1. Why does the Oregon Health Authority collect information on payment arrangements?

The Oregon Health Authority (OHA) has set goals to improve the health of persons in Oregon while keeping the cost of health care sustainable. Some of the methods identified for meeting these goals are alternate payment methodologies meant to incentivize the right care at the right time over quantity of care and a focus on primary care to promote health and prevent disease progression. In 2019, OHA identified five use cases for payment arrangement data for OHA which were reviewed with industry representatives.

In 2021, three things happened that broadened the use of payment arrangement files:

- The Oregon Health Leadership Council and OHA jointly sponsored the Oregon Value-based Payment Compact which also uses summary (not specific contract level) data from the payment arrangement files;
- OHA stopped requiring coordinated care organizations to submit an annual primary care report and agreed to use the information from the payment arrangement file instead; and
- The Department of Consumer and Business Services stopped requiring a separate prominent carriers report from insurers and agreed to use the information from the payment arrangement file instead.

As the use of alternate payment methodologies increases, claims-level data alone cannot tell the full story of health services and costs. At best, OHA can impute a value to the service provided under a capitation plan. Collecting data at the contract level (which is how the majority of alternate payment methodologies are paid) provides a solid foundation of use within Oregon. OHA has chosen to use the payment model fields based on HCP-LAN categories to collect data in APAC. Descriptions appear in the lookup table for field PRAPM102: Payment Models.

2. Who is required to submit payment arrangement files?

Insurers, third-party administrators and coordinated care organizations who have been identified as mandatory reporters for the All Payer All Claims (APAC) must submit the payment arrangement file as Appendices 1 and 2. Voluntary reporters, such as self-insured organizations reporting through ERISA may submit the files.

File name	Carrier	Third-party Administrator	Dental plan (Carrier)	CCO
Appendix 1: Payment Arrangement	✓	✓	✓	✓
Appendix 2: Payment Arrangement Control	✓	✓	✓	✓

In addition, an insurer identified by the Department of Consumer and Business Services as a prominent carrier (based on premiums charged) who is not identified by APAC (based on number of covered lives) may submit voluntarily.

3. When are files submitted?

APAC publishes the file submission schedule several years in advance. Files are due September 30 of each year for data on the previous calendar year and must reach acceptance status (pass all validation rules) by October 14.

4. What data is reported? (Selection criteria for report)

a. Contracts used in Oregon

The payment arrangement file content is selected based on where the policy represented was sold/issued (i.e., sitused) for group policies and where the individual lives for individual policies. This is different than the selection for the claims data files which are based on member residence. Because of the difference in selection criteria, the information provided in the payment arrangement files, even within the fee-for-service (FFS) category, will not be an exact match to data received in claims files.

b. Payments related to medical and dental services

The payment arrangement file is submitted for medical and for dental services. At this time, APAC expects to receive separate files for medical and dental if an insurer offers both types of coverage. Pharmacy contracts are not required but may be reported if the insurer chooses to do so. This would most often occur when pharmacy costs are included in the payment methodology reported for a healthcare provider.

c. Time period reported

Payment arrangement files contain data for all contracts with a performance period (when services are provided) within the previous calendar year. It is possible that the performance dates start earlier than the reporting period or end after the reporting period, but the currently reported (previous calendar year) must be included in the performance period. The payment arrangement file is based on the contract performance period, not when the payments occurred. The file submission date does allow for a minimum of nine months ‘run out’ for payment amounts to be determined. Reported payments that include months outside the reporting period will be prorated.

Performance period **examples** and when reported in payment arrangement files			
Performance period under contract	2020 file submitted Sept 30, 2021	2021 file submitted Sept 30, 2022	2022 file submitted Sept 30, 2023
January 1 – December 31, 2020	Yes	No	No
July 1, 2020 – June 30, 2021	Yes	Yes	No
July 1, 2020 – June 20, 2022	Yes	Yes	Yes

d. Report all payment methodologies including fee for service

All payment methodologies are reported including FFS contracts/payments. OHA is directed to determine the percent of health care service payments covering primary care services and the percent of health care service payments that fall under an alternative payment methodology. This information cannot be determined without all payments being reported. See the lookup table for field PRAPM102: Payment Models for specific information on the different types of payment models supported in the report.

5. Structure of the report

a. How to report a contract that includes more than one payment model

In instances in which a single contract arrangement consists of more than one payment model, the payments should be stratified and reported on separate rows.

For example, if a contract includes a portion for fee-for-service (FFS), and an additional bonus payment for meeting certain performance and quality incentives, the data reporter would report the amount of the payment that was FFS, as well as the amount that was for pay-for-performance. These data would occupy two separate rows in the submission for a given line of business with the same Contract ID.

Another example would be if a contract that is based on FFS and includes shared savings and shared risk, the data reporter would report the amount of FFS payments on one row, and any shared savings or shared risk payments on another row.

Note that there are payment model values (PRAPM103) for both FFS with a link to an alternate payment methodology (code = 1A) and FFS without a known link to APM (code = 1). Data reporters should use the value that best matches their circumstances for a given payment model.

b. Determining member months

Member months relevant to determining the per member per month costs are collected in PRAPM106. PRAPM106 is required when reporting the following types of payment models:

- Payments based on Patient-Centered Primary Care Home (PCPCH) tier level (2Ai)
- Condition-Specific Population-Based Payments (4A)
- Comprehensive Population-Based Payments (4B)
- Integrated Finance and Delivery System Payments (4C)
- Capitation Payments Not Linked to Quality (4N)

When required, mandatory reporters should include the total number of members (represented in member months) that participated in the payment methodology category under the specific contract being reported. This will require identifying the number of members served monthly under the payment model and line of business for each Contract ID. For example, a comprehensive population-based payment (Payment Model = 4B) paid for one member from January through December would count as 12 member months.

It is important to note, however, that a given member could be reflected across multiple payment methodologies and contracts (for example, if the same individual received services from multiple providers in the same reporting period). Therefore, OHA realizes that the sum of all member months (PRAPM106) associated with the various payment models may exceed the actual total of unique member months. That is why values A and V for PRAPM103 are required. See below Question 5c for how to report values “A” and “V”.

c. What are Payment Models A and V (valid values for PRAPM103) and how should they be reported?

Although they are included as valid values for PRAPM103, the field for payment models, codes “A” and “V” are not truly payment models. 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 deduplicated member months) for insurance policies 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 data reporter was the primary payer.

Valid value “V” is meant to capture the total enrollment (reported in deduplicated member months) for insurance policies during the previous calendar year limited to certain alternative payment arrangement categories (see what payment models require member months to be reported in Question 5b). Total enrollment should align with the inclusion criteria of NAIC/SERFF filings and should only be reported for those members for whom the data reporter was the primary payer.

For each line of business reported, payment models A and V are required data rows and 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” and “V”
PRAPM106: Member Months

Note that even if a data reporter has only FFS arrangement for a given line of business, the payment model V is still a required data row with the value “0” in PRAPM106 Member Months (see the example of Payment Arrangement File in Question 5g).

d. Determination of primary care

Primary care claims (PRAPM107) and primary care non-claims payment amounts (PRAPM108) shall be reported separately from total claims (PRAPM109) and total non-claims payment amounts (PRAPM110). 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. OHA uses the definition of primary care established by the Department of Consumer and Business Services in OAR 836-053-1505. Primary care

payments are defined as payments made to a primary care provider for a primary care service (both must apply):

1. **Primary Care Provider**: Any providers that practice within one of the state's designated Patient Centered Primary Care Home (PCPCH) practices or any providers that have one of the taxonomy codes listed in the lookup table for Appendix 1, **and**
2. **Primary Care Service**: Any of the services listed in either the table of procedure codes or the table of diagnostic codes listed in the lookup table for Appendix 1. Note: costs associated with services provided in hospital and ambulatory surgical center settings do not count toward primary care spending.

See Lookup Table PRAPM107 in Appendix 1 file layout for detailed taxonomy, ICD and CPT codes.

e. Reporting zero or negative amounts for the contract

Negative payments should be reported when a data reporter receives money from a contracted entity, as opposed to paying money out. For example, data reporters should use a negative number for a payment a contracted entity makes to the data reporter in the form of a shared risk payment arrangement.

There may also be instances in which a data reporter should enter $0 for a given payment to convey important details about that contract. For example, if a Mandatory Reporter has a shared savings arrangement with a FFS base but at the end of the contract period the provider has not achieved the threshold to initiate any shared savings payments, the data reporter shall enter the payment amounts for FFS with link to APM (Category 1A) and enter $0 in another row for Alternative Payment Models with Shared Savings (Category 3A). This conveys that the Mandatory Reporter had a shared savings payment arrangement with the provider instead of FFS arrangement but that the threshold for the Shared Savings payment was not met.

f. Grouping small payments

There should be one row per each unique combination of Contract ID (PRAPM003), Line of Business (PRAPM102), Payment Model (PRAPM103), Billing Provider Name (PRAPM008 and PRAPM006), and Performance Period (PRAPM104 and PRAPM105). It is possible that one provider receives multiple payments from a data reporter under the same contract and the same payment model during a given performance period. In that case, data reporters should roll all of those payments into one row in the payment arrangement file.

g. An example of Payment Arrangement File

For illustrative purposes, below is an example of the 2019 Payment Arrangement File. The actual PAF can be submitted in excel file as the table below, or it can also be submitted as tab delimited flat file without header.

PRAPM003 Contract ID	PRAPM018 Billing Provider or Org NPI	PRAPM004 Billing Provider or Org Tax ID	PRAPM008 Billing Provider Last Name or Org	PRAPM006 Billing Provider First Name	PRAPM101 Billing Provider or Org Entity Type	PRAPM102 Line of Business	PRAPM103 Payment Model	PRAPM104 Perf. Period Start Date	PRAPM105 Perf. Period End Date	PRAPM106 Member Months	PRAPM107 Total Primary Care Claims Payments	PRAPM108 Total Primary Care Non-Claims Payments	PRAPM109 Total Claims Payments	PRAPM110 Total Non-Claims Payments	PRAPM201 Hospital Indicator
PR50879	1122334455	123456789	Jones	David	1	COMM	1	20190101	20191231		20000	0	80000	0	0
PR50879	1122334455	123456789	Jones	David	1	COMM	2C	20190101	20191231		0	0	0	30000	0
PR50879	1122334455	123456789	Jones	David	1	COMM	4B	20180701	20190630	10000	0	30000	0	50000	0
PR50879	1122334455	123456789	Jones	David	1	COMM	4B	20190701	20200630	30000	0	90500	0	160000	0
PR50879	1122334455	123456789	Jones	David	1	MADV	1	20190101	20191231		10000	0	50000	0	9
PR20003	2435689021	432876543	Smith Pediatrics		2	COMM	1	20190101	20191231		10000	0	400000	0	1
PR23634	3725497542	852222534	ABC Health		6	COMM	1	20190101	20191231		320000	0	700000	0	1
						COMM	A			2000000					
						COMM	V			35000					
						MADV	A			130000					
						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 models (PRAPM103), and performance periods (PRAPM104 and PRAPM105). Each of these stratifications needs to be reported separately in the Payment Arrangement File.

Blank fields represent elements that do not have to be reported for that stratification. For example, in the first two rows of data, PRAPM106 (member months) is blank because member months do not need to be reported for payment arrangement “1” (FFS) and “2C” (pay for performance).

Payment amounts of $0 represent no payment of that type. For example, in the first row, payment arrangement “1” (FFS) is all claims based, so PRAPM108 and PRAPM110 are 0. In the second row, because payment arrangement “2C” (pay for performance) is all non-claims based, PRAPM107 and PRAPM109 are both 0. Additionally, this incentive payment had no primary care related portion, therefore PRAPM108 is also 0.

The purpose of the last four rows with PRAPM103 = “A” or “V” is to capture the total enrollment for insurance policies during the previous calendar year. When PRAPM103 = “A” it is meant to report the total deduplicated member months in PRAPM106, which should be a positive integer. When PRAPM103 = “V”, it is to report the total deduplicated member months under alternative payment setting. Not all the insurers have the alternative payment models for their members. When an insurer has only the FFS setting for a line of business, “0” should be reported in PRAPM106 in the row of PRAPM103 = “V” (please see the last row of the above example). Note that PRAPM103 = “A” and “V” are the required rows for each line of business in a payment arrangement file.

6. Where can I find the current file layout?

Current file layouts, submission schedule, and other information are available on the APAC Data Submissions webpage. File layouts are incorporated by reference in APAC's rules. This means any change to the file layout (other than a typographical error) must be published and adopted through formal rulemaking.

7. What if I find an error in files we already submitted?

Contact the APAC program (apac.admin@odhsoha.oregon.gov) and HSRI (apachelp@hsri.com) immediately for specific advice. Generally speaking,

- If the error is found within two weeks of scheduled submission date, a replacement file can be submitted following directions from HSRI.
- If the error is found after files have been processed, a resubmission can be scheduled but it may take months before the updated information is available to OHA.

Each data file contains one year of data. Errors from previous years cannot be fixed in subsequent years' data files and will require resubmission of corrected data files for each year found to be in error.

8. What validation rules are applied to the files?

Validation rules are available in the data submission portal (left menu, Guides > Validation Rules). Below are the rules in effect May 2023 but please use the online guide for the most recent information.

Note that each field might have more than one validation rule applied. For example, Element PRAPM003 has three associated validation rules in the table below.

Payment Arrangement file validation rules

ID	Element	Name	Description	Issue Type	Threshold
807	PRAPM003	Populated Contract ID	When PRAPM103 is not A or V, a valid entry means that the field is not blank.	Exemption	99%
835	PRAPM003	Identifier Length Contract ID	A valid entry means that the field has sufficient characters to be unique.	Exemption	100%
841	PRAPM003	Conditional Blank Contract ID	When PRAPM103 is A or V, blank is required.	Exemption	99%
842	PRAPM018	Conditional Blank Billing Provider or Organization NPI	When PRAPM103 is A or V, blank is required.	Exemption	99%
808	PRAPM018	Populated Billing Provider or Organization NPI	When PRAPM103 is not A or V, a valid entry means that the field is not blank.	Exemption	99%
809	PRAPM018	Valid Billing Provider or Organization NPI	When not blank, a valid entry means the value is in the list of standard values.	Exemption	99%
813	PRAPM004	Populated Billing Provider or Organization Tax ID	When PRAPM103 is not A or V, a valid entry means that the field is not blank.	Exemption	99%
814	PRAPM004	Valid Billing Provider or Organization Tax ID	When not blank, a valid entry means the value consists of nine digits.	Exemption	100%

ID	Element	Name	Description	Issue Type	Threshold
843	PRAPM004	Conditional Blank Billing Provider or Organization Tax ID	When PRAPM103 is A or V, blank is required.	Exemption	99%
844	PRAPM008	Conditional Blank Billing Provider Last Name or Organization	When PRAPM103 is A or V, blank is required.	Exemption	99%
815	PRAPM008	Populated Billing Provider Last Name or Organization	When PRAPM103 is not A or V, a valid entry means that the field is not blank.	Exemption	99%
816	PRAPM006	Populated Billing Provider First Name	When PRAPM103 is not A or V and provider is not an organization or facility, a valid entry means that the field is not blank.	Exemption	0%
845	PRAPM006	Conditional Blank Billing Provider First Name	When PRAPM103 is A or V, blank is required.	Exemption	0%
862	PRAPM006	Populated Billing Provider First Name - Billing Provider is Person	When PRAPM101 is 1, a valid entry means that the field is not blank.	Exemption	100%
806	PRAPM101	Valid Billing Provider or Organization Entity Type	When not blank, a valid entry means the value is in the list of standard values.	Exemption	100%

ID	Element	Name	Description	Issue Type	Threshold
846	PRAPM101	Conditional Blank Billing Provider or Organization Entity Type	When PRAPM103 is A or V, blank is required.	Exemption	99%
817	PRAPM101	Populated Billing Provider or Organization Entity Type	When PRAPM103 is not A or V, a valid entry means that the field is not blank.	Exemption	99%
818	PRAPM102	Valid Line of Business	When not blank, a valid entry means the value is in the list of standard values.	Exemption	100%
810	PRAPM102	Populated Line of Business	A valid entry means that the field is not blank.	Exemption	100%
811	PRAPM103	Populated Payment Model	A valid entry means that the field is not blank.	Exemption	100%
819	PRAPM103	Valid Payment Model	When not blank, a valid entry means the value is in the list of standard values.	Exemption	100%
820	PRAPM104	Populated Performance Period Start Date	When PRAPM103 is not A or V, a valid entry means that the field is not blank.	Exemption	98%
821	PRAPM104	Valid Performance Period Start Date	When not blank, a valid entry means the value is in CCYYMMDD format.	Exemption	100%

ID	Element	Name	Description	Issue Type	Threshold
847	PRAPM104	Conditional Blank Performance Period Start Date	When PRAPM103 is A or V, blank is required.	Exemption	98%
848	PRAPM105	Conditional Blank Performance Period End Date	When PRAPM103 is A or V, blank is required.	Exemption	98%
861	PRAPM105	Bounded Performance Period Dates	Either start or end date should be within the 12 month submission date range.	Exemption	100%
822	PRAPM105	Populated Performance Period End Date	When PRAPM103 is not A or V, a valid entry means that the field is not blank.	Exemption	98%
823	PRAPM105	Valid Performance Period End Date	When not blank, a valid entry means the value is in CCYYMMDD format.	Exemption	100%
824	PRAPM106	Populated Member Months	When PRAPM103 is 2Ai, 4A, 4B, 4C or 4N, a valid entry means that the field is not blank.	Exemption	98%
812	PRAPM106	Valid Member Months	When not blank, a valid entry means the value is in integer format.	Exemption	100%
825	PRAPM107	Populated Total Primary Care Claims Payments	When PRAPM103 is not A or V, a valid entry means that the field is not blank.	Exemption	99%
826	PRAPM107	Valid Total Primary Care Claims Payments	When not blank, a valid entry means the value is in explicit 2-decimal format.	Exemption	100%

ID	Element	Name	Description	Issue Type	Threshold
827	PRAPM107	Bounded Total Primary Care Claims Payments	A valid entry is not greater than the amount of Total Claims Payments (PRAPM109).	Exemption	100%
853	PRAPM107	Non-Negative Total Primary Care Claims Payments	When not blank, a valid entry is greater then or equal to zero.	Exemption	100%
849	PRAPM107	Conditional Blank Total Primary Care Claims Payments	When PRAPM103 is A or V, blank is required.	Exemption	99%
850	PRAPM108	Conditional Blank Total Primary Care Non-Claims Payments	When PRAPM103 is A or V, blank is required.	Exemption	99%
828	PRAPM108	Populated Total Primary Care Non-Claims Payments	When PRAPM103 is not A or V, a valid entry means that the field is not blank.	Exemption	99%
829	PRAPM108	Valid Total Primary Care Non-Claims Payments	When not blank, a valid entry means the value is in explicit 2-decimal format.	Exemption	100%
830	PRAPM108	Bounded Total Primary Care Non-Claims Payments	A valid entry is not greater than the amount of Total Non-Claims Payments (PRAPM110).	Exemption	100%
794	PRAPM109	Populated Total Claims Payments	When PRAPM103 is not A or V, a valid entry means that the field is not blank.	Exemption	99%

ID	Element	Name	Description	Issue Type	Threshold
795	PRAPM109	Valid Total Claims Payments	When not blank, a valid entry means the value is in explicit 2-decimal format.	Exemption	100%
851	PRAPM109	Conditional Blank Total Claims Payments	When PRAPM103 is A or V, blank is required.	Exemption	99%
854	PRAPM109	Non-Negative Total Claims Payments	When not blank, a valid entry is greater then or equal to zero.	Exemption	100%
852	PRAPM110	Conditional Blank Total Non-Claims Payments	When PRAPM103 is A or V, blank is required.	Exemption	99%
796	PRAPM110	Populated Total Non-Claims Payments	When PRAPM103 is not A or V, a valid entry means that the field is not blank.	Exemption	99%
797	PRAPM110	Valid Total Non-Claims Payments	When not blank, a valid entry means the value is in explicit 2-decimal format.	Exemption	100%
924	PRAPM201	Populated Hospital Indicator	A valid entry means that the field is not blank.	Exemption	99%
925	PRAPM201	Valid Hospital Indicator	When not blank, a valid entry means the value is in the list of standard values.	Exemption	100%
799	PRAPM202	Enforce Blank	Field must be blank.	Exemption	100%
800	PRAPM203	Enforce Blank	Field must be blank.	Exemption	100%
801	PRAPM204	Enforce Blank	Field must be blank.	Exemption	100%

ID	Element	Name	Description	Issue Type	Threshold
802	PRAPM205	Enforce Blank	Field must be blank.	Exemption	100%
803	PRAPM206	Enforce Blank	Field must be blank.	Exemption	100%
804	PRAPM207	Enforce Blank	Field must be blank.	Exemption	100%
792	PRAPM208	Enforce Blank	Field must be blank.	Exemption	100%
793	PRAPM209	Enforce Blank	Field must be blank.	Exemption	100%
805	PRAPM210	Enforce Blank	Field must be blank.	Exemption	100%

Primary Care Control Totals Validation Rules

ID	Element	Name	Description	Issue Type	Threshold
836	PRAPMCT101	Confirmed Submitted File	Name is expected to match between files.	Exemption	100%
837	PRAPMCT101	Populated Submitted File	A valid entry means that the field is not blank.	Exemption	100%
838	PRAPMCT102	Valid Data Rows	When not blank, a valid entry means the value is greater than or equal to zero.	Exemption	100%
831	PRAPMCT102	Populated Data Rows	A valid entry means that the field is not blank.	Exemption	100%
855	PRAPMCT102	File Confirmed Data Rows	Totals are expected to match between files.	Exemption	100%
948	PRAPMCT103	File Confirmed Member Months (COMM)	Totals are expected to match between files.	Exemption	100%
949	PRAPMCT103	File Confirmed Member Months (MADV)	Totals are expected to match between files.	Exemption	100%

ID	Element	Name	Description	Issue Type	Threshold
950	PRAPMCT103	File Confirmed Member Months (CCO)	Totals are expected to match between files.	Exemption	100%
951	PRAPMCT103	File Confirmed Member Months (PEBB)	Totals are expected to match between files.	Exemption	100%
952	PRAPMCT103	File Confirmed Member Months (OEBB)	Totals are expected to match between files.	Exemption	100%
916	PRAPMCT103	Populated Member Months	A valid entry means that the field is not blank.	Exemption	100%
918	PRAPMCT104	Populated Total Primary Care Claims Payments	A valid entry means that the field is not blank.	Exemption	99.9%
933	PRAPMCT104	File Confirmed Total Primary Care Claims Payments (COMM)	Totals are expected to match between files.	Exemption	99.9%

ID	Element	Name	Description	Issue Type	Threshold
934	PRAPMCT104	File Confirmed Total Primary Care Claims Payments (MADV)	Totals are expected to match between files.	Exemption	99.9%
935	PRAPMCT104	File Confirmed Total Primary Care Claims Payments (CCO)	Totals are expected to match between files.	Exemption	99.9%
936	PRAPMCT104	File Confirmed Total Primary Care Claims Payments (PEBB)	Totals are expected to match between files.	Exemption	99.9%
937	PRAPMCT104	File Confirmed Total Primary Care Claims Payments (OEBB)	Totals are expected to match between files.	Exemption	99.9%
939	PRAPMCT105	File Confirmed Total Primary Care Non-Claims Payments (MADV)	Totals are expected to match between files.	Exemption	99.9%
940	PRAPMCT105	File Confirmed Total Primary Care Non-Claims Payments (CCO)	Totals are expected to match between files.	Exemption	99.9%

ID	Element	Name	Description	Issue Type	Threshold
941	PRAPMCT105	File Confirmed Total Primary Care Non-Claims Payments (PEBB)	Totals are expected to match between files.	Exemption	99.9%
942	PRAPMCT105	File Confirmed Total Primary Care Non-Claims Payments (OEBB)	Totals are expected to match between files.	Exemption	99.9%
915	PRAPMCT105	Populated Total Primary Care Non-Claims Payments	A valid entry means that the field is not blank.	Exemption	99.9%
938	PRAPMCT105	File Confirmed Total Primary Care Non-Claims Payments (COMM)	Totals are expected to match between files.	Exemption	99.9%
928	PRAPMCT106	File Confirmed Total Claims Payments (COMM)	Totals are expected to match between files.	Exemption	99.9%

ID	Element	Name	Description	Issue Type	Threshold
929	PRAPMCT106	File Confirmed Total Claims Payments (MADV)	Totals are expected to match between files.	Exemption	99.9%
930	PRAPMCT106	File Confirmed Total Claims Payments (CCO)	Totals are expected to match between files.	Exemption	99.9%
931	PRAPMCT106	File Confirmed Total Claims Payments (PEBB)	Totals are expected to match between files.	Exemption	99.9%
932	PRAPMCT106	File Confirmed Total Claims Payments (OEBB)	Totals are expected to match between files.	Exemption	99.9%
919	PRAPMCT106	Populated Total Claims Payments	A valid entry means that the field is not blank.	Exemption	99.9%
917	PRAPMCT107	Populated Total Non-Claims Payments	A valid entry means that the field is not blank.	Exemption	99.9%
943	PRAPMCT107	File Confirmed Total Non-Claims Payments (COMM)	Totals are expected to match between files.	Exemption	99.9%

ID	Element	Name	Description	Issue Type	Threshold
944	PRAPMCT107	File Confirmed Total Non-Claims Payments (MADV)	Totals are expected to match between files.	Exemption	99.9%
945	PRAPMCT107	File Confirmed Total Non-Claims Payments (CCO)	Totals are expected to match between files.	Exemption	99.9%
946	PRAPMCT107	File Confirmed Total Non-Claims Payments (PEBB)	Totals are expected to match between files.	Exemption	99.9%
947	PRAPMCT107	File Confirmed Total Non-Claims Payments (OEBB)	Totals are expected to match between files.	Exemption	99.9%
926	PRAPMCT108	Populated Line of Business	A valid entry means that the field is not blank.	Exemption	0%
927	PRAPMCT108	Valid Line of Business	When not blank, a valid entry means the value is in the list of standard values.	Exemption	0%

9. Resources to find out more

Both OHA APAC and HSRI are available to answer questions. If you are unsure of the question, please email to both and they will sort it out. Otherwise, send

- Policy, compliance, file layout and procedural questions to apac.admin@odhsoha.oregon.gov
- Validation rules, notices received from the portal, and technical questions to apachelp@hsri.org

Resources regarding file layouts, submission schedule, frequently asked questions, links to laws and rules, and recorded trainings can be found on the APAC Data Submitter page:https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/APAC-Data-Submissions.aspx

APAC posts meeting recordings and notes from Technical Advisory Group (TAG) meetings here: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims-TAG.aspx.

Within the HSRI data submission portal, there are also file layouts and the current validation rules, validation reports, submission reports, a user manual, and technical frequently asked questions. The HSRI data submission portal can be found here: https://www.apac.norc.org/

Additional information on the Value-based Compact work is available at https://www.oregon.gov/oha/hpa/dsi-tc/pages/value-based-payment.aspx.

The document referenced in the CCO contracts are available here; Roadmap (2019) and Technical Guide (2022).