

## Oregon All Payer All Claims – Frequently Asked Questions

### Claims data files (Appendices A-G)

#### Subscriber Billed Premium File (Appendix F)

**1. 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.

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

**A:** The Subscriber Billed Premium File 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 the file, a fully-insured plan is any plan where policyholders make premium payments to the data submitter such that the submitter can report the payments. These include group plans, individual-market plans, and stand-alone prescription drug plans. Information captured by this data submission 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.

The Subscriber Billed Premium File 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.<sup>1</sup>

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<sup>1</sup> 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.

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### Claims data files (Appendices A-G)

<b>Employer group</b>	<b>Subscriber + dependent</b>	<b>Amount used to build premium</b>
ABC Business	Employee (subscriber) only	\$1,000
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 produce the Subscriber Billed Premium File.

Please note that the Subscriber Billed Premium File includes Subscriber ID, which is also included in the 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.

## Oregon All Payer All Claims – Frequently Asked Questions

### Payment Arrangement File and Payment Arrangement Control File (Appendices 1 & 2)

**1. Q: What is the objective of the annual Payment Arrangement File and the Payment Arrangement Control File?**

**A:** The goal of the Payment Arrangement File is to account for all primary care and non-primary care related dollars disbursed by Mandatory Reporters, by payment model type, using the inclusion criteria of the annual NAIC/SERFF filings. These different types of expenditures are referred to as “payment models” and include both claims-related payments (i.e. traditional fee-for-service) and non-claims related payments. Mandatory Reporters shall submit separate information for each line of business and payment model held with each Contract ID and shall differentiate spending on primary care from spending on non-primary care. OHA should be able to sum up all payments made to the same Contract ID to capture total payments. This submission is designed to satisfy the statutory mandates around reporting on alternative payment methodologies.

The goal of the Payment Arrangement *Control* File is to collect summary data pertaining to the Payment Arrangement File such as record counts, which will be used to confirm that the Payment Arrangement File is received and loaded correctly.

**2. Q: Who needs to file the Payment Arrangement and Payment Arrangement Control File? Do Voluntary Reporters have to submit these files?**

**A:** No. Only those submitters who have been identified as Mandatory Reporters based on OAR 409-025-0110 are required to submit the Payment Arrangement File and Payment Arrangement Control File. Voluntary Reporters are encouraged to submit these files but are not required to do so.

**3. Q: Will the Payment Arrangement Files replace the data filed by carriers in current NAIC/SERFF filings?**

**A:** No. The Payment Arrangement Files will not replace the NAIC/SERFF filings sent to Oregon’s Division of Financial Regulation.

**4. Q: What if my organization is a Mandatory Reporter but does not currently file the NAIC/SERFF filing with the Division of Financial Regulation? Does my organization still need to submit the Payment Arrangement Files?**

**A:** Yes, if your organization has been identified as an APAC Mandatory Reporter and carries a required line of business for the Payment Arrangement Files

(commercial, dental, Medicare Advantage, Public Employees' Benefit Board, Oregon Educators' Benefit Board, or Medicaid Coordinated Care Organization), your organization must submit the data. In other words, submission of the Payment Arrangement Files is not dependent on the actual filing of NAIC/SERFF reports in Oregon; rather the Payment Arrangement Files use the same inclusion criteria as the NAIC/SERFF filings.

**5. Q: Is there any difference between the data reported in the Payment Arrangement Files and the data reported in the other APAC files (e.g. eligibility, claims, provider, etc.)?**

**A:** Yes, the selection criteria are different between the claims-related files submitted quarterly and the Payment Arrangement files submitted annually. In the claims-related files, data is reported for members residing in Oregon or for members enrolled in a plan for which the state is the payer (such as PEBB and OEBC). In other words, the data in the other APAC files is based on the member's state of residency. For the Payment Arrangement Files, 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 resides in Washington but has commercial coverage through their private employer based in Portland, Oregon, information for this individual would be included in the Payment Arrangement Files but not in the other APAC files. Conversely, if an Oregon resident works in Washington and has insurance coverage through their employer, their data would be included in the other APAC files, but not in the Payment Arrangement Files.

**6. Q: What lines of business are required to be included in the Payment Arrangement File?**

**A:** Mandatory Reporters shall submit the Payment Arrangement files for the following lines of business: commercial, dental, Medicaid CCO's, Medicare Advantage, Public Employees' Benefit Board and Oregon Educators' Benefit Board. Mandatory Reporters are not required to file this report for prescription drug-only plans.

**7. Q: What payments must be included in the Payment Arrangement Files?**

**A:** Mandatory Reporters should include all payments made under insurance policies that align with NAIC/SERFF inclusion criteria for which they are the primary payer. Mandatory Reporters are not required to separate out pharmacy services. All claims and non-claims payments shall be reported for each Contract ID, by line of business and payment arrangement model.

**8. Q: What is the timeframe (“performance period”) of the payments included in the Payment Arrangement Files?**

**A:** The Payment Arrangement Files shall include all payments made under insurance policies that align with NAIC/SERFF inclusion criteria, related to medical/dental care or contracts **during the previous calendar year**. Payments related to medical/dental care or contracts include:

- Payments made on a fee-for-service basis for medical/dental services *performed* during the previous calendar year, including fee-for-service payments with a link to APM as well as fee-for-service payments without known link to APM;
- The following types of contract payments that fully or partially span the provision of services during the previous calendar year\*:
  - a. Foundational payments for infrastructure and operations, which includes payments associated with the Patient Centered Primary Care Home program;
  - b. Pay for reporting;
  - c. Pay for performance;
  - d. Shared savings payments, with a link to quality;
  - e. Shared savings payments with downside risk, with a link to quality;
  - f. Condition-specific population-based payments, with a link to quality;
  - g. Comprehensive population-based payments, with a link to quality;
  - h. Integrated finance and delivery system payments, with a link to quality;
  - i. Risk-based payments with no link to quality; and
  - j. Capitated payments with no link to quality.

For additional descriptions of these payment models, reference the Health Care Payment Learning and Action Network’s “APM Framework” found here: <https://hcp-lan.org/apm-refresh-white-paper/>.

\* Mandatory Reporters shall include the details of *all payments that span any part of the previous calendar year* and shall include the start and end date of the contract in the data submission. For example, if a contract is based on the calendar year (CY2018), the Mandatory Reporter would submit details of the payment in the 2019 Payment Arrangement Files submission with the following start and end dates:

Performance Period Start Date (PRAPM104): 20180101  
Performance Period End Date (PRAPM105): 20181231

When contracts fall partly outside of the previous calendar year (“performance period”) and payments therefore cannot be exclusively attributed to the previous calendar year, the payment shall still be reported, in full, along with the contract period start and end dates. For example, for a contract period of July 2017 through June 2018, the Mandatory Reporter would submit the following start and end dates:

Performance Period Start Date (PRAPM104): 20170701  
Performance Period End Date (PRAPM105): 20180630

OHA will then prorate these payments (and associated member months where

applicable) for the previous calendar year.

**9. Q: What if a given payment arrangement is made up of several different components? For example, what if a payment includes a portion for fee-for-service, and an additional bonus payment for meeting certain performance and quality incentives?**

**A:** In instances when a single contract arrangement consists of several components, Mandatory Reporters should stratify these payments and report them on separate lines. In the above example, the Mandatory Reporter would report the amount of the payment that was for fee-for-service (FFS), as well as the amount that was for pay-for-performance; these data would occupy two separate rows in the submission with the same Contract ID.

Additionally, if a Mandatory Reporter has a contract that is based on FFS and includes shared savings and shared risk, the Mandatory Reporter would report the amount of FFS payments on one row, and another row for 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 APM (code = 1A) and FFS without known link to APM (code = 1). Mandatory Reporters should use the value that best matches their circumstance for a given payment arrangement.

**10. Q: When would a Mandatory Reporter report a negative or zero-dollar payment?**

**A:** Negative payments should be reported when a Mandatory Reporter *receives* money from a contracted entity, as opposed to paying money out. For example, a payment a contracted entity makes to the Mandatory Reporter under a shared risk payment arrangement.

There may also be instances in which a Mandatory 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 Mandatory 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 a FFS arrangement, but that the threshold for the Shared Savings payment was not met. Additionally, the use of the payment model category 1A conveys that the payment had a link to an APM.

**11. Q: What reporting stratifications should be used in the Payment Arrangement Files?**

**A:** All payments to billing providers and organizations must be reflected only once per Line of Business, such that the sum of a Mandatory Reporter's payments to a billing provider or organization, accurately reflects the total payments made to that billing provider or organization for that Line of Business and spanning that performance period. If payments to a billing provider or organization 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.

**12. Q: 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?**

**A:** Mandatory Reporters 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, the Mandatory Reporter shall provide detailed information about how that financial parent disbursed the large payment to the various provider groups it contains. If the more detailed information is unavailable, the Payment Arrangement File should include the payment made to the financial parent.

**13. Q: How are the different "payment" elements in the Payment Arrangement File defined and how do they relate to one another?**

**A:** There are four payment elements in the Payment Arrangement File; two that relate to primary care payments and two that relate 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).

**14. Q: What should be reported in instances when a certain provider does not have any alternative payment model contracts? For example, what if a provider only receives payments under a fee-for-service (with no link to APM) arrangement? How should we report the total payments made to this provider?**

**A:** The Payment Arrangement File is meant to capture *all* payments, not just alternative payments. For example, both fee-for-service with no link to APM, and alternative payment methodologies are included in the Payment Arrangement File as required payment models for reporting. Therefore, if the only payment made to a billing provider was under a FFS arrangement with no link to APM, 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 billing provider or organization for contracts during the reporting period, should they be omitted from the Payment Arrangement File.

**15. Q: What are Payment Models 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 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 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 limited to certain alternative payment arrangement categories. 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

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

**A:** OHA is using the definition 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 below, **and**
2. **Primary Care Service:** Any of the services listed in either the table of procedure codes or the table of diagnostic codes shown below. Note: costs associated with services provided in hospital and ambulatory surgical center settings do not count toward primary care spending.

**Primary Care Provider Taxonomy Table (condition #1):**

<b>Taxonomy code</b>	<b>Description</b>
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

**Primary Care Service Table (condition #2)**

<b>CPT Codes</b>	<b>Description</b>
59400	Routine obstetric care including vaginal delivery (global code) *60% of payment
59510	Routine obstetric care including cesarean delivery (global code) *60% of payment
59610	Routine obstetric care including VBAC delivery (global code) *60% of payment
59618	Routine obstetric care including attempted VBAC delivery (global code) *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
96160-96161	Administration of health risk assessment
96372	Therapeutic, prophylactic, or diagnostic injection
98966-98968	Nonphysician telephone services
98969	Online assessment, mgmt services by nonphysician
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
99339-99340	Physician supervision of patient in home or rest home
99341-99345	Home visit for a new patient
99347-99350	Home visit for an established patient
99381-99387	Preventive medicine initial evaluation
99391-99397	Preventive medicine periodic reevaluation
99401-99404	Preventive medicine counseling and/or risk reduction intervention
99406-99407	Smoking and tobacco use cessation counseling visit
99408-99409	Alcohol and/or substance abuse screening and brief intervention
99411-99412	Group preventive medicine counseling and/or risk reduction intervention
99429	Unlisted preventive medicine service
99441-99443	Telephone calls for patient mgmt
99444	Non-face-to-face on-line Medical Evaluation
99495-99496	Transitional Care Management Services
G0008-G0010	Administration of influenza virus, pneumococcal, hepatitis b vaccine
G0396-G0397	Alcohol and/or substance abuse assessment
G0438-G0439	Annual wellness visit, personalized prevention plan of service
G0442	Annual alcohol screening
G0443	Brief behavioral counseling for alcohol misuse
G0444	Annual depression screening
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	Comprehensive assessment of and care planning for pts. requiring chronic care mngm't
G0507	Care management services for behavioral health conditions
G0513-G0514	Prolonged preventive service

ICD-10 Code	Description
Z00	Encounter for general exam without complaint
Z000	Encounter for general adult medical examination
Z0000	Encounter for general adult medical exam without abnormal findings
Z0001	Encounter for general adult exam with 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 with abnormal findings
Z00129	Encounter for routing child health exam without abnormal findings
Z008	Encounter for other general examination
Z014	Encounter for gynecological examination
Z0141	Encounter for routing gynecological examination
Z01411	Encounter for gynecological exam, general, routing with abnormal findings
Z01419	Encounter for gynecologic exam, general, routing without abnormal findings

**17. Q: How should member months (PRAPM106) be calculated in the Payment Arrangement file?**

**A:** PRAPM106 is only 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 reported stratification. This will require identifying the number of members (monthly) served under the payment arrangement model and line of business, for each Contract ID. For example, a comprehensive populated-based payment (Payment Model = 4B) 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 the various payment models may exceed the actual total of unique member months. That is why values A and V for PRAPM103 are required.

**18. Q: What should the Payment Arrangement file look like when submitted?**

**A:** For illustrative purposes, below is an example of the 2019 Payment Arrangement submission. An actual Payment Arrangement file 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 Total Non-Claims Payments
Contract ID	Provider NPI	Provider Tax ID	Last Name	First Name	Entity Type	Line of Business	Payment Model	Perf. Period Start	Perf. Period End	Member Months	Total PC Claims Payments	Total PC Non-Claims Payments	Total Claims Payments	
PR50879	1122334455	123456789	Jones	David	1	COMM	2C	20160101	20161231		0	0	0	30000.00
PR50879	1122334455	123456789	Jones	David	1	COMM	4B	20150701	20160630	10000	0	30000.00	0	50000.00
PR50879	1122334455	123456789	Jones	David	1	COMM	4B	20160701	20170630	30000	0	90500.00	0	160000.00
PR50879	1122334455	123456789	Jones	David	1	COMM	1	20160101	20161231		20000.00	0	80000.00	0
PR50879	1122334455	123456789	Jones	David	1	MADV	1	20160101	20161231		10000.00	0	50000.00	0
PR20003	2435689021	432876543	Smith Pediatrics		2	COMM	1	20160101	20161231		10000.00	0	400000.00	0
PR23634	3725497542	852222534	ABC Health		6	COMM	1	20160101	20161231		320000.00	0	700000.00	0
						COMM	A			2000000				
						MADV	A			130000				
						COMM	V			35000				
						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 row of data, PRAPM106 (member months) is blank because member months do not need to be reported for payment arrangement “2C” (pay for performance).

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

**19. Q: What is the submission schedule for the Payment Arrangement Files?**

**A:** The Payment Arrangement Files shall include all payments related to the provision of care during the Payment Arrangement Submission Performance Period (i.e. the previous calendar year). Mandatory Reporters shall submit the Payment Arrangement Files as specified in the Data Submission Schedule.

**20. Q: What are some of the calculations that OHA will perform using the data submitted in the Payment Arrangement Files?**

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

Primary care spending as a percentage of total spending =

$$\frac{\text{Total Primary Care Claims Payments (PRAPM107)} + \text{Total Primary Care Non-Claims Payments (PRAPM108)}}{\text{Total Claims Payments (PRAPM109)} + \text{Total Non-Claims Payments (PRAPM110)}}$$

Per member per month medical spending for a given line of business =

$$\frac{\text{Total Claims Payments (PRAPM109)}}{\text{Member Months (PRAPM106)}}$$

**21. Q: What is the process for requesting waivers, exceptions and extensions to the Payment Arrangement File submission requirements?**

**A:** Mandatory Reporters may request data element waivers or deadline extensions to the Payment Arrangement File reporting requirements. The form for requesting waivers or extensions is 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 civil penalties if correction does not occur within thirty days.

**22. Q: What is the required file format and naming convention for submission of the Payment Arrangement Files?**

**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 Payment Arrangement files shall use the same SFTP account that is used to submit all other APAC files to the state of Oregon. Please contact Milliman ([oap.medinsight@milliman.com](mailto:oap.medinsight@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:

Payment Arrangement File	<Payer Abbreviation>_<Submitter Abbreviation>_ <b>SupplAPM_Provider</b> _<Submission Month - CCYYMM>_< File Create Date - CCYYMMDD>.dat
Payment Arrangement Control File	<Payer Abbreviation>_<Submitter Abbreviation>_ <b>SupplAPM_ControlTotals</b> _<Submission Month - CCYYMM>_< File Create Date - CCYYMMDD>.dat

Example – For Payer ABCD’s calendar year 2018 Payment Arrangement file, being submitted by ABCD, due 9/30/2019 and created 9/18/2019, the filenames would be:

*ABCD\_ABCD\_SupplAPM\_Provider\_201909\_20190918.dat*

*ABCD\_ABCD\_SupplAPM\_ControlTotals\_201909\_20190918.dat*

For Payer Identifiers, see **2020 Mandatory Reporters and Abbreviations** PDF document on the APAC website

(<https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/APAC-Data-Submissions.aspx>)

**23. Q: How can we ensure that FFS payments that have a link to an APM arrangement are accurately reflected in the data?**

A: Mandatory Reporters may, if they so choose, use the payment arrangement type “1A - FFS with link to APM” to reflect FFS payments that are connected to an APM. This is strictly optional and not required.

**24. Q: How should a mandatory reporter account for services that are associated with multiple APM arrangements?**

A: If a given provider’s services or claims could be included in more than one payment arrangement, the mandatory reporter has discretion as to which arrangement they want to reflect these payments. It is very important that the mandatory reporter not double count any services or claims in the Payment Arrangement file.

For example, a carrier has a fee-for-service arrangement with Dr. Smith with a potential quality bonus. The same carrier also has a shared savings arrangement with a medical group, of which Dr. Smith is a part. When compiling the Payment Arrangement file, the mandatory reporter can choose where to include Dr. Smith’s fee-for-service payments: in the arrangement with a quality bonus or the arrangement with shared savings. The mandatory reporter should use a uniform approach for their file. One approach could be that the mandatory reporter defaults to the payment arrangement that is the most advanced on the HCP-LAN category framework. For the example above, category 3A – shared savings – is more advanced than category 2C – pay for quality.

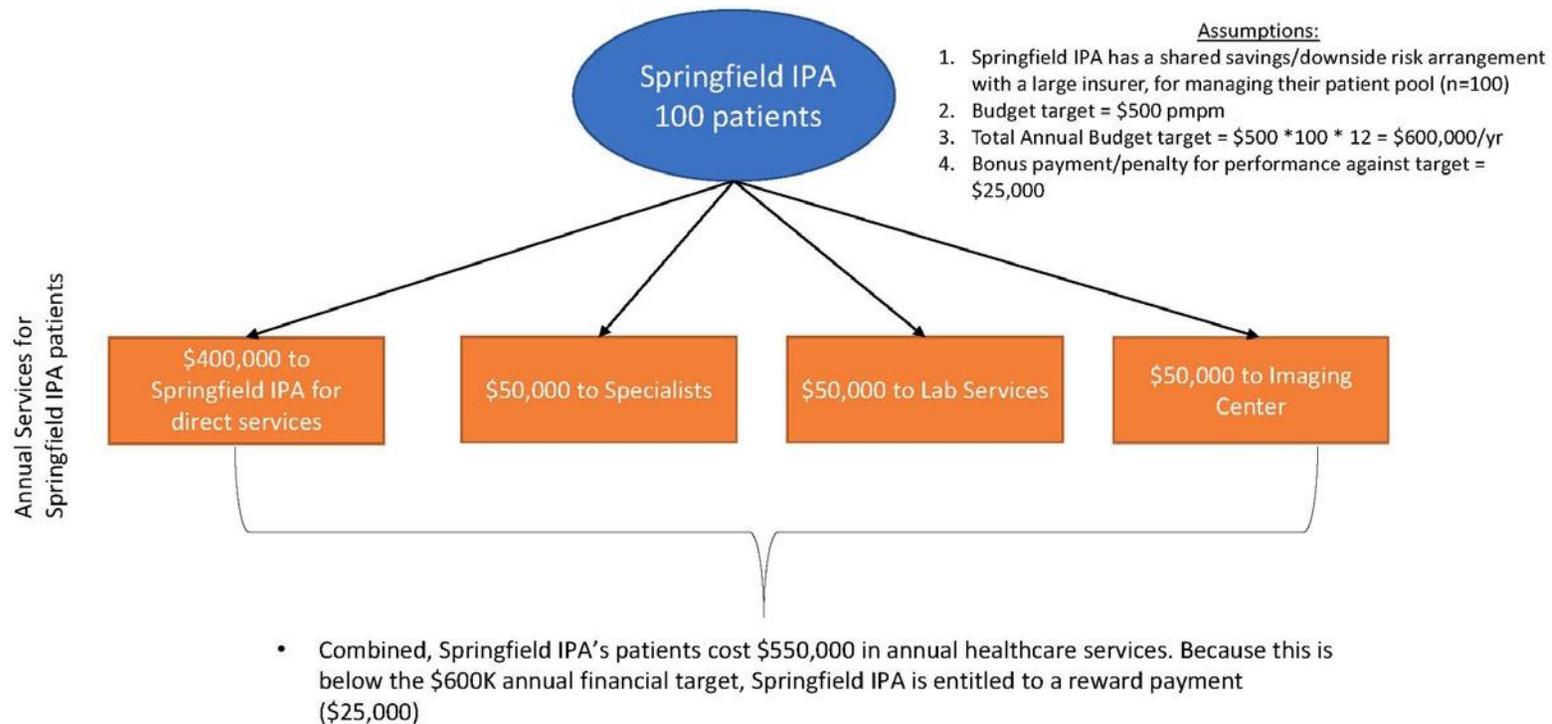
The following question about attribution may in some instances be relevant for this question and answer about multiple APM arrangements.

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The following question (Question #25) only pertains to those Mandatory Reporters who have Payment Arrangements in HCP LAN categories 3 or 4 (shared savings, shared savings with downside risk, condition-specific population-based payments, comprehensive population-based payments, or integrated finance and delivery system payments) and the Mandatory Reporter wants to use a patient attribution logic when accounting for payments associated with these payment arrangements. **This is optional.**

**25. Q: How can we accurately report the relationship between the FFS payments on behalf of a patient or enrollee who is subject to an APM arrangement, the billing provider or entity that receives the FFS payment, and the provider or entity that bears the risk for the APM arrangement that the patient/enrollee is subject to?**

A: Some types of billing provider and entities do not directly enter into alternative payment arrangements with payers, although the services they provide are counted towards the spending (and occasionally utilization) goals of an APM arrangement that another provider or entity has. See below diagram for an example.



In this example, Springfield IPA is responsible for managing the cost of their 100 patients and is given a financial reward (\$25,000) if their patients fall below this PMPM target each year, as part of a Shared Savings/Downside Risk Arrangement. During the year, Springfield IPA’s patients receive care directly from Springfield IPA providers, from other specialists, from a lab services provider, and from an imaging center. All of these services are paid on an FFS basis and are counted towards Springfield IPA’s PMPM target.

To give Springfield IPA credit for bearing the risk for these costs and accurately reflect that these FFS payments have a link to an APM, Mandatory Reporters have the **option** of categorizing these payments as “FFS with Link to APM” (PRAPM103 = 1A). **This designation is entirely up to the Mandatory Reporting entity; it is not required.** In this scenario, all the FFS with Link to APM payments would use the same Contract ID (PRAPM003); the Contract ID for Springfield IPA. The Billing Provider information (NPI, Tax ID, Name, Entity Type) would continue to correlate to the actual billing provider or entity receiving the payment (e.g. Dr. Jones, the specialists, lab services, imaging).

For illustrative purposes, below is an example of the 2019 Payment Arrangement submission reflecting the above example with Springfield IPA. An actual Payment Arrangement file 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
Contract ID	Provider NPI	Provider Tax ID	Last Name or Organization	First Name	Entity Type	Line of Business	Payment Model	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 Springfield IPA's Contract ID	Springfield IPA's NPI	Springfield IPA's Tax ID	Springfield IPA		1	COMM	1A	20180101	20181231		200000	0	400000	0
2 Springfield IPA's Contract ID	Specialist NPI	Specialist Tax ID	Specialist Last Name	Spec. First Name	1	COMM	1A	20180101	20181231		0	0	50000	0
3 Springfield IPA's Contract ID	Lab Services NPI	Lab Services Tax ID	Lab Services Corp.		2	COMM	1A	20180101	20181231		0	0	50000	0
4 Springfield IPA's Contract ID	Imaging Center NPI	Imaging Center Tax ID	Imaging Center LLC		2	COMM	1A	20180101	20181231		0	0	50000	0
5 Springfield IPA's Contract ID	Springfield IPA's NPI	Springfield IPA's Tax ID	Springfield IPA		1	COMM	3B	20180101	20181231			0	0	25000

Some notes on the example above:

Rows 1-4 represent the FFS with Link to APM payments (Payment Model 1A) made on behalf of Springfield IPA’s patients that are included in the APM target (as identified through the Contract ID). The first payment (row 1) is to Springfield IPA itself for services performed directly for their patients, Rows 2-4 represent payments to other providers and entities (as identified through the Provider NPI, Tax ID, Last Name, First Name, Entity Type) for services rendered on *behalf of* Springfield IPA’s patients, and in connection to the APM with Springfield IPA.

Row 5 represents the Shared Savings/Downside Risk payment (Payment Model 3B) that Springfield IPA received for effectively managing the cost of its patients.

We can sum up all payments made to the Contract ID to see the total payments made for the population that Springfield IPA managed. We can also view the payments according to who the dollars actually went to (using the NPI, Tax ID, Last Name, First Name) fields.

**26. Q: Should Mandatory Reporters submit separate Payment Arrangement Files (Appendix 1 & 2) – one for dental payments and another file for medical and other payments?**

A: Yes. Dental payments should be submitted on a separate Payment Arrangement File. File naming convention – for payer ABCD’s calendar year 2019 Payment Arrangement File submission, being submitted by ABCD, due 9/30/2020 and created 9/18/2020, the filenames would be the following:

Appendix 1: ABCD\_ABCD\_DENTALSupplAPM\_DProvider\_202009\_20200918.dat

Appendix 2: ABCD\_ABCD\_DENTALSupplAPM\_DControlTotals\_202009\_20200918.dat

Payment Arrangement File (App1)	<payer abbreviation>_<submitter abbreviation>_DENTALSupplAPM_DProvider_<submission month – CCYYMM>_<file create date – CCYYMMDD>.dat
Payment Arrangement Control File (App2)	<payer abbreviation>_<submitter abbreviation>_DENTALSupplAPM_DControlTotals_<submission month – CCYYMM>_<file create date – CCYYMMDD>.dat

**27. Q: How should Mandatory Reporters deal with payments made directly to subscribers as reimbursements for the subscribers’ cost-sharing (e.g. copays)?**

A: Mandatory Reporters should include these payments in the Payment Arrangement File.

**28. Q: Are dental services included in the definition of primary care?**

A: No, Oregon’s definition of primary care does not include dental or dental-related care. OHA expects that dental carriers would not submit any dollar amounts in the primary care fields in the Payment Arrangement File.

**29. Q: Where can data submitters view data validation checks for the Payment Arrangement Files (Appendix 1 & 2)?**

A: A list of Payment Arrangement Files (Appendix 1 & 2) data validation checks is available. Please contact the APAC program for documentation: [apac.admin@state.or.us](mailto:apac.admin@state.or.us).

**30. Q: How should CCOs reflect payments to health plan partners, who then contract with health care providers?**

A: A CCO may serve as a contracting intermediary between OHA and multiple other Medicaid health plans through contracts with health plan partners (including acute care, dental and behavioral health plans). Payments to health plan partners do not constitute payments to health care providers unless the provider is an integrated finance and delivery system. However, a payment arrangement by a

health plan partner to its provider partners that meets VBP requirements may be included as part of the CCO's VBP report to OHA. This answer is reflected in the OHA CCO VBP Technical Guide (<https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Technical-Guide.pdf>)

**31. Q: OHA modified the CCO Quality Incentive Program in 2020 to focus on pay for reporting as opposed to pay for performance. Do CCOs' pay for reporting payment arrangements count towards the CCO 2.0 VBP targets?**

A: No. Only payment arrangements that are 2C (pay-for-performance) and higher count towards the VBP target percentages. It is worth noting that, for the CCO 2.0 VBP target calculation OHA does not dictate the quality metrics CCOs use with their network nor does OHA specify the quality benchmarks that determine when performance payments need to be made. CCOs may modify the metrics or benchmarks with their network.

**32. Q: How does OHA define "risk"?**

A: To count as LAN Category 3B for OHA reporting, the payment arrangement must include a meaningful level of downside risk to ensure that arrangements put real dollars at risk for a provider. Consistent with the Centers for Medicare and Medicaid Services (CMS) definition of meaningful risk for advanced VBPs under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), OHA requires each of the following three risk-sharing model attributes to be included in payment arrangements for providers:

- Risk exposure cap<sup>1</sup>: at least 3% of expected expenditures (for example, total cost of care for an attributed population) or 8% of payer revenues
- Risk sharing rate<sup>2</sup>: at least 30% of all losses (not just those above the minimum loss rate)
- Minimum loss rate<sup>3</sup>: no more than 4%

Providers may, of course, assume more risk than prescribed by these parameters, and many total cost of care risk-sharing agreements do involve more risk than prescribed by these minimum requirements. This answer is reflected in the OHA CCO VBP Technical Guide (<https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Technical-Guide.pdf>)

For example, a CCO has a shared-savings and shared-risk arrangement (3B) with a provider group and the agreed upon budget is \$5 million. The parties also agreed to a risk exposure cap of 3%, although it could have been higher, and a minimum loss rates of 0%, although it could have been as high as 4%. The risk sharing rate is 40%, although it could have been as low as 30%. The provider group exceeds the budget by incurring \$5,250,000,

<sup>1</sup> The applicable parameter depends on how risk is applied in the provider/payer contract. The revenue-based nominal amount standard, defined by CMS in the paragraph above, is only applicable if financial risk under the payment arrangement is defined in terms of revenue. The risk exposure cap refers to the threshold that defines the maximum potential amount of risk to which a provider could be subjected.

<sup>2</sup> The risk sharing rate refers to how the CCO and providers would share the risk.

<sup>3</sup> This refers to the size of the loss that must be incurred against the budget target before the CCO and provider begin to share the loss.

which is 5% more than the budget of \$5 million. The provider group owes the CCO 40% of the losses, which equals \$100,000. This arrangement qualifies as meaningful risk because the minimum loss rate is no more than 4%, the risk exposure cap is at least 3%, and the risk sharing rate is at least 30%.

	Meaningful Risk Thresholds	Details from example above	Calculation
Risk exposure cap	Must be at least 3% (3%-100%)	3%	$[0.03 * \$5M] = \$150K$  Note: This is the maximum amount the provider will owe the CCO related to downside risk under this contract.
Risk sharing rate	Must be at least 30% (30%-100%)	40%	$[0.4 * \$250K] = \$100K$  This is the amount the provider owes to the CCO based on contract performance.
Minimum loss rate	No more than 4% (0%-4%)	0%	NA; at 0%, any expense above the contract budget triggers downside risk sharing at the contracted risk sharing rate

### 33. Q: How will OHA calculate each CCO's VBP target achievement?

A: The numerator for each CCO's VBP target achievement will be calculated by summing all contracts that have a component that is LAN category 2C or higher. For example, a CCO has a fee-for-service arrangement with a potential quality incentive payment with a provider group. By the end of the contract period the CCO has paid the group \$1 million in fee-for-service and another \$10,000 in quality incentive payments. The CCO's Payment Arrangement File should reflect two separate rows for this contract: one row for the \$1 million payment and a second row for the \$10,000 payments. Both rows should have the same Contract ID. OHA will count the entire \$1,010,000 that the CCO paid as qualifying toward the VBP target because the contract included a component that was 2C or higher. The Payment Arrangement File is the source for calculating each CCO's total VBP spending.

The denominator for each CCO's VBP target achievement will be the value that is in the "Total Medical Expenses" field in the year-end Exhibit L Financial Report, tab L19. Dividing the numerator by the denominator yields the CCO's VBP percentage.