Alternative Payment Model Data Submission Manual

10 CCR 2505-5

September 8, 2020

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

1. Introduction

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

Alternative payment models (APM) are defined as payments made to providers outside traditional fee-for-service model. This includes: Foundational Payments for Infrastructure and Operations, Pay for Reporting, Pay-for-Performance, APMs with Shared Savings, APMs with 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 System, Capitated Payments NOT Linked to Quality.

The first submission, which is a test file of APM data for 2017, is due from payers in July 2020. Final files for each of three calendar years from 2017-2020 are due by September 30, 2020.

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

2. Why Collect APM Data?

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

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

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

3. File Submission Instructions and Schedule

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

Alternative Payment Model and Drug Rebate Data Submission Schedule	
Date	**Files Due**
July 1, 2020	• Waiver request due (if applicable)
July 15, 2020	• Test files of data for 2017 due
September 30, 2020	• Final files for three calendar years: 2017, 2018 and 2019

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

Naming conventions should follow the template:

TESTorPROD_PayerID_SubmissionYearDueFileTypeVersionNumber.xlsx

For example, the following naming conventions will be used for testing and production in 2020:

TEST_0000_2020AMv01. xlsx
PROD_0000_2020CTv02. xlsx

4. Waivers

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

CIVHC will consider requests from data submitters for file exemptions under certain circumstances. Data submitters should submit a waiver request for the 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 your circumstances do not fall under items 1, 2, or 3 above, please contact CIVHC.

If you believe you are unable to fully comply with the Data Submission Guide'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.

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

5. Changes to APM Data Submission Manual

The following are changes to this APM Data Submission Manual, which were adopted following the Data Submission Guide v11.5 Rule Hearing on April 15, 2020.

- Change the criteria for selecting members for the APM submission. Last year payers submitted APM data for members covered by group policies sold/issued in Colorado (situs). This year payers are required to submit APM data for members residing in Colorado.
- Add a requirement that payers report APM members and payments to providers by insurance product type code.
- Change the definition of primary care to the one adopted by the Colorado Primary Care Payment Reform Collaborative.
- Change the APM categories from a custom categorization scheme to the Health Care Payment Learning & Action Network (HCP LAN) categories, an APM framework that was developed by a national, federally-funded multi-stakeholder group to classify APMs and track progress toward payment reform.
- Clarify inclusion criteria for payments to only include payments from payers to health care providers

6. Data Submission of APM Details – General Rules

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

The following are general rules for completing the first file. The content of the APM data submission files are displayed in pages 14-19. A sample of a completed file is included in Appendix B. Rules for completing the control total file can be found in section 6.

Level of Reporting APM Information

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

Payers should include only information pertaining members who reside state of Colorado. This requirement represents a change from last year, when payers were instructed to submit information for policies sold in Colorado (situs).

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

Now, for example, if an individual lives in Wyoming but has commercial coverage through their employer based in Colorado, information for this individual would be NOT be included. Conversely, if a Colorado resident works in Wyoming and has commercial coverage through their employer, their data would be included. This is opposite the approach from last year.

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

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

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

Types of Payments

Reported payments for medical care or contracts should include:

- Payments made on a **fee-for-service** basis for medical services performed during the APM submission performance period;
- **Foundational payments for infrastructure and operations** for contracts that fully or partially span the APM submission performance period;
- Payments, including incentives and penalties, related to **reporting quality measurement results** for contracts that fully or partially span the APM submission performance period;
- Payments, including incentives and penalties, based on **performance in quality measurement results** for contracts that fully or partially span the APM submission performance period;
- Incentive payments under APMs with **shared savings**, for contracts that fully or partially span the APM submission performance period;
- Incentives and penalties paid under APMs with **shared savings and downside risk** for contracts that fully or partially span the APM submission performance period;
- Payments representing a share of savings under **risk-based contracts that are NOT linked to quality** and that fully or partially span the APM submission performance period
- **Population-based payments for comprehensive treatment of specific conditions**, for contracts that fully or partially span the APM submission performance period

- **Prospective, population-based payments that are comprehensive and cover all healthcare needs for a population**, for contracts that fully or partially span the APM submission performance period
- **Salary expenditures for Integrated Delivery Systems** (IDS) which correspond to the provision of care during the APM submission performance period;
- **Prospective, population-based payments that are NOT linked to quality** for contracts that fully or partially span the APM submission performance period

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 these lines of business: prescription drugs only, dental benefits only.

Here 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;

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

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 2017, claims payments to a provider should include payments for services incurred during the year with payment dates through September 2020. Non-claims payments should include payments for contract periods/services during 2017, with payment dates through September 2020. This performance period should be documented as AM007 (Performance Year) = 2017.

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.

Reporting Payments

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 AM010 and AM012 (claims payments) should be populated with the payment amounts and AM011 and AM013 (non-claims payments) should both reflect $0. Only in instances where there is no payment at all made to a particular billing provider or organization for contracts during the reporting period, should they be omitted from the file.

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

In cases where payments to a billing provider include primary care and non-primary care, payments that are attributable to primary care only should be estimated and reported in the primary care payment categories (AM010 and AM011).

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

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.

Finally, 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.

Defining Primary Care

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:

A. **Outpatient services delivered by primary care providers** (which includes 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	Procedure Requirement		Service Provider Taxonomy Requirement		Billing Provider Taxonomy Requirement
A	Primary Care (defined by CPT-4 codes in *Appendix E, Table 3*)	+	Primary Care (defined by taxonomies in *Appendix E, Table 1*)	+	None
B	Primary Care (defined by CPT-4 codes in *Appendix E, Table 3*)		Other Primary Care (defined by taxonomies in *Appendix E, Table 2*)		Primary Care (defined by taxonomies in *Appendix E, Table 1*)

Code sets referenced above can be found in Appendix E in this document. 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.

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. This programming code includes filters to select only services with relevant outpatient places of service (see lines 103-104 and 176-177 in *APM Primary Care Code FINAL*).

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.

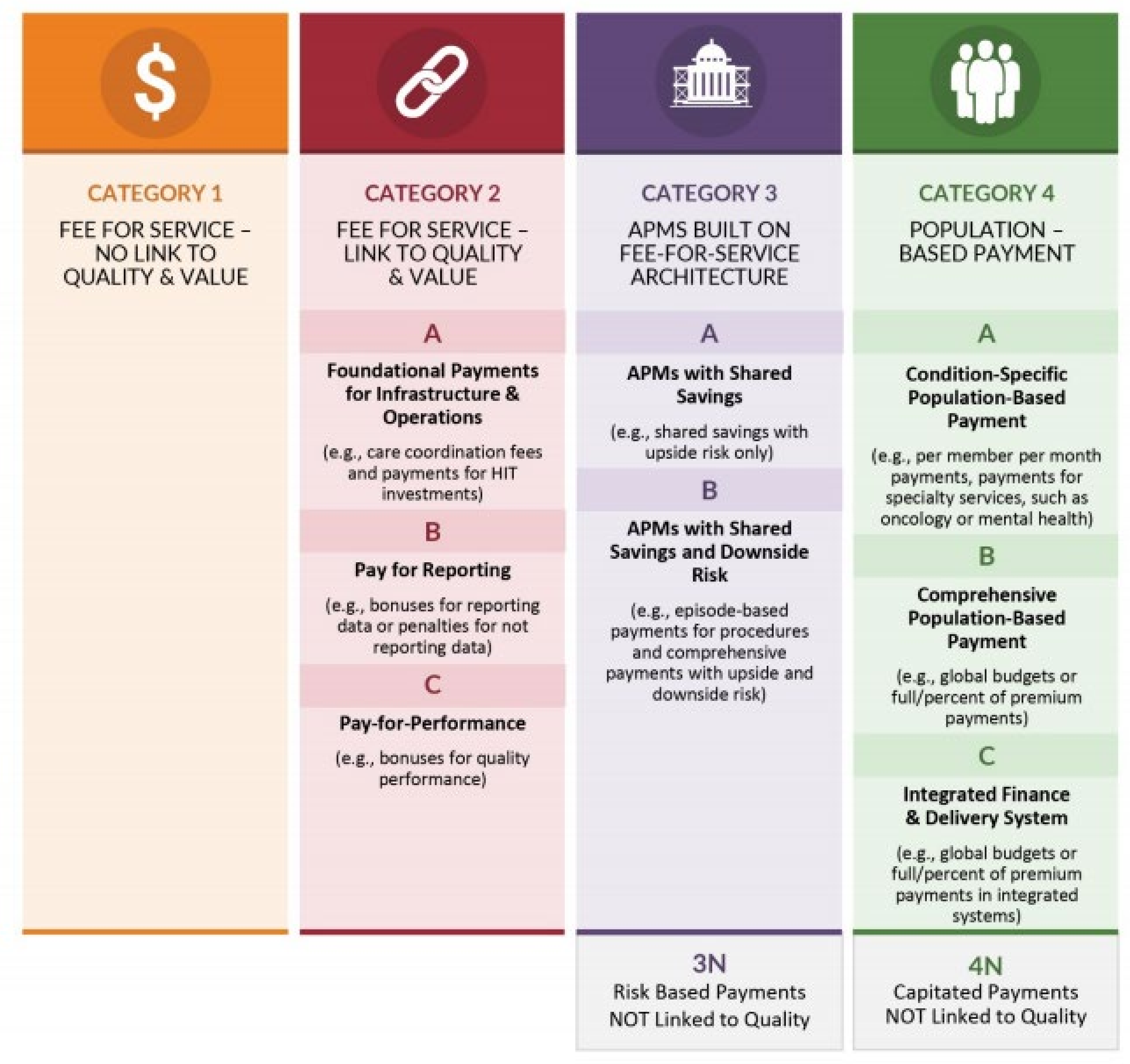
Note that a given member could receive services from multiple providers in the same reporting period, all of whom received payments under APMs with shared savings and downside risk and condition-specific population-based payments. When this occurs, the sum of all member months associated with alternative payment arrangements will exceed the actual total of unique member months. The control total file is intended eliminate the duplication of member months (see section 7).

APM Categories

For payment model assignment, payers should classify 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 and a table with the definition of each APM Framework category follows.

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 Framework



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.

The type of APM to which a provider organization and a member should be attributed is determined by the contractual arrangement between the payer and the provider organization.

For example, for a 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 (4B) in the payment arrangement category column (AM006). The payment amount should be recorded under the non-claims payments fields (AM011 and AM013).

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 (3B). The payment amount associated with the FFS payment mechanism should be recorded under the claims payments fields (AM010 and AM012) and the financial settlement should be recorded under the non-claims payments fields (AM011 and AM013). Both the claims and non-claims elements to the 3B arrangement should be reported on the same 3B record.

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

Please see Appendix F for a mapping of last year's APM categories to this year's HCP LAN categories.

7. Data Submission of APM Control Totals – General Rules

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

The following are general rules for completing the second, Control Total file. The content of the Control Total data submission file is displayed in page 17. A sample of a completed file is included in Appendix C.

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, and payment arrangement category 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), and Payment Arrangement Category (CT006). 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 4B) 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 4B payment arrangement category should represent the distinct count of member months, the member months from the APM file need to be deduplicated. Therefore, the member months should be equal to 12, not 24 under APM category 4B.

All Member Months (CT008) includes all de-duplicated member months for the associated Year (CT004) and Insurance Product Type Code (CT005), 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 and insurance product type code.**

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

> Example: Suppose a PPO member visits two different providers in 2017. One provider is reimbursed under a pay-for-performance arrangement (2C) and the other provider is reimbursed under an APM with shared savings and downside risk (3B). 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 D to find examples of these member months scenarios.

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), and Payment Arrangement Category (CT006) and separated into the same categories defined in the APM file (claims vs non-claims and primary care vs total payments). The totals reported in the Control Total file should align with the sum of payments reported in the APM file.

8a. APM Data Submission File Content and Dictionary

APM File Header Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	N/A – Excel file	AM
HD002	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC
HD003	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC
HD004	Beginning Month	date	N/A – Excel file	CCYYMM (Example: 200801)
HD005	Ending Month	date	N/A – Excel file	CCYYMM (Example: 200812)
HD006	Record count	int	N/A – Excel file	Total number of records submitted in the APM file, excluding header and trailer records

APM File Trailer Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	N/A – Excel file	AM
TR002	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC
TR003	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC
TR004	Beginning Month	date	N/A – Excel file	CCYYMM (Example: 200801)
TR005	Ending Month	date	N/A – Excel file	CCYYMM (Example: 200812)
TR006	Extraction Date	date	N/A – Excel file	CCYYMMDD

APM File

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

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM003	Billing Provider Tax ID	varchar	N/A – Excel file	Tax ID of billing provider. Do not code punctuation.	R
AM004	Billing Provider Last Name or Organization Name	varchar	N/A – Excel file	Full name of provider billing organization or last name of individual billing provider.	R
AM005	Billing Provider Entity	char	N/A – Excel file	F = Facility G = Provider group I = IPA P = Practitioner	R
AM006	Payment Arrangement Category	varchar	N/A – Excel file	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
AM007	Performance Year	int	N/A – Excel file	Effective year of performance period for reported Insurance Product Type Code and Payment Arrangement Type. CCYY format	R
AM008	Insurance Product Type Code	varchar	N/A – Excel file	See lookup table B.1.A	R
AM009	Member Months	int	N/A – Excel file	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
AM010	Total Primary Care Claims Payments	numeric	N/A – Excel file	Sum of all associated claims payments, including patient cost-sharing amounts that pertain to primary care. Primary Care Services are to be identified based on the definition provided in table B.1.K.	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. This value should never exceed the amount of Total Claims Payments (AM012).	
AM011	Total Primary Care Non-Claims Payments	numeric	N/A – Excel file	Sum of all associated non-claims payments that pertain to primary care. Primary Care Services are to be identified based on 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. This value should never exceed the amount of Total Non-Claims Payments (AM013).	R
AM012	Total Claims Payments	numeric	N/A – Excel file	Sum of all associated claims payments, including patient cost-sharing amounts. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no claims payments made	R
AM013	Total Non-Claims Payments	numeric	N/A – Excel file	Sum of all associated non-claims payments. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no non- claims payments made	R
AM014	Billing Provider Office City	varchar	N/A – Excel file	Physical address	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM015	Billing Provider Office State	char	N/A – Excel file	Physical address - Use postal service standard 2 letter abbreviations.	R
AM016	Billing Provider Office Zip	varchar	N/A – Excel file	Physical address - Minimum 5-digit code.	R
AM017	Record Type	char	N/A – Excel file	AM	R

8b. APM Data Submission Control Total File and Dictionary

CT File Header Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	N/A – Excel file	CT
HD002	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC
HD003	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC
HD004	Beginning Month	date	N/A – Excel file	CCYYMM (Example: 200801)
HD005	Ending Month	date	N/A – Excel file	CCYYMM (Example: 200812)
HD006	Record count	int	N/A – Excel file	Total number of records submitted in the Control Total file, excluding header and trailer records

CT File Trailer Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	N/A – Excel file	CT
TR002	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC
TR003	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC
TR004	Beginning Month	date	N/A – Excel file	CCYYMM (Example: 200801)
TR005	Ending Month	date	N/A – Excel file	CCYYMM (Example: 200812)
TR006	Extraction Date	date	N/A – Excel file	CCYYMMDD

CT File

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
CT001	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC	R
CT002	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC	R
CT003	Submitted File	text	N/A – Excel file	File name of the APM file	R
CT004	Performance Year	numeric	N/A – Excel file	Year of reporting, submit in YYYY format	R
CT005	Insurance Product Type Code	varchar	N/A – Excel file	See lookup table B.1.A	R
CT006	Payment Arrangement Category	varchar	N/A – Excel file	See look up table B.1.J Payment arrangement type reported.	R
CT007	Payment Arrangement Category Member Months	numeric	N/A – Excel file	Total, de-duplicated member months associated with payment arrangement category identified in CT006 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	R
CT008	All Member Months	numeric	N/A – Excel file	Total enrollment during the previous calendar year, regardless of payment arrangement type 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. The value in this field will repeat in the Control Total file for each reported year/insurance product type code combination.	
CT009	Total Alternative Arrangement Member Months	numeric	N/A – Excel file	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 combination.	R
CT010	Sum of Primary Care Claims Payments	numeric	N/A – Excel file	Sum of Total Primary Care Claims Payments, as reported in AM file	R
CT011	Sum of Primary Care Non-Claims Payments	numeric	N/A – Excel file	Sum of Total Primary Care Non-Claims Payments, as reported in AM file	R
CT012	Sum of Claims Payments	numeric	N/A – Excel file	Sum of Total Claims Payments, as reported in AM file	R
CT013	Sum of Non-Claims Payments	numeric	N/A – Excel file	Sum of Total Non-Claims Payments, as reported in AM file	R
CT014	Record Type	char	N/A – Excel file	CT	R

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

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

Consistent with the CQI process, the APCD will consider requests from data submitters to provide file exemptions for their Alternative Payment Model (APM) and Drug Rebate files. This policy is intended to recognize the special circumstances for each payer (see section 4 of the Data Submission Manuals) and document their exempt status for APM or Drug Rebate submissions.

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

For waivers of a particular file type:

- The year for which the file exemption is requested.
- The file type for which the exemption is requested.
- An explanation as to why the data submitter is unable to submit the file.
- An original signed certification by the organization's Chief Information Officer or Regulatory Compliance Office that includes the above information and asserts that the data submitter cannot meet the requirements because the requested information is not available and cannot be derived from the data submitter's information systems.

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

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

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

Data File Name	Detailed description of reason

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

Submitted by: ____
Name Title Date

____
Signature

Appendix B: Sample of Completed APM Detailed Data File

AM001	AM002	AM003	AM004	AM005	AM006	AM007	AM008	AM009	AM010	AM011	AM012	AM013	AM014	AM015	AM016	AM017
Billing Provider Number	National Billing Provider ID	Billing Provider Tax ID	Billing Provider Last Name or Organization Name	Billing Provider Entity *F = Facility* *G = Provider Group* *I = IPA* *P = Practitioner*	Payment Arrangement Category	Performance Year	Insurance Product Type Code	Member Months	Total Primary Care Claims Payments	Total Primary Care Non-Claims Payments	Total Claims Payments	Total Non-Claims Payments	Billing Provider Office City	Billing Provider Office State	Billing Provider Office Zip	Record Type
11111	1111111111	111111111	ABC Group	G	01	2017	HM	N/A	$ -	$ -	$ 15,706,699.86	$ -	Denver	CO	80223	AM
22222	2222222222	222222222	XYZ Primary Care Group	G	01	2017	HM	N/A	$ 758,783.84	$ -	$ 758,783.84	$ -	Monument	CO	80132	AM
22222	2222222222	222222222	XYZ Primary Care Group	G	01	2017	12	N/A	$ 126,031.65	$ -	$ 126,031.65	$ -	Monument	CO	80132	AM
33333	3333333333	333333333	Great Doctors Group	G	2C	2017	16	N/A	$ 58,528,165.45	$ 250,349.00	$ 225,108,328.64	$ 500,394.00	Denver	CO	80210	AM
44444	4444444444	444444444	Super Great Hospital	F	01	2017	12	N/A	$ -	$ -	$ 44,973,705.92	$ -	Ft Collins	CO	80523	AM
44444	4444444444	444444444	Super Great Hospital	F	4A	2017	12	647	$ -	$ -	$ -	$ 323,500.00	Ft Collins	CO	80523	AM
55555	5555555555	555555555	U Get Better Hospital	F	2A	2017	MM	N/A	$ -	$ -	$ -	$ 1,000,000.00	Boulder	CO	80301	AM
66666	6666666666	666666666	Number 1 Clinic	F	2B	2017	12	N/A	$ -	$ -	$ -	$ 50,000.00	Sedalia	CO	80135	AM
77777	7777777777	777777777	Dr Fix It Group	G	3A	2017	16	4,977	$ -	$ -	$ 1,493,157.00	$ 65,000.00	Pagosa Springs	CO	81147	AM
88888	8888888888	888888888	Sub-par Docs	G	3B	2017	12	203,260	$ -	$ -	$ 60,978,135.00	$ (1,000,000.00)	Denver	CO	80022	AM
99999	9999999999	999999999	Cloud 9 Group	G	3N	2017	HM	4,488	$ -	$ -	$ 1,346,579.00	$ 13,498.00	Limon	CO	80828	AM
12121	1212121212	121212121	Primary Care Rock Star IPA	I	4B	2017	12	7,618	$ -	$ 3,228,584.58	$ -	$ 3,228,584.58	Colorado Springs	CO	80941	AM
23232	2323232323	232323232	Meryl Streep, MD	P	4C	2017	16	3,265	$ -	$ 189,000.00	$ -	$ 189,000.00	Vail	CO	81658	AM
34343	3434343434	343434343	We Love Bones Orthopedic Clinic	G	4N	2017	HM	816	$ -	$ -	$ -	$ 160,752.00	Buena Vista	CO	81211	AM

Please note that this example only contains a years' worth of data with only 12 providers. Production files should include 3 years' worth of data and contain all billing providers who received payments from payers.

Appendix C: Sample of Completed APM Control Total File

CT001	CT002	CT003	CT004	CT005	CT006	CT007	CT008	CT009	CT010	CT011	CT012	CT013	CT014
Payer Code	Payer Name	Submitted File	Performance Year	Insurance Product Type Code	Payment Arrangement Category	Payment Arrangement Category Member Months	All Member Months	Total Alternative Arrangement Member Months	Sum of Primary Care Claims Payments	Sum of Primary Care Non-Claims Payments	Sum of Claims Payments	Sum of Non-Claims Payments	Record Type
0000	Example Insurance Company	PROD_0000_2020AMv01.txt	2017	HM	01	0	12,875,396	5,513,496	$ 790,472,062.02	$ -	$ 3,952,360,310.12	$ -	CT
0000	Example Insurance Company	PROD_0000_2020AMv01.txt	2017	HM	3N	5,369,485	12,875,396	5,513,496	$ -	$ 25,279,507.80	$ -	$ 72,227,165.15	CT
0000	Example Insurance Company	PROD_0000_2020AMv01.txt	2017	HM	4N	235,613	12,875,396	5,513,496	$ -	$ 624,272,434.56	$ -	$ 1,783,635,527.30	CT
0000	Example Insurance Company	PROD_0000_2020AMv01.txt	2017	16	01	0	2,397,847	20,489	$ 147,213,418.72	$ -	$ 736,067,093.59	$ -	CT
0000	Example Insurance Company	PROD_0000_2020AMv01.txt	2017	16	3B	20,489	2,397,847	20,489	$ 8,360,186.40	$ 500,678.00	$ 41,800,932.00	$ 500,678.00	CT
0000	Example Insurance Company	PROD_0000_2020AMv01.txt	2017	12	01	0	2,512,156	122,710	$ 4,620,476.00	$ -	$ 10,286,282.00	$ -	CT
0000	Example Insurance Company	PROD_0000_2020AMv01.txt	2017	12	2C	0	2,512,156	122,710	$ 482,645.00	$ 20,384,627.00	$ 666,050.10	$ 28,130,785.26	CT
0000	Example Insurance Company	PROD_0000_2020AMv01.txt	2017	12	3A	30,563	2,512,156	122,710	$ -	$ -	$ 102,947.00	$ 20,371.00	CT
0000	Example Insurance Company	PROD_0000_2020AMv01.txt	2017	12	4C	92,649	2,512,156	122,710	$ -	$ 102,548.00	$ -	$ 926,482.00	CT

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

Appendix D: Control Total Member Months Reporting

			Values are unique to Performance Year + IPT Code + Payment Arrangement Category	Values are unique to Performance Year + IPT Code and consistent across all rows		
			Research Question: What % of members received care under a specific arrangement category?	Denominator	Research Question: What % of members received care under any alternative arrangement?	
CT004	CT005	CT006	CT007	CT008	CT009	
Performance Year	Insurance Product Type Code	Payment Arrangement Category	Payment Arrangement Category Member Months	All Member Months	Total Alternative Arrangement Member Months	
2017	HM	01	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.
2017	HM	4A	235,613	12,875,396	5,513,496	
2017	HM	4B	5,369,485	12,875,396	5,513,496	
2017	16	01	0	2,397,847	20,489	Note: CT009 should be populated for FFS (LAN category 1) rows. We would also expect that CT009 to be less than CT008.
2017	16	3B	20,489	2,397,847	20,489	
2017	12	01	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 E: 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
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

Taxonomy Code	Description	Taxonomy Type
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
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

Taxonomy Code	Description	Taxonomy Type
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
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
103TF0000X	Psychologist - Family	Behavioral Health

Taxonomy Code	Description	Taxonomy Type
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

Procedure Code	Description
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/<
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)

Procedure Code	Description
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
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)

Procedure Code	Description
54056	CRYOSURGERY PENIS LESION(S)
55250	REMOVAL OF SPERM DUCT(S)
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
58100	BIOPSY OF UTERUS LINING
58110	BX DONE W/COLPOSCOPY ADD-ON
58120	DILATION AND CURETTAGE

Procedure Code	Description
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**
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

Procedure Code	Description
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
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

Procedure Code	Description
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
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

Procedure Code	Description
97802	MEDICAL NUTRITION INDIV IN
97803	MED NUTRITION INDIV SUBSEQ
97804	MEDICAL NUTRITION GROUP
98925	OSTEOPATH MANJ 1-2 REGIONS
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
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

Procedure Code	Description
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
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

Procedure Code	Description
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
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

Procedure Code	Description
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
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

Procedure Code	Description
1111F	DSCHRG MED/CURRENT MED MERGE
1220F	PT SCREENED FOR DEPRESSION
3016F	PT SCRND UNHLTHY OH USE
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

Procedure Code	Description
98967-98968	Non-physician telephone services
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
G0444	DEPRESSION SCREEN ANNUAL
G0445	HIGH INTEN BEH COUNS STD 30M
G0447	BEHAVIOR COUNSEL OBESITY 15M
G0463	HOSPITAL OUTPT CLINIC VISIT

Procedure Code	Description
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
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

Procedure Code	Description
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

Appendix F: Mapping of 2019 APM Categories to 2020 HCP LAN Categories

2019 APM Categories			HCP LAN Categories		
Code	Value	Definition/Example	Code	Value	Definition/Example
FS	FFS	Payments made to a billing provider under a traditional fee-for-service model, where each service rendered to a patient is separately reimbursed. FFS includes: Diagnosis Related Groups (DRGs), per-diem payments, fixed procedure code-based fee schedule (e.g. Medicare's Ambulatory Payment Classifications (APCs), claims-based payments adjusted by performance measures, and discounted charges-based payments.	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.
OT	Other, Non-FFS	All other payments made to a billing provider which are not based on a FFS model, including payments for health information technology structural changes; payments or expenses for supplemental staff or supplemental activities integrated into the practice, such as practice coaches, patient educators, or patient navigators; and other infrastructure payments.	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
PP	Pay for Performance /Payment Penalty	Annual payments or penalties made to a billing provider for performance against non-financial goals (quality and utilization metrics) during reporting year.	2C	Pay-for-Performance	Payments (incentives or penalties) based on performance in meeting goals for quality measures (e.g. bonuses for quality performance)

2019 APM Categories			HCP LAN Categories		
Code	Value	Definition/Example	Code	Value	Definition/Example
SH	Shared Savings /Shared Risk	Annual payments or penalties made to the billing provider for performance against spending targets during reporting year.	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)

2019 APM Categories			HCP LAN Categories		
Code	Value	Definition/Example	Code	Value	Definition/Example
BU	Bundled/Episode-Based	Payments made to a billing provider where a set budget was set for a defined episode of care for a specific condition (e.g. knee replacement) delivered by providers across multiple provider types	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)
			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).

2019 APM Categories			HCP LAN Categories		
Code	Value	Definition/Example	Code	Value	Definition/Example
PC	Patient-Centered Primary Care Home / Patient-Centered Medical Home	Payment for recognition as a Patient-Centered Primary Care Home (PCPCH) or other type of Patient-Centered Medical Home (PCMH), including recognition under a proprietary PCMH initiative. Only reported for payments exclusively for PCPCH or other PCMH recognition. FFS, pay-for-performance, shared savings, and capitation payments made for members in a PCPCH or other PCMH should be reported under those payment arrangement categories.			Depends on payment arrangement: • Fee-for-service – Category 01; • Infrastructure payments – Category 2A; • Pay-for-performance – Category 2C; • Shared savings – Category 3A; • Shared savings with downside risk – Category 3B; • Population-based payments – Category 4A or 4B
			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)

2019 APM Categories			HCP LAN Categories		
Code	**Value**	**Definition/Example**	**Code**	**Value**	**Definition/Example**
CU	Capitation – Unspecified	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for a set of services for a defined population, for which it cannot be determined if the arrangement is a global budget or limited budget arrangement.			These are population-based payments, but categorization depends on a) whether they are prospective or retrospective, b) the breadth of services covered and c) whether payments are linked to quality: Retrospective payment – Category 3A or Category 3B Retrospective payment and not linked to quality – Category 3N Prospective payment and: Condition-specific – Category 4A Comprehensive – Category 4B Integrated finance and delivery system – Category 4C Not linked to quality – Category 4N

2019 APM Categories			HCP LAN Categories		
Code	Value	Definition/Example	Code	Value	Definition/Example
LB	Limited Budget	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for a non-comprehensive set of services to be delivered by a single provider organization (e.g. capitated primary care or oncology services)	3A (if payments made retrospectively)	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 (if payments made retrospectively)	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)
			4A (if payments made prospectively)	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).

2019 APM Categories			HCP LAN Categories		
Code	**Value**	**Definition/Example**	**Code**	**Value**	**Definition/Example**
GB	Global Budget	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for either a: • Comprehensive set of services for a broadly defined population • Defined set of services, where certain benefits such as BH or Rx are carved out and not part of the budget Must, at a minimum, include physician services and IP/OP hospital services.	3A (if payments made retrospectively)	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 (if payments made retrospectively)	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)
			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)

2019 APM Categories			HCP LAN Categories		
Code	Value	Definition/Example	Code	Value	Definition/Example
ID	Integrated Delivery System	One or more legal entities encompassing financing and delivery of a full-spectrum of healthcare services under a mutually exclusive contract agreement. Resources and decision-making rights are shared across entities, and reimbursement is not dependent on services provided.	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.

Appendix G: Frequently Asked Questions

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

Test files for Alternative Payment Models, Drug Rebate and Control Totals are due by July 15, 2020. Test files should include data for calendar year 2017.

Final production files are due by September 30, 2020. Production files must be submitted with data for three previous calendar years – 2017, 2018, 2019.

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

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

TESTorPROD_PayerID_SubmissionYearDueFileTypeVersionNumber.xlsx

For example, the following naming conventions will be used for testing and production in 2020:
TEST_0000_2020AMv01. xlsx
PROD_0000_2020CTv02. 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) **My organization submits claims data under multiple CIVHC-assigned payer codes. How should I handle this?**

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

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

These files require information for each of the three most recent calendar years (2019, 2018 and 2017).

Payments include:

- Payments made on a fee-for-service basis for medical services *performed* during the file submission period;
- The following types of contract payments that fully or partially span the provision of services during the file submission period*:

  2A Foundational Payments for Infrastructure and Operations
  2B Pay for Reporting
  2C Pay-for-Performance
  3A APMs with Shared Savings
  3B APMs with Shared Savings and Downside Risk
  3N Risk Based Payments NOT Linked to Quality
  4A Condition-Specific Population-Based Payment
  4B Comprehensive Population-Based Payment
  4C Integrated Finance and Delivery System Payments
  4N Capitated Payments NOT Linked to Quality

* Payers should report the details of all payments that span any part of the submission period.

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.

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

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

Please submit these waiver documents no later than July 1, 2020.

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

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

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

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

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

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

11) **What 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.

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

Population of the member months field (AM009) is only required when reporting certain types of payment arrangements such as population-based payments. When required, your organization should include the total number of members (represented in member months) that participated in the reported APM. This will require identifying the number of members (monthly) served under the payment arrangement model for each billing provider or contract ID. For example, a comprehensive population-based payment (Payment Model = 4B) paid for a member for January through December would count as 12-member months. If your organization covers a person for even one day of the month, even if it's the 1st or the 31st, then this counts as a member month.

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

13) **Should we be reporting information (NPI, tax ID, entity type) for the entity/organization a payment is actually sent to or the providers within that**

organization that receive the payment? For example, if a large payment is sent to the financial parent of a health system, should we report what is sent to the financial parent, or should we figure out how the financial parent distributed this payment to its providers?

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

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

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

In instances when a single contract consists of several components (but is paid out in a single check), your organization should separate these payment types and report them on separate fields. In the above example, this arrangement might be considered pay-for-performance. Your organization would report 2C (Pay for Performance model) in AM006, the amount of the payment that was FFS in the claims payments fields (AM010 and AM012), and the amount that was a pay-for-performance bonus in the non-claims payments fields (AM011 and AM013).

Additionally, 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 (AM010 and AM012), and the amount for any shared savings or shared savings with downside risk payments in the non-claims payments fields (AM011 and AM013).

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

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

Claims payments fields (AM010 and AM012) 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 both the member portion and the plan paid portion (i.e., the total allowed amount).

Non-claims payments fields (AM011 and AM013) 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.

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

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

There may also be instances in which your organization should enter $0 for a given payment to convey important details about that contract. For example, if your organization has a shared savings arrangement with a FFS base but at the end of the contract period the provider did not achieve the threshold necessary to receive shared savings payments, you should enter the payment amounts for FFS and enter $0 in another row for Alternative Payment Models with shared savings (code 3A). This conveys that your organization had a shared savings payment arrangement with the provider, instead of a traditional FFS arrangement, but that the threshold for the Shared Savings payment was not met.

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

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

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

CIVHC is using the definition established by the 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:

A. **Outpatient services delivered by primary care providers** (which includes 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)

Please refer to Appendix E 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.

19) What should be included in Record Type (AM017)?

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

20) What should be included in Record Type (CT014)?

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

21) 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 and Control Total 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 remaining issues have been resolved, CIVHC will notify you by email.

Appendix H: SFTP Submission Instructions

CO APCD New File Types

Submitter Instructions

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

1. File Transmission

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

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

Connection Information for the SFTP Server:

- Server Name: transfer.norc.org
- User: the account name issued via secure download
- Password: the SFTP password issued via secure download
- Directory: [root]/incoming/APM_CT_DR

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

2. File Format

Files should be submitted in Excel format (.xlsx, .xls, or .csv) through the SFTP server. These files do not contain sensitive data and therefore are not required to be compressed and encrypted. 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.