO USE TXMNT COUNSELING
4001F	TOBACCO USE TXMNT PHARMACOL
4004F	PT TOBACCO SCREEN RCVD TLK
4290F	Alcohol and/or drug assessment or screening
4293F	Pt screened for high risk sexual behavior
4306F	Alcohol and/or Drug use counseling services
4320F	Alcohol and/or Drug use counseling services
90848 - 90899	Services to patients for evaluation and treatment of mental illnesses that require psychiatric services
96158-96159	Health behavior intervention, individual face-to-face
96164-96165	Health behavior intervention, group (two or more patients), face-to-face
96167-96168	Health behavior intervention, family (with the patient present), face-to-face
96170-96171	Health behavior intervention, family (without the patient present), face-to-face
97151-97158	Behavior Identification Assessment, administered by QHP, each 15 minutes of QHP's time face-to-face with patient and/or guardian(s)/caregivers(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
98967-98968	Non-physician telephone services

Procedure Code	Description
G0008	ADMIN INFLUENZA VIRUS VAC
G0009	ADMIN PNEUMOCOCCAL VACCINE
G0010	ADMIN HEPATITIS B VACCINE
G0101	CA SCREEN; PELVIC/BREAST EXAM
G0123	SCREEN CERV/VAG THIN LAYER
G0179	MD RECERTIFICATION HHA PT
G0180	MD CERTIFICATION HHA PATIENT
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
G0396	ALCOHOL/SUBS INTERV 15-30MN
G0397	Alcohol or substance abuse assessment
G0402	INITIAL PREVENTIVE EXAM
G0403	EKG FOR INITIAL PREVENT EXAM
G0404	EKG TRACING FOR INITIAL PREV
G0405	EKG INTERPRET & REPORT PREVE
G0438	PPPS, INITIAL VISIT
G0439	PPPS, SUBSEQ VISIT
G0442	ANNUAL ALCOHOL SCREEN 15 MIN
G0443	BRIEF ALCOHOL MISUSE COUNSEL

Procedure Code	Description
G0444	DEPRESSION SCREEN ANNUAL
G0445	HIGH INTEN BEH COUNS STD 30M
G0447	BEHAVIOR COUNSEL OBESITY 15M
G0463	HOSPITAL OUTPT CLINIC VISIT
G0476	HPV COMBO ASSAY CA SCREEN
G0502	Initial psychiatric collaborative care management
G0503	Subsequent psychiatric collaborative care management
G0504	Initial or subsequent psychiatric collaborative care management
G0505	Cognition and functional assessment
G0506	COMP ASSES CARE PLAN CCM SVC
G0507	Care management services for behavioral health conditions
G0513	PROLONG PREV SVCS, FIRST 30M
G0514	Prolonged preventive service
G2058	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month;
G2064-G2065	Comprehensive care management services for a single high-risk disease
H0002	ALCOHOL AND/OR DRUG SCREENIN
H0031	MH HEALTH ASSESS BY NON-MD
H0049	ALCOHOL/DRUG SCREENING
H1000	PRENATAL CARE ATRISK ASSESSM
H1001	ANTEPARTUM MANAGEMENT
Q0091	OBTAINING SCREEN PAP SMEAR
S0610	ANNUAL GYNECOLOGICAL EXAMINA

Procedure Code	Description
S0612	ANNUAL GYNECOLOGICAL EXAMINA
S0613	ANN BREAST EXAM
S0622	PHYS EXAM FOR COLLEGE
S9444	Parenting Classes, non-physician provider, per session
S9445	PT EDUCATION NOC INDIVID
S9446	PT EDUCATION NOC GROUP
S9447	Infant safety (including cardiopulmonary resuscitation classes nonphysician provider, per session)
S9449	WEIGHT MGMT CLASS
S9451	EXERCISE CLASS
S9452	Nutrition classes non-physician provider per session
S9454	Stress management classes non-physician provider per session
S9470	NUTRITIONAL COUNSELING, DIET
T1015	CLINIC SERVICE

Table 4: Defining Outpatient Setting (Place of Service Codes)

Place of Service Code	Description
02	Telehealth
03	School
11	Office
12	Home
13	Assisted Living Facility
19	Off Campus – Outpatient Hospital

Place of Service Code	Description
22	On Campus – Outpatient Hospital
25	Birthing Center
49	Independent Clinic
50	Federally Qualified Health Center
53	Community Mental Health Center
72	Rural Health Clinic

Appendix H: Frequently Asked Questions

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

   Test files for Alternative Payment Models (AM, CT, AC) and Drug Rebate (DR, PB) 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 will have complete 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 their TEST file(s).

   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 Alternative Payment Model (APM) files?**

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

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

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

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

The Control Total file supplements the APM file by collecting summary information about the distribution of payments under various payment models. It is used to confirm that the APM file from each submitter was received and loaded correctly. It is also used to understand the adoption of APMs by line of business (e.g., Commercial, Medicaid, Medicare Advantage) in Colorado via de-duplicated member months.

5) **What is the objective of the Contract Information Supplement (AC) File?**

The goal of collecting the supplemental contract information is to facilitate discussions with payers about their alternative payment model contracts with providers. Each of the data elements represent a question that CIVHC consistently asked payers related to each payment model when assisting them with categorizing payments into the Expanded Non-Claims Payment framework. The addition of the supplemental contract information will standardize and streamline this effort. CIVHC does not intend to share this information publicly.

6) **What level of granularity should be included in the Contract Information (AC) Supplement?**

The supplement should include an entry for each type of contract represented in the APM and Control Total files (e.g. episode-based payments for orthopedic procedures or mental health-specific population-based payments). There does not need to be an entry for each individual provider contract. Contracts that are entirely fee-for-service also do not need to be included.

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

For the APM and Control Total files, please submit separate files for each payer code. If you are unable to report these data by payer code, please contact CIVHC. We will work with you to

develop modified data specifications that accommodate your data limitations and allow CIVHC to fulfill its statutory obligations. Please note that these instructions for the APM file differ from instructions related to the Drug Rebate file.

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

These files require information for each of the three most recent calendar years (2022, 2023 and 2024). The year (AM009, CT004) should be assigned based on service or incurred date rather than paid date. Include all 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.

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

Please submit these waiver documents no later than April 1, 2025.

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

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

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

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

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

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

13) **What are the differences between the data reported in the APM files and the data reported in the other claims files (eligibility, claims, provider, etc.)?**

One difference between the aggregated data reported in the APM files and the claim-level data reported in the monthly claims files is the inclusion of data for Substance Use Disorder (SUD). Monthly claims files do not include SUD claims, but data submitters should include SUD data in APM filings of aggregated claims and non-claims payments.

Another difference is the inclusion of non-claims payments in the APM files; one of the main purposes of the APM file is to understand the total payments (claims and non-claims payments) to providers for care delivered to residents of Colorado. Monthly claims files do not capture most non-claims payments.

14) How should member months (AM011) be calculated?

Population of the member months field (AM011) is only required when reporting certain types of payment arrangements such as population-based payments. When required, your organization should include the total number of members (represented in member months) that participated in the reported APM. This will require identifying the number of members (monthly) served under the payment arrangement model for each billing provider or contract ID. For example, a comprehensive population-based payment (Payment Model = D5) paid for a member for January through December would count as 12-member months. If your organization covers a person for even one day of the month, even if it's the 1st or the 31st, then this counts as a member month.

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

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

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

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

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

In instances when a single contract consists of several components (but is paid out in a single check), your organization should separate these payment types and report them in separate fields on a single AM file record. In the above example, this arrangement might be considered pay-for-performance. Your organization would report B2 (Pay for Performance model) in AM007, the amount of the payment that was FFS in the claims payments fields (AM012, AM013, AM016, and AM017), and the amount that was a pay-for-performance bonus in the non-claims payments fields (AM014, AM015, AM018, and AM019).

If your organization has a contract that is based on FFS and includes shared savings or shared savings with a downside risk, the payer would report the amount of FFS payments in the claims payments fields (AM012, AM013, AM016, and AM017), and the amount for any shared savings or shared savings with downside risk payments in the non-claims payments fields (AM014, AM015, AM018, and AM019). Both claims and non-claims dollars would be reported on a single AM file record with the appropriate Expanded Framework categorization in AM007.

17) **How are the different "payment" variables (AM012-AM020) defined?**

There are nine payment variables in the APM file in four major categories; two categories that relate to primary care payments, two that relate to total payments, and one that relates to recoupments from providers. The two total primary care payment elements (AM012 and AM014) should be subsets of the total payment elements (AM016 and AM018), respectively. Total Primary Care Claims Payments (AM012) should be a subset of the value input for Total Claims Payments (AM016) and Total Primary Care Non-Claims Payments (AM014) should be a subset of the value input for Total Non-Claims Payments (AM018).

Each Total payment field also has a corresponding Payer Portion amount field (AM013, AM015, AM017, AM019). The Payer Portion should always be a subset of the Total payment amount.

Total Claims payments fields (AM012 and AM016) should include payments that were directly tied to a claim. These transactions would be found in the Medical Claims (MC) files submitted to CIVHC each month. It should include the total allowed amount -- member portion (copay + coinsurance + deductible) plus the plan paid portion.

Total non-claims payments fields (AM014 and AM018) should include payments made outside of the claim transaction. This would include transactions such as incentive payments, capitation payments, payments for infrastructure, and any payments from the provider to the payer (i.e., penalties) in downside risk arrangements.

Recoupments from Providers (AM020) is meant to capture the total payments received from providers to payers as a result of missed quality metrics, missed spending targets, or APM reconciliation payments.

18) **How is the Prospective Payment Flag defined?**

Prospective payments refer to any payments made to providers in advance of services rendered. Typically, these are based on predetermined payment amounts for services.

Payments associated with contracts that include prospective payments for series should be submitted with a Prospective Payment Flag (AM008) = 'Y'. This flag should be set to 'Y' even if retrospective reconciliation is also part of the payment contract.

Payments associated with contracts that do not include any prospective payments should be submitted with AM008 = 'N'.

Please direct any specific questions to CIVHC.

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

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

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

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

The APM file is meant to capture all payments, not just alternative payments. For example, both fee-for-service and alternative payment methodologies are included in the APM file as required payment models for reporting. Therefore, if the only payment made to one or more Billing Provider IDs was under a FFS arrangement, then the claims payments fields (AM012 and AM016) should be populated with the payment amounts and non-claims payments fields (AM014 and AM018) should reflect $0. Only in instances where there is no payment at all made to a particular billing provider or organization for contracts during the reporting period should they be omitted from the APM file.

21) What is the definition of primary care for reporting element AM012 (claims)?

CIVHC is using the definition established by the Colorado Primary Care Payment Reform Collaborative. This definition was operationalized as payments made to a primary care provider for a primary care service. Included in this definition are services delivered by behavioral health providers who practice in an integrated primary care setting.

The primary care definition consists of two components that should be summed to produce total primary care payments:

- Outpatient services delivered by primary care providers (which include OB/GYN providers), defined by a combination of primary care provider taxonomy and primary care CPT-4 procedure codes

- Outpatient services delivered by behavioral health providers, nurse practitioners and physician assistants, defined by a combination of the "other" provider taxonomy and primary care CPT-4 procedure codes AND billed by a primary care provider (defined by primary care taxonomy)

Please refer to Appendix F for the taxonomy and CPT-4 procedure code sets relevant to the definition above. To assist you in calculating primary care payments from claims, CIVHC will provide SQL code that you can use as the basis for extracting these data from your systems. As always, please contact CIVHC if you have questions about how to implement the new definition of primary care.

22) What is the definition of primary care for reporting element AM014 (non-claims)?

Include non-claims-based payments for services delivered by:

- Providers with specialties in the primary care taxonomy (Appendix F, Table 1)

- Behavioral health providers with a specified taxonomy (Appendix F, Table 2) that deliver care that is integrated with primary care (i.e., either within the primary care practice or through working relationships that involve close communication and collaboration with primary care providers)

- Payments to Nurse Practitioners and Physician Assistants (Appendix F, Table 2) that deliver primary care or work within a primary care practice

Please reach out to CIVHC if your organization is unable to identify specific service providers within a large contract and needs assistance allocating or estimating non-claims primary care expenditures.

23) What should be included in Record Type (AM999)?

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

24) What should be included in Record Type (CT999)?

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

25) 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 APM, Control Total, and Contract Supplement files. If your files have not been received in the correct folder by the due date, a representative from CIVHC will send an email requesting immediate submission.

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.

Appendix I: 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 J: CO APCD Data Submission Guide Version 16 Testing Instructions

Last Updated: June 23, 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), Value Based Purchasing Contract (VB), and 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 06/23/2025		

Testing Requirements

7/1/2025 – 7/15/2025

- 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 15th.
- 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:

- Annual Files in .txt format (AM, CT, CF, 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 Annual 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)
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), Member Capitation (CF), 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_2025AMv01.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.

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

- 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 CO APCD Production Portal to track the progress of your file. 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 Prod Portal. Login to the Prod 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 Prod 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