CIVHC

CENTER FOR IMPROVING
VALUE IN HEALTH CARE

Prescription Drug Rebate

Data Submission Manual | June 2026

Navigation

Acknowledgement

The Center for Improving Value in Health Care (CIVHC) bases its approach to collecting information about Prescription Drug Rebates on a program established by the Massachusetts Center for Healthcare Information and Analysis (CHIA). The instructions in this document include language from a 2018 Data Specification Manual to payers about requirements for submitting data on drug rebates. We wish to express our thanks to CHIA for their generous assistance in the creation of this document.

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.

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

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

Why Collect Drug Rebate Data?

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

File Submission Instructions and Schedule

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

Alternative Payment Model and Drug Rebate Data Submission Schedule	
Date	**Files Due**
April 1, 2026	Waiver request due (if applicable)
July 1, 2026	Test files of data for 2023, 2024, 2025 due
August 1, 2026	Deadline to update contact list in Portal for each file type
September 1, 2026	Final files for three calendar years: 2023, 2024 and 2025
November 1, 2026	Deadline for all DR files to pass intake validation
November 15, 2026	Deadline for attestation form to be signed and submitted to CIVHC

For the 2026 submission year, files will be submitted either via .csv format or text format (.txt). Please see the chart below for specific instructions for each file type and links to Excel templates, if applicable. The **DR** file types associated with this manual are highlighted in **orange** below for your convenience.

File Type	**Format**
AM: Alternative Payment Model	.txt
CT: APM Control Total	.txt
AC: APM Contract (formerly 2nd tab in CT file)	.csv
DR: Drug Rebate	**.txt**
PB: PBM Contract (formerly 2nd tab in DR file)	**.csv**
PD: Prescription Drug Affordability Board	.csv
VB: Value-Based Pharmacy Contract	.csv
CF: Member Capitation File	.txt

You can find all templates for .txt files in the Submitter Resources section here: Submitter Resources - CIVHC.org.

Please note that there will be no templates for .csv files since these files do not contain headers.

All file names must follow the template designated in DSG v17:

PB file should be submitted in CSV format (.csv) and DR files should be submitted in text format (.txt).

PayerCode_FileType_PeriodStartDate_PeriodEndDate_RowCount_ProdFlag_FixedWidthInd_Create Date

- Payer Code = Unique identifier assigned to each payer by the CO APCD's data administrator
- FileType = A two-character code that indicates which file is being submitted:
    1. 'DR' = Drug Rebate
    2. 'PB' = PBM Contract
- PeriodStartDate = YYYYMM format. The start month of the submission year/compliance year.
- PeriodEndDate = YYYYMM format. The end month of the submission year/compliance year.
- RowCount (no commas) = Total number of records submitted in the file, excluding header and trailer records
    1. For DR files, if payer cannot fill in the "RowCount" section of the file naming convention, then a "0" can be used instead. For example: COCXXXX_DR_202601_202612_0_T_DL_20260822
- ProdFlag = A one-character code that indicates whether a file is a 'Test' file or a 'Production' file:
    1. 'T' = Test
    2. 'P' = Production
- DelimitedFileInd = A two-character code that indicates whether a file is reported with delimiters:
    1. 'DL' = Delimiters included
- CreateDate (YYYYMMDD)

For example, the following naming conventions will be used for testing and production in 2026:

- COCXXXX_DR_202601_202612_4500_P_DL_20260822.txt
- COCXXXX_PB_202601_202612_10_P_DL_20260730.csv

Waivers

CIVHC will work collaboratively with payers to ensure that required drug rebate data are submitted in a manner that satisfies the intent of the 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 DR 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 **Drug Rebate** filing if the organization meets one of the following criteria:

1. Payer does not provide prescription drug benefits (e.g. payer only provides medical benefits, payer only provides dental benefits, etc.)

2. Payer only provides supplemental insurance (e.g. Medicare Supplemental policies only)

3. Payer does not receive any rebates or other compensation from drug manufacturers/PBMs

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

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

If you believe your organization is not obligated to submit a **Drug Rebate** or **PBM Contract** file, but one of the three criteria above are not applicable, please contact CIVHC.

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

Changes to the Drug Rebate Submission Manual

The following are changes to this Drug Rebate Data Submission Manual, which were adopted following the DSG v17 Rule Hearing on November 20, 2025.

- Updates to Length and Required/Optional fields of data elements for the DR file
    - Changed and added Header and Trailer Records
- Changes to naming convention for the DR file
    - Changed naming convention to align with new data warehouse specifications following data vendor transition
- Changed PB file format from Excel format to .csv format
- Updates to Type and Length fields of data elements for the PB file

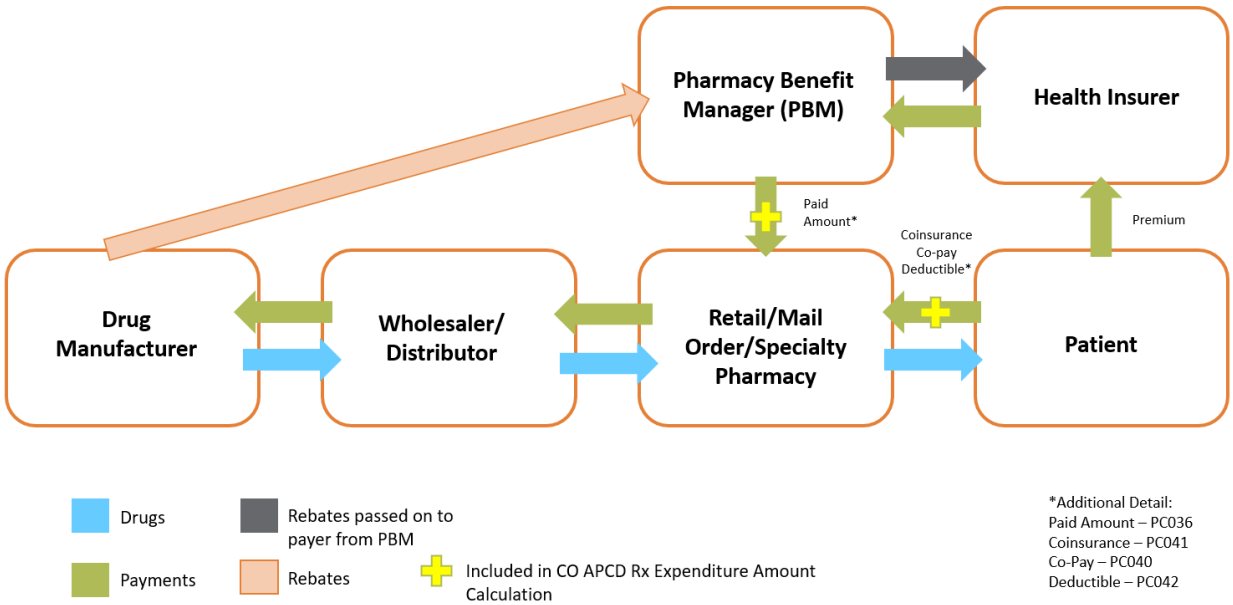
Data Submission of Prescription Drug Rebate Details

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

- Drug Rebate file (DR): Captures data related to pharmacy expenditures and rebates received from drug manufacturers.
- Pharmacy Benefit (PB): Captures summary information about a payer's contract with its PBM.

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

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



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.

DRUG REBATE DATA SPECIFICATIONS

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

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

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

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

12	Preferred Provider Organization (PPO) - Commercial
13	Point of Service (POS) - Commercial
15	Indemnity Insurance - Commercial
16	Health Maintenance Organization (HMO) Medicare Advantage
17	Dental Maintenance Organization (DMO)
HM	Health Maintenance Organization - Commercial
19	Prescription Drug Only Insurance – Commercial
EP	Exclusive Provider Organization (EPO) - Commercial
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MD	Medicare Part D
MP	Medicare Primary
QM	Qualified Medicare Beneficiary
TV	Title V

99	Other
SP	Medicare Supplemental (Medi-gap) plan
CP	Medicaid CHIP
MS	Medicaid Fee for service
MM	Medicaid Managed care
CS	Commercial Supplemental plan
ME	Medicare Advantage Preferred Provider Organization (PPO)
ML	Medicare Advantage Indemnity Plan
MO	Medicare Advantage Point of Service (POS) Plan
S1	Medicare Special Needs Plan – Chronic Condition
S2	Medicare Special Needs Plan – Institutionalized
S3	Medicare Special Needs Plan-Dual Eligible

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

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

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

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

Total Pharmacy Expenditure Amount (DR008):

Instruction also applicable to:

- Pharmacy Expenditure Amount for Specialty Drugs (DR009),
- Pharmacy Expenditure Amount for Non-Specialty Brand Drugs (DR0010), and
- Pharmacy Expenditure Amount for Non-specialty Generic Drugs (DR011)

The sum of all incurred claim allowed payment amounts to pharmacies for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit in a given calendar year. This amount shall include member cost sharing amounts. This shall include all incurred claims for individuals included in the member population regardless of where the prescription drugs are dispensed (i.e., includes claims from in-state and out-of-state providers). Pharmacy Expenditure amounts should reflect all paid pharmacy claims for the applicable reporting period and should not be limited solely to claims associated with manufacturers' rebates.

Claims should be attributed to a calendar year based on the prescription fill date. Pharmacy Expenditure amounts should include a count of all paid prescriptions. Do not count claims that have been fully reversed. Additionally, do not count reversal versions of claims.

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

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

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

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

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

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

Instruction also applicable to:

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

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

Rebates: "Rebates" will include price concessions, price discounts, or discounts of any sort that reduce payments, a partial refund of payments or any reductions to the ultimate amount paid; a performance based financial reward; a financial reward for inclusion of a drug in a preferred drug list or formulary or preferred formulary position; market share incentive payments and rewards; credits; remuneration or payments for the provision of utilization or claim data to manufacturers for rebating, marketing, outcomes insights, or any other purpose; rebates, regardless of how categorized, and all Other Compensation to carriers, their PBMs, rebate aggregators, subsidiaries, any affiliated holding and/or parent company or within the parent organization, and all other organizational affiliates. The rebate terms of the reduction must be fixed and disclosed in writing to the payer.

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

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

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

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

Total Count of Prescriptions Filled (DR016):

Instruction also applicable to:

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

The distinct count of all incurred claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit in a given calendar year. This shall include all incurred claims for individuals included in the member population regardless of where the prescription drugs are dispensed (i.e., includes claims from in-state and out-of-state providers). Pharmacy Count amounts should reflect all paid pharmacy claims for the applicable reporting period and should not be limited solely to claims associated with manufacturers' rebates.

Claims should be attributed to a calendar year based on the date of fill. Prescription counts should include a count of all *paid prescriptions.* Do not count claims that have been fully reversed. Additionally, do not count reversal versions of claims.

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

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

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

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

Record Type (DR999): Record type identifier: DR

Data Submission of PBM Contract Information

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

PBM CONTRACT DATA SPECIFICATIONS

The payer is expected to record prescription drug rebate data in the Prescription Drug Rebate Submission DSG 17 Excel template. Below is a description of each field.

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

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

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

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

Code	Insurance Type Code Description
CP	Medicaid CHIP
S1	Medicare Special Needs Plan-Chronic Condition
S2	Medicare Special Needs Plan-Institutionalized
S3	Medicare Special Needs Plan-Dual Eligible

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

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

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

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

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

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

Drug Rebate File Content

For fields that are populated with a list, use semicolons instead of commas to separate the values.

For fields that are populated with free text and commas are expected to be part of the text, use double quotes as text qualifier.

Drug Rebate File Header Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	HD
HD002	File Type	char	2	DR
HD003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
HD004	Payer Name	varchar	75	Distributed by CIVHC
HD005	Beginning Month	date	6	YYYYMM. For annual files, this is the beginning month of the submission year/compliance year. For example: 202601.
HD006	Ending Month	date	6	YYYYMM For annual files, this is the ending month of the submission year/compliance year. For example: 202612.
HD007	Record count	int	10	Total number of records submitted in the Drug Rebate file, excluding header and trailer records
HD008	Med_BH PMPM	int	7	Place holder. Leave field blank.
HD009	Pharmacy PMPM	int	7	Place holder. Leave field blank.
HD0010	Dental PMPM	int	7	Place holder. Leave field blank.
HD011	Vision PMPM	int	7	Place holder. Leave field blank.
HD012	Test File Flag	char	1	T=File submitted is a test file; P=File submitted is a production file.

Submitted to CIVHC via SFTP in .txt file format.

Drug Rebate File Trailer Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	TR
TR002	File Type	char	2	DR
TR003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
TR004	Payer Name	varchar	75	Distributed by CIVHC
TR005	Beginning Month	date	6	YYYYMM. For annual files, this is the beginning month of the submission year/compliance year. For example: 202601.
TR006	Ending Month	date	6	YYYYMM For annual files, this is the ending month of the submission year/compliance year. For example: 202612.
TR007	Extraction Date	date	8	YYYYMM

Drug Rebate File

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
DR001	Payer Code	varchar	7	Distributed by CIVHC	R
DR002	Payer Name	varchar	75	Distributed by CIVHC	R
DR003	Insurance Type Code/Product	char	2	See Lookup Table B-1. A	R
DR004	Calendar Year	Year	4	4-digit Year for the most recent calendar year time period reported in this submission	R
DR005	Drug Manufacturer NDC/NHRIC Labeler Code	varchar	5	The first four or five digits in the 11-digit national drug code (NDC) format that is assigned to the manufacturer by the Food & Drug Administration (FDA). Include leading zero's Labeler code can be found on the FDA website. https://www.fda.gov/industry/structured-product-labeling-resources/ndcnhric-labeler-codes	R
DR006	Labeler Code Firm Name	varchar	200	Firm name associated with NDC/NHRIC labeler	R
DR007	Therapeutic Class	varchar	70	Therapeutic class of drug eg., 28:00. Leave the field blank if there is no available drug class for a reported NDC.	O

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
DR008	Total Pharmacy Expenditure Amount	Numeric	15	The sum of all incurred claim allowed payment amounts to pharmacies for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit in a given calendar year. This amount shall include member cost sharing amounts. This shall also include all incurred claims for individuals included in the member population regardless of where the prescription drugs are dispensed (i.e., includes claims from in-state and out-of-state providers). Claims should be attributed to a calendar year based on the date of fill. (Allowed amount should include direct drug costs and exclude non-claim costs. This amount will not reflect prescription drug rebates in any way) Two explicit decimal places (e.g., 200.00).	R
DR009	Pharmacy Expenditure Amount: Specialty Drugs	Numeric	15	The total expenditure for a specialty drug. Specialty drug expenditure and rebate amounts should be mutually exclusive from non-specialty brand drug and non-specialty generic drug expenditure and rebate amounts. Drug defined as a specialty drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	R
DR0010	Pharmacy Expenditure Amount: Non-	Numeric	15	The total expenditure for Non-Specialty Brand Drugs. Non-specialty brand drug expenditure and rebate amounts should be mutually exclusive from	R

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

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
DR013	Prescription Drug Rebate/Other Compensation Amount: Specialty Drugs	Numeric	15	Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts for all specialty drugs. Specialty drug expenditure and rebate amounts should be mutually exclusive from non-specialty brand drug and non-specialty generic drug expenditure and rebate amounts. Drug defined as a specialty drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	R
DR014	Prescription Drug Rebate/Other Compensation Amount: Non-Specialty Brand Drugs	Numeric	15	Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts for all Non-Specialty Brand Drugs. Non-specialty brand drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty generic drug expenditure and rebate amounts. A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	R
DR015	Prescription Drug Rebate/Other Compensation Amount: Non-	Numeric	15	Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts for all Non-Specialty Generic Drugs. Non-specialty generic drug expenditure and rebate amounts should	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
	Specialty Generic Drugs			be mutually exclusive from specialty drug and non-specialty brand drug expenditure and rebate amounts. A drug defined as a non-specialty generic drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	
DR016	Total Count of Prescriptions Filled	int	15	Total count of all prescriptions filled by members.	R
DR017	Count of Prescriptions Filled: Specialty Drugs	int	15	Total count of all specialty prescriptions filled by members. A drug defined as a specialty drug under the terms of a payer's contract with its PBM.	R
DR018	Count of Prescriptions Filled: Non-Specialty Brand Drugs	int	15	Total count of all non-specialty brand prescriptions filled by members. A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM.	R
DR019	Count of Prescriptions Filled: Non-	int	15	Total count of all non-specialty generic prescriptions filled by members.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
	Specialty Generic Drugs			A drug defined as a non-specialty generic drug under the terms of a payer's contract with its PBM.	
DR020	Comments	varchar	1000	Use this field to provide additional information or describe any caveats regarding data in the Drug Rebate submission.	O
DR999	Record Type	char	2	DR	R

PBM Contract Information Content

For fields that are populated with a list, use semicolons instead of commas to separate the values.

For fields that are populated with free text and commas are expected to be part of the text, use double quotes as text qualifier.

Submitted to CIVHC via SFTP in .csv file format.

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PB001	Payer Code	varchar	7	Distributed by CIVHC's data administrator	R
PB002	Payer Name	varchar	75	Distributed by CIVHC	R
PB003	Pharmacy Benefit Manager Name	varchar	75	The name of a pharmacy benefit manager (PBM) that provided any of the following services in a given insurance category and calendar year: claims	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				processing, drug formulary management, or manufacturer drug rebate contracting.	
PB004	Insurance Product Type code	char	2	See lookup table B.1.A Payers shall report for all insurance categories for which they have business.	R
PB005	Calendar Year	year	4	4-digit year for the calendar year time period reported in this submission	R
PB006	Drug Formulary Management?	varchar	4	Identify whether an individual PBM organization performed all, some, or none of the drug formulary management for its pharmacy benefit within a given insurance category and year. Three possible responses: All, Some, None	R
PB007	Manufacturer Drug Rebate Contracting?	varchar	4	Identify whether an individual PBM organization performed all, some, or none of the manufacturer drug rebate contracting for its pharmacy benefit within a given insurance category and year. Three possible responses: All, Some, None	R
PB008	Percent Rebate Passed to Carrier	decimal	4	Identify the proportion of total rebates and other compensation that is passed through to the carrier from the PBM.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				If the percent passed to carrier is 90%, submit as .9.	
PB009	Comments	varchar	1000	Use this field to provide additional information or describe any caveats regarding data in the PBM Contract submission	O

Appendix A: Waiver Instructions and Form

Data Submitter Request Form

Waiver of Annual File Submissions

Waiver Tracking	
To be Completed by Data Submitter	
Annual File Submission Year:	2026
Data Submitter Code (**one** per form):	*ENTER ONPOINT-ASSIGNED CODE (e.g., COC0900)*
Data Submitter Name (**one** per form):	*ENTER FULL ENTITY NAME*
Data Submitter Contact Name:	
Data Submitter Contact Email:	
Date of Form Submission to CIVHC:	
To be Completed by CIVHC	
CIVHC Reviewer:	*ENTER FULL NAME, ENTER UNABBREVIATED TITLE*
CIVHC Decision:	*DECISION*
Date of CIVHC Decision:	*DATE*

Contents

Data Submitter Request Form

Waiver of Annual File Submissions

Regulatory Background

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 Data Submitters to support their compliance with regulatory submission requirements.

In addition to monthly file submissions, Data Submitters are required 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 regulation 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.

Waiver Request Instructions

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

1. Indicate under Waiver Request Details which files are requested waived from the annual submission requirement and provide the reason for waiver request.
2. Read the Agreement to Waiver Conditions at the end of this document.
3. Certify this form with a signature from the organization's authorized signatory 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 (this date is subject to change if the form is not submitted timely by the Data Submitter). A new waiver request must be submitted every calendar year, and an approved waiver applies only to the submission year in which it is approved.

Data Submitter Request Form

Waiver of Annual File Submissions

Waiver Request Details

See 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]	*SELECT FROM DROP-DOWN LIST*
	CIVHC Decision: ☐ **Approved** ☐ **Denied**
☐ CT – APM Control Total[1]	*SELECT FROM DROP-DOWN LIST*
	CIVHC Decision: ☐ **Approved** ☐ **Denied**
☐ AC – APM Contract Information[1]	*SELECT FROM DROP-DOWN LIST*
	CIVHC Decision: ☐ **Approved** ☐ **Denied**

[1] Annual submission requires the three (3) calendar years preceding the reporting year (e.g., the 2026 submission will include files for 2023, 2024, and 2025 reporting years).

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Data Submitter Request Form

Waiver of Annual File Submissions

Drug Rebate (DR) Files	
File Abbreviation and Name	**Reason for Waiver Request**
☐ DR – Drug Rebate Data[1]	*SELECT FROM DROP-DOWN LIST*
	CIVHC Decision: ☐ **Approved** ☐ **Denied**
☐ PB – PBM Contract Information[1]	*SELECT FROM DROP-DOWN LIST*
	CIVHC Decision: ☐ **Approved** ☐ **Denied**
☐ PD – PDAB Collection Information[2 3]	*SELECT FROM DROP-DOWN LIST*
	CIVHC Decision: ☐ **Approved** ☐ **Denied**
☐ VB – VBPC Collection Information[4]	*SELECT FROM DROP-DOWN LIST*
	CIVHC Decision: ☐ **Approved** ☐ **Denied**

[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 2026 submission will include the 2025 reporting year).
[4] Annual submission requires the four (4) calendar years preceding the submission year (e.g., the 2026 submission will include files for 2022, 2023, 2024, and 2025 reporting years).

Data Submitter Request Form

Waiver of Annual File Submissions

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)

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 **6/30/2027**, 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 Request Form

Waiver of Annual File Submissions

Data Submitter Authorized Signatory	
Signature:	(Electronic or handwritten accepted)
Name:	*ENTER FULL NAME*
Title:	*ENTER UNABBREVIATED TITLE*
Date:	

Appendix B: Sample Files

Prescription Drug Rebate File

```
HD|DR|COCXXXX|Example Insurance Company|202601|202612|26|||||P
COCXXXX|Example Insurance Company|12|2023|11111|DrugMakrz|28:00|3090635.52|405112.50|1215337.51|1470185.51|37087626.12|20769070.63|14093297.93|2225257.57|810225|97227|332192|380805||DR
COCXXXX|Example Insurance Company|12|2023|11111|DrugMakrz|12:00|344464.32|1246.51|253950.02|89267.79|8421620.22|4716107.32|3200215.68|505297.21|249300|29916|102213|117171||DR
COCXXXX|Example Insurance Company|12|2023|11111|DrugMakrz|8:00|39833.11|17866.50|19599.53|2367.08|1314491.64|736115.32|499506.82|78869.50|35733|4287|14650|16794||DR
COCXXXX|Example Insurance Company|12|2024|11111|DrugMakrz|4:00|388471.14|65441.25|196323.75|126706.14|4273182.54|2392982.22|1623809.37|256390.95|130882|15705|53661|61514||DR
COCXXXX|Example Insurance Company|12|2024|22222|AstroPharm|22:00|2840510.50|486135.01|1309659.04|1044716.45|48288677.65|27041659.48|18349697.51|2897320.66|972270|116672|398630|456966||DR
COCXXXX|Example Insurance Company|12|2024|22222|AstroPharm|12:00|213819.86|14958.03|190890.05|7971.78|3484417.80|1951273.97|1324078.76|209065.07|299160|35899|122655|140605||DR
COCXXXX|Example Insurance Company|12|2024|33333|Atlantis Drug|80:00|49595.91|21439.81|21502.26|6653.84|843129.28|472152.40|320389.13|50587.76|42879|5145|17580|20153||DR
COCXXXX|Example Insurance Company|HN|2025|11111|DrugMakrz|8:00|485856.45|78529.52|282082.57|125244.36|5830276.32|3264954.74|2215505.00|349816.58|157059|18847|64394|73817||DR
COCXXXX|Example Insurance Company|HN|2025|11111|DrugMakrz|4:00|2772856.36|583362.18|1252697.94|936796.24|69321404.50|38819986.52|26342133.71|4159284.27|1166724|140006|478356|548360||DR
COCXXXX|Example Insurance Company|HN|2025|22222|AstroPharm|22:00|24237492.01|179496.01|22263870.82|1794125.18|11762126.88|6586791.05|4469608.21|705727.61|358992|43079|147186|168726||DR
COCXXXX|Example Insurance Company|HN|2025|33333|Atlantis Drug|28:00|2704619.76|25727.76|1982324.44|696567.56|1628017.08|911689.56|618646.49|97681.02|51455|6174|21096|24184||DR
COCXXXX|Example Insurance Company|HN|2025|33333|Atlantis Drug|28:00|46854897.40|94235.40|34593662.25|12166999.75|8989472.32|5034104.5|3415999.48|539368.34|188470|22616|77273|88581||DR
TR|DR|COCXXXX|Example Insurance Company|202601|202612|20250830
```

PBM Contract Information File

Please note that .csv file should not include any column headers

```
0,Example Insurance Company,DrugsRUs,12,2025,All,Some,0.80,"ExampleComments",
0,Example Insurance Company,DrugsRUs,13,2025,All,Some,0.80,"ExampleComments",
0,Example Insurance Company,DrugsRUs,15,2025,All,Some,0.80,"ExampleComments",
0,Example Insurance Company,BestRx,MM,2025,None,Some,1.00,"ExampleComments",
0,Example Insurance Company,DrugsRUs,12,2024,All,Some,0.85,"ExampleComments",
0,Example Insurance Company,DrugsRUs,13,2024,All,Some,0.85,"ExampleComments",
0,Example Insurance Company,DrugsRUs,15,2024,All,Some,0.85,"ExampleComments",
0,Example Insurance Company,BestRx,MM,2024,None,Some,1.00,"ExampleComments",
0,Example Insurance Company,DrugsRUs,12,2023,All,Some,0.87,"ExampleComments",
0,Example Insurance Company,DrugsRUs,13,2023,All,Some,0.87,"ExampleComments",
0,Example Insurance Company,DrugsRUs,15,2023,All,Some,0.87,"ExampleComments",
0,Example Insurance Company,BestRx,MM,2023,None,Some,1.00,"ExampleComments",
```

Link: Submitter Resources - CIVHC.org

Appendix C: Frequently Asked Questions

1. When is each file due?

Test files for Alternative Payment Models, Drug Rebate and Control Totals are due by July 1, 2026. Test files should include data for the three previous calendar years: 2023, 2024, and 2025.

Final production files are due by September 01, 2026. Production files must be submitted with data for three previous calendar years – 2023, 2024, and 2025.

2. How should the files be submitted and named?

Files should be submitted in .csv format or text format (.txt) through the SFTP server. Naming conventions should follow the template in DSG 17:

PayerCode_FileType_PeriodStartDate_PeriodEndDate_RowCount_ProdFlag_FixedWidthInd_Create Date

- Example:
    i. COCXXXX_DR_202601_202612_X_T_DL_2026XXXXXX
    ii. COCXXXX_DR_202601_202612_X_P_DL_2026XXXXXX
    iii. COCXXXX_PB_202601_202612_X_T_DL_2026XXXXXX
    iv. COCXXXX_PB_202601_202612_X_P_DL_2026XXXXXX

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

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

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

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

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

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

Fill dates corresponding to each of the three most recent calendar years (2023, 2024 and 2025) should be reported in these files.

6. What is the process for requesting waivers to the Drug Rebate file submission requirements?

Please complete the form shown in Appendix A, "Data Submission Waiver Instructions - APM and Drug Rebate Files" and email it to submissions@civhc.org. CIVHC will review the document and return to the submitter with the waiver decision. If approved, CIVHC will complete the Waiver Tracking section with the decision and decision date. CIVHC will then provide this document to you for your records. If the waiver is not approved, CIVHC will send back form with comments to the submitter. Please submit these waiver documents no later than April 1, 2026.

7. Will you be joining these files to the other claims files (MC, PC, ME, MP) that we submit to the APCD?
No, we will not join these files to the data in the APCD. However, we will compare total allowed amounts and other comparable elements in these files to aggregated CO APCD data to ensure the numbers are in the same ballpark.

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

Payers should base these records on fill date.

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

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

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

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

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

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

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

CIVHC uses the definition refined under DSG 15 for rebates and other compensation. Payers should report only rebate amounts that are associated with payments for prescriptions filled during the reported calendar year. Payers should report retroactive payments in the calendar year when the associated prescriptions were filled.

"Rebates" will include price concessions, price discounts, or discounts of any sort that reduce payments, a partial refund of payments or any reductions to the ultimate amount paid; a performance based financial reward; a financial reward for inclusion of a drug in a preferred drug list or formulary or preferred formulary position; market share incentive payments and rewards; credits; remuneration or payments for the provision of utilization or claim data to manufacturers for rebating, marketing, outcomes insights, or any other purpose; rebates, regardless of how categorized, and all Other Compensation to carriers, their PBMs, rebate aggregators, subsidiaries, any affiliated holding and/or parent company or within the parent organization, and all other organizational affiliates. The rebate terms of the reduction must be fixed and disclosed in writing to the payer.

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

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

This cell should be used if a payer cannot fully complete the Drug Rebate file to the specifications outlined in the DSG. The payer should enter an explanation of how their submission differs from the specifications. Reminder: for fields that are populated with free text and commas are expected to be part of the text, use double quotes as text qualifier.

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

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

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

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

Appendix D: SFTP Submission Instructions

Please note that there is no separate test or production environment for monthly or annual files. All files submitted to the CO APCD via its data vendor Onpoint go through the standard protocol as stated in the User Guide below.

The following is an excerpt from page 18 of the 'User Guide for Onpoint CDM' resource in the Documentation section of Data Harbor (Onpoint's Data Submission Portal). Note that Data Harbor was formerly known as Onpoint CDM.

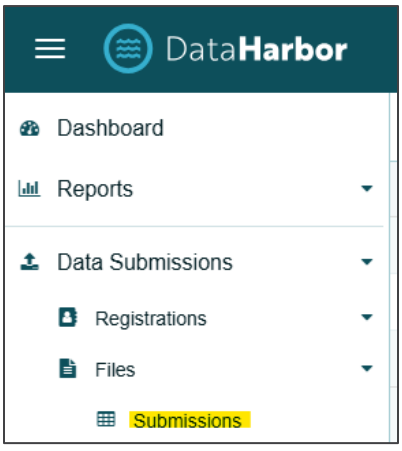
Whether a user's data collection initiative allows direct identifiers or requires the de-identification of sensitive fields to eliminate the possibility of ePHI recovery, the use of secure file transfer protocol (SFTP) paired with PGP encryption is Onpoint's recommended method for transmitting files.

To facilitate this process, Onpoint CDM leverages a managed file transfer application for secure file transfer and receipt. Our SFTP server is accessible from a wide range of SFTP client utilities and open-source solutions (e.g., WinSCP, FileZilla, etc.) as well as through a Hypertext Transfer Protocol Secure (HTTPS) online portal. (Please note that use of the online portal requires the establishment of a password that expires regularly for security reasons. We therefore highly recommend establishing connectivity with our systems using an SSH key, which eliminates the password requirement.)

SFTP data exchanges with Onpoint CDM must be both encrypted using the OpenPGP standard and signed by the sender prior to transfer to ensure file integrity. Onpoint's SFTP server accepts files of any size and offers users an approach that can be fully scripted on their end to facilitate automation.

For a thorough walk-through of the SFTP process, including step-by-step instructions for installing and configuring standard software, please see the directory of reference materials in the main menu's Documentation component or reach out to an Onpoint administrator (cdm-support@onpointhealthdata.org)

Submitters can track the status of submitted files in the Data Harbor Portal under the Files → Submissions option.



Appendix E: CO APCD Data Submission Guide Version 17 Testing Instructions

Last Updated: June 16, 2026

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 17 format for the Colorado APCD.

Data Submission Guide Version 17 Overall Implementation Timeline

DSG 17 Timeline		
Task	**Due Date**	**Complete**
Payer Connect Calls	Bimonthly	Ongoing
Request for DSG feedback (monthly and annual files)	Ongoing	✓
Initial Payer feedback due	8/1/2025	✓
CIVHC distribute updated DSG 17 draft based on stakeholder feedback	9/1/2025	✓
CIVHC File Rule Packet with HCPF	10/4/2025	✓
Public Review Meeting	10/27/2025	✓
Executive Director Hearing	11/20/2025	✓
Rule Effective	3/1/2026	✓
Monthly Data Files (ME, MC, PC, MP, *DC, *VC) Testing and Implementation		
Submitter Testing of DSG17 (ME, MP, MC, PC, *DC, and *VC)	6/1 – 6/30	Ongoing
DSG v17	7/1/2026	
May 2026 Submissions Due in DSG v17 – no less than 120 days after Rule Effective Date	7/1/2026	
May 2026 Submissions must be in a Status of Validation Passed	7/15/2026	
Annual Data File (AM, CT, DR, AC, VB, PD, PB) Testing and Implementation		
Annual File Submission Waivers Due	4/1/2026	✓
Test files with 2023, 2024, 2025 data due (AM, CT, AC, DR, PB)	7/1/2026	
Test files with 2022, 2023, 2024, 2025 data due (VB)		
Test files with 2025 data due (PD, CF)		
Production files with above reporting data by file type due	9/1/2026	
Timeline updated 6/16/2026		

Testing Requirements

7/1/2026

- Transmit properly named, compressed, and encrypted files via SFTP to the Onpoint Data Harbor.
- 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 intake validation issues by resubmission and/or variance requests.

Overview of Testing Steps

1. **Prepare Annual files in DSG v17 Format:** Properly name files and headers "T" according to the instruction outlined in DSG v17. 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.

3. **Transfer of Compressed and Encrypted File(s) via SFTP:** Transfer the compressed and encrypted files via the SFTP server.

4. **Review and Resolve Validation Issues:** After receiving a notification email, login and review validation issues. Resolve any intake issues.

Step 1: Prepare Annual files in DSG v17 Format.

Name **annual files** according to the file naming convention outlined in DSG v17:

Annual File Naming Convention - All annual files submitted to the CO APCD shall have a naming convention to facilitate file management without requiring access to the contents.

All file names will follow the template:

PayerCode_FileType_PeriodStartDate_PeriodEndDate_RowCount_ProdFlag_FixedWidthInd_Create Date

- Examples
    i. COCXXXX_AM_202601_202612_45000_T_DL_20250422
    ii. COCXXXX_AM_202601_202612_45000_P_DL_20250422
- Payer Code = Unique identifier assigned to each payer by the CO APCD's data administrator
- FileType = A two-character code that indicates which file is being submitted:
    i. 'AM' = Alternative Payment Model
    ii. 'CT' = Control Total
    iii. 'CF' = Member Capitation
    iv. 'DR' = Drug Rebate

v. 'PB' = PBM Contract Supplement
vi. 'PD' = PDAB
vii. 'VB' = Value Based Purchasing Contract

- PeriodStartDate (YYYYMM format)
  i. The start month of the submission year. For example: 202601
- PeriodEndDate (YYYYMM format)
  i. The end month of the submission year. For example: 202612
- RowCount (no commas)
  i. Total number of records submitted in the file, excluding header and trailer records
  ii. For AM, CT, DR, and CF files if payer cannot fill in the "RowCount" section of the file naming convention, then a "0" can be used instead. For example: COCXXXX_AM_202601_202612_0_T_DL_20250422
  iii. For AC, PB, PD, and VB files, a nonzero integer is required
- ProdFlag = A one-character code that indicates whether a file is a 'Test' file or a 'Production' file:
  i. 'T' = Test
  ii. 'P' = Production
- DelimitedFileInd = A two-character code that indicates whether a file is reported with delimiters:
  i. 'DL' = Delimiters included

Step 2: Transfer of Compressed and Encrypted File(s) via SFTP

SFTP data exchanges with Onpoint CDM must be both encrypted using the OpenPGP standard and signed by the sender prior to transfer to ensure file integrity. Onpoint's SFTP server accepts files of any size and offers users an approach that can be fully scripted on their end to facilitate automation.

For a thorough walk-through of the SFTP process, including step-by-step instructions for installing and configuring standard software, please see the directory of reference materials in the main menu's Documentation component or reach out to an Onpoint administrator (cdm-support@onpointhealthdata.org).

Step 3: Monitoring Submissions

You will receive an email notifying you of the file status once the intake validations are complete. You can monitor your submissions in the Data Harbor portal.

Step 4: Submission Notification, Review and Resolve Validation Issues

As part of this testing period, we expect you to review the validation results and resolve intake issues by resubmitting a corrected file and/or variance request.

Files with a "Pass" status have passed our data intake validations and will move on to the Level 2 data quality validation process.

Feedback and Questions

If you encounter any issues, please reach out to an Onpoint administrator (cdm-support@onpointhealthdata.org).