OFFICE OF HEALTH ANALYTICS
All Payer All Claims Data Reporting Program
Kate Brown, Governor

421 SW Oak Street, Suite 850
Portland, OR 97204
www.oregon.gov/oha/hpa/analytics

Memorandum

To: All Payer All Claims Mandatory Reporters

From: Stacey Schubert, Research & Data Manager

Date: August 7, 2017

Subject: Version 2018.0.0 of APAC data file layouts

This memorandum announces revisions to the data file layouts for the All Payer All Claims (APAC) Data Reporting Program. Version 2018.0.0 implements the changes listed on pages 19-20, which are briefly summarized here:

Appendix A: Removed of all references to ICD-9. Do not populate the following fields as of 1/1/2018: QC05, QC06, QC22, and QC23.

Appendix B: Do not populate the following fields as of 1/1/2018: QC013, QC014, QC015, QC016, QC018, QC019, and QC020. Corrected error in lookup table ME202.

Appendix C: Do not populate MP017 as of 1/1/2018.

> **IMPORTANT**
>
> **The following columns have been removed from the file layout as of 1/1/2018:**
>
> MP018A, QC004, QC006, QC011, QC021, QC022, QC023, QC024, QC025, QC026, QC027, QC028, QC029, QC030.
>
> The completed file will have 14 fewer columns as of 1/1/2018. Please note that the file will still end with ten blank fields following MP018.

Appendix D: Do not populate PC047 as of 1/1/2018.

Appendix E: Updated lookup table CFCT1 to reflect mandatory reporters in 2018.

Appendix F: No changes.

Appendix G: No changes.

Appendix H: No changes.

Schedule A: Updated to extend through 2019.

These revisions become effective for submission dates beginning January 2018. Please see Schedule A for more information regarding submission due dates and the data to be included in each submission.

If you anticipate difficulty meeting submission deadlines, please complete Form APAC-1 (Waiver or Exception of Reporting Requirements). Completed APAC-1 forms should be submitted to APAC.Admin@dhsoha.state.or.us prior to data submission. Form APAC-1 and Schedule A are available at the APAC web site: http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx.

APAC Mandatory Reporters
OAR 409-025-0110 states that the following entities, as defined in ORS 442.464, shall be Mandatory Reporters to APAC:

- Carriers and licensed TPAs with calculated mean total lives of 5,000 or higher (as identified by OHA using information collected by the Department of Consumer and Business Services);
- All PBMs;
- All CCOs;
- All reporting entities with Dual Eligible Special Needs Plans in Oregon;
- All insurers providing coverage funded under Parts A, B, or D of Title XVIII of the Social Security Act;
- All insurers offering a health benefits plan in Oregon's health insurance exchange; and
- All insurers providing group health insurance plans to PEBB and OEBB members.

Every year, OHA uses the above criteria to identify all APAC Mandatory Reporters. The list of Mandatory Reporters is made available in Lookup Table CFCT1 found in Appendix E.

Reporting Requirements
All APAC Mandatory Reporters must submit all APAC Appendices (A-H) by the submission due dates found in Schedule A. Mandatory Reporters who anticipate difficulty meeting submission deadlines, should submit Form APAC-1. Voluntary Reporters may elect to participate by notifying OHA in writing.

Mandatory and voluntary reporters shall include all required lines of business in Appendix A-H data files, unless otherwise noted in the instructions at the top of each appendix. If they wish, mandatory and voluntary reporters may submit data files for the voluntary lines of business and may not submit data files for any excluded lines of business.

- Required lines of business include:
  (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) PEBB and OEBB health insurance plans; and
  (I) Self-insured plans not subject to ERISA;

- Voluntary lines of business include:
  (A) Self-insured plans subject to ERISA

- Excluded lines of business include:
    (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) Vision-only insurance; and
    (K) Workers compensation.

Appendix Inclusion Criteria
Each APAC Appendix has its own appendix-specific inclusion criteria (as defined in OAR 409-025-0100).

- Eligibility File (Appendix B)
  The inclusion criteria for the Eligibility File (Appendix B) are:
  1. Member's mailing address is in Oregon; or
  2. Member's mailing address is outside Oregon and member is enrolled in a plan for which the state is the payer (such as PEBB and OEBB)

  Appendix B shall include eligible spouse and/or dependent(s) covered by a member that meets at least one of the inclusion criteria above—regardless of the mailing address of eligible spouse or dependent(s).

- Medical Claims and Pharmacy Claims File (Appendices A and D)
  The inclusion criteria for the Medical Claims and Pharmacy Claims files are:
  1. All final medical and pharmacy claims associated with the individuals included in the Eligibility File (Appendix B).

  Starting in 2016, substance use data must be reported to OHA. OHA will only report the substance use data at an aggregate level. It will not report, or release, claim-level substance use data.

- Provider File (Appendix C)
  The inclusion criteria for the Provider file are:
  1. All providers associated with the claims reported in the Medical Claims or Pharmacy Claims files (Appendices A and D).

- Control File (Appendix E)
  The inclusion criteria for the Control file are:
  1. Summary data pertaining to Appendices A-F

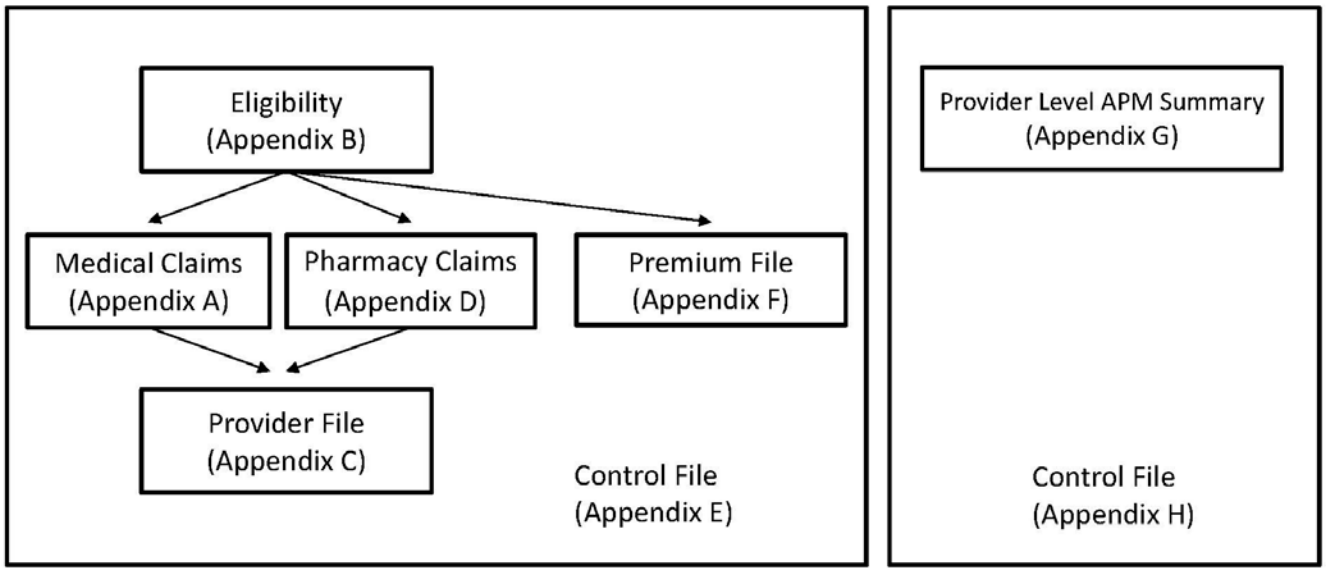
- Subscriber Billed Premium File (Appendix F)
  The inclusion criteria for the Premium file are:

1. Premium data associated with the individuals included in the Eligibility File (Appendix B) who are enrolled in fully-insured commercial and Medicare Advantage plans.

PBMs that offer stand-alone prescription drug plans are required to submit Appendix F. A stand-alone prescription drug plan is a prescription drug plan for which the PBM collects premiums, administer claims, and pays claims. Subscribers to such plans, and their premium amounts, should be included in Appendix F. **PBMs that contract with an insurance carrier to offer prescription drug plans, and that do not collect premiums for such plans, are not required to submit Appendix F.** In these cases, the insurance carriers that collect the premiums for these plans will submit Appendix F. See "APAC Appendix F: FAQs" (further in this document) for additional information about Appendix F.

- <u>Annual Supplemental Provider Level APM Summary (Appendix G) and Control File (Appendix H)</u>
  Appendices G and H are unrelated to the Eligibility File (Appendix B) or any of the other appendices. The inclusion criteria for the APM Summary File are:
  1. Billing providers and organizations that received payments under insurance policies that align with NAIC/SERFF inclusion criteria, and for which the Mandatory Reporter was the primary payer.

Relationship between APAC Appendices
As outlined in the section above, some APAC Appendices are interrelated. For example, Appendix B serves as the starting point for identifying claims, providers, and subscriber billed premiums to be included in Appendices A, C, D, F and E (see diagram below). Appendices G and H have no relation to any of the other appendices.



File Submissions
For new mandatory reporters, test files shall be submitted on a schedule that is mutually agreeable to Milliman and the mandatory reporter. Production files are due on or before the due dates listed in Schedule A. Data file naming conventions are given in Appendix E and H. All files shall be tab delimited unless otherwise specified in the data file layouts. Files shall be

transmitted to Milliman's secure FTP site and shall be encrypted prior to transmission. Mandatory reporters shall consult with Milliman on acceptable encryption methods.

Submit Final Paid Claims

Each submission shall include final claims (paid, denied, or encounter only) for dates of service within the range specified in Schedule A. For example, the January 31, 2018 submission shall include claims with dates of service from January 1, 2017 to December 31, 2017. Do not include claims with dates of service outside the range specified in Schedule A. Similarly, the Eligibility File shall not include enrollment segments which terminated prior to the date range specified in Schedule A. For example, a member with eligibility that terminated May 15, 2016 should be excluded from the January 31, 2018 submission, which covers eligibility from January 1, 2017 to December 31, 2017.

Subsequent submissions shall include four calendar quarters and shall fully replace claims (paid, denied, or encounter only) in overlapping quarters. See Schedule A for more details on the date ranges to be included with each submission. The eligibility, provider, and subscriber monthly premium files shall also be fully replaced with each submission. The eligibility file shall not include enrollment segments which terminated prior to the submission's date range.

Data System Limitations

If you anticipate difficulty extracting any required data fields, please file Form APAC-1 (Waiver or Exception of Reporting Requirements) with this office as soon as possible. This form is available at the APAC website. Do not file Form APAC-1 for data fields that are not required. Populate as many of the inpatient diagnosis and procedure codes as is feasible within the limitations of your data system. Payment fields for institutional claims may be populated at the first revenue line if paid only at the header level; in this case payment fields for additional claim lines shall be left blank (do not enter zero).

The data file layouts are contained in Appendices A to H. Please email APAC.Admin@dhsoha.state.or.us if you have additional questions.

APAC Appendix F: FAQs

Q: Should billed premium reported for Medicare Advantage plans include federal share?

A: Billed premium for Medicare Advantage plans should not include the portion of the premium paid by the federal government, as these amounts are publicly available and will be obtained by data users from publicly available tables.

Q: How should data submitters report billed premium for group plans?

A: Appendix F of the APAC file layout requires data submitters to report billed premium for subscribers in fully-insured commercial and Medicare Advantage plans. For purposes of submitting Appendix F, a fully-insured plan is any plan where policyholders make premium payments to the data submitter such that the submitter can report the payments in Appendix F. These include group plans, individual-market plans, and stand-alone prescription drug plans. Information captured by Appendix F will be used by the Division of Financial Regulation for its individual and small group rate review process, and will be used more broadly for evaluating the financial impact of health care coverage on Oregonians.

Appendix F requires reporting of a billed premium amount for each subscriber in each month (i.e., it requires reporting billed premium at the subscriber level). For employer-group coverage, insurance carriers bill employers one premium amount for all employees (subscribers) and employee dependents in the group (i.e., carriers bill at the group level rather than the subscriber level). Employers collect the employee portion of premiums and any employer contribution to the premium, and use the aggregated dollars to pay the group premium. Carriers do not bill employees directly, and are unlikely to have information about premium amounts collected by the employer on a subscriber basis. Several data submitters have asked OHA to clarify how billed premiums should be reported for employer groups given that these premiums are billed at the group level.

For employees (subscribers) in group plans, OHA expects data submitters to report the dollar amounts that were used to build the group premium. OHA anticipates submitters will have stored the dollar amounts used to calculate the group premium amount that is billed to employers. A hypothetical example of this information is below.[1]

Employer group	Subscriber + dependent combination	Amount used to build premium
ABC Business	Employee (subscriber) only	$1,000

[1] If ABC Business's coverage group includes 4 employee-only subscribers, 2 employee-plus-spouse subscribers, 2 employee-plus-children subscribers, and 3 employee-plus-family subscribers, then ABC Business's monthly premium bill = 4 X $1,000 + 2 X $1,800 + 2 X $2,400 + 3 X $2,800 = $28,000.

ABC Business	Employee (subscriber) plus spouse	$1,800
ABC Business	Employee (subscriber) plus children	$2,400
ABC Business	Employee (subscriber) plus family	$2,800

OHA understands that the dollar amounts used to build the group premium may be stored outside a data submitter's claims system, the source of most data submitted to APAC. It may be necessary to map these dollar amounts to the appropriate subscriber in order to report Appendix F.

Please note that Appendix F includes Subscriber ID, which is also included in Appendix B: Eligibility File. Subscriber ID on the billed premium file will be used to link billed premium information with other eligibility and other data in APAC.

APAC Appendix G and H: FAQs

Q: What is the objective of the Annual Supplemental Provider Level APM Summary file (Appendix G) and the Control Total file (Appendix H) submissions?

A: The goal of Appendix G is to account for all primary care and non-primary care related dollars disbursed by Mandatory Reporters, by payment arrangement type, using the inclusion criteria of the annual NAIC/SERFF filings. These different types of expenditures are referred to as "payment arrangement categories" in Appendix G, and include both claims-related payments (i.e. traditional fee-for-service) and non-claims related payments (e.g. Capitation, Global Budget, Pay for Performance). Mandatory Reporters shall submit separate information for each line of business and payment arrangement category held with each billing provider or organization, and shall differentiate spending on primary care from spending on non-primary care. Only one set of provider attributes (e.g. NPI, organization name, Tax ID) should be reported with each unique Billing Provider or Organization Plan ID (except when reporting payment arrangements "A" and "V"). This submission is designed to satisfy the statutory mandates around reporting on alternative payment methodologies.

The goal of Appendix H is to collect summary data pertaining to Appendix G, such as record counts, which will be used to confirm that the data file is received and loaded correctly.

Q: Who needs to file Appendices G and H? Will non-Mandatory APAC Reporters have to submit Appendices G and H?

A: No. Only those submitters who have been identified as Mandatory Reporters based on OAR 409-025-0110 need to submit Appendices G and H. Appendices G and H do not expand which entities are Mandatory Reporters to APAC; rather they expand the reporting requirements of current Mandatory Reporters.

Q: Will Appendices G and H replace the data filed by carriers in current NAIC/SERFF filings?

A: No. Appendices G and H will not replace the NAIC/SERFF filings sent to Oregon's Division of Financial Regulation.

Q: What if my organization does not currently file the NAIC/SERFF filing with the Division of Financial Regulation? Does my organization still need to submit Appendices G and H?

A: Yes, if your organization has been identified as an APAC Mandatory Reporter and carries a required lines of business for Appendices G and H (commercial, Medicare Advantage, Public Employees' Benefit Board and Oregon Educators'

Benefit Board), your organization must submit Appendices G and H. In other words, Appendices G and H are not dependent on the actual filing of NAIC/SERFF reports in Oregon; rather Appendices G and H use the same inclusion criteria as the NAIC/SERFF filings.

Q: Is there any difference between the data reported in Appendices A-F and the data reported in Appendices G and H?

A: Yes. In Appendices A-F, data is reported for members with a mailing address in Oregon or for members enrolled in a plan for which the state is the payer (such as PEBB and OEBB). In other words, the data in Appendices A-F is based on the member's state of residency. For Appendices G and H, OHA is collecting data using the inclusion criteria of the annual NAIC/SERFF filings. The NAIC/SERFF inclusion criteria is based on the state that the policy was sold/issued in ("situs") for group policies, and state of residence for policies sold on the individual market.

For example, if an individual lives in Washington but has commercial coverage through their employer based in Portland, Oregon, information for this individual would be included in Appendices G-H but not in Appendices A-F. Conversely, if an Oregon resident works in Washington and has commercial coverage through their employer, their data would be in included in Appendices A-F, but not in Appendices G-H.

Q: What are the required lines of business for inclusion in Appendix G?

A: Mandatory reporters shall file Appendix G for the following lines of business: commercial, Medicare Advantage, Public Employees' Benefit Board and Oregon Educators' Benefit Board. Mandatory reporters are not required to file this report for the following lines of business: Medicaid, prescription drugs only, dental benefits only and third party administrators of ERISA self-insured lines of business.

Q: What billing providers and organizations must be included in Appendix G?

A: Billing providers and organizations included in Appendix G shall only be those that received payments under insurance policies that align with NAIC/SERFF inclusion criteria, and Mandatory Reporters shall only submit data for which they are the primary payer. To the extent possible, OHA is looking for payments related to medical services only in Appendix G, however, Mandatory Reporters are not required to separate out pharmacy services or dental services in cases when both medical and pharmacy and/or dental services are included in a single contract or payment arrangement. All claims and non-claims payments shall be reported for each billing provider or organization, by line of business and payment arrangement type.

Q: What types of payments should be included in Appendix G and what is the performance period?

A: Appendix G shall include all payments made under insurance policies that align with NAIC/SERFF inclusion criteria, related to medical care or contracts during the previous calendar year (hereafter referred to as the APM Submission Performance Period). Payments related to medical care or contracts include:

- Payments made on a fee-for-service basis for medical services performed during the APM Submission Performance Period;
- Global and capitation type payments 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;
- Payments related to performance incentives or penalties for contracts that fully or partially span the APM Submission Performance Period;
- Shared savings and risk for contracts that fully or partially span the APM Submission Performance Period;
- Infrastructure payments; and
- Patient-Centered Primary Care Home (PCPCH) or other type of patient-centered medical home (PCMH) recognition for the APM Submission Performance Period.

For example, CY2016 payments should be included in the 2017 submission of Appendix G:

Performance Period Start Date (PRAPM104): 20160101
Performance Period End Date (PRAPM105): 20161231

When payments correspond to contract periods that fall partly outside of the APM Submission Performance Period, and payments cannot be exclusively attributed to the APM Submission Performance Period (e.g., annual shared savings payment for a contract running from July to June), they shall be reported, in full, along with the contract period start and end dates. For example, for a contract period of 7/1/15-6/30/16, mandatory submitters should report the following in their 2017 submissions of Appendix G:

Performance Period Start Date (PRAPM104): 20150701
Performance Period End Date (PRAPM105): 20160630

OHA will prorate these payments (and associated member months where applicable) based on the amount of time during the contract that corresponds to the APM Submission Performance Period.

Q: What reporting stratifications should be used in Appendix G?

A: All payments to billing providers and organizations must be attributed to one, and only one, reporting stratification. Data shall be stratified by Billing Provider or Organization, Line of Business, Payment Arrangement Category, and performance period (except for payment arrangements A and V). In the event that payments to a provider span multiple lines of business that cannot be distinguished for reporting purposes, payments must be apportioned across applicable lines of business using a suitable methodology determined by the mandatory reporter (e.g., plan membership distribution across lines of business).

Primary care claims and non-claims payment amounts shall be reported separately from total claims and non-claims payments. In cases where payments encompass primary care as well as other non-primary care, payments shall be apportioned to reflect the amounts attributable to primary care only

Q: Should we be reporting information 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 APM-related 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?

A: In the example given where the financial parent receives a large APM-related payment for all of their providers, Appendix G should *only* include the payment made to the financial parent. Mandatory Reporters should not parse out which providers received what portion of the payment under the financial parents' umbrella. If, in addition to the large APM-related payment received by the financial parent, additional payments were made to the individual providers, then those additional provider payments should be reported in Appendix G as well. In this way, payments will not be over-reported and OHA will be able to sum all of the payments to see the total dollars paid out by each Mandatory Reporter.

Q: How are the different "Payment" elements in Appendix G defined and how do they relate to one another?

A: There are four payment elements in Appendix G; two that pertain to primary care payments and two that pertain to total payments. The two primary care payment elements (PRAPM107 and 108) should be subsets of the total payment elements (PRAPM109 and 110), respectively. Total Primary Care Claims Payments (PRAPM107) should be a subset of the value input for Total Claims Payments (PRAPM109) and Total Primary Care Non-Claims Payments (PRAPM108) should be a subset of the value input for Total Non-Claims Payments (PRAPM 110).

OHA will add the values in PRAPM 107 and 108 to arrive at the total dollars paid (by September 30th of the following year) *for primary care* services/contracts during the APM Submission Performance Period. Similarly, OHA will add the values in PRAPM 109 and 110 to arrive at the *total* dollars paid for healthcare services/contracts during the APM Submission Performance Period.

Q: In what instances would a payment arrangement (e.g. capitation) have *both* associated claims payments (PRAPM 107 and 109) *and* associated non-claims payments (PRAPM 108 and 110)?

A: It will be rare for a contract or payment arrangement to have both claims and non-claims related payments. For example, there are typically no claims-based payments made to billing providers under capitation or pay-for-performance arrangements, since these payment arrangements typically consist of predetermined budgets that have no direct connection to patients' actual claims. In these instances, $0 should be reported for Total Primary Care Claims Payments (PRAPM107) and Total Claims Payments (PRAPM109). Conversely, there are typically no non-claims payments under fee-for-service arrangements and submitters would report $0 in the associated fields.

Q: What should be reported in instances when a certain billing provider or organization does not have any alternative payment arrangement contracts? For example, what if a provider only receives payments under a fee-for-service arrangement? How should we report the total payments made to this provider?

A: Appendix G is meant to capture *all* payments, not just alternative payments. For example, both fee-for-service and "other" are included in Appendix G as required payment arrangement categories for reporting. Therefore, if the only payment made to a billing provider was under a FFS arrangement, then PRAPM107 and 109 should be populated with the payment amounts and PRAPM 108 and 110 (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 Appendix G. Again, please note that as part of Appendix G, Mandatory Reporters are required to report on payment arrangements not typically considered to be APMs, including FFS payments and "other, non FFS" payments.

Q: What are Payment Arrangements A and V (valid values for PRAPM103) and how should they be reported?

A: Although they are included as valid values for PRAPM103, codes "A" and "V" are not truly payment arrangement categories. Instead, these values are meant to capture enrollment, as specified below, over the previous calendar year, for insurance policies issued in Oregon.

Valid value “A” is meant to capture the total enrollment (reported in de-duplicated member months) for insurance policies during the previous calendar year. Total enrollment should align with inclusion criteria of NAIC/SERFF filings, and should only be reported for those members for whom the Mandatory Reporter was the primary payer.

Valid value “V” is meant to capture the total enrollment (reported in de-duplicated member months) for insurance policies during the previous calendar year, but only across certain alternative payment arrangement categories (i.e. Global Budget, Limited Budget, Capitation, Integrated Delivery System, and Patient-Centered Primary Care Homes). Total enrollment should align with inclusion criteria of NAIC/SERFF filings, and should only be reported for those members for whom the Mandatory Reporter was the primary payer.

Both Payment Arrangements A and V should only be reported once for every distinct line of business (PRAPM102), and should only include the following three elements:

- PRAPM102: Line of Business
- PRAPM103: Should be populated as “A”
- PRAPM106: Member Months

Q: What is the definition of primary care for reporting elements PRAPM107 and PRAPM108?

A: Mandatory reporters are required to operationalize OAR 836-053-1505 by defining primary care provider to include any providers that practice within one of the state’s designated Patient Centered Primary Care Home (PCPCH) practices, as well as any providers that have one of the following taxonomy/specialty codes:

Taxonomy code	**Description**
261QF0400X	Federally Qualified Health Center
261QP2300X	Primary care clinic
261QR1300X	Rural Health Center
207Q00000X	Physician, family medicine
207R00000X	Physician, general internal medicine
175F00000X	Naturopathic medicine
208000000X	Physician, pediatrics
2084P0800X	Physician, general psychiatry
2084P0804X	Physician, child and adolescent psychiatry
207V00000X	Physician, obstetrics and gynecology
207VG0400X	Physician, gynecology
208D00000X	Physician, general practice
363L00000X	Nurse practitioner
363LA2200X	Nurse practitioner, adult health

363LF0000X	Nurse practitioner, family
363LP0200X	Nurse practitioner, pediatrics
363LP0808X	Nurse practitioner, psychiatric
363LP2300X	Nurse practitioner, primary care
363LW0102X	Nurse practitioner, women's health
363LX0001X	Nurse practitioner, obstetrics and gynecology
363A00000X	Physician's assistant
363AM0700X	Physician's assistant, medical
207RG0300X	Physician, geriatric medicine
175L00000X	Homeopathic medicine
2083P0500X	Physician, preventive medicine
364S00000X	Certified clinical nurse specialist
163W00000X	Nurse, non-practitioner

Mandatory Reporters are required to operationalize OAR 836-053-1505 by defining primary care services to include any healthcare services provide by a primary care provider (see definition above) based on the following procedures codes or diagnoses:

CPT Codes	**Description**
99201-99205	Office or outpatient visit for a new patient
99211-99215	Office or outpatient visit for an established patient
99241-99245	Office or other outpatient consultations
99341-99345	Home visit for a new patient
99347-99350	Home visit for an established patient
99381-99385	Preventive medicine initial evaluation
99391-99395	Preventive medicine periodic reevaluation
99401-99404	Preventive medicine counsel and/or risk reduction intervention
99411-99412	Group prev. medicine counsel and/or risk reduction intervention
99420	Administration and interpretation of health risk assessments
99429	Unlisted preventive medicine service
59400 (global code)	Routine obstetric care incl. vaginal delivery– 60% of payment
59510 (global code)	Routine obstetric care incl. cesarean delivery– 60% of payment
59610 (global code)	Routine obstetric care incl. VBAC delivery– 60% of payment
59618 (global code)	Routine obs. care incl. attempted VBAC delivery – 60% of payment

90460-90461	Immunization through age 18, including provider consult
90471-90472	Immunization by injection
90473-90474	Immunization by oral or intranasal route
99386-99387	Initial preventive medicine evaluation
99396-99397	Periodic preventive medicine reevaluation
G0402	Welcome to Medicare visit
G0438-G4039	Annual wellness visit
T1015	Clinic visit, all-inclusive
Primary ICD-10 code	**Description**
Z00	Encntr for general exam w/o complaint, susp or reprtd dx
Z000	Encounter for general adult medical examination
Z0000	Encntr for general adult medical exam w/o abnormal findings
Z0001	Encounter for general adult medical exam w abnormal findings
Z001	Encounter for newborn, infant and child health examinations
Z0011	Newborn health examination
Z00110	Health examination for newborn under 8 days old
Z00111	Health examination for newborn 8 to 28 days old
Z0012	Encounter for routine child health examination
Z00121	Encounter for routine child health exam w abnormal findings
Z00129	Encntr for routine child health exam w/o abnormal findings
Z008	Encounter for other general examination
Z014	Encounter for gynecological examination
Z0141	Encounter for routine gynecological examination
Z01411	Encntr for gyn exam (general) (routine) w abnormal findings
Z01419	Encntr for gyn exam (general) (routine) w/o abn findings

Q: How should member months (PRAPM106) be calculated in Appendix G?

A: PRAPM106 is only required when reporting certain types of payment arrangements such as global budget, limited budget, and capitated payments. When required, Mandatory Reporters should include the total number of members (represented in member months) that participated in the reported stratification. This will require identifying the number of members (monthly)

served under the payment arrangement category and line of business, for each billing provider or organization. For example, capitation paid for a member for January through December would count as 12 member months. See above Q/A for how to report values “A” and “V”.

It’s important to note however, that a given member could be reflected across multiple stratifications (for example, if the same individual received services from multiple providers in the same reporting period, all of whom received non-claims payments). Therefore, OHA realizes that the sum of all member months (PRAPM106) associated with alternative payment arrangements will exceed the actual total of unique member months. That is why values A and V for PRAPM103 are required.

Q: What should Appendix G look like when submitted?

A: For illustrative purposes, below is an example of the 2016 Appendix G submission. An actual Appendix G submission would be tab-delimited and would not have header rows.

	PRAPM003	PRAPM018	PRAPM004	PRAMP008	PRAPM006	PRAMP101	PRAPM102	PRAPM103	PRAPM104	PRAPM105	PRAPM106	PRAPM107	PRAPM108	PRAPM109	PRAPM110
	Provider Plan ID	Provider NPI	Provider Tax ID	Last Name	First Name	Entity Type	Line of Business	Pay Arngm't	Perf. Period Start	Perf. Period End	Member Months	Total PC Claims Payments	Total PC Non-Claims Payments	Total Claims Payments	Total Non-Claims Payments
1	PR50879	1122334455	123456789	Jones	David	1	COMM	P	20160101	20161231		0	0	0	30000.00
2	PR50879	1122334455	123456789	Jones	David	1	COMM	C	20150701	20160630	10000	0	30000.00	0	50000.00
3	PR50879	1122334455	123456789	Jones	David	1	COMM	C	20160701	20170630	30000	0	90500.00	0	160000.00
4	PR50879	1122334455	123456789	Jones	David	1	COMM	F	20160101	20161231		20000.00	0	80000.00	0
5	PR50879	1122334455	123456789	Jones	David	1	MADV	F	20160101	20161231		10000.00	0	50000.00	0
6	PR20003	2435689021	432876543	Smith Pediatrics		2	COMM	F	20160101	20161231		10000.00	0	400000.00	0
7	PR23634	3725497542	852222534	ABC Health		6	COMM	F	20160101	20161231		320000.00	0	700000.00	0
8							COMM	A			2000000				
9							MADV	A			130000				
10							COMM	V			35000				
11							MADV	V			0				

Some notes on the example above:

- The first five rows all represent payments made to the same provider (David Jones), but for different lines of business (PRAPM102), payment arrangements (PRAPM103), and performance periods (PRAPM104 and PRAPM105). Each of these stratifications needs to be reported separately in Appendix G.
- Blank fields represent elements that do not have to be reported for that stratification. For example, in the first row of data, PRAPM106 (member months) is blank because member months do not need to be reported for payment arrangement “P” (pay for performance).
- Payment amounts of $0 represent no payment of that particular type. For example, in the first row, because payment arrangement “P” (pay for performance) is all non-claims based, PRAPM107 and PRAPM109 are both blank. Additionally, this particular incentive payment had no primary care related portion, therefore PRAPM108 is also blank.

Q: What is the submission schedule for Appendix G and H?

A: Appendix G shall include all payments related to the provision of care during the APM Submission Performance Period (i.e. the previous calendar year). Mandatory reporters shall submit Appendix G and H as specified in Schedule A.

Q: What are some of the calculations that OHA will perform using the data submitted in Appendix G?

A: In the future, OHA may use the data submitted in Appendix G to produce the SB231: Primary Care Spending report to the Oregon State Legislature. Examples of some of the calculations that OHA may use, include:

(1) Primary care spending as a percentage of total spending =
Total Primary Care Claims Payments (PRAPM107) + Total Primary Care Non-Claims Payments (PRAPM108)
Total Claims Payments (PRAPM109) + Total Non-Claims Payments (PRAPM110)

(2) Per member per month medical spending for a given line of business =
Total Claims Payments (PRAPM109)
Member Months (PRAPM106)

Q: What is the process for requesting waivers, exceptions and extensions to Appendix G and H submission requirements?

A: Mandatory reporters may request data element waivers or deadline extensions to Appendix G and H reporting requirements. The form for requesting waivers or extensions will be made available on the APAC website (http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx) and must be submitted as outlined in OAR 409-025-0140. OHA will review each request on a case by case basis.

Mandatory reporters that have not correctly submitted data or received a waiver within timelines outlined in OAR 409-025-0140 will be considered non-compliant, and OHA will take action to impose penalties.

Q: What is the required file format and naming convention for submission of Appendix G and H?

A: All files shall be tab delimited unless otherwise specified in the data file layouts. Header rows containing data element names should not be included. Data elements must be populated in the order listed in the Data File Layout for each file.

Mandatory reporters submitting APM files shall use the same SFTP account that is used to submit all other APAC files to the state of Oregon. Please contact Milliman (apac_support@milliman.com) if you have any questions about this

SFTP account or you need the names of the individuals listed as the primary APAC contacts for your organization. The file naming convention shall adhere to the following formats:

Appendix G	<*Payer Abbreviation*>_<Submitter Abbreviation>_**SupplAPM_Provider**_<*Submission Month - CCYYMM*>_< *File Create Date - CCYYMMDD*>.dat
Appendix H	<*Payer Abbreviation*>_<Submitter Abbreviation>_**SupplAPM_ControlTotals**_<*Submission Month - CCYYMM*>_< *File Create Date - CCYYMMDD*>.dat

Example – For Payer ABCD's calendar year 2016 Annual Supplemental APM submission, being submitted by ABCD, due 9/30/2017 and created 9/18/2017, the filenames would be:

ABCD_ABCD_SupplAPM_Provider_201709_20170918.dat
ABCD_ABCD_SupplAPM_ControlTotals_201709_20170918.dat

For Payer Identifiers, see Lookup Table CFCT1 in Appendix E.

Version 2018.0.0 changes (to be implemented for 1/31/18 submission)

Appendix A:

1. Removed of all references to ICD-9 in the following fields:
    a. MC041
    b. MC042
    c. MC043
    d. MC044
    e. MC045
    f. MC046
    g. MC047
    h. MC048
    i. MC049
    j. MC050
    k. MC051
    l. MC052
    m. MC053
    n. MC058
    o. MC058A
    p. MC058B
    q. MC058C
    r. MC058D
    s. MC058E
    t. MC058F
    u. MC058G
    v. MC058H
    w. MC058J
    x. MC058K
    y. MC058L
    z. MC058M
2. Do not populate the following fields as of 1/1/2018:
    a. QC05
    b. QC06
    c. QC22
    d. QC23

Appendix B:

1. Do not populate the following fields as of 1/1/2018:
    a. QC013
    b. QC014
    c. QC015
    d. QC016
    e. QC018
    f. QC019
    g. QC020
2. Corrected error in code 7 of lookup table ME202

Appendix C:

1. Do not populate MP017 as of 1/1/2018.
2. **IMPORTANT: The following columns have been removed from the file layout as of 1/1/2018:**
    a. MP018A
    b. QC004
    c. QC006
    d. QC011
    e. QC021
    f. QC022
    g. QC023
    h. QC024
    i. QC025
    j. QC026
    k. QC027
    l. QC028
    m. QC029
    n. QC030.

    The completed file will have 14 fewer columns as of 1/1/2018. Please note that the file will still end with ten blank fields following MP018.

Appendix D:

1. Do not populate PC047 as of 1/1/2018.

Appendix E:

2. Updated lookup table CFCT1 to reflect mandatory reporters in 2018.

Appendix F: No changes

Appendix G: No changes

Appendix H: No changes

Schedule A:

1. Updated to extend through 2019.

Version 2017.1.0 changes (implemented 5/30/17)

Appendix A: No changes

Appendix B: No changes

Appendix C: No changes

Appendix D: No changes

Appendix E: No changes

Appendix F: No changes

Appendix G:

1. Changed required lines of business in PRAPM102 from “commercial fully insured” to “commercial”.
2. Added “A” and “V” to list of valid values for PRAPM103.
3. Added instruction “payment arrangement A and V must be reported once for every distinct line of business” to PRAPM103.
4. Added instruction “not required for PRAPM103=A and V”, for the following fields
    a. PRAPM003
    b. PRAPM018
    c. PRAPM004
    d. PRAPM008
    e. PRAPM006
    f. PRAPM101
    g. PRAPM104
    h. PRAPM105
    i. PRAPM107
    j. PRAPM108
    k. PRAPM109
    l. PRAPM110
5. Added instruction “for payment arrangement A and V, include all unduplicated member months during the previous calendar year, for which insurer was the primary payer” to PRAPM106.
6. Added instruction to align inclusion criteria with annual NAIC/SERFF filings, for the following fields:
    a. PRAPM106
    b. PRAPM107
    c. PRAPM108
    d. PRAPM109
    e. PRAPM110
7. Clarified that PRAPM107 is to include “paid claims” only.
8. Clarified that PRAPM109 is to include “paid claims” only.
9. Edited table PRAPM103 as follows:
    a. Code: A. Value: All Member Months. Definition: This value is meant to capture the total enrollment (reported in de-duplicated member months) during the previous calendar year. Total enrollment should align with the inclusion criteria of NAIC/SERFF filings, and should only be reported for those members for whom the Mandatory Reporter was the primary payer. This value must be reported only once for every distinct line of business (PRAPM102).
    b. Code: V. Value: Alternative Arrangement Member Months. Definition: This value is meant to capture the total enrollment (reported in de-duplicated member months), across payment arrangement categories G, L, C, I and H, during the previous calendar year. Total enrollment should align with inclusion criteria of NAIC/SERFF filings, and should only be reported for those members for whom the Mandatory Reporter was the primary payer.

This value must be reported only once, for every distinct line of business (PRAPM102).

Appendix H: No changes

Schedule A: No changes