**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 situsedin 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).

| Data Element | Name | Type | Max. length | Required? | Description/valid values | Error Threshold |
|---|---|---|---|---|---|---|
| PRAPM003 | Contract ID | Text | 30<br><br>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.<br><br>If PRAPM103 = A, then leave this field blank<br>If PRAPM103 = V, then leave this field blank | 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<br><br>If PRAPM103 = 2Ai, then report the PCPCH Practice ID in this field<br><br>If PRAPM103 = A, then leave this field blank<br>If PRAPM103 = V, then leave this field blank | 1.0% |
| PRAPM004 | Billing Provider or | Text | 9 | Yes | Federal taxpayer's ID of the billing provider or organization/facility which received the payment from | 1.0% |

| Data Element | Name | Type | Max. length | Required? | Description/valid values | Error Threshold |
|---|---|---|---|---|---|---|
| | Organization Tax ID | | | | the mandatory reporter. Include leading zeros and do not include dashes. Example: 012345678<br><br>If PRAPM103 = A, then leave this field blank<br>If PRAPM103 = V, then leave this field blank | |
| 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<br><br>If PRAPM103 = A, then leave this field blank<br>If PRAPM103 = V, then leave this field blank | 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.<br><br>If PRAPM103 = A, then leave this field blank<br>If PRAPM103 = V, then leave this field blank | 1.0% |
| PRAPM101 | Billing Provider or Organization Entity Type | Text | 2 | Yes | Valid Values:1 – Person, 2 – Facility, 3 – Professional Group, 4 – Retail Site, 5 – E-Site, 6 – Financial Parent, 7 – Transportation, 8 – Other<br>See Lookup Table PRAPM101 (Appendix 1)<br><br>If PRAPM103 = A, then leave this field blank<br>If PRAPM103 = V, then leave this field blank | 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<br>MADV = Medicare Advantage<br>CCO = Medicaid CCOs<br>PEBB = Public Employees' Benefit Board<br>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)<br><br>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.<br><br>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<br><br>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.<br><br>If PRAPM103 = A, then leave this field blank<br>If PRAPM103 = V, then leave this field blank | 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.<br><br>If PRAPM103 = A, then leave this field blank<br>If PRAPM103 = V, then leave this field blank | |
| 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<br><br>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.<br><br>No decimal places; round to nearest integer. Example: 12345<br><br>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.<br><br>Reference OAR 409-025-0100 for the definition of primary care and Lookup Table PRAPM107 for specific taxonomy, procedure code and diagnosis codes used.<br><br>Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care claims payments made. | 1.0% |

| Data Element | Name | Type | Max. length | Required? | Description/valid values | Error Threshold |
|---|---|---|---|---|---|---|
| | | | | | This value should never exceed the amount of Total Claims Payments (PRAPM109).<br><br>If PRAPM103 = A, then leave this field blank<br>If PRAPM103 = V, then leave this field blank | |
| 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.<br><br>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.<br><br>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.<br><br>This value should never exceed the amount of Total Non-Claims Payments (PRAPM110).<br><br>If PRAPM103 = A, then leave this field blank<br>If PRAPM103 = V, then leave this field blank | 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.<br><br>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 claims payments made.<br><br>If PRAPM103 = A, then leave this field blank<br>If PRAPM103 = V, then leave this field blank | |
| 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.<br><br>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<br><br>If PRAPM103 = A, then leave this field blank<br>If PRAPM103 = V, then leave this field blank | 1.0% |
| PRAPM201 | Hospital indicator | Text | 1 | Yes | Payment recipient is a hospital or is known to include a hospital. Valid values: 1 (yes) 0 (no or not known to include hospital) 9 (unknown) | 1.0% |
| 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 delivered by particular types of clinicians (e.g. primary care, orthopedics). |

| Code | Value | Definition/Example |
|---|---|---|
| 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.<br><br>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.<br><br>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.<br><br>Enrollment should only be reported for members in payment categories 2Ai, 4A, 4B, 4C and 4N.<br><br>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.<br><br>This value must be reported only once for every distinct line of business (PRAPM102).<br><br>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.

## Lookup Table PRAPM107: Total Primary Care Claims Payments

Primary care claims payments are payments made to a primary care provider (condition 1) for a primary care service (condition 2). Payments must be to a primary care provider for a primary care service.

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

| Taxonomy code | Description |
|---|---|
| 261QF0400X | Federally Qualified Health Center |
| 261QP2300X | Primary care clinic |
| 261QR1300X | Rural Health Center |
| 207Q00000X | Physician, family medicine |
| 207R00000X | Physician, general internal medicine |
| 175F00000X | Naturopathic medicine |
| 208000000X | Physician, pediatrics |
| 2084P0800X | Physician, general psychiatry |
| 2084P0804X | Physician, child and adolescent psychiatry |
| 207V00000X | Physician, obstetrics and gynecology |
| 207VG0400X | Physician, gynecology |
| 208D00000X | Physician, general practice |
| 363L00000X | Nurse practitioner |
| 363LA2200X | Nurse practitioner, adult health |
| 363LF0000X | Nurse practitioner, family |
| 363LP0200X | Nurse practitioner, pediatrics |
| 363LP0808X | Nurse practitioner, psychiatric |
| 363LP2300X | Nurse practitioner, primary care |
| 363LW0102X | Nurse practitioner, women's health |
| 363LX0001X | Nurse practitioner, obstetrics and gynecology |
| 363A00000X | Physician's assistant |
| 363AM0700X | Physician's assistant, medical |
| 207RG0300X | Physician, geriatric medicine |
| 175L00000X | Homeopathic medicine |
| 2083P0500X | Physician, preventive medicine |
| 364S00000X | Certified clinical nurse specialist |
| 163W00000X | Nurse, non-practitioner |
| 202D00000X | Integrative Medicine Physician |

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**Primary Care Service Table (condition 2 – CPT or ICD)**

| CPT Codes | Description |
|---|---|
| 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, management 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 management |
| 99444 | Non-face-to-face on-line Medical Evaluation |
| 99495-99496 | Transitional Care Management Services |
| 99483 | Cognition and functional assessment |
| 99484 | Care management services for behavioral health conditions |

| | |
|---|---|
| 99492 | Initial psychiatric collaborative care management |
| 99493 | Subsequent psychiatric collaborative care management |

| **CPT codes continued** | **Description** |
|---|---|
| 99494 | Initial or subsequent psychiatric collaborative care management |
| 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 management |

| **ICD-10 Code** | **Description** |
|---|---|
| G0507 | Care management services for behavioral health conditions |
| G0513-G0514 | Prolonged preventive service |
| 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 |

## Appendix 2: Payment Arrangement Control File

| Data Element | Name | Type | Max. length | Required? | Description/valid values | Error Threshold |
|---|---|---|---|---|---|---|
| PRAPMCT101 | Submitted File | Text | 60 | Yes | Data File Name<br>Example:<br>*ABCD_ABCD_SupplAPM_Provider_201609_20160918.dat*<br>. | 0% |
| PRAPMCT102 | Data Rows | Numeric | 10 | Yes | Number of data rows in the submitted file for line of business indicated in PRAPMCT108. | 0% |
| PRAPMCT103 | Member Months | Numeric | 10 | Yes | Sum of member months for line of business indicated in PRAPMCT108.<br>No decimal places; round to nearest integer. Example: 12345 | 0.1% |
| PRAPMCT104 | Total Primary Care Claims Payments | Numeric | 14 | Yes | Sum of Total Primary Care Claims Payments for line of business indicated in PRAPMCT108 | 0.1% |
| PRAPMCT105 | Total Primary Care Non-Claims Payments | Numeric | 14 | Yes | Sum of Total Primary Care Non-Claims Payments for line of business indicated in PRAPMCT108 | 0.1% |
| PRAPMCT106 | Total Claims Payments | Numeric | 14 | Yes | Sum of Total Claims Payments for line of business indicated in PRAPMCT108 | 0.1% |
| PRAPMCT107 | Total Non-Claims Payments | Numeric | 14 | Yes | Sum of Total Non-Claims Payments for line of business indicated in PRAPMCT108 | 0.1% |
| PRAPMCT108 | Line of Business | Text | 4 | Yes | Indicates insurance line of business. Only report the following lines of business using the codes below:<br><br>COMM = Commercial<br>MADV = Medicare Advantage<br>CCO = Medicaid CCOs<br>PEBB = Public Employees' Benefit Board<br>OEBB = Oregon Educators' Benefit Board | 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