Payment Arrangement Files

All mandatory reporters except Pharmacy Benefit Managers must report payment arrangements on an annual basis. Payment arrangement files must include data for group contracts sitused in Oregon and data for individual contracts where the subscriber resides in Oregon. OAR 409-025-0125

Appendix 1: Payment Arrangement File

Note: PBM's that offer stand-alone prescription drug plans are not required to file this report, nor do they have to file a Form APAC-1 (waiver or exception of reporting requirements).

When 'null' is used in the description, the field should be blank. Do not submit 'NULL' within the field.

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
PRAPM003	Contract ID	Text	30 Min. length 2	Yes	Internal ID of the entity receiving the payment or bearing the risk. Contract ID can be proprietary (i.e. specific to the payer reporting the data) but should be consistent throughout all reporting so that all payments/risk attributed to the same Contract ID can be summed up to capture the total payments/risk attributable to that contract entity by the payer. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM018	Billing Provider or Organization NPI	Text	10	Yes	NPI for the billing provider or organization which received the payment from the mandatory reporter If PRAPM103 = 2Ai, then report the PCPCH Practice ID in this field If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
PRAPM004	Billing Provider or Organization Tax ID	Text	9	Yes	Federal taxpayer's ID of the billing provider or organization/facility which received the payment from the mandatory reporter. Include leading zeros and do not include dashes. Example: 012345678 If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM008	Billing Provider Last Name or Organization	Text	100	Yes	Last name of the billing provider or the full name of the organization which received the payment from the mandatory reporter If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM006	Billing Provider First Name	Text	25	Situational	First name of the billing provider which received the payment from the mandatory reporter. Leave blank if the provider is an organization or facility. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM101	Billing Provider or Organization Entity Type	Numeric	2	Yes	Valid Values:1 – Person, 2 – Facility, 3 – Professional Group, 4 – Retail Site, 5 – E-Site, 6 – Financial Parent, 7 – Transportation, 8 – Other See Lookup Table PRAPM101 (Appendix 1) If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM102	Line of Business	Text	4	Yes	Indicates insurance line of business. Only report the following lines of business using the codes below:	0.0%

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
					COMM = Commercial MADV = Medicare Advantage CCO = Medicaid CCOs PEBB = Public Employees' Benefit Board OEBB = Oregon Educators' Benefit Board	
PRAPM103	Payment Model	Text	1	Yes	Indicates the payment model type that is being reported. See Lookup Table PRAPM103 (Appendix 1) If there is more than one payment type with a single Contract ID, then separately report each payment type. Note: All Payment Models are mutually exclusive with respect to payments and payments to the same Contract ID will be summed up to capture the total payments to that contract. Valid value "A" and "V" must be reported once for every distinct line of business (PRAPM102)	0.0%
PRAPM104	Performance Period Start Date	Date	8	Yes	Effective date of performance period for reported Insurance Line of Business and Payment Arrangement Type. CCYYMMDD If varying performance periods apply to a billing provider or organization (for a particular line of business and payment arrangement type), report results on separate lines. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	2.0%
PRAPM105	Performance Period End Date	Date	8	Yes	End date of performance period for reported Insurance Line of Business and Payment Arrangement Type. CCYYMMDD	2.0%

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
					If varying performance periods apply to a billing provider or organization (for a particular line of business and payment arrangement type), report results on separate lines. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	
PRAPM106	Member Months	Numeric	7	Situational	Total number of members in reported stratification that participate in the reported payment arrangement, expressed in months of membership Membership should align with what is reported in annual NAIC/SERFF filings and should only be reported for those members for whom the mandatory reporter is the primary payer. No decimal places; round to nearest integer. Example: 12345 Report this field only when PRAPM103 = 2Ai, 4A, 4B, 4C or 4N.	2.0%
PRAPM107	Total Primary Care Claims Payments	Numeric	14	Yes	Sum of all associated primary care claims payments (paid claims only), including patient cost-sharing amounts, that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings. Reference the way OHA operationalizes OAR 836-053-1500 through 836-053-1510 and any supplemental documents referenced in those OARs for the definition of primary care. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization	1.0%

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
					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 (PRAPM109). If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	
PRAPM108	Total Primary Care Non-Claims Payments	Numeric	14	Yes	Sum of all associated non-claims payments that pertain to primary care, that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings. Reference the way OHA operationalizes OAR 836-053-1500 through 836-053-1510 and any supplemental documents referenced in those OARs for the definition of primary care. 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 (PRAPM110). If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM109	Total Claims Payments	Numeric	14	Yes	Sum of all associated claims payments (paid claims only), including patient cost-sharing amounts, that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings.	1.0%

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
					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. If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	
PRAPM110	Total Non-Claims Payments	Numeric	14	Yes	Sum of all associated non-claims payments that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings. 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 If PRAPM103 = A, then leave this field null If PRAPM103 = V, then leave this field null	1.0%
PRAPM201					For future implementation	N/A
PRAPM202					For future implementation.	N/A
PRAPM203					For future implementation.	N/A
PRAPM204					For future implementation.	N/A
PRAPM205					For future implementation.	N/A
PRAPM206					For future implementation.	N/A
PRAPM207					For future implementation.	N/A
PRAPM208					For future implementation.	N/A
PRAPM209					For future implementation.	N/A
PRAPM210					For future implementation.	N/A

File naming convention is

For payers submitting medical files:
<payer abbreviation>_<submitter abbreviation> _APMProvider_<Year>_<file created date_timestamp>.dat

Example OMIP_OMIP_APMProvider_2020_20210930_010101.dat

For payers submitting dental files:
<payer abbreviation>_<submitter abbreviation> _DENTAL_APMProvider__<Year>_<file created date_timestamp>.dat

Note: There is a double underscore between file type and year for all dental files.

Example OMIP_OMIP_DENTAL_APMProvider__2020_20210930_010101.dat

Lookup Table PRAPM101: Billing Provider or Organization Entity Type

This field contains all valid values for types of billing provider or organization entity types

Code	Value	Definition/Example
1	Person	Physician, clinician, orthodontist, and any individual that is licensed/certified to perform healthcare services
2	Facility	Hospital, health center, long-term care, rehabilitation, and any building that is licensed to transact healthcare services
3	Professional Group	Collection of licensed/certified healthcare professionals that are practicing healthcare services under the same entity name and Federal Tax ID Number
4	Retail Site	Brick-and-mortar licensed/certified place of transaction that is not solely a healthcare entity (i.e., pharmacies, independent laboratories, vision services)
5	E-Site	Internet-based order/logistic system of healthcare services, typically in the form of durable medical equipment, pharmacy, or vision services.
6	Financial Parent	Financial governing body that does not perform healthcare services itself but directs and finances healthcare service entities, usually through a board of directors
7	Transportation	Any form of transport that conveys a patient to/from a healthcare provider
8	Other	Any type of entity not otherwise defined that performs health care services

Lookup Table PRAPM103: Payment Models

This field contains all valid values for types of payment models. These values are based on the HCP-LAN framework. For more information on HCP-LAN and some of the models below, see: https://hcp-lan.org.

Code	Value	Definition/Example
1A	Fee for Service With Link to APM	Payments based on the volume of services, for services that are subject to an APM, regardless of whether the billing provider or entity holds the APM contract (i.e. bears the risk) for the service. **Note: if a mandatory reporter cannot identify payments that qualify for this category, default to category 1 – Fee for Service Without Known Link to APM.**
1	Fee for Service Without Known Link to APM	Payments based on volume of services, on behalf of patients or enrollees, with no known link to an APM
2Ai	Payments based on Patient Centered Primary Care Home (PCPCH) tier level	Payment for recognition as a PCPCH, or per-member per-month payment for members in a PCPCH.
2Aii	Foundational payments for infrastructure and operations – that are not based on PCPCH tier level	Foundational payments to improve care delivery, such as care coordination fees and payments for investments in HIT.
2B	Pay for Reporting	Bonus payments for reporting data on quality, or penalties for not reporting data.
2C	Pay for Performance	Bonus payments for high performance on clinical quality measures, or penalties for poor performance.
3A	Alternative Payment Models with Shared Savings	Payments made under arrangements that are based on cost (and occasionally utilization) performance, as long as quality targets are met. Examples include: Bundled payment with upside risk only; episode-based payments for procedure-based clinical episodes with shared savings only.
3B	Alternative Payment Models with Shared Savings and Downside Risk	Payments or penalties made under arrangements that both reward and penalize cost (and occasionally utilization) performance, as long as quality targets are met. Examples include: Episode-based payments for procedures and comprehensive payments with upside and downside risk.
3N	Risk Based Payments Not Linked to Quality	Payments that do not take quality into account
4A	Condition-Specific Population-Based Payment	Prospective, population-based payment for a certain set of condition specific-services (e.g. oncology, mental health, diabetes) or for care

Code	Value	Definition/Example
		delivered by particular types of clinicians (e.g. primary care, orthopedics).
4B	Comprehensive Population-Based Payment	Prospective, population-based payments for all of an individual's health care needs.
4C	Integrated Finance and Delivery System	Payments for comprehensive care that integrate the financing arm with a delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, and in others, they consist of delivery systems that offer their own insurance products.
4N	Capitation Payments Not Linked to Quality	Payments that do not take quality into account.
A	All Member Months	Total enrollment during the previous calendar year. Enrollment should be reported (in de-duplicated member months) for insurance policies that align with the inclusion criteria of annual 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)
V	Alternative Arrangement Member Months	Total enrollment in alternative payment arrangements during the previous calendar year. Enrollment should only be reported for members in payment categories 2Ai, 4A, 4B, 4C and 4N. Enrollment should be reported (in de-duplicated member months) for insurance policies that align with the inclusion criteria of annual 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). Note: In many cases, the value reported for code "V" will be a subset of the value reported for code "A".

***Note: Although they are valid values for PRAPM103, codes "A" and "V" are not payment arrangement categories. Instead, these values capture total enrollment, as specified, in policies that align with the inclusion criteria of annual NAIC/SERFF filings.

Appendix 2: Payment Arrangement Control File

Note: PBM's that offer stand-alone prescription drug plans are not required to file this report, nor do they have to file a Form APAC-1 (waiver or exception of reporting requirements).

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
PRAPMCT101	Submitted File	Text	60	Yes	Data File Name Example: *ABCD_ABCD_SupplAPM_Provider_201609_20160918.dat.*	0%
PRAPMCT102	Data Rows	Numeric	10	Yes	Number of data rows in the submitted file	0%
PRAPMCT103	Member Months	Numeric	10	Yes	Sum of member months. No decimal places; round to nearest integer. Example: 12345	0%
PRAPMCT104	Total Primary Care Claims Payments	Numeric	14	Yes	Sum of Total Primary Care Claims Payments	0%
PRAPMCT105	Total Primary Care Non-Claims Payments	Numeric	14	Yes	Sum of Total Primary Care Non-Claims Payments	0%
PRAPMCT106	Total Claims Payments	Numeric	14	Yes	Sum of Total Claims Payments	0%
PRAPMCT107	Total Non-Claims Payments	Numeric	14	Yes	Sum of Total Non-Claims Payments	0%

File naming convention is
For payers submitting medical files:
<payer abbreviation>_<submitter abbreviation> _APMTotals_<Year>_<file created date_timestamp>.dat

Example: OMIP_OMIP_APMTotals_2020_20210930_010101.dat

For payers submitting dental files:
<payer abbreviation>_<submitter abbreviation> _DENTAL_APMTotals__<Year>_<file created date_ timestamp>.dat

Note: There is a double underscore between file type and year for all dental files.
Example: OMIP_OMIP_DENTAL_APMTotals__2020_20210930_010101.dat