CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10802	**Date: May 14, 2021**
	Change Request 11768

NOTE: This Transmittal is no longer sensitive and is being re-communicated. This instruction may now be posted to the Internet. Transmittal 10706, dated March 31, 2021, is being rescinded and replaced by Transmittal 10802, dated, May 14, 2021 to remove the provider education instruction, which was business requirement 11768.43. All other information remains the same.

SUBJECT: Direct Contracting (DC) Model - Professional and Global Options: Total Care Capitation (TCC), Primary Care Capitation (PCC), Advanced Payment Option (APO), Telehealth Expansion, 3-day SNF Rule Waiver, Post-Discharge and Care-Management Home Visits – Implementation

I. SUMMARY OF CHANGES: This change request (CR) is for the purpose of establishing the necessary systems' changes to implement the Direct Contracting (DC) Model, its associated payment waivers, and benefit enhancements.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021 - Analysis, Design, and Some Coding; April 5, 2021 - Complete Coding, Testing, and Implementation

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Attachment - Demonstrations

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I. GENERAL INFORMATION

A. Background: The Direct Contracting (DC) Model creates a new opportunity for the Centers for Medicare & Medicaid Services (CMS) to test an array of financial risk-sharing arrangements, leveraging lessons learned from other Medicare Accountable Care Organization (ACO) initiatives, such as the Medicare Shared Savings Program (SSP) and the Next Generation ACO (NGACO) Model, as well as innovative approaches from Medicare Advantage (MA) and private sector risk-sharing arrangements. As an ACO-like Model, DC allows participating organizations to take on the financial risk for Medicare Part A and B expenditures (all institutional and professional claims) for a defined population of fee-for-service Medicare beneficiaries over a defined period of time (5 years, separated into 1-year increments called Performance Years (PYs)).

The following Model features will be discussed in more detail below:

- Participating organizations, or Direct Contracting Entities (DCEs) (note: in prior Models, these organizations were referred to as 'ACOs'), are legal entities that enter into a contract with CMS to take on financial and outcomes-based risk for the defined population of Medicare beneficiaries.
- DCEs will form partnerships with Part A and B healthcare providers that share financial and medical responsibility for providing coordinated care to the defined beneficiary population. There are two roles (corresponding to degree of partnership with preferred partners having a more limited affiliation) these providers can play: Participant Providers or Preferred Providers. DC defines all professional providers (both Participant and Preferred) by the unique combination of Tax Identification Number (TIN) and Individual National Provider Identifier (NPI) ('TIN-iNPI') and facility providers (both Participant and Preferred) by the unique combination of organizational billing NPI and CMS Certification Number ('oNPI-CCN'). A provider serving as a Participant or Preferred Provider for a DCE is referred to as an 'aligned provider' to that DCE.
- The population of Medicare beneficiaries that a DCE and its Providers will be responsible for (the 'aligned beneficiaries') is defined through a process called 'alignment' in which beneficiaries are identified through one of two methods: 1. Claims-based alignment, in which beneficiaries are aligned if the plurality of their Primary Care services in the past were provided by DCE Participant Providers; and 2. Voluntary alignment, in which beneficiaries can choose to align themselves to a DCE.

<u>Role of the Shared System Maintainers (SSMs)</u>

Under DC, the payment for Medicare services provided to aligned beneficiaries through traditional FFS claims processing rules will remain unchanged. However, DC has built in two types of flexibilities to help DCEs and their providers better coordinated care (note: each is discussed in more detail later in the document):

- Payment Mechanisms (PMs) allow Providers to elect reduced FFS claim payments in return for their DCE receiving predictable prospective monthly payments from CMS that are processed outside of the claims system. These mechanisms function similarly to Population Based Payment (PBP) and AIPBP (All-inclusive) in NGACO. In DC, there are three PMs: Total Care Capitation (TCC), Professional Care Capitation (PCC), and Advanced Payment Option (APO). More discussion of the policy goals and operational details is included below.
- Benefit Enhancements (BEs) are waivers to Medicare payment rules that offer flexibility for care coordination and delivery. They allow beneficiaries to receive services and Providers to receive payments for those services that are not otherwise covered by Medicare under those circumstances. There are four BEs included in this Change Request (CR) (see below for more detail).

The SSMs will receive monthly, full-replacement files that specify the list of 1. beneficiaries (with start and end dates of their alignment to the DCE); 2. providers (with start and end dates of their alignment to the DCE) and each provider's set of PMs and BEs, (with corresponding start and end dates of their participation in each). **Fundamentally, the role of the SSMs in Direct Contracting is to identify when a claim is provided by an aligned Provider to a beneficiary aligned to the same DCE and is subject to a PM or BE, and then apply that PM (i.e., reduce the allowed charges) or BE (i.e., pay the claim that otherwise would be denied) rule accordingly**.

Note that aligned beneficiaries can receive care from unaligned Providers (i.e., providers that have no connection to the DCE). Similarly, aligned Providers will continue to provide care to unaligned beneficiaries. Lastly, not all aligned Providers will participate in all PMs or BEs (more detail on the rules for participation below). In all of these cases, the claims will be handled normally by the FFS claims processing system.

Besides receiving the monthly Beneficiary and Provider lists and processing the PMs and BEs accordingly, **all other Model operations occur outside of the FFS claims system (i.e., no additional requirements will be made of the SSMs or MACs)**. These other functions include: determining Provider eligibility and creating the monthly Provider lists; running claims-alignment and voluntary alignment to determine the aligned beneficiaries and determining eligibility for those beneficiaries; recording whether each Provider participates in each PM or BE, and documenting those choices on the monthly Provider lists; calculating the prospective monthly payments made to DCEs in lieu of the reduced claim payments from the PMs (and making those payments); conducting financial reconciliation to hold DCEs accountable for the Part A and B expenditures for the aligned beneficiaries each PY; etc.

Additional detail on Participant and Preferred Providers

As mentioned above, Participating and Preferred Providers aligned to a DCE bill Medicare for institutional and professional services and are identified by their 'oNPI-TIN' for institutional providers and 'TIN-iNPI' for professional services. The following providers are eligible to serve as Participant or Preferred Providers:

- **Eligible** *(non-exhaustive)*: Physicians or other Practitioners (e.g., Nurse Practitioners) in group practice arrangements, networks of individual practices of physicians or other practitioners, hospitals (acute care, long-term acute care hospitals (LTACHs), psychiatric), Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facility (IRFs), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Critical Access Hospitals (CAHs, Method I and Method II), hospices, home health agencies, laboratories and imaging facilities

- **Ineligible**: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, ambulance suppliers, drug or device manufacturers, providers and suppliers excluded or otherwise prohibited from participation in Medicare or Medicaid

While there is a distinction between Participant and Preferred Providers, this difference will not result in different requirements of the SSMs for this CR. For reference, a summary of the key differences is available in Table 1 of Appendix E.

Typically, Participant and Preferred Providers are aligned for an entire PY (i.e., one calendar year) and those decisions are typically made prior to the start of that PY. However, both Participant and Preferred Providers are able to be added during the year and are able to drop from alignment during the year in increments of one month (i.e., the start of a Provider's alignment will always be the first of the month and the end of a Provider's alignment will always be the end of the month). PMs may only be added prior to the start of the PY, i.e. the initial list of providers who elect FFS reductions can only shrink month-to-month. BEs may be added or removed freely throughout the year depending on the DCE and/or provider's choice.

Additional detail on Aligned Beneficiaries

As mentioned above, beneficiaries will be aligned to a DCE through claims or voluntary alignment. To remain aligned, beneficiaries must also meet both Medicare and DC eligibility requirements. These include continuous enrollment in both Part A and B, not being enrolled in a Medicare health care plan (e.g., MA, Program of All-inclusive Care for the Elderly (PACE)), maintaining residence within the DCE's service area and not moving outside of that service area. Beneficiaries that lose eligibility during the year are de-aligned from the DCE from that point forward in minimum increments of one month, but are not retroactively removed and may not be added back in subsequent months. For example, a beneficiary that is aligned to a DCE starting January 1st of a PY and then moves outside of the DCE's service area on March 15 will be de-aligned from that DCE starting April 1st and will maintain alignment for January through March.

Importantly, beneficiary eligibility information can sometimes become known and reflected in the Medicare Enrollment Database (EDB) and Integrated Data Repository (IDR) several months after a change occurs. In the previous example, the SSMs may not have learned that the beneficiary moved from the DCE's service area until June, and as such, a claim with date of service (DOS) in April would be submitted and processed based on the April alignment files, which would be revised the subsequent month.

For issues strictly of Model eligibility, however, (like moving out of the service area), this CR includes instructions for how to handle such beneficiaries' claims, but identifying these conditions will not be required of the SSMs. Generally speaking, DC's policy is to re-process claims subject to PMs (i.e., pay the full allowed charges for a claim that was originally reduced when first adjudicated) but not to re-process claims subject to BEs (i.e., do not subsequently deny a claim that was originally paid).

Additional detail on Payment Mechanisms

As described above, DC is providing DCEs flexibility in how Participant and Preferred Providers participating in PMs are compensated. By converting reimbursement that would normally be distributed through the FFS claims processing system into predictable monthly payments to participants, DCEs will have greater leverage to enter into downstream payment arrangements with their aligned providers and can incent them to work together and coordinate care for their aligned beneficiaries, with the potential to generate better outcomes and lower costs.

Each DCE must choose one of two Payment Mechanisms:

- Total Care Capitation (TCC): monthly capitation payments for all institutional and professional services covered under the Model furnished to aligned beneficiaries where participant providers and

suppliers agree to a 100% claims reduction, and preferred providers and suppliers may elect a claims reduction between 1% and 100%. This is equivalent to NGACO's AIPBP.

- Primary Care Capitation (PCC): monthly capitation payments for a limited set of institutional and professional services furnished to aligned beneficiaries where participant providers and suppliers and preferred providers and suppliers elect a claims reduction between 1% and 100%.

    - Advanced Payment Option (APO): DCEs that elect PCC are also able to choose APO which is complementary to PCC since it functions similarly but applies to all institutional and professional services **not** covered by PCC.
- As stated in the bullet above, PCC and APO are complementary, but how they are defined (i.e., what is considered PCC vs APO) differs for professional and institutional claims:

    - Professional claims - PCC vs APO: this determination is made at the claim line level. All services at the claim line level are subject to PCC if 1. The service billed is one of the CPT/HCPCS codes in Table 1 of Appendix C; **and** 2. The claim's rendering provider's specialty code is one of the specialties listed in Table 2 of Appendix C. All other services are subject to APO (i.e., any CPT/HCPCS code **not** included in Table 1, or any CPT/HCPCS code included in Table 1 if the claim specialty code is **not** included in Table 2 of Appendix C). For reference, a summary of the key differences is available in Table 2 of Appendix E.
    - Institutional claims – PCC vs APO: this determination is made at the claim-header level. All services provided by FQHCs or RHCs are subject to PCC, whereas all services provided by all other institutional providers are considered APO. For reference, a summary of the key differences is available in Table 3 of Appendix E.
- In addition, due to the challenges in implementing the payment reduction on institutional claims, i.e. claims cannot be reduced at the claim-line level, and the distinct billing requirements of FQHCs, RHCs, and CAH Method 2 facilities, payment reductions on institutional claims have special requirements listed below and to Table 3 of Appendix E:
    - All payment reductions on institutional claims shall be made using the claim's TIN-organizational (billing) National Provider Identifier (oNPI) and CMS Certification Number (CCN) (TIN-oNPI-CCN)
    - All institutional providers may elect TCC which shall be applied to all institutional claims billed by the TIN-oNPI-CCN
- Finally, claims where a beneficiary has opted out of data sharing or that are related to alcohol and substance-abuse treatment shall not be reduced by the Payment Mechanisms, and shall not be shared in the weekly pass-through file. This policy is in compliance with Substance Abuse and Mental Health Services Administration (SAMHSA) regulations for DC beneficiaries and legally binding agreements between the DCEs and Medicare. Claims, however, will not be retroactively adjusted to reflect this information. For example, claims for beneficiaries who opt-out of data sharing during the PY will not be shared or reduced prospectively, however, no claims for these beneficiaries will be adjusted retrospectively to reflect this change

Similar to how PBP and AIPBP function in NGACO, these Payment Mechanisms result in monthly payments from CMS (the Innovation Center) to the DCE, which then reimburses its providers based on their downstream arrangement, and payments through the claims systems are reduced to those providers. Providers who do not have an agreement with the DCE, will continue to receive normal FFS reimbursements for all the beneficiaries they treat, including aligned beneficiaries. For additional information regarding these payment mechanisms, see the attached White Paper in Appendix A or refer to Table 4 of Appendix E.

Additional detail on Proposed Coverage Benefit Enhancements

DC will offer six coverage BEs, four currently provided in the NGACO Model (Telehealth Expansion, 3-Day SNF Rule Waiver, Post-Discharge Home Visits, and Care Management Home Visits) and two additional BEs that have not yet been implemented in any prior model (Homebound Home Health Waiver

and Concurrent Care for Beneficiaries that Elect the Medicare Hospice). For summary information regarding new coverage BEs, please refer to Table 5 of Appendix E or CR 11863. Please note that these latter two BEs will not be activated by CR 11768.

- Telehealth Expansion - DCEs will have the option to participate in this waiver, which expands current telehealth services to include asynchronous (also known as "store-and-forward") telehealth in the specialties of dermatology and ophthalmology for both new and established patients, eliminates the rural geographic component of originating site requirements, and allows the originating site to include a beneficiary's home.
- 3-Day SNF Rule Waiver - DCEs will be offered a waiver of the three-day inpatient stay requirement prior to admission to participating SNF or acute-care hospitals or CAHs with swing-bed approval for SNF services.
- Post-Discharge Home Visits - DCEs can participate in waivers to allow payment for certain home visits furnished to non-homebound aligned beneficiaries by auxiliary personnel (as defined in 42 C.F.R. § 410.26(a)(1)) under general supervision, rather than direct supervision, incident to the professional services of physicians or other practitioners in DC.
- Care Management Home Visits - DCEs can participate in waivers to allow payment for certain home visits to aligned beneficiaries proactively and in advance of potential hospitalization.
- **(NEW)** Homebound Home Health Waiver – DCEs will be able to participate in a waiver to allow payment for certain home health services for beneficiaries that are not homebound (see CR 11863 for detail).
- **(NEW)** Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit – DCEs will be able to participate in a waiver to allow payment for certain curative or conventional care services for beneficiaries who elect hospice beyond Traditional Medicare (see 11863 for detail).

As mentioned above, the SSMs are being directed to pay claims subject to the six coverage BEs listed above when the claim is for a service provided to an aligned beneficiary by a Provider aligned to the same DCE (during dates when both are eligible and actively aligned) that is participating in the relevant BE.

For reference, the list below provides a high-level outline of the sections that make up CR 11768:

1. DC program setup, relevant file, transfer process, and testing requirements
2. DC demo code precedence rules:
3. Overview of payment mechanisms/BEs and claims eligible for reduction
4. Conditions for the implementation of PMs and sequence
5. The downstream flow of Payment Mechanism data
6. Sequestration requirements
7. Inpatient and home health related requirements
8. BE processing
9. PM and BE reprocessing
10. Weekly Reduction extract and data flows

Finally, there are several attachments referenced within this CR listed below that are available in the Transmittals. Any changes to tables in Appendixes B, C, or D during the implementation of the DC Model shall be updated through a recurring CR.

- Appendix A – White Paper
- Appendix B – Alcohol and Substance Abuse Code Codes
- Appendix C – Primary Care Capitation Codes and Provider Specialty Codes
- Appendix D – Telehealth, Post-discharge Home Visits, and Care Management Home Visit Codes
- Appendix E – Background Artifacts
- Appendix F – Bene_Provider Test Data Collection_Template

- Appendix G – CMMI Fee-For-Service (FFS) Shared System Maintainer (SSM) and the Accountable Care Organization - Operational System (ACO-OS) Interface Control Document (ICD)

B. Policy: Section 1115A of the Social Security Act (the Act) establishes CMMI to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries' care. Section 1115A(d)(1) of the Act authorizes the Secretary to waive such requirements of Title XVIII of the Act as may be necessary solely for purposes of carrying out the testing by CMMI of certain innovative payment and service delivery models, including the DC Model.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
11768.1	Contractors shall prepare their systems to process DC institutional and professional claims on or after April 1, 2021.					X	X		X	
11768.2	Contractors shall use Medicare Demonstration Special Processing Number, (demo code herein), '92' to identify DC claims.					X	X		X	BCRC, HIGLAS, IDR, NCH
11768.3	The Contractor shall modify consistency edit '0014' to include demo code '92' as a valid demo code when received on an Inpatient/Skilled Nursing Facility Claim Record (HUIP), Outpatient Claim Record (HUOP), Home Health Claim Record (HUHH), Hospice Claim Record (HUHC), and Part B Claim Record (HUBC).								X	
11768.4	The ACO-OS Contractor shall transmit a recurring Provider Alignment File to Multi-Carrier System at the Perspecta Virtual Data Center (VDC). This file is referred to as the *ACO-OS to Part A/Part B Direct Contracting Provider Record Detail* in Table 57 of the ICD. **Note:** • **The Provider Alignment File will be sent on a monthly basis initially beginning on or about March 2021, but based on business need, an ad-hoc file may be sent more frequently, e.g. weekly, biweekly, etc.**						X			ACO OS, CMS, VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11768.4.1	Contractors shall be prepared to accept the data elements on the initial Provider Alignment File for each DCE.					X	X			
11768.4.2	MCS shall send the Fiscal Intermediary Standard System (FISS) the Provider Alignment File records for providers that submit institutional claim forms, i.e. records that do not have a participant Tax Identification Number (TIN).						X			
11768.4.3	SSMs shall plug unique identifiers on the transmit record for Common Working File (CWF) when a claim adjustment is initiated due to a beneficiary or provider alignment file update. Please refer to BR.39.1 for more detail.					X	X			
11768.5	The ACO-OS Contractor shall transmit a recurring Beneficiary Alignment File to the CWF at the CWF HP Host. This file is referred to as the *Direct Contracting Beneficiary Record Detail* in Table 51 of the ICD. **Note:** • **The DC record identifier is "DTL_BEN."** • **The Direct Contracting Entity (DCE) Identifier field will identify the DCE to which the beneficiary is aligned.** • **The Beneficiary Alignment File will be sent on a monthly basis beginning on or about March 2021, but based on business need, an ad-hoc file may be sent more frequently, e.g. weekly, biweekly, etc.**								X	ACO OS, CMS, VDC
11768.5.1	CWF shall provide the Beneficiary Alignment File with the most current Health Insurance Claim Number (HICN) to the Perspecta VDC for MCS and FISS to receive.					X	X		X	VDC
11768.5.2	The Contractor shall modify Accountable Care Organization Beneficiary (ACOB) File and online Health Insurance Master Record (HIMR) Display to include the new DC Model based on the updated								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Beneficiary Alignment File and the new identifier.									
11768.6	Contractors shall maintain an update date in their internal file which will reflect the date the updated Provider Alignment and Beneficiary Alignment Files were loaded into the SSMs. The field shall be viewable to the MACs.						X		X	
11768.6.1	Contractors shall process the updated Provider Alignment and Beneficiary Alignment Files as full replacement files.					X	X		X	STC
11768.7	Contractors shall perform limited testing to ensure the file is well-formed prior to production. Contractors shall reference Tables 49-54 for beneficiary-related information and Table 55-60 for provider-related in the ICD. For example, the following validation checks shall be performed on the Provider and Beneficiary Alignment File to ensure: • The Header Record is present and fields populated with valid information; • The Trailer Record is present and fields populated with valid information; and • The actual count of Detail Records matches the Detail Record Count in the File Trailer record.					X	X		X	STC
11768.7.1	Contractors shall modify current response file to acknowledge receipt of the Beneficiary Alignment File and send a response via Exchange File Transfer (EFT). Please refer to Tables 49 – 54 in the ICD.								X	STC
11768.7.2	Contractors shall produce a response file that indicates specific records and fields that did not pass the validation checks by using defined error codes if any errors are encountered. The response file will be sent via EFT. Contractors shall refer to Table 79 in the ICD for the relevant error codes.						X		X	STC
11768.8	The ACO-OS shall send the Beneficiary and Provider Alignment test file to the VDCs, and transmit the test file to the MACs one month prior to production installation, on or about March 1st, 2021.	X	X							CMS, VDC
11768.8.1	The ACO-OS shall send the Beneficiary and Provider Alignment test file to the STC two months prior to									CMS, VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	production installation, on or about February 1st, 2021.									

11768.8.2	The Single Testing Contractor (STC) and the MACs shall provide to CMS the data to create the test file by December 31st, 2020. To assist with the creation of the test file, the STC and MACs shall:
	
	• Provide a list of at a minimum 5 to 15 providers as indicated by TIN-oNPI-CCN for Part A MACs and TIN-iNPI for Part B MACs
	• Provide a list of 5 to 15 beneficiaries as indicated by their HICN/MBI
	• These sample Providers and Beneficiaries shall be provided in a spreadsheet file using Appendix F, Bene_Provider Test Data Collection_Template.
	• Send encrypted data to:
	  • Yani Mellacheruvu (CMS/OIT) at Yani.Mellacheruvu@cms.hhs.gov AND
	  • Aparna Vyas (CMS/OIT) at Aparna.Vyas@cms.hhs.gov
		X	X							ACO OS, STC

11768.8.3	Impacted parties will make themselves available for up to 3 calls during the User Acceptance (UAT) to discuss any testing issues.* **Note:** • Issues that arise during the testing period should be addressed during the monthly CMMI FFS Working Group (FWG) or via a Quality Control Number (QCN).	X	X			X	X		X	CMS, VDC
11768.9	The Contractors shall create/modify on-line screens to display Provider Alignment File data to include file update history.					X	X			
11768.9.1	The Contractors shall create/modify online screens to display Beneficiary Alignment File data to include file update history.					X	X			
11768.10	The Contractors shall utilize the online table of alcohol and substance abuse Healthcare Common	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Procedure Coding System (HCPC) codes and/or Internal Classification of Disease 10 diagnosis/procedure codes that is maintained by the A/B MACs based on Tables 1 – 3 in Appendix B**.** • Table 1: CPT Codes are identified at the claim-line level for professional claims **only** • Table 2: ICD-10-PCS Codes are identified at the claim-header level for institutional claims **only** • Table 3: ICD-10-CM Codes are identified at the claim-line level for professional claims and claim-header level for institutional claims									
11768.10.1	CMS shall create a recurring CR to update changes to tables found in Appendix B (Alcohol and Substance Abuse Codes), Appendix C (Primary Care Capitation Codes and Provider Specialty Codes), or Appendix D (Telehealth Post-discharge Home Visits and Care Management Home Visit Codes).									CMS
11768.11	The Contractors shall follow these demo code precedence rules for deciding the position of demo code "92" on an institutional or professional claim: • If demo code '86', (Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)), is present in the first position on the claim, move demo code '92' to the first position, and move the remaining codes down one position. **DC has precedence.** • If demo code '75', (Comprehensive Care for Joint Replacement (CJR)), is present in the first position on the claim, move demo code '92' to the first position, and move the remaining codes down one position. **DC has precedence** • If demo code '92' is in the first position, and demo code '94', (End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model) is present on the claim, move demo code '94' to the first position, and move the remaining demo codes down one position. **ETC has precedence.** • If demo code '92' is in the first position, and demo code '87', (Radiation Oncology (RO)					X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Model), is present on the claim, move demo code '87' to the first position and move the remaining demo codes down one position. **RO has precedence.** • If the claim- or claim-line includes the Oncology Care Model (OCM) Monthly Enhanced Oncology Service's (MEOS) HCPCS codes G9473 or G9678 with a From date or DOS from 04/01/2021 to 06/30/2022, the claim should be excluded. **The DC demo code should not be appended.** **Note**: • **CMS has proactively identified the models that we believe could overlap with the DC Model. As models retire or emerge this list will be updated.**									
11768.11.1	The Contractors shall follow these demo code precedence rules for deciding the position of demo code "92" on an institutional or professional claim: • If demo code '92' is in the first position, and demo code '31', (Veteran's Medicare Remittance Advice (VA MRA) project), is present on the claim, move demo code '31' to the first position and move the remaining demo codes down one position. **VA MRA has precedence.** • If the claim is a Home Health Request for Anticipated Payment claim (Type of Bill 322), the claim is ineligible for the demo code '92'.					X	X			
11768.12	Contractors shall process professional and supplier claims and append demo code '92' as DC claims when: • The claim-line has an aligned provider (Billing TIN – rendering provider NPI (TIN-iNPI)) AND						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The claim-line has a beneficiary aligned to the same DC Entity Identifier as the provider AND • The DOS on the claim is on or within the Beneficiary's Effective Start Date and the Beneficiary's Effective End Date with that DC Entity as indicated on the ACOB Auxiliary File AND • The DOS on the claim-line is on or within the Provider's Effective Start Date and Provider's Effective End Date of affiliation with that DCE* **Note: *** • **For physician / supplier claims, the claim detail rendering provider is used for this evaluation. The demo code is appended if at least one claim-line meets the criteria.**									
11768.12.1	The Contractor shall return as unprocessable an incoming claim if the provider appends a demo code of '92' in Item 19 of the CMS-1500 or its electronic equivalent, 2300 Loop REF Segment 'Demonstration Project Identifier' (REF01=P4 and REF02=92). The Contractor shall use the following messages: • CARC 132 – "Prearranged demonstration project adjustment." • RARC: N763 - "The demonstration code is not appropriate for this claim; resubmit without a demonstration code. • Group Code: CO (Contractual Obligation)		X							
11768.12.2	Contractors shall process institutional claims and append demo code '92' as DC claims when: • The claim-header has an aligned provider (using the oNPI-CCN) AND • The claim-header has a beneficiary aligned to the same DC Entity Identifier as the billing provider AND • The From date on the claim-header is on or within the Beneficiary's Effective Start Date and the Beneficiary's Effective End Date with					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	that DC Entity as indicated on the ACOB Auxiliary File AND • The From date on the claim-header is on or within the Provider's Effective Start Date and Provider's Effective End Date of affiliation with that DCE **Note:** • The DC Entity Identifier is DXXXX.									
11768.12.2.1	Contractors shall return to provider an incoming claim if the provider appends demo code '92' in the Form Locator 63 Treatment Authorization Code of the CMS-1450 or its electronic equivalent, 2300 Loop REF Segment 'Demonstration Project Identifier' (REF01=P4 and REF02=92).	X				X				
11768.12.3	The Contractor shall follow NGACO processing rules and systematically remove Value Code Q0 and/or a Q1 on an incoming Institutional claim if the provider appends either to the claim. **Note:** • **Q0 represents the amount Medicare would have paid prior to the reduction.** • **Q1 represent the actual reduction amount.**	X				X				
11768.13	The Contractor shall bypass edit 61#E when: • Demo code '92' is present on the claim-detail AND DOS is on or after April 1, 2021								X	
11768.14	Contractors shall note that: • All provider types, i.e. Participant, Preferred Providers, and Affiliates, can have multiple BEs which may each have different effective start and end dates. • Providers may have one of four combinations of payment mechanisms: TCC alone, PCC alone, PCC and APO, or APO alone (note: a					X	X			IDR, STC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	single provider may not elect both TCC and APO or both TCC and PCC). • These Payment Mechanisms are mutually exclusive for professional claims. While a professional Provider/Supplier can participate in ('elect') both APO and PCC, only one of the two will apply to a single claim detail / claim-line. • PCC or BE indicator '8' (PCC) is a new indicator for DC. • Certain institutional claims and TOBs have restrictions on PCC and APO.									
11768.14.1	Contractors shall not apply the claims reduction or carry the BE indicator of '1', '5', or '8' when an alcohol and/or substance abuse procedure or diagnosis code found in Tables 1 – 3 of Appendix B is present on the claim-header or claim-line. • Table 1: CPT Codes are identified at the claim-line level for professional claims **only** • Table 2: ICD-10-PCS Codes are identified at the claim-header level for institutional claims **only** • Table 3: ICD-10-CM Codes are identified at the claim-line level for professional claims and claim-header level for institutional claims					X	X			
11768.14.1.1	Contractor shall not apply the DC adjustment for BE indicators '1', '5', or '8', (APO, TCC, or PCC), for Provider's who have elected to receive Periodic interim payments (PIP) on institutional claims.					X				
11768.14.1.2	Contractors shall not apply the DC adjustment for BE indicators '1', '5', or '8', (APO, TCC, or PCC), to institutional or professional health professional shortage area (HPSA) payments.					X	X			
11768.14.1.3	The Contractor shall not apply the payment reduction for BE indicators '1', '5', or '8', (APO, TCC, or PCC), to institutional claims with inpatient hospital add on payment value codes 17, 18, 19, 77 and Q7 for claims with From dates on or after 04/01/2021.*					X				PS&R

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Note: * • **17 = Operating Outlier Amount** • **18 = Operating Disproportionate Share Hospital Amount (DSH)** • **19 = Operating Indirect medical education on Unibill (IME)** • **77 = Medicare new technology add-on payment** • **Q7 = Islet Isolation Add-on payment amount**									
11768.14.1.3.1	The Contractor shall apply DC adjustment for BE indicators '1', '5', or '8', (APO, TCC, or PCC), to add on payments in BR.14.1.3 for all other Types of Bill except inpatient hospital (TOB 011x)					X				PS&R
11768.14.1.4	The Contractor shall update Edit 46#7 to bypass for demo code '92'.								X	
11768.14.1.5	SSMs shall not reduce the amount being sent to Medicare Secondary Payer Payment (MSPPAY) Module.					X	X			
11768.14.1.5.1	SSMs shall send the actual savings amount (not reduced) to the MSP savings report.					X	X			
11768.14.1.6	Contractor shall not apply DC adjustment for BE indicators '1', '5', or '8', (APO, TCC, or PCC) OR share claims in the Weekly TCC/PCC/APO Reduction File if the Beneficiary Data Sharing Preference Indicator is set to 'N'. Contractors shall share a beneficiary's data when the Beneficiary Data Sharing Preference Indicator is set to 'Y'.					X	X		X	
11768.15	The Contractor shall define an aligned provider using the Billing TIN – individual, rendering provider's NPI (iNPI) combination to apply the payment mechanisms, (BE indicators '1', '5', or '8') for professional claims.						X			
11768.15.1	If the aligned professional/supplier Provider elected BE indicator '1' (APO), then the Contractor should apply percentage reduction to the claim-line						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(professional) where: • The claim-line rendering provider **specialist is not** one of the Primary Care Specialist codes in Table 2 or has one of the Primary Care Specialist codes in Table 2, but does not have a Primary Care Based Service Code in Table 1 of Appendix C (i.e., the service is a **not a** PCC-eligible service) AND • The claim-line includes an aligned provider* AND • The claim-line includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The DOS on the claim-line is on or within the Beneficiary's Effective Start Date and the Beneficiary's Effective End Date as indicated on the ACOB Auxiliary File AND • The DOS on the claim-line is on or within the Provider's Effective Start Date and Provider's Effective End Date. **Note: *** • **For physician/supplier claims, the claim detail rendering provider is used for this evaluation. The demo code is appended if at least one claim detail line meets the criteria.**									
11768.15.2	If the aligned professional/supplier Provider elected BE indicator '5' (TCC), then the Contractor should apply percentage reduction to the claim-line (professional) where: • The claim-line includes an aligned provider AND • The claim-line includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The DOS on the claim-line is on or within the Beneficiary's Effective Start Date and the Beneficiary's Effective End Date as indicated on the ACOB Auxiliary File AND						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The DOS on the claim-line is on or within the Provider's Effective Start Date and Provider's Effective End Date.									
11768.15.3	If the aligned professional/supplier Provider elected BE indicator '8' (PCC) and not BE indicator '1' (APO) (i.e., the only Payment Mechanism the Provider elects is PCC), then the Contractors should apply BE indicator '8' reduction amount to every claim-line (professional) where: • Present on the claim-line is one of the CTP/HCPCS codes in Table 1 **and** the rendering provider has one of the Primary Care Specialist codes in Table 2 of Appendix C, (i.e., the service is a PCC-eligible service) AND • The claim-line includes an aligned provider AND • The claim-line includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The DOS on the claim-line is on or within the Beneficiary's Effective Start Date and the Beneficiary's Effective End Date as indicated on the ACOB Auxiliary File AND • The DOS on the claim-line is on or within the Provider's Effective Start Date and Provider's Effective End Date.						X			
11768.15.4	If the aligned professional/supplier Provider has elected both BE indicator '8' (PCC) AND BE indicator '1' (APO) (i.e., the Provider elects both PCC and APO), then: The contractor shall first, apply BE indicator '8' (PCC) percentage reduction to the claim-line (professional) where: • Present on the claim-line is one of the CTP/HCPCS codes in Table 1 **and** the rendering provider has one of the Primary Care Specialist codes in Table 2 of Appendix C, (i.e., the service is a PCC-eligible service) AND						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The claim-line includes an aligned provider AND • The claim-line includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The DOS on the claim-line is on or within the Beneficiary's Effective Start Date and the Beneficiary's Effective End Date as indicated on the ACOB Auxiliary File AND • The DOS on the claim-line is on or within the Provider's Effective Start Date and Provider's Effective End Date.									
11768.15.5	The contractor shall first, apply BE indicator '8' (PCC) percentage reduction to the claim-line (professional) as outlined in BR 15.4: And then, apply BE indicator '1' (APO) percentage reduction to the claim-line (professional) where: • The claim-line rendering provider **specialist is not** one of the Primary Care Specialist codes in Table 2 or has one of the Primary Care Specialist codes in Table 2, but does not have a Primary Care Based Service Code in Table 1 of Appendix C (i.e., the service is a **not a** PCC-eligible service) AND • The claim-line includes an aligned provider AND • The claim-line includes an aligned beneficiary to the same DC Entity Identifier as the provider* AND • The DOS on the claim-line is on or within the Beneficiary's Effective Start Date and the Beneficiary's Effective End Date as indicated on the ACOB Auxiliary File AND • The DOS on the claim-line is on or within the Provider's Effective Start Date and Provider's Effective End Date. **Note:** • **BR 14.4 was split due to character limits in eCHIMP.**						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11768.16	The Contractor shall define an aligned provider using the oNPI-CCN to apply the payment mechanisms, (BE indicators '1', '5', or '8') for institutional claims.					X				
11768.16.1	Excluding TOB 77x (FQHCs) and 71x (RHCs) claims, if the aligned institutional Provider elected BE indicator '1' (APO), then the Contractor should apply percentage reduction to the claim-header (institutional) where: • The claim-header includes an aligned provider AND • The claim-header includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The From date on the claim-header is on or within the Beneficiary's Effective Start Date and the Beneficiary's Effective End Date as indicated on the ACOB Auxiliary File AND • The From date on the claim-header is on or within the Provider's Effective Start Date and Provider's Effective End Date.					X				
11768.16.2	If the aligned institutional Provider elected BE indicator '5' (TCC), then the Contractor should apply percentage reduction to the claim-header (institutional) where: • The claim-header includes an aligned provider AND • The claim-header includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The From date on the claim-header is on or within the Beneficiary's Effective Start Date and the Beneficiary's Effective End Date as indicated on the ACOB Auxiliary File AND • The From date on the claim-header is on or within the Provider's Effective Start Date and Provider's Effective End Date.					X				
11768.16.3	If the aligned institutional Provider elected BE indicator '8' (PCC) (i.e., the only Payment Mechanism					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the Provider elects is PCC), then the Contractors should apply BE indicator '8' reduction amount to the claim-header (institutional) where: • The claim's TOB is 77x or 71x* AND • The claim-header includes an aligned provider AND • The claim-header includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The From date on the claim-header is on or within the Beneficiary's Effective Start Date and the Beneficiary's Effective End Date as indicated on the ACOB Auxiliary File AND • The From date on the claim-header is on or within the Provider's Effective Start Date and Provider's Effective End Date. **Note: *** • **The PCC reduction is only applicable for FQHC and RHC facilities billing institutional claims and applies to all services billed.**									
11768.17	Contractors shall use the payment amount after applying the DC BE indicators '1', '5', or '8' for recoupment purposes, where recoupment is applicable.	X	X							
11768.18	Contractors shall use the payment amount after applying the DC BE indicators '1', '5', or '8', (APO, TCC, or PCC), for 1099 reporting purposes.	X	X							
11768.19	Contractors shall send fields related to the DC APO, TCC, and PCC, (BE indicators '1', '5', or '8'), reductions and value codes to support the Provider Statistical and Reimbursement (PS&R) reporting.					X				PS&R
11768.20	For all claims with the DC reduction applied, i.e. BE indicators '1', '5', or '8', Contractors shall use the following messages: • Claims Adjustment Reason Code (CARC): 132 "Prearranged demonstration project adjustment."	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Remittance Advice Remark Code (RARC): N83: "No appeal rights. Adjudicative decision based on the provisions of a demonstration project." • Group Code: CO (for contractual obligation)									
11768.21	CWF shall allow for the possibility of demo code '92' to be selected for the COBA claims crossover process, i.e. it shall not by-pass these demonstration claims if the claim carries either coinsurance or deductible amounts. Normal COB processing rules will apply to claims with demo code '92' appended.								X	BCRC
11768.21.1	The SSMs shall ensure that demo code '92' is included on all outbound 837 crossover claims transmitted to the COB Contractor (COBC) shall balance in accordance with Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 837 version 5010 requirements.					X	X			BCRC
11768.21.2	The Contractors shall calculate coinsurance and deductible amounts for claims with demo code '92' present in the same manner as they would in the absence of the demonstration, i.e. based on the amount Medicare would have paid in the absence of the demonstration.					X	X			BCRC
11768.22	Contractors shall report all claims paid under DC Model on the provider Remittance Advice (RA) together with all FFS claim payments.					X	X			
11768.22.1	Contractors shall show the final payment amount and the reduction amount for claims where the Provider's BE indicators '1', '5', or '8' was applied to the claim on all RAs created.					X	X			
11768.22.2	The Contractor shall modify the Standard Paper Remittance (SPR) and PC-Print to rename Population Based Payment (PBP) and AIPBP fields. **Note:** • **APO = Advanced Payment Option** • **PCC = Primary Care Capitation** • **TCC = Total Care Capitation**					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11768.23	Contractors shall ensure that the MSN will show the amount that would have been paid if not for the Provider's APO, TCC, or PCC reduction as the provider paid amount, i.e. BE indicators '1', '5', or '8'.					X	X			
11768.23.1	Contractors shall ensure the amount in the, *"Maximum You May Be Billed,"* section reflects the Beneficiary's liability prior to the DC APO, TCC, or PCC reduction, i.e. BE indicators '1', '5', or '8'.					X	X			
11768.23.2	Contractors shall display the full allowed amount on the MSN when TCC or PCC reduction is 100 percent, i.e. BE indicators '5' or '8'.					X	X			
11768.24	Contractors shall pass the payment amount after applying the BE indicators '1', '5', or '8' to the Healthcare Integrated General Ledger Accounting System (HIGLAS).					X	X			
11768.25	Contractors shall apply any clean claim interest payments based off the amount after applying the DC Reduction for claims with the BE indicators '1', '5', or '8'. The clean claim interest calculation will occur after the application of the reduction.					X	X			
11768.26	Contractors shall calculate 1) the total allowed charges (after Traditional FFS processing); then 2) apply the sequestration adjustment; 3) then apply the DC reduction for claims when: • The Provider has BE indicators '1', '5', or '8' identified on the Provider Alignment File.					X	X			
11768.27	The Contractor shall continue to apply sequestration to the value code amounts. (Note: The value codes on the face of the claim should continue to show the full amount before Sequestration, the reduction should occur in the background, except for Home Health (HH) claims.					X				PS&R
11768.27.1	Contractors shall reduce the Home Health PPS claim value codes 64, 65 and 17 where the BE indicator '1',					X				PS&R

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	'5', or '8' and the adjustment is less than 100% after Sequestration is applied .* **Note: *** • **17 = Operating Outlier Amount** • **64 = HH Reimbursement - Part A** • **65 = HH Reimbursement - Part B**									
11768.28	Contractors shall send inpatient hospital claims with the reduction, where add on payments are being paid separately, to HIGLAS					X				PS&R
11768.28.1	Contractors shall not send HH claims that receive an 100% reduction from the BE indicator '1', '5', or '8' adjustment to HIGLAS.					X				PS&R
11768.28.2	Contractors shall send HH claims that receive a reduction less than 100% from the BE indicator '1', '5', or '8' adjustment to HIGLAS.					X				PS&R
11768.28.3	Contractors shall reduce the Home Health PPS claim value codes 64, 65 and 17 where the BE indicator '1', '5', or '8' adjustment is less than 100% after Sequestration is applied.* **Note: *** • **17 = Operating Outlier Amount** • **64 = HH Reimbursement - Part A** • **65 = HH Reimbursement - Part B**					X				PS&R
11768.28.4	Contractors shall flag demo code '92' claims with BE indicator '1', '2', '3', '4' , '5', '7', '8', '9' or 'B' present on the claim-header or claim-line when the claim is denied.					X	X			
11768.29	Contractors shall apply BE indicator '2' on DC Synchronous and Asynchronous telehealth institutional claims Type of Bill (TOB) 85x, with Revenue (Rev.) codes 96x, 97x and 98x when: • The claim-header includes an aligned provider (using oNPI-CCN combination) AND					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The claim-header is for a beneficiary aligned to the same DC Entity Identifier as the provider AND • The aligned Provider elected BE indicator '2' as indicated on the Provider Alignment File AND • The From date is on or within the Beneficiary Effective Start Date and 90 days after the Beneficiary Effective End Date as indicated on the ACOB Auxiliary File AND • The From date on the claim-header is on or within the Provider's Effective Start Date and Provider's Effective End Date. • Present on the claim-header is one of the HCPCS codes in Table 1 or 2 of Appendix D.									
11768.29.1	Contractors shall apply BE indicator '3' on DC Post Discharge Home Visit institutional claims TOB 85x, with Rev. codes 96x, 97x and 98x, for licensed clinicians under the general supervision of a DC Provider when: • The claim-header includes an aligned provider (using oNPI-CCN combination) AND • The claim-header includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The aligned Provider elected BE indicator "3" as indicated on the Provider Alignment File AND • The From date is on or within the Beneficiary Effective Start Date and 90 days after the Beneficiary Effective End Date as indicated on the ACOB Auxiliary File AND • The From date on the claim-header is on or within the Provider's Effective Start Date and Provider's Effective End Date. • Present on the claim-line is one of the HCPCS codes in Table 3 of Appendix D.	X				X				
11768.29.2	Contractors shall apply BE indicator '7' on DC Care Management Home Visit institutional claims TOB 85x, with Rev. codes 96x, 97x and 98x, for licensed clinicians under the general supervision of a DC					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Provider when: • The claim-header includes an aligned provider (using oNPI-CCN combination) AND • The claim-header includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The aligned Provider elected BE indicator "7" as indicated in the Provider Alignment File AND • The DOS is on or within the Beneficiary Effective Start Date and on or within 90 days after the Beneficiary Effective End Date as indicated in the ACOB Auxiliary File AND • The From date on the claim-header is on or within the Provider's Effective Start Date and Provider's Effective End Date. • Present on the claim-line is one of the HCPCS codes listed in Table 4 of Appendix D. **Note:** • The licensed clinician may bill for "incident to" services. • These are paid as CAH Method II services.									
11768.30	Contractors shall process DC Synchronous telehealth professional claims with Place of Service (POS) = 02 (Telehealth) when: • The claim-line includes an aligned provider (using the Billing TIN-iNPI) AND • The claim-line is for a beneficiary aligned to the same DC Entity Identifier as the provider AND • The aligned Provider elected BE indicator '2' as indicated on the Provider Alignment File AND • The DOS is on or within the Beneficiary Effective Start Date and 90 days after the Beneficiary Effective End Date of the beneficiary's alignment record with the DC entity as indicated on the ACOB Auxiliary File AND		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The DOS on the claim-line is on or within the Provider's Effective Start Date and Provider's Effective End Date AND • Present on the claim-line is one of the HCPCS codes listed in Table 1 of Appendix D.									
11768.30.1	Contractors shall process DC Asynchronous telehealth professional claims when: • The claim-line includes an aligned provider (using the Billing TIN-iNPI) AND • The claim-line includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The aligned Provider elected BE indicator '2' as indicated on the Provider Alignment File AND • The DOS is on or within the Beneficiary Effective Start Date and 90 days after the Beneficiary Effective End Date as indicated on the ACOB Auxiliary File AND • The DOS on the claim-line is on or within the Provider's Effective Start Date and Provider's Effective End Date AND • Present on the claim-line is one of the HCPCS codes listed in Table 2 of Appendix D.		X				X			
11768.30.2	Contractors shall allow and process DC Post Discharge Home Visit professional claims for licensed clinicians under the general supervision of a DC Provider when: • The claim-line includes an aligned provider (using the Billing TIN-iNPI) AND • The claim-line includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The aligned Provider elected BE indicator "3" as indicated on the Provider Alignment File AND • The DOS is on or within the Beneficiary Effective Start Date and 90 days after the Beneficiary Effective End Date as indicated on the ACOB Auxiliary File AND		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The DOS on the claim-line is on or within the Provider's Effective Start Date and Provider's Effective End Date AND • Present on the claim-line is one of the HCPCS codes listed in Table 3 of Appendix D. **Note:** • The licensed clinician may bill for "incident to" services.									
11768.30.3	Contractors shall allow and process DC Care Management Home Visit professional claims for licensed clinicians under the general supervision of a DC Provider when: • The claim-line includes an aligned provider (using the Billing TIN-iNPI) AND • The claim-line includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The aligned Provider elected BE indicator "7" as indicated on the Provider Alignment File AND • The DOS is on or within the Beneficiary Effective Start Date and 90 days after the Beneficiary Effective End Date as indicated on the ACOB Auxiliary File AND • The DOS on the claim-line is on or within the Provider's Effective Start Date and Provider's Effective End Date AND • Present on the claim-line is one of the HCPCS codes listed in Table 4 of Appendix D. **Note:** • **The licensed clinician may bill for "incident to" services.**		X				X			
11768.30.4	Contractors shall revise existing claim edits as necessary to ensure asynchronous telehealth (BE indicator '2'), post-discharge home visit, (BE indicator '3'), and care management home visit, (BE indicator						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	'8') procedure codes are only payable to providers who are participating in the DC Model and have elected the applicable benefit enhancement.									
11768.30.5	For institutional claims, the SSM shall bypass all 3-day qualifying stay edits for SNF and SB provider claims with a DC 3-day stay waiver when: • The claim-header includes an aligned provider AND • The claim-header includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • BE indicator '4' is present on the claim-header AND • The From date is on or within the Beneficiary Start Date and 90 days after the Beneficiary Effective End Date as indicated on the ACOB					X				
11768.31	Contractors shall display MSN Message 63.10 on DC claims where BE indicator '1', '2', '3', '5', '7', or '8' is present on the claim-header or claim-detail. **English -** *You got this service from a provider who coordinates your care through a Direct Contracting Entity (DCE). For more information about care coordination from your DCE, talk with your doctor or call 1-800-MEDICARE (1-800-633-4227).* **Spanish** - *Recibió este servicio de un proveedor que coordina su atención a través de una Entidad Contratante Directa (DCE). Para obtener más información sobre la coordinación de la atención de su DCE, hable con su médico o llame al 1-800-MEDICARE (1-800-633-4227)*	X	X			X	X			
11768.31.1	Contractors shall display MSN Message 63.11 on DC claims where BE indicator '4' is present on the claim-header. **English -** *Your Direct Contracting Entity (DCE) may have made it possible for you to stay at this nursing facility, without first having to stay in a hospital for 3 days. Ask your doctor to tell you more about your DCE or call 1-800-MEDICARE (1-800-633-4227).*	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Spanish - *Su Entidad Contratante Directa (DCE) puede haber hecho posible que permanezca en este centro de enfermería, sin tener que permanecer en un hospital por 3 días. Pídale a su médico que le diga más sobre su DCE o llame al 1-800-MEDICARE (1-800-633-4227).*									
11768.32	Contractors shall modify utilization edit '5346' to reject an incoming HUOP claim (TOB 85x with Rev. Code(s) 96x, 97x, or 98x) received with demo code '92' when: • The Beneficiary's record indicates a Home Health Episode History (HHEH) present with or without date of earliest billing activity (DOEBA)/ date of latest billing activity (DOLBA) AND • The Provider's BE indicator '3' is present at the claim-header AND • The From date on the incoming claim is on or after 04/01/2021 and on or within the beneficiary's Home Health Episode Start and End Dates.								X	
11768.32.1	Contractor shall modify utilization edit '5346' to reject an incoming HUOP claim (TOB 85x with Rev. Code(s) 96x, 97x, or 98x received with demo code '92' when: • The Beneficiary's record indicates a HHEH present with or without DOEBA/DOLBA Dates AND • The Provider's BE indicator '7' is present at the claim-header AND • The From date on the claim-header is on or after 04/01/2021 and on or within the Beneficiary's Home Health Episode Start and End Dates.								X	
11768.33	Contractor shall modify utilization edit '5346' to reject an incoming HUBC claim received with demo code '92' when:								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The Beneficiary's record indicates a HHEH present with or without DOEBA/DOLBA Dates AND • The Provider's BE indicator '3' or '7' is present at the claim-header AND • The DOS on the claim is on or after 04/01/2021 and on or within the Beneficiary's Home Health Episode Start and End Dates.									
11768.34	The Contractor shall modify IUR code '7125' to generate IUR on HUIP, HUOP, HUHH, HUHC, and HUBC claims submitted with demo code '92' when: • The DOS or From date is **NOT** on or within the Beneficiary Effective Start Date and Beneficiary Effective Date as indicated on the ACOB Auxiliary File OR • The Beneficiary Effective End Date is one day before the Beneficiary Effective Start Date in the Beneficiary Alignment File, (i.e. never eligible) AND • BE indicators '1' (APO), '5' (TCC), or '8' (PCC) is present on the claim-header or claim-line OR • The DOS is on or after 04/01/2021. **Note:** • **CWF applies IUR code '7125' to the claim to indicate to FISS/MCS that the claim should be reprocessed without the demo code '92.'**								X	
11768.34.1	The Contractor shall reprocess institutional claims previously processed under the DC (i.e. have a demo code '92') when the beneficiary is retroactively adjusted, i.e. are no longer attributed to DCE, when: • The From date on the claim-header is **NOT** on or within the Beneficiary's Effective Start Date and the Beneficiary's End Date as indicated on the ACOB Auxiliary File, (i.e. eligible, but terminated) OR					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The Beneficiary Effective End Date is one day before the Beneficiary Effective Start Date in the Beneficiary Alignment File, (i.e. never eligible) AND • BE indicators '1' (APO), '5' (TCC), or '8' (PCC) is present on the claim-header AND • The DOS is on or after 04/01/2021. **Note:** • **CWF applies IUR code '7125' to the claim to indicate to FISS/MCS that the claim should be reprocessed without the demo code '92.'**									
11768.34.2	The Contractor shall reprocess professional claims previously processed under the DCM (i.e. have a demo code '92') when a beneficiary record is retroactively adjusted, i.e. are no longer attributed to DCE, when: • The DOS on the claim-line is **NOT** on or within the Beneficiary's Effective Start Date and the Beneficiary's End Date as indicated on the ACOB Auxiliary File, (i.e. eligible, but terminated) OR • The Beneficiary Effective End Date is one day before the Beneficiary Effective Start Date in the Beneficiary Alignment File, (i.e. never eligible) AND • BE indicators '1' (APO), '5' (TCC), or '8' (PCC) is present on the claim-line AND • The DOS is on or after 04/01/2021 **Note:** • **CWF applies IUR code '7125' to the claim to indicate to FISS/MCS that the claim should be reprocessed without the demo code '92.'**						X			
11768.34.3	The Contractor shall reprocess institutional claims previously processed under the DC (i.e. have a demo					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	code '92') when the provider's alignment record is retroactively adjusted, i.e. are no longer attributed to DCE, when: • The From date on the claim-header is **NOT** on or within the Provider's Effective Start Date and the Provider's End Date (i.e. eligible, but terminated) OR • The Provider Effective End Date is one day before the Provider Effective Start Date in the Provider Alignment File (i.e. never eligible) AND • BE indicators '1' (APO), '5' (TCC), or '8' (PCC) is present on the claim-header AND • The DOS is on or after 04/01/2021									
11768.34.4	The Contractor shall reprocess professional claims previously processed under the DC (i.e. have a demo code '92') when the provider's alignment record is retroactively adjusted, i.e. are no longer attributed to DCE, when: • The DOS on the claim-line is NOT on or within the Provider's Effective Start Date and the Provider's End Date (i.e. eligible, but terminated) OR • The Provider Effective End Date is one day before the Provider Effective Start Date in the Provider Alignment (i.e. eligible, but terminated) AND • BE indicators '1' (APO), '5' (TCC), or '8' (PCC) is present on the claim-header or claim-line AND • The DOS is on or after 04/01/2021						X			
11768.35	Contractors shall retain any positive enhancements that were applicable on the original claim and add any new positive enhancements.					X	X			
11768.36	Contractors shall apply claims processing edit logic, audit, medical review, MSP , and fraud and abuse activities, appeals and overpayment processes for DC Model claims in the same manner as normal FFS claims.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11768.37	The Contractor shall treat DC patients the same as non-DC Medicare patients for cost reporting purposes.	X								PS&R
11768.38	The Contractor shall ensure A/B Crossover edit '7123' will bypass when: • The incoming covered SNF claim (21x) or covered Swing Bed (SB) Prospective Payment System (PPS) (18x) claim contains BE indicator '4' AND • A claim-header or claim-line has demo code '92' appended AND • Posted to history is an Inpatient Hospital claim that does not meet the qualifying stay criteria AND • The SNF (21x) or SB PPS (18x) Admission Date is on or after 04/01/2021. • The From date is on or within the Beneficiary Start Date and 90 days after the Beneficiary Effective End Date as indicated in the ACOB Auxiliary File. **Note:** • **CWF will only read BE indicator '4' to bypass edit '7123'.** • **Demo Code '92' takes precedence over Demo Code '75' or '86' for edit 7123.**								X	
11768.39	Contractors shall generate the Weekly APO/TCC/PCC Reduction File that will be sent from the VDCs to the Baltimore Data Center (BDC), (pass-through), for professional and institutional claims with the demo code '92' where BE indicators '1', '5', and '8' adjustment was applied. Details on the pass-through file are provided in Table 57 of the ICD.								X	VDC
11768.39.1	Contractors shall populate new values in the existing Mass Adjustment Indicator field on the CWF claim transmission record of professional and institutional claims to facilitate the population of the CLMH-ADJUST-REASON-CODE in the Weekly APO/TCC/ PCC Reduction File. • Beneficiary Alignment Change (Value 'B')					X	X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Provider Alignment Change (Value 'P') • Other (Value 'O') For Part A records, with Demo Code '92' and BE Indicators '1', '5' and '8', the following should apply to populate the CLMH-ADJUST-REASON-CODE:* • CWF should populate value 'B' for Beneficiary Alignment Change using the TOB 'xxG' • CWF should populate value 'P' for Provider Alignment Change using the TOB 'xxI' • CWF should populate value 'O' for Other when neither TOB 'xxG' or 'xxI' apply **Note: *** • For adjustment claims created due to a DC Beneficiary Alignment change (TOB = 'xxG'), FISS will populate the "Mass Adjustment Indicator" field on the CWF transmit file with a "B". • For adjustment claims created due to a DC Provider Alignment change (TOB = 'xxI'), FISS will populate the "Mass Adjustment Indicator" field on the CWF transmit file with a "P". • For claims with the "CWF Action Code" equal to "3", FISS will populate the "Mass Adjustment Indicator" field on the CWF transmit file with an "M" or an "O". • For all other claims, FISS will populate the "Mass Adjustment Indicator" field on the CWF transmit file with a 'space'.									
11768.39.1.1	For Part B records, with Demo Code '92' and BE Indicators '1', '5' and '8', the following should apply to populate the CLMH-ADJUST-REASON-CODE: • When the Mass Adjustment Indicator field is 'B' for Beneficiary Alignment Change should populate value 'B for the CLMH-ADJUST-REASON-CODE								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• When the Mass Adjustment Indicator file is 'P' for Provider Alignment Change should populate value 'P' for the CLMH-ADJUST-REASON-CODE • When value other than 'B' or 'P' present in the Mass Adjustment Indicator file then populate 'O' Other for the CLMH-ADJUST-REASON-CODE **Note:** • **BR 39.1 was split due to character limits in eCHIMP.**									
11768.39.2	CWF Host shall work with CMS to ensure that all parties who need access to this weekly reduction file have access by 04/01/2021.									CMS, CWF Host, VDC
11768.40	Contractors shall ensure the claim- or claim-line level identifier when a rendered service is applicable will flow to downstream systems including but not limited to: National Claims History (NCH), Integrated Data Repository (IDR), and Chronic Condition Warehouse (CCW).					X	X		X	
11768.41	Contractors shall send the Value Code "Q0" (zero) for institutional claims and Other Amount Indicator 'J' for non-institutional claims and Value Code of "Q1" for Institutional Claims or new Other Amount Indicator of 'L' for non-institutional Claims on the CWF claim transmission record and to the IDR for purposes of data analysis and reporting.					X	X			IDR
11768.41.1	The Contractor shall apply the actual amount of the DC reduction, i.e. BE indicators '1', '5', or '8', to Value Code "Q1."					X				
11768.42	CWF and the SSMs shall perfrom Integrated testing during the alpha period of this CR.					X	X		X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	• CR8140 • CR 9151 • CR 9322 • CR 9656 • CR 10044 • CR 10824 • CR 10907 • CR 11340 • CR 11350

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sarah Wheat, sarah.wheat@cms.hhs.gov , Patrick Welsh, Patrick.Welsh@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 7

1. Direct Contracting (DC) Model - Professional and Global Options: Total Care Capitation (TCC), Primary Care Capitation (PCC), Advanced Payment Option (APO), Telehealth Expansion, 3-day SNF Rule Waiver, Post-Discharge and Care-Management Home Visits – Implementation Background

The Direct Contracting (DC) Model creates a new opportunity for the Centers for Medicare & Medicaid Services (CMS) to test an array of financial risk-sharing arrangements, leveraging lessons learned from other Medicare Accountable Care Organization (ACO) initiatives, such as the Medicare Shared Savings Program and the Next Generation ACO (NGACO) Model, as well as innovative approaches from Medicare Advantage (MA) and private sector risk-sharing arrangements. This model is part of a strategy by the CMS Center for Medicare and Medicaid Innovation (Innovation Center) to use the redesign of primary care as a platform to drive broader health care delivery system reform. The DC Model creates a variety of pathways for taking on financial risk supported by enhanced flexibilities. Because the model reduces burden, supports a focus on complex, chronically and seriously ill patients, and aims to encourage organizations to participate that have not typically participated in Medicare fee-for-service (FFS), Innovation Center models, or both, we anticipate that this model will appeal to a broad range of physician organizations and other types of health organizations. The DC Model provides an opportunity for health care providers that have not previously been eligible for the Shared Savings Program, the NGACO Model, or both due to an insufficient number of assigned or aligned Medicare FFS beneficiaries. In addition, the DC Model offers another model option for NGACO Model participants to consider after the NGACO Model ends in December 2020.

Under the DC Model, CMS will test three voluntary risk-sharing options: 1) Professional, a lower-risk option (50 percent Shared Savings/Shared Losses) 2) Global, a full risk option (100 percent Shared Savings/Shared Losses) and 3) Geographic, forthcoming.

The DC Model will test a Direct Contracting Entity's (DCE) capacity to take on financial risk for the total Parts A and B costs for a defined population of fee-for-service Medicare beneficiaries, while ensuring the Model's fiscal sustainability. DCEs are similar to ACOs in that they have "Participant and Preferred Providers," clinicians who bill Medicare for services.

CMS is requiring Capitation Payment Mechanisms in Direct Contracting to provide DCEs with an opportunity to administer the flow of funds while they manage total cost of care. By giving DCEs the funds to pay for services and increased flexibilities, DCEs will have greater leverage to enter into downstream payment arrangements that can incent providers to work together and coordinate care for a defined set of aligned beneficiaries, with the potential to generate better outcomes and lower costs.

The DC Model is structured to have an implementation period beginning in 2020, followed by five performance years. Payments under the Model will not begin until the first performance year, 2021.

Throughout the model's lifecycle there will be opportunity to broaden the scope of the Model by incorporating new features including: increased access to health care providers and services, the advancement of patient-centered care, and the development of enhanced benefits available to

beneficiaries used to engage them in their health care decisions. The change requests (CRs) listed below may be used to inform the development of the requirements for CR 11484.

Next Generation Accountable Care Organization - Implementation - CR9151

Next Generation Accountable Care Organization (NGACO) Year Three Benefit Enhancements - CR1044

Next Generation Accountable Care Organization (NGACO) - All Inclusive Population Based Payment (AIPBP) Implementation - CR9656

Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS - CR10907

2. Change Request

This change request (CR) is for the purpose of implementing the Direct Contracting Model's proposed plan to implement a series of payment and benefits enhancements (BEs) mechanisms under its Professional and Global Options and for designing business requirements for an implementation CR effective for the initial performance year (2021) of the program. Upon the conclusion of these calls, the DC team will have developed an implementation strategy for proper initiation of these payment mechanisms and BEs under the Professional and Global Options for Direct Contracting beginning January 1, 2021.

The DC team seeks to develop business requirements for the following payment mechanisms and benefit enhancements: ***Total Care Capitation (TCC), Primary Care Capitation (PCC), Advanced Payment Option (APO), Telehealth Expansion, 3-day SNF Rule Waiver, and Post-Discharge and Care Management Home Visits.***

3. Proposed Payment Mechanisms

Overview

- *The DC Model uses a variety of payment mechanisms that will require changes to the claims processing systems. These include capitation, advanced payments, and benefit enhancements, which are waivers to Medicare payment rules that offer flexibility for care coordination and delivery. While DCEs will be required to receive payment through capitation, advance payments and benefit enhancements are optional.*

Capitation Payment Options: Total Care Capitation (TCC) and Primary Care Capitation (PCC)

- *Direct Contracting will test the use of capitated per-beneficiary per-month (PBPM) payments made from CMS to the Direct Contracting Entity (DCE). CMS anticipates*

that these capitated payments will support a range of DCE activities including not only delivery of care, but also infrastructure to support the provision of primary care and care coordination services to aligned beneficiaries, including investments in resources, technology, and processes.

- *Total Care Capitation (TCC)*
    - *A PBPM capitated payment for all services provided by DC Participant Providers (and Preferred Providers to the extent the DCE has an arrangement with them) to aligned beneficiaries, reflecting the estimated total cost of care for the DCE's aligned population. The amount of the TCC will be based on a prospective, regionally trended, risk adjusted, discounted performance year benchmark representing the costs of all Part A and Part B services that will be furnished to the DCE's beneficiaries during the performance year. Please note, this alternative payment mechanism is only available to DCEs in the Global option of the model.*
    - *Under TCC, all FFS claims will continue to be submitted to CMS. CMS will fully adjudicate claims, but will not make payment to DC Participant Providers; payments to Preferred Providers will be based on the terms of the agreements between the Preferred Providers and the DCEs. Preferred Providers who do not have an agreement with the DCE or who are not associated with the DCE, (who are not Participant or Preferred providers) will continue to receive normal fee-for-service (FFS) reimbursements for all the beneficiaries they treat, including aligned beneficiaries.*

- *Primary Care Capitation (PCC)*
    - *A PBPM capitated payment for primary care services provided by DC Participant Providers (and Preferred Providers to the extent the DCE has an arrangement with them) to aligned beneficiaries equaling to seven percent of the estimated total cost of care for the DCE's aligned population. The amount of the PCC will be seven percent of the prospective, regionally trended, risk adjusted, discounted Performance Year benchmark representing the costs of all Part A and Part B services that will be furnished to the DCE's beneficiaries during the performance year. Please note that PCC is required for DCEs participating in the Professional option. DCEs participating in the Global option will select either PCC or TCC.*
    - *All FFS claims will continue to be submitted to CMS. CMS will fully adjudicate claims, but will not make payment to DC Participant Providers for the primary care services covered by the PCC. Payments out of the PCC to Preferred Providers for primary care services will be based on the terms of the agreements between the Preferred Providers and the DCEs. Providers who do not have an agreement with a DCE, will continue to receive normal fee-for-service (FFS) reimbursements for all the beneficiaries they treat, including aligned beneficiaries. CMS will continue to make normal FFS reimbursements to DC Participant Providers and Preferred Providers for non-primary care services subject to the DCE selecting the Advanced Payment Option described below.*

- *All FFS claims will continue to be submitted to CMS, and CMS will make coverage and eligibility determinations and assess beneficiary liability. Beneficiary liabilities will be calculated based on what Medicare would have paid in absence of PCC, TCC, or Advanced Payment, and Medicare Summary Notice (MSNs) should reflect the amount that would have been paid. Similarly, remittance notices still need to be sent to DCE Participant Providers and Preferred Providers (just as they would receive remittance notices if not participating in Direct Contracting).*

Advanced Payment Option (APO)

- *In addition to the two Capitation options listed above, DCEs may choose to participate in a "claims reduction" mechanism referred to as "Advanced Payment", which builds upon the Alternative Payment Mechanism in the NGACO model referred to as "Population Based Payments." The Advanced Payment provides DCEs with additional flexibility to enter into innovative payment arrangements with their Participant and Preferred Providers.*
- *Advanced Payment can apply to any FFS claim amounts that CMS continues to reimburse to the DCE's Participant and Preferred Providers. DCEs can enter into arrangements whereby CMS would reduce the claims payment amount for the DC Participant Providers (PCC only) and Preferred Providers (TCC or PCC), between 1% and 100% of the value of the FFS claims payment amount, as agreed to by the DCE and the provider.*
- *Advanced Payments cannot exceed the DCE's Performance Year Benchmark and will be reconciled against actual FFS claims at Final Financial Reconciliation.*
- *Similar to how PBP functions in NGACO, the Advanced Payment is paid by CMS (the Innovation Center) to the DCE, who then reimburses its providers their share based on what was negotiated between the DCE and its providers, and payments through the claims systems are reduced to those providers.*

4. Proposed Benefit Enhancements

Overview

- *Direct Contracting will continue to offer four of the benefit enhancements currently provided in the Next Generation ACO model: Telehealth Expansion, 3-Day SNF Rule Waiver, Post-Discharge Home Visits, and Care Management Home Visits. CMS also plans to offer 3*

additional benefit enhancements to DCEs starting in Performance Year 1 which will be included in a separate CR at a later date.

Telehealth Expansion

- *Eliminates the rural geographic component of originating site requirements and allows a beneficiary's home to serve as an approved originating site.*
- *This waiver expands current telehealth services provided by the Bipartisan Budget Act of 2018 to include asynchronous (also known as "store-and-forward") telehealth in the specialties of dermatology and ophthalmology for both new and established patients.*
- *Asynchronous telehealth includes the transmission of recorded health history through a secure electronic communications system to a practitioner who uses the information to evaluate the case, or render a service outside of a real-time interaction.*
- *Distant site practitioners will bill for these new services using Innovation Center specific asynchronous telehealth codes. The distant site practitioner must be a DC Participant or Preferred Provider who has elected to use this benefit enhancement, and beneficiaries must be aligned to a DCE that has selected this benefit enhancement.*

3-Day SNF Rule Waiver

- *DCEs will be offered a waiver of the three-day inpatient stay requirement prior to admission to a skilled nursing facility (SNF) or acute-care hospital or CAH with swing-bed approval for SNF services.*
- *This benefit enhancement will allow eligible DC beneficiaries to be admitted to qualified DC Participants or Preferred Providers either directly, or with an inpatient stay of fewer than three days. DCEs will identify the SNFs and swing-bed hospitals with which they will partner in this benefit enhancement.*
- *Partner SNFs and swing-bed hospitals may be either DC Participants or Preferred Providers. A partner SNF must have an overall rating of three or more stars under the CMS 5-Star Quality Rating System in at least seven of the previous twelve months, as reported on the Nursing Home Compare website.*

Post-Discharge Home Visits

- *DCEs can participate in waivers to allow payment for certain home visits furnished to non-homebound aligned beneficiaries by auxiliary personnel (as defined in 42*

C.F.R. § 410.26(a)(1)) under general supervision, rather than direct supervision, incident to the professional services of physicians or other practitioners in the DC model.

- *Under this benefit enhancement, a beneficiary is eligible to receive up to nine post-discharge home visits within 90 days following discharge from a qualifying facility.*

Care Management Home Visits

- *DCEs can participate in waivers to allow payment for certain home visits to aligned beneficiaries proactively and in advance of potential hospitalization.*
- *The items and services provided as part of these home visits are those that would be covered under Medicare Part B as "incident to" the services of a physician or practitioner, and would be furnished by auxiliary personnel (as defined in 42 C.F.R. § 410.26(a) (1)) under general supervision, rather than direct supervision.*
- *An eligible beneficiary is permitted to receive up to twelve care management home visits within a calendar year.*

Appendix B: Alcohol and Substance Abuse Codes

Table 1, Table 2, and Table 3 contain procedures, codes, and diagnoses for alcohol and substance abuse-related treatment, which CMS will exclude from the Direct Contracting Model Claims Line Feeds and from claims reductions for alternative payment mechanisms for a Direct Contracting Entity (DCE).

Table 1: HCPC/CPT Codes

HCPC/CPT Codes	Description
G2172	All-inclusive payment for services related to highly coordinated and integrated opioid use disorder (OUD) treatment services furnished for the demonstration project
4320F	Patient counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence
H0005	Alcohol and/or drug services; Group counseling by a clinician
H0006	Alcohol and/or drug services; case management
H0007	Alcohol and/or drug services; crisis intervention (outpatient)
H0008	Alcohol and/or drug services; sub-acute detox (hospital inpatient)
H0009	Alcohol and/or drug services; Acute detox (hospital inpatient)
H0010	Alcohol and/or drug services; Sub-acute detox (residential addiction program inpatient)
H0011	Alcohol and/or drug services; acute detox (residential addiction program inpatient)
H0012	Alcohol and/or drug services; Sub-acute detox (residential addiction program outpatient)
H0013	Alcohol and/or drug services; acute detox (residential addiction program outpatient)
H0014	Alcohol and/or drug services; ambulatory detox
H0015	Alcohol and/or drug services; intensive outpatient
H0050	Alcohol and/or Drug Service, Brief Intervention, per 15 minutes
99408	Alcohol and substance (other than tobacco) abuse structure screening (e.g., AUDIT, DAST) and brief intervention (SBI) services; 15-30 minutes
99409	Alcohol and substance (other than tobacco) abuse structure screening (e.g., AUDIT, DAST) and brief intervention (SBI) services; Greater than 30 minutes
H0034	Alcohol and/or drug abuse halfway house services, per diem
H0047	Alcohol and/or Drug abuse services, not otherwise specified
H2035	Alcohol and/or drug treatment program, per hour
H2036	Alcohol and/or drug treatment program, per diem
H0020	Alcohol and/or drug services; methadone administration and/or service (provisions of the drug by a licensed program)
S9475	Ambulatory Setting substance abuse treatment or detoxification services per diem
T1006	Alcohol and/or substance abuse services, family/couple counseling
T1007	Alcohol and/or substance abuse services, treatment plan development and or modification
T1008	Day Treatment for individual alcohol and/or substance abuse services

HCPC/CPT Codes	Description
T1009	Child sitting services for children of individuals receiving alcohol and/or substance abuse services
T1010	Meals for individuals receiving alcohol and/or substance abuse services (when meals are not included in the program
T1011	Alcohol and/or substance abuse services not otherwise classified
T1012	Alcohol and/or substance abuse services, skill development
0078U	Pain management (opioid-use disorder) genotyping panel, 16 common variants (ie, abcb1, comt, dat1, dbh, dor, drd1, drd2, drd4, gaba, gal, htr2a, httlpr, mthfr, muor, oprk1, oprm1), buccal swab or other germline tissue sample, algorithm reported as positive or negative risk of opioid-use disorder
G2011	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes
G2067	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a medicare-enrolled opioid treatment program)
G2068	Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)
G2069	Medication assisted treatment, buprenorphine (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)
G2070	Medication assisted treatment, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)
G2071	Medication assisted treatment, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)
G2072	Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)
G2073	Medication assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)
G2074	Medication assisted treatment, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)
G2075	Medication assisted treatment, medication not otherwise specified; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a medicare-enrolled opioid treatment program)

HCPC/CPT Codes	Description
G2076	Intake activities, including initial medical examination that is a complete, fully documented physical evaluation and initial assessment by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician qualified personnel that includes preparation of a treatment plan that includes the patient's short-term goals and the tasks the patient must perform to complete the short-term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psycho- social, economic, legal, or other supportive services that a patient needs, conducted by qualified personnel (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
G2077	Periodic assessment; assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
G2078	Take-home supply of methadone; up to 7 additional day supply (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
G2079	Take-home supply of buprenorphine (oral); up to 7 additional day supply (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
G2080	Each additional 30 minutes of counseling in a week of medication assisted treatment, (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)
G9562	Patients who had a follow-up evaluation conducted at least every three months during opioid therapy
G9578	Documentation of signed opioid treatment agreement at least once during opioid therapy
G9584	Patient evaluated for risk of misuse of opiates by using a brief validated instrument (e.g., opioid risk tool, soapp-r) or patient interviewed at least once during opioid therapy
G9621	Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling
J0570	Buprenorphine implant, 74.2 mg
M1034	Adults who have at least 180 days of continuous pharmacotherapy with a medication prescribed for oud without a gap of more than seven days
M1035	Adults who are deliberately phased out of medication assisted treatment (mat) prior to 180 days of continuous treatment

HCPC/CPT Codes	Description
Q9991	Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
Q9992	Injection, buprenorphine extended-release (sublocade), greater than 100 mg
G2172	All-inclusive payment for services related to highly coordinated and integrated opioid use disorder (OUD) treatment services furnished for the demonstration project

Table 2: ICD-10-PCS Inpatient Procedure Codes

ICD-10-PCS Codes	Description
HZ2ZZZZ	Detoxification Services for Substance Abuse Treatment
HZ30ZZZ	Individual Counseling for Substance Abuse Treatment, Cognitive
HZ31ZZZ	Individual Counseling for Substance Abuse Treatment, Behavioral
HZ32ZZZ	Individual Counseling for Substance Abuse Treatment, Cognitive-Behavioral
HZ33ZZZ	Individual Counseling for Substance Abuse Treatment, 12-Step
HZ34ZZZ	Individual Counseling for Substance Abuse Treatment, Interpersonal
HZ35ZZZ	Individual Counseling for Substance Abuse Treatment, Vocational
HZ36ZZZ	Individual Counseling for Substance Abuse Treatment, Psychoeducation
HZ37ZZZ	Individual Counseling for Substance Abuse Treatment, Motivational Enhancement
HZ38ZZZ	Individual Counseling for Substance Abuse Treatment, Confrontational
HZ39ZZZ	Individual Counseling for Substance Abuse Treatment, Continuing Care
HZ3BZZZ	Individual Counseling for Substance Abuse Treatment, Spiritual
HZ40ZZZ	Group Counseling for Substance Abuse Treatment, Cognitive
HZ41ZZZ	Group Counseling for Substance Abuse Treatment, Behavioral
HZ42ZZZ	Group Counseling for Substance Abuse Treatment, Cognitive-Behavioral
HZ43ZZZ	Group Counseling for Substance Abuse Treatment, 12-Step
HZ44ZZZ	Group Counseling for Substance Abuse Treatment, Interpersonal
HZ45ZZZ	Group Counseling for Substance Abuse Treatment, Vocational
HZ46ZZZ	Group Counseling for Substance Abuse Treatment, Psychoeducation
HZ47ZZZ	Group Counseling for Substance Abuse Treatment, Motivational Enhancement
HZ48ZZZ	Group Counseling for Substance Abuse Treatment, Confrontational
HZ49ZZZ	Group Counseling for Substance Abuse Treatment, Continuing Care
HZ4BZZZ	Group Counseling for Substance Abuse Treatment, Spiritual
HZ50ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Cognitive
HZ51ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Behavioral
HZ52ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Cognitive-Behavioral
HZ53ZZZ	Individual Psychotherapy for Substance Abuse Treatment, 12-Step
HZ54ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Interpersonal
HZ55ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Interactive
HZ56ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Psychoeducation
HZ57ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Motivational Enhancement

ICD-10-PCS Codes	Description
HZ58ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Confrontational
HZ59ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Supportive
HZ5BZZZ	Individual Psychotherapy for Substance Abuse Treatment, Psychoanalysis
HZ5CZZZ	Individual Psychotherapy for Substance Abuse Treatment, Psychodynamic
HZ5DZZZ	Individual Psychotherapy for Substance Abuse Treatment, Psychophysiological
HZ63ZZZ	Family Counseling for Substance Abuse Treatment
HZ80ZZZ	Medication Management for Substance Abuse Treatment, Nicotine Replacement
HZ81ZZZ	Medication Management for Substance Abuse Treatment, Methadone Maintenance
HZ82ZZZ	Medication Management for Substance Abuse Treatment, Levo-alpha-acetyl-methadol (LAAM)
HZ83ZZZ	Medication Management for Substance Abuse Treatment, Antabuse
HZ84ZZZ	Medication Management for Substance Abuse Treatment, Naltrexone
HZ85ZZZ	Medication Management for Substance Abuse Treatment, Naloxone
HZ86ZZZ	Medication Management for Substance Abuse Treatment, Clonidine
HZ87ZZZ	Medication Management for Substance Abuse Treatment, Bupropion
HZ88ZZZ	Medication Management for Substance Abuse Treatment, Psychiatric Medication
HZ89ZZZ	Medication Management for Substance Abuse Treatment, Other Replacement Medication
HZ90ZZZ	Pharmacotherapy for Substance Abuse Treatment, Nicotine Replacement
HZ91ZZZ	Pharmacotherapy for Substance Abuse Treatment, Methadone Maintenance
HZ92ZZZ	Pharmacotherapy for Substance Abuse Treatment, Levo-alpha-acetyl-methadol (LAAM)
HZ93ZZZ	Pharmacotherapy for Substance Abuse Treatment, Antabuse
HZ94ZZZ	Pharmacotherapy for Substance Abuse Treatment, Naltrexone
HZ95ZZZ	Pharmacotherapy for Substance Abuse Treatment, Naloxone
HZ96ZZZ	Pharmacotherapy for Substance Abuse Treatment, Clonidine
HZ97ZZZ	Pharmacotherapy for Substance Abuse Treatment, Bupropion
HZ98ZZZ	Pharmacotherapy for Substance Abuse Treatment, Psychiatric Medication
HZ99ZZZ	Pharmacotherapy for Substance Abuse Treatment, Other Replacement Medication

Table 3: ICD-10-CM Diagnosis Codes

ICD-10-CM Diagnosis Codes	Description
F10.10	Alcohol abuse, uncomplicated
F10.14	Alcohol abuse with alcohol-induced mood disorder
F10.19	Alcohol abuse with unspecified alcohol-induced disorder
F10.20	Alcohol dependence, uncomplicated
F10.21	Alcohol dependence, in remission
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.26	Alcohol dependence with alcohol-induced persisting amnestic disorder
F10.27	Alcohol dependence with alcohol-induced persisting dementia

ICD-10-CM Diagnosis Codes	Description
F10.29	Alcohol dependence with unspecified alcohol-induced disorder
F10.94	Alcohol use, unspecified with alcohol-induced mood disorder
F10.96	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia
F10.99	Alcohol use, unspecified with unspecified alcohol-induced disorder
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium
F10.129	Alcohol abuse with intoxication, unspecified
F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
F10.159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.180	Alcohol abuse with alcohol-induced anxiety disorder
F10.181	Alcohol abuse with alcohol-induced sexual dysfunction
F10.182	Alcohol abuse with alcohol-induced sleep disorder
F10.188	Alcohol abuse with other alcohol-induced disorder
F10.220	Alcohol dependence with intoxication, uncomplicated
F10.221	Alcohol dependence with intoxication delirium
F10.229	Alcohol dependence with intoxication, unspecified
F10.230	Alcohol dependence with withdrawal, uncomplicated
F10.231	Alcohol dependence with withdrawal delirium
F10.232	Alcohol dependence with withdrawal with perceptual disturbance
F10.239	Alcohol dependence with withdrawal, unspecified
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.280	Alcohol dependence with alcohol-induced anxiety disorder
F10.281	Alcohol dependence with alcohol-induced sexual dysfunction
F10.282	Alcohol dependence with alcohol-induced sleep disorder
F10.288	Alcohol dependence with other alcohol-induced disorder
F10.920	Alcohol use, unspecified with intoxication, uncomplicated
F10.921	Alcohol use, unspecified with intoxication delirium
F10.929	Alcohol use, unspecified with intoxication, unspecified
F10.950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions
F10.951	Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations
F10.959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
F10.980	Alcohol use, unspecified with alcohol-induced anxiety disorder
F10.981	Alcohol use, unspecified with alcohol-induced sexual dysfunction
F10.982	Alcohol use, unspecified with alcohol-induced sleep disorder
F10.988	Alcohol use, unspecified with other alcohol-induced disorder
F11.10	Opioid abuse, uncomplicated
F11.14	Opioid abuse with opioid-induced mood disorder
F11.19	Opioid abuse with unspecified opioid-induced disorder

ICD-10-CM Diagnosis Codes	Description
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence, in remission
F11.23	Opioid dependence with withdrawal
F11.24	Opioid dependence with opioid-induced mood disorder
F11.29	Opioid dependence with unspecified opioid-induced disorder
F11.90	Opioid use, unspecified, uncomplicated
F11.93	Opioid use, unspecified with withdrawal
F11.94	Opioid use, unspecified with opioid-induced mood disorder
F11.99	Opioid use, unspecified with unspecified opioid-induced disorder
F11.120	Opioid abuse with intoxication, uncomplicated
F11.121	Opioid abuse with intoxication delirium
F11.122	Opioid abuse with intoxication with perceptual disturbance
F11.129	Opioid abuse with intoxication, unspecified
F11.150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11.159	Opioid abuse with opioid-induced psychotic disorder, unspecified
F11.181	Opioid abuse with opioid-induced sexual dysfunction
F11.182	Opioid abuse with opioid-induced sleep disorder
F11.188	Opioid abuse with other opioid-induced disorder
F11.220	Opioid dependence with intoxication, uncomplicated
F11.221	Opioid dependence with intoxication delirium
F11.222	Opioid dependence with intoxication with perceptual disturbance
F11.229	Opioid dependence with intoxication, unspecified
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.281	Opioid dependence with opioid-induced sexual dysfunction
F11.282	Opioid dependence with opioid-induced sleep disorder
F11.288	Opioid dependence with other opioid-induced disorder
F11.920	Opioid use, unspecified with intoxication, uncomplicated
F11.921	Opioid use, unspecified with intoxication delirium
F11.922	Opioid use, unspecified with intoxication with perceptual disturbance
F11.929	Opioid use, unspecified with intoxication, unspecified
F11.950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11.951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F11.959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F11.981	Opioid use, unspecified with opioid-induced sexual dysfunction
F11.982	Opioid use, unspecified with opioid-induced sleep disorder
F11.988	Opioid use, unspecified with other opioid-induced disorder
F12.10	Cannabis abuse, uncomplicated
F12.19	Cannabis abuse with unspecified cannabis-induced disorder
F12.20	Cannabis dependence, uncomplicated
F12.21	Cannabis dependence, in remission

ICD-10-CM Diagnosis Codes	Description
F12.29	Cannabis dependence with unspecified cannabis-induced disorder
F12.90	Cannabis use, unspecified, uncomplicated
F12.99	Cannabis use, unspecified with unspecified cannabis-induced disorder
F12.120	Cannabis abuse with intoxication, uncomplicated
F12.121	Cannabis abuse with intoxication delirium
F12.122	Cannabis abuse with intoxication with perceptual disturbance
F12.129	Cannabis abuse with intoxication, unspecified
F12.150	Cannabis abuse with psychotic disorder with delusions
F12.151	Cannabis abuse with psychotic disorder with hallucinations
F12.159	Cannabis abuse with psychotic disorder, unspecified
F12.180	Cannabis abuse with cannabis-induced anxiety disorder
F12.188	Cannabis abuse with other cannabis-induced disorder
F12.220	Cannabis dependence with intoxication, uncomplicated
F12.221	Cannabis dependence with intoxication delirium
F12.222	Cannabis dependence with intoxication with perceptual disturbance
F12.229	Cannabis dependence with intoxication, unspecified
F12.250	Cannabis dependence with psychotic disorder with delusions
F12.251	Cannabis dependence with psychotic disorder with hallucinations
F12.259	Cannabis dependence with psychotic disorder, unspecified
F12.280	Cannabis dependence with cannabis-induced anxiety disorder
F12.288	Cannabis dependence with other cannabis-induced disorder
F12.920	Cannabis use, unspecified with intoxication, uncomplicated
F12.921	Cannabis use, unspecified with intoxication delirium
F12.922	Cannabis use, unspecified with intoxication with perceptual disturbance
F12.929	Cannabis use, unspecified with intoxication, unspecified
F12.950	Cannabis use, unspecified with psychotic disorder with delusions
F12.951	Cannabis use, unspecified with psychotic disorder with hallucinations
F12.959	Cannabis use, unspecified with psychotic disorder, unspecified
F12.980	Cannabis use, unspecified with anxiety disorder
F12.988	Cannabis use, unspecified with other cannabis-induced disorder
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13.14	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder
F13.19	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission
F13.24	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
F13.26	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.29	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.90	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated

ICD-10-CM Diagnosis Codes	Description
F13.94	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder
F13.96	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F13.97	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.99	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13.121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13.129	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F13.150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.181	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13.221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13.229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13.231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13.232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13.239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F13.250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder

ICD-10-CM Diagnosis Codes	Description
F13.288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder
F13.920	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated
F13.921	Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium
F13.929	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified
F13.930	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated
F13.931	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal delirium
F13.932	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal with perceptual disturbances
F13.939	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified
F13.950	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.951	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.959	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.980	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.981	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.982	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.988	Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder
F14.10	Cocaine abuse, uncomplicated
F14.14	Cocaine abuse with cocaine-induced mood disorder
F14.19	Cocaine abuse with unspecified cocaine-induced disorder
F14.20	Cocaine dependence, uncomplicated
F14.21	Cocaine dependence, in remission
F14.23	Cocaine dependence with withdrawal
F14.24	Cocaine dependence with cocaine-induced mood disorder
F14.29	Cocaine dependence with unspecified cocaine-induced disorder
F14.90	Cocaine use, unspecified, uncomplicated
F14.94	Cocaine use, unspecified with cocaine-induced mood disorder
F14.99	Cocaine use, unspecified with unspecified cocaine-induced disorder
F14.120	Cocaine abuse with intoxication, uncomplicated
F14.121	Cocaine abuse with intoxication with delirium
F14.122	Cocaine abuse with intoxication with perceptual disturbance
F14.129	Cocaine abuse with intoxication, unspecified
F14.150	Cocaine abuse with cocaine-induced psychotic disorder with delusions
F14.151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
F14.159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified

ICD-10-CM Diagnosis Codes	Description
F14.180	Cocaine abuse with cocaine-induced anxiety disorder
F14.181	Cocaine abuse with cocaine-induced sexual dysfunction
F14.182	Cocaine abuse with cocaine-induced sleep disorder
F14.188	Cocaine abuse with other cocaine-induced disorder
F14.220	Cocaine dependence with intoxication, uncomplicated
F14.221	Cocaine dependence with intoxication delirium
F14.222	Cocaine dependence with intoxication with perceptual disturbance
F14.229	Cocaine dependence with intoxication, unspecified
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14.280	Cocaine dependence with cocaine-induced anxiety disorder
F14.281	Cocaine dependence with cocaine-induced sexual dysfunction
F14.282	Cocaine dependence with cocaine-induced sleep disorder
F14.288	Cocaine dependence with other cocaine-induced disorder
F14.920	Cocaine use, unspecified with intoxication, uncomplicated
F14.921	Cocaine use, unspecified with intoxication delirium
F14.922	Cocaine use, unspecified with intoxication with perceptual disturbance
F14.929	Cocaine use, unspecified with intoxication, unspecified
F14.950	Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions
F14.951	Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations
F14.959	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified
F14.980	Cocaine use, unspecified with cocaine-induced anxiety disorder
F14.981	Cocaine use, unspecified with cocaine-induced sexual dysfunction
F14.982	Cocaine use, unspecified with cocaine-induced sleep disorder
F14.988	Cocaine use, unspecified with other cocaine-induced disorder
F15.10	Other stimulant abuse, uncomplicated
F15.14	Other stimulant abuse with stimulant-induced mood disorder
F15.19	Other stimulant abuse with unspecified stimulant-induced disorder
F15.20	Other stimulant dependence, uncomplicated
F15.21	Other stimulant dependence, in remission
F15.23	Other stimulant dependence with withdrawal
F15.24	Other stimulant dependence with stimulant-induced mood disorder
F15.29	Other stimulant dependence with unspecified stimulant-induced disorder
F15.90	Other stimulant use, unspecified, uncomplicated
F15.93	Other stimulant use, unspecified with withdrawal
F15.94	Other stimulant use, unspecified with stimulant-induced mood disorder
F15.99	Other stimulant use, unspecified with unspecified stimulant-induced disorder
F15.120	Other stimulant abuse with intoxication, uncomplicated
F15.121	Other stimulant abuse with intoxication delirium
F15.122	Other stimulant abuse with intoxication with perceptual disturbance

ICD-10-CM Diagnosis Codes	Description
F15.129	Other stimulant abuse with intoxication, unspecified
F15.150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions
F15.151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations
F15.159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
F15.180	Other stimulant abuse with stimulant-induced anxiety disorder
F15.181	Other stimulant abuse with stimulant-induced sexual dysfunction
F15.182	Other stimulant abuse with stimulant-induced sleep disorder
F15.188	Other stimulant abuse with other stimulant-induced disorder
F15.220	Other stimulant dependence with intoxication, uncomplicated
F15.221	Other stimulant dependence with intoxication delirium
F15.222	Other stimulant dependence with intoxication with perceptual disturbance
F15.229	Other stimulant dependence with intoxication, unspecified
F15.250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15.251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15.259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
F15.281	Other stimulant dependence with stimulant-induced sexual dysfunction
F15.282	Other stimulant dependence with stimulant-induced sleep disorder
F15.288	Other stimulant dependence with other stimulant-induced disorder
F15.920	Other stimulant use, unspecified with intoxication, uncomplicated
F15.921	Other stimulant use, unspecified with intoxication delirium
F15.922	Other stimulant use, unspecified with intoxication with perceptual disturbance
F15.929	Other stimulant use, unspecified with intoxication, unspecified
F15.950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
F15.951	Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations
F15.959	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified
F15.980	Other stimulant use, unspecified with stimulant-induced anxiety disorder
F15.981	Other stimulant use, unspecified with stimulant-induced sexual dysfunction
F15.982	Other stimulant use, unspecified with stimulant-induced sleep disorder
F15.988	Other stimulant use, unspecified with other stimulant-induced disorder
F16.10	Hallucinogen abuse, uncomplicated
F16.14	Hallucinogen abuse with hallucinogen-induced mood disorder
F16.19	Hallucinogen abuse with unspecified hallucinogen-induced disorder
F16.20	Hallucinogen dependence, uncomplicated
F16.21	Hallucinogen dependence, in remission
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder

ICD-10-CM Diagnosis Codes	Description
F16.29	Hallucinogen dependence with unspecified hallucinogen-induced disorder
F16.90	Hallucinogen use, unspecified, uncomplicated
F16.94	Hallucinogen use, unspecified with hallucinogen-induced mood disorder
F16.99	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder
F16.120	Hallucinogen abuse with intoxication, uncomplicated
F16.121	Hallucinogen abuse with intoxication with delirium
F16.122	Hallucinogen abuse with intoxication with perceptual disturbance
F16.129	Hallucinogen abuse with intoxication, unspecified
F16.150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions
F16.151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations
F16.159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16.183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
F16.188	Hallucinogen abuse with other hallucinogen-induced disorder
F16.220	Hallucinogen dependence with intoxication, uncomplicated
F16.221	Hallucinogen dependence with intoxication with delirium
F16.229	Hallucinogen dependence with intoxication, unspecified
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16.288	Hallucinogen dependence with other hallucinogen-induced disorder
F16.920	Hallucinogen use, unspecified with intoxication, uncomplicated
F16.921	Hallucinogen use, unspecified with intoxication with delirium
F16.929	Hallucinogen use, unspecified with intoxication, unspecified
F16.950	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions
F16.951	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations
F16.959	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified
F16.980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder
F16.983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)
F16.988	Hallucinogen use, unspecified with other hallucinogen-induced disorder
F18.10	Inhalant abuse, uncomplicated

ICD-10-CM Diagnosis Codes	Description
F18.14	Inhalant abuse with inhalant-induced mood disorder
F18.17	Inhalant abuse with inhalant-induced dementia
F18.19	Inhalant abuse with unspecified inhalant-induced disorder
F18.20	Inhalant dependence, uncomplicated
F18.21	Inhalant dependence, in remission
F18.24	Inhalant dependence with inhalant-induced mood disorder
F18.27	Inhalant dependence with inhalant-induced dementia
F18.29	Inhalant dependence with unspecified inhalant-induced disorder
F18.90	Inhalant use, unspecified, uncomplicated
F18.94	Inhalant use, unspecified with inhalant-induced mood disorder
F18.97	Inhalant use, unspecified with inhalant-induced persisting dementia
F18.99	Inhalant use, unspecified with unspecified inhalant-induced disorder
F18.120	Inhalant abuse with intoxication, uncomplicated
F18.121	Inhalant abuse with intoxication delirium
F18.129	Inhalant abuse with intoxication, unspecified
F18.150	Inhalant abuse with inhalant-induced psychotic disorder with delusions
F18.151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
F18.159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
F18.180	Inhalant abuse with inhalant-induced anxiety disorder
F18.188	Inhalant abuse with other inhalant-induced disorder
F18.220	Inhalant dependence with intoxication, uncomplicated
F18.221	Inhalant dependence with intoxication delirium
F18.229	Inhalant dependence with intoxication, unspecified
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F18.280	Inhalant dependence with inhalant-induced anxiety disorder
F18.288	Inhalant dependence with other inhalant-induced disorder
F18.920	Inhalant use, unspecified with intoxication, uncomplicated
F18.921	Inhalant use, unspecified with intoxication with delirium
F18.929	Inhalant use, unspecified with intoxication, unspecified
F18.950	Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions
F18.951	Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations
F18.959	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified
F18.980	Inhalant use, unspecified with inhalant-induced anxiety disorder
F18.988	Inhalant use, unspecified with other inhalant-induced disorder
F19.10	Other psychoactive substance abuse, uncomplicated
F19.14	Other psychoactive substance abuse with psychoactive substance-induced mood disorder
F19.16	Other psychoactive substance abuse with psychoactive substance-induced persisting amnestic disorder

ICD-10-CM Diagnosis Codes	Description
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19.19	Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder
F19.20	Other psychoactive substance dependence, uncomplicated
F19.21	Other psychoactive substance dependence, in remission
F19.24	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F19.26	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.29	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
F19.90	Other psychoactive substance use, unspecified, uncomplicated
F19.94	Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder
F19.96	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting amnestic disorder
F19.97	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
F19.99	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder
F19.120	Other psychoactive substance abuse with intoxication, uncomplicated
F19.121	Other psychoactive substance abuse with intoxication delirium
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances
F19.129	Other psychoactive substance abuse with intoxication, unspecified
F19.150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
F19.151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
F19.159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F19.180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
F19.181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
F19.182	Other psychoactive substance abuse with psychoactive substance-induced sleep disorder
F19.188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated
F19.221	Other psychoactive substance dependence with intoxication delirium
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19.229	Other psychoactive substance dependence with intoxication, unspecified

ICD-10-CM Diagnosis Codes	Description
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19.231	Other psychoactive substance dependence with withdrawal delirium
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19.239	Other psychoactive substance dependence with withdrawal, unspecified
F19.250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19.259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19.282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F19.920	Other psychoactive substance use, unspecified with intoxication, uncomplicated
F19.921	Other psychoactive substance use, unspecified with intoxication with delirium
F19.922	Other psychoactive substance use, unspecified with intoxication with perceptual disturbance
F19.929	Other psychoactive substance use, unspecified with intoxication, unspecified
F19.930	Other psychoactive substance use, unspecified with withdrawal, uncomplicated
F19.931	Other psychoactive substance use, unspecified with withdrawal delirium
F19.932	Other psychoactive substance use, unspecified with withdrawal with perceptual disturbance
F19.939	Other psychoactive substance use, unspecified with withdrawal, unspecified
F19.950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions
F19.951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations
F19.959	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified
F19.980	Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder
F19.981	Other psychoactive substance use, unspecified with psychoactive substance-induced sexual dysfunction
F19.982	Other psychoactive substance use, unspecified with psychoactive substance-induced sleep disorder
F19.988	Other psychoactive substance use, unspecified with other psychoactive substance-induced disorder

ICD-10-CM Diagnosis Codes	Description
F55.0	Abuse of antacids
F55.1	Abuse of herbal or folk remedies
F55.2	Abuse of laxatives
F55.3	Abuse of steroids or hormones
F55.4	Abuse of vitamins
F55.8	Abuse of other non-psychoactive substances
R78.0	Finding of alcohol in blood
Z71.41	Alcohol abuse counseling and surveillance of alcoholic
Z71.51	Drug abuse counseling and surveillance of drug abuser

Table 1: Primary Care Based Services Proposed to be Included Under the Primary Care Capitation

	HCPC/CPT	Description
1	96160	Administration of patient-focused health risk assessment instrument
2	96161	Administration of caregiver-focused health risk assessment instrument
3	99201	New Patient, brief
4	99202	New Patient, limited
5	99203	New Patient, moderate
6	99204	New Patient, comprehensive
7	99205	New Patient, extensive
8	99211	Established Patient, brief
9	99212	Established Patient, limited
10	99213	Established Patient, moderate
11	99214	Established Patient, comprehensive
12	99215	Established Patient, extensive
13	99304	Initial Nursing Facility Care
14	99305	Initial Nursing Facility Care
15	99306	Initial Nursing Facility Care
16	99307	Subsequent Nursing Facility Care
17	99308	Subsequent Nursing Facility Care
18	99309	Subsequent Nursing Facility Care
19	99310	Subsequent Nursing Facility Care
20	99311	Subsequent Nursing Facility Care
21	99312	Subsequent Nursing Facility Care
22	99313	Subsequent Nursing Facility Care
23	99314	Subsequent Nursing Facility Care
24	99315	Nursing Facility Discharge Services
25	99316	Nursing Facility Discharge Services
26	99317	Nursing Facility Discharge Services
27	99318	Other Nursing Facility Care
28	99324	New Patient, brief
29	99325	New Patient, limited
30	99326	New Patient, moderate
31	99327	New Patient, comprehensive
32	99328	New Patient, extensive
33	99334	Established Patient, brief
34	99335	Established Patient, moderate
35	99336	Established Patient, comprehensive
36	99337	Established Patient, extensive
37	99339	Brief
38	99340	Comprehensive
39	99341	New Patient, brief
40	99342	New Patient, limited
41	99343	New Patient, moderate
42	99344	New Patient, comprehensive
43	99345	New Patient, extensive
44	99347	Established Patient, brief
45	99348	Established Patient, moderate
46	99349	Established Patient, comprehensive

47	99350	Established Patient, extensive
48	99354	Prolonged visit, first hour
49	99355	Prolonged visit, add'l 30 mins
50	99421	Online digital, Established Patient, 5–10 mins
51	99422	Online digital, Established Patient, 10–20 mins
52	99423	Online digital, Established Patient, 21+ mins
53	99441	Phone, Established Patient, 5–10 mins – Note: for PHE only
54	99442	Phone, Established Patient, 10–20 mins – Note: for PHE only
55	99443	Phone, Established Patient, 21+ mins – Note: for PHE only
57	99484	Monthly services furnished using BHI models
58	99487	Extended care coordination time for especially complex patients (first 60 mins)
59	99489	Add'l care coordination time for especially complex patients (30 mins)
60	99490	Comprehensive care plan establishment/implementations/revision/monitoring
62	99492	Initial psychiatric collaborative care management, first 70 mins
63	99493	Subsequent psychiatric collaborative care management, first 60 mins
64	99494	Initial or subsequent psychiatric collaborative care management, add'l 30 mins
65	99495	Communication (14 days of discharge)
66	99496	Communication (7 days of discharge)
67	99497	ACP first 30 mins – Note: subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation
68	99498	ACP add'l 30 mins – Note: subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation
69	G0402	Welcome to Medicare visit
70	G0438	Annual wellness visit
71	G0439	Annual wellness visit
72	G0442	Annual alcohol misuse screening
73	G0443	Annual alcohol misuse counseling
74	G0444	Annual depression screening
75	G0463	Professional Services Provided in ETA Hospitals
76	G0506	Add'l work for the billing provider in face-to-face assessment or CCM planning
77	G2010	Remote evaluation, Established Patient – Note: for PHE only
78	G2012	Brief communication technology-based service, 5-10 mins of medical discussion – Note: for PHE only

Table 2: Primary Care Specialist Table

Code[i]	Specialty
1	General Practice
8	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical nurse specialist
97	Physician Assistant

[i] The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf.

Appendix D: Synchronous and Asynchronous Telehealth, Post Discharge Home Visits, Care Management Home Visits - Code Tables

Table 1 contains codes for Synchronous Telehealth indicated by Benefit Enhancement "2"

Table 2 contains codes for Asynchronous Telehealth indicated by Benefit Enhancement "2"

Table 3 contains codes for Post Discharge Home Visits indicated by Benefit Enhancement "3"

Table 4 contains codes for Care Management Home Visits indicated by Benefit Enhancement "7"

.

Table 1: Healthcare Common Procedure Coding System (HCPCS) codes for Synchronous Telehealth

HCPCS Code	Short Descriptors
G9481	Remote E/M new pt 10 mins.
G9482	Remote E/M new pt 20 mins.
G9483	Remote E/M new pt 30 mins.
G9484	Remote E/M new pt 45 mins.
G9485	Remote E/M new pt 60 mins.
G9486	Remote E/M established pt 10 mins
G9487	Remote E/M established pt 15 mins
G9488	Remote E/M established pt 25 mins
G9489	Remote E/M established pt 40 mins
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPPS); first visit
G0439	Annual wellness visit; includes a personalized prevention plan of service (PPPS); subsequent visit

Table 2: Healthcare Common Procedure Coding System (HCPCS) codes for Asynchronous Telehealth

HCPCS Code	Descriptors
G9868	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use only in a Medicare-approved CMMI model, less than 10 minutes
G9869	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use only in a Medicare-approved CMMI model, less than 10-20 minutes
G9870	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use only in a Medicare-approved CMMI model, less than 20 or more minutes

Table 3: Healthcare Common Procedure Coding System (HCPCS) codes for Post Discharge Home Visits

HCPCS Code	Short Descriptors
G2001	Post-Discharge Home Visit new patient 20 minutes
G2002	Post-Discharge Home Visit new patient 30 minutes
G2003	Post-Discharge Home Visit new patient 45 minutes
G2004	Post-Discharge Home Visit new patient 60 minutes
G2005	Post-Discharge Home Visit new patient 75 minutes
G2006	Post-Discharge Home Visit existing patient 20 minutes
G2007	Post-Discharge Home Visit existing patient 30 minutes
G2008	Post-Discharge Home Visit existing patient 45 minutes
G2009	Post-Discharge Home Visit existing patient 60 minutes
G2013	Post-Discharge Home Visit existing patient 75 minutes
G2014	Post-Discharge care plan over 30 minutes
G2015	Post-Discharge care plan over 60 minutes

Table 4: Healthcare Common Procedure Coding System (HCPCS) codes for Care Management Home Visits

HCPCS Code	Short Descriptors
G0076	Care Management Home Visits new patient 20 minutes
G0077	Care Management Home Visits new patient 30 minutes
G0078	Care Management Home Visits new patient 45 minutes
G0079	Care Management Home Visits new patient 60 minutes
G0080	Care Management Home Visits new patient 75 minutes
G0081	Care Management Home Visits exist patient 20 minutes
G0082	Care Management Home Visits exist patient 30 minutes
G0083	Care Management Home Visits exist patient 45 minutes
G0084	Care Management Home Visits exist patient 60 minutes
G0085	Care Management Home Visits existing patient 75 minutes
G0086	Care Management Home Visits care plan overs 30 minutes
G0087	Care Management Home Visits care plan overs 60 minutes

Appendix E – Background Artifacts

Table 1: Participant Provider and Preferred Provider Distinction

	Participant Providers, Provider Type = 'S'	Preferred Providers, Provider Type = 'P'[i]
Contribute to alignment?	Yes	No
Report quality?	Yes	No
Allowed to overlap with other models?	No	Yes
Can participate in Payment Mechanisms?	Yes, required for some	Yes, optional for all
Can participant in Benefit Enhancements	Yes, optional for all	Yes, optional for all

Table 2: PCC vs. APO for Professional Claims

PCC vs APO for Professional claims	Specialty codes in Table 2 of Appendix D	All other specialty codes
CPT/HCPCS codes in Table 1 of Appendix D	PCC	APO
All other CPT/HCPCS codes	APO	APO

Table 3: PCC vs. APO for Institutional Claims

PCC vs APO for Institutional claims	FQHCs/RHCs	All other institutional providers
PCC	All services	No services
APO	No services	All services

Table 4: Summary table of TCC, PCC, and APO features

	TCC	PCC	APO
Relevant claims / services	All institutional and professional services	**Professional** claims (line-level): Only CPT/HCPCS codes in Table 1 on claims with specialty code in Table 2 of Appendix D **Institutional** claims: all services billed by FQHCs and RHCs regardless of HCPCS or revenue code	**Professional** claims (line-level): All services not subject to PCC (i.e., all CPT/HCPCS codes **not** in Table 1 or CPT/HCPCS codes in Table 1 with specialty codes **not** in Table 2 of Appendix D). **Institutional** claims: all services billed by all institutional providers besides FQHCs and RHCs
Available to:	Providers aligned to DCEs choosing TCC	Providers aligned to DCEs choosing PCC	Providers aligned to DCEs choosing PCC

Not available to:		Providers billing institutional bill types (TOB) other than FQHCs and RHCs	FQHCs and RHCs billing NPIs for institutional providers
Participant providers:	Mandatory claims reduction of 100%	Optional; those that opt in can choose claims reduction of 1-100%	Optional; those that opt in can choose claims reduction of 1-100%
Preferred Providers:	Optional; those that opt in can choose claims reduction of 1-100%	Optional; those that opt in can choose claims reduction of 1-100%	Optional; those that opt in can choose claims reduction of 1-100%

Table 5: Additional Detail on the Homebound Home Health Waiver and Concurrent Care for Beneficiaries that Elect the Medicare Hospice

	Traditional Medicare	DC Benefit Enhancement
Homebound Home Health Waiver (BE Indicator "9")		
Eligibility criteria	• Bene must need the assistance of a supportive device, special transportation, or another person to leave their residence OR • Have a condition that makes leaving his or her home medically contraindicated AND • There must be a normal inability to leave the home AND • Leaving home must require a considerable and taxing effort	• Otherwise qualify for home health services under Traditional Medicare, but bene not required to have a normal inability to leave the home • Aligned bene has at least 1 unplanned inpatient admission or ED visit in the prior 12 months AND • Have at least 2 chronic conditions AND • Have 1 of 3: inpatient service utilization, frailty, and/or social isolation
Requirements of SSMs		• Activate this BE • Ignore the homebound requirement for home health services for aligned bene and provider but otherwise follow requirements regarding Medicare coverage and payment for home health services under Traditional Medicare • Ensure the home health services are rendered in beneficiary's home or place of residence during the certified episode of care period.
Responsibilities outside SSMs		• CMS vets and grants DCEs the BE using the Homebound Home Health Waiver Form • CMS monitors provider utilization of the waiver
Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit (BE Indicator "B")		

Eligibility criteria for curative / conventional care	• Beneficiaries who are **not** enrolled in Medicare Hospice benefit	• Beneficiaries enrolled in Medicare Hospice benefit
Requirements of SSMs		• Discontinue existing claims-based edits to prevent non-hospice claims from processing while a beneficiary is Hospice-enrolled for both hospice and non-hospice organizations aligned to the DCE • Reimburse claims related to concurrent care provided to aligned Hospice-enrolled beneficiaries from organizations aligned to the DCE that are otherwise appropriate for payment under Traditional Medicare
Responsibilities outside SSMs		• Aligned organizations define and provide CMS a set of concurrent care services. • CMS monitors provider utilization of the waiver

[i] These provider type values are found in Table 57 of the ICD.

ACO/ESCO/Entity/Practice ID	Provider Type (Refer ICD for more details)	Provider TIN	Provider Organizational NPI (oNPI)	Provider Individual NPI (iNPI)	Provider CCN	Record Type (Refer ICD for more details on the codes)	Record Type in human friendly words	Provider/Enhancement Effective Start Date	Provider/Enhancement Effective End Date	Part A Percentage Reduction (see ICD for format)	Part B Percentage Reduction (see ICD for format)	ETC_IND (only for CKCC model)	ACO/ESCO/Entity/Practice ID	Delete Flag (Valid Value – 'D' or BLANK)	Beneficiary HICN	Beneficiary Effective Start Date CCYYMMDD	Beneficiary Effective End Date CCYYMMDD	Beneficiary Host ID (Refer ICD for more details)	Beneficiary Host ID in human friendly words – Region	Beneficiary Gender (Valid Value – M – Male F – Female U – Unknown)	Beneficiary Medical Data Sharing Preference Indicator (Valid Value – Y = Yes N = No)	Population Indicator Note: applicable for PCF model only	QCP Indicator Note: Applicable only for KCF and CKCC models only
This filed is optional, ESCO/ C team will fill with Test IDs Examples: PCF: PCF9999 NGACO: Y999 VTAPM: F999 CEC: E9999 DC: D9999 KCF: K9999 ACF: A9999												This column is applicable for only CKCC Model	This filed is optional, ESCO/ C team will fill with Test IDs Examples: PCF: PCF9999 NGACO: Y999 VTAPM: F999 CEC: E9999 DC: D9999 KCF: K9999 ACF: A9999									this column is applicable for only PCF Model	This column is applicable for only CKCC & ACF Model

Centers for Medicare & Medicaid Services
CMS Target Life Cycle (TLC)

CMMI Fee-For-Service (FFS) Shared System Maintainer (SSM) and the Accountable Care Organization – Operational System (ACO-OS) Interface Control Document (ICD)

Version 8.6

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1 Introduction

The Accountable Care Organization – Operational System (ACO-OS) handles the data collection and exchange required to manage the Next Generation Accountable Care Organization (NGACO) Model, the Vermont All Payer (VT APM) Model, the Comprehensive End Stage Renal Disease Care (CEC) Model, the Direct Contracting Model, the Kidney Care Choices (KCC) Model, and the Primary Care First (PCF) Model. The ACO-OS must effectively incorporate data that the Centers for Medicare & Medicaid Services (CMS) currently manage with new data the ACOs and the ESRD Care Organizations (ESCOs) produce. The system must help CMS and these organizations manage, track, and report data so that the ACOs and ESCOs (who will be referred to collectively throughout this document as Entities) understand the totality of care provided to their beneficiaries.

This Integrated Control Document (ICD) specifies interface requirements that the ACO-OS and the Fee-for-Service Shared System Maintainers (FFS SSMs) must meet. In this document, the phrase “FFS SSMs” refers to the following Shared Systems: Common Working File (CWF) Application, Fiscal Intermediary Shared System (FISS), and Multi-Carrier System (MCS). This ICD describes the interface concept of operations (ConOps), defines the message structure and protocols that govern data interchange, and identifies the communication paths along which data are expected to flow.

1.1 Purpose

This ICD describes the relationship between the ACO-OS and the Medicare FFS SSMs for Provider and Beneficiary information as it relates to NGACO, VT APM, CEC, Direct Contracting, KCC, and PCF Models.

1.2 Project Overview

The Center for Medicare & Medicaid Innovation (CMMI) has developed the Medicare NGACO Model as one of the next-generation provider-based ACO models. The NGACO Model and VT APM operate in the traditional FFS Medicare program and maintains key aspects of the Medicare Shared Savings Program and former Pioneer Demonstration, and includes new design elements to test whether greater financial risk, more predictable financial targets and payment, benefit enhancements, and a focus on beneficiary engagement can collectively accelerate and sustain improvement in healthcare value.

The CEC Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD. Through the CEC Model, CMS will partner with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care. The CEC Model will implement design elements with implications for the FFS system that includes benefit enhancements to give Entities the tools to direct care and engage beneficiaries in their own care. The model also offers increased monitoring to account for different financial incentives and the provision of enhanced benefits.

KCC is designed to help health care providers reduce the cost and improve the quality of care for patients with late-stage chronic kidney disease and ESRD. This Model also aims to delay the need for dialysis and encourage kidney transplantation.

KCC has two pathways namely Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC) based on the provider participation.

1. KCF is a pathway available for Entities comprising of Medicare enrolled participants who must only be nephrology practices and their nephrologists.
2. CKCC is a pathway available for Entities comprising of nephrologists, transplant providers, and other kidney care providers - including dialysis facilities. In this pathway, entities are not enrolled in Medicare.

The payment model options available under Direct Contracting aim to reduce expenditures while preserving or enhancing quality of care for beneficiaries. By aligning financial incentives, providing a prospectively determined and predictable revenue stream for participants, and putting a greater emphasis on beneficiary choice, the payment model option aims to transform risk-sharing arrangements in Medicare FFS, broaden participation in CMS Innovation Center (IC) models, empower beneficiaries, and reduce provider burden.

PCF is designed for primary care practices with advanced primary care capabilities, including those that specialize in caring for complex, chronically ill patient populations, that are prepared to accept increased financial risk in exchange for greater flexibility and potential rewards based on practice performance. This model is also designed to include practices that specialize in caring for high need, serious illness populations.

Practices under Primary Care First can choose from three participation options:

1. Practices choose to participate only in the PCF-General component of Primary Care First, and not in the Seriously Ill Population (SIP) component, i.e. “PCF-General practices”
2. Practices choose to participate only in the SIP component of Primary Care First, and not in the PCF-General component, i.e. “SIP-only practices”
3. Practices choose to participate in both the SIP and PCF-General components of Primary Care First, i.e. “hybrid practices.”

The PCF payment structure offers two different payment methodologies:

1. Total Primary Care Payment (TPCP) – Utilizes a professional Population-Based Payment (professional PBP), paid on a quarterly basis or a flat fee for each primary care visit, paid on a claim-by-claim basis.
2. Performance-Based Adjustment (PBA) – Based on quality and patient performance measures and paid on a quarterly basis.

This ICD provides the following information:

- A general interface description
- Assumptions, where appropriate
- A description of the data exchange format and exchange protocol
- Estimated data exchange size and frequency

2 ICD Overview

The ACO-OS sends the NGACO Beneficiary file with the following information to the Common Working Files (CWF) at the CWF HP Host:

- NGACO Beneficiary File Header
- NGACO Beneficiary Record Detail
- NGACO Beneficiary File Trailer

The ACO-OS sends the VT APM Beneficiary file with the following information to the Common Working Files (CWF) at the CWF HP Host:

- VT APM Beneficiary File Header
- VT APM Beneficiary Record Detail
- VT APM Beneficiary File Trailer

The ACO-OS sends the Part A/Part B NGACO/VT APM Provider file with the following information to the Multi-Carrier System (MCS) at the Hewlett Packard (HP) Virtual Data Center (VDC):

- Part A/Part B NGACO/VT APM Provider File Header
- Part A/Part B NGACO/VT APM Provider Record Detail
- Part A/Part B NGACO/VT APM Provider File Trailer

ACO-OS receives the NGACO Beneficiary Response file with the following information from the CWF:

- NGACO Beneficiary Response File Header
- NGACO Beneficiary Response Record Detail
- NGACO Beneficiary Response File Trailer

ACO-OS receives the VT APM Beneficiary Response file with the following information from the CWF:

- VT APM Beneficiary Response File Header
- VT APM Beneficiary Response Record Detail
- VT APM Beneficiary Response File Trailer

ACO-OS receives the Part A/Part B NGACO/VT APM Provider Response file with the following information from the MCS:

- Part A/Part B NGACO/VT APM Provider Response File Header
- Part A/Part B NGACO/VT APM Provider Response Record Detail
- Part A/Part B NGACO/VT APM Provider Response File Trailer

ACO-OS receives the following pass-through file from CWF for NGACO and VT APM. The details on the pass-through file are provided in Appendix B.

- Weekly All-Inclusive Population Based Payment (AIPBP) Reduction File

ACO-OS will receive the following pass-through file from CWF for Direct Contracting from 01/01/2021 onward. The details on the pass-through file are provided in Appendix C.

- Weekly Advanced Payment Option (APO)/Total Care Capitation (TCC)/Primary Care Capitation (PCC) Reduction File

ACO-OS will receive the following pass-through file from CWF for CKCC from 01/01/2021 onward. The details on the pass-through file are provided in Appendix D.

- Weekly TCC/Quarterly Capitation Payment (QCP) Reduction File

ACO-OS will receive the following pass-through file from CWF for KCC from 01/01/2021 onward. The details on the pass-through file are provided in Appendix E.

- Weekly QCP Reduction File

ACO-OS sends the CEC Beneficiary file with the following information to the CWF at the CWF HP Host:

- CEC Beneficiary File Header
- CEC Beneficiary Record Detail
- CCE Beneficiary File Trailer

ACO-OS sends the CEC Participant file with the following information to the MCS at the HP VDC:

- CEC Participant File Header
- CEC Participant Record Detail
- CEC Participant File Trailer

ACO-OS receives the CEC Beneficiary Response file with the following information from the CWF:

- CEC Beneficiary Response File Header
- CEC Beneficiary Response Record Detail
- CEC Beneficiary Response File Trailer

ACO-OS receives the CEC Participant Response file with the following information from the MCS:

- CEC Participant Response File Header
- CEC Participant Response Record Detail
- CEC Participant Response File Trailer

The ACO-OS sends the CKCC Beneficiary file with the following information to the CWF at the CWF HP Host:

- CKCC Beneficiary File Header
- CKCC Beneficiary Record Detail
- CKCC Beneficiary File Trailer

The ACO-OS sends the KCF Beneficiary file with the following information to the CWF at the CWF HP Host:

- KCF Beneficiary File Header
- KCF Beneficiary Record Detail
- KCF Beneficiary File Trailer

The ACO-OS sends the Direct Contracting Beneficiary file with the following information to the CWF at the CWF HP Host:

- Direct Contracting Beneficiary File Header
- Direct Contracting Beneficiary Record Detail
- Direct Contracting Beneficiary File Trailer

The ACO-OS sends the PCF Beneficiary file with the following information to the CWF at the CWF HP Host:

- PCF Beneficiary File Header
- PCF Beneficiary Record Detail
- PCF Beneficiary File Trailer

The ACO-OS sends the Part A/Part B CKCC/KCF Provider file with the following information to the MCS at the HP VDC:

- Part A/Part B CKCC/KCF Provider File Header
- Part A/Part B CKCC/KCF Provider Record Detail
- Part A/Part B CKCC/KCF Provider File Trailer

The ACO-OS sends the Part A/Part B Direct Contracting Provider file with the following information to the MCS at the HP VDC:

- Part A/Part B Direct Contracting Provider File Header
- Part A/Part B Direct Contracting Provider Record Detail
- Part A/Part B Direct Contracting Provider File Trailer

The ACO-OS sends the Part B PCF Provider file with the following information to the MCS at the HP VDC:

- Part B PCF Provider File Header
- Part B PCF Provider Record Detail
- Part B PCF Provider File Trailer

ACO-OS sends the CKCC/KCF Participant file with the following information to the MCS at the Companion Data Services (CDS):

- CKCC/KCF Participant File Header
- CKCC/KCF Participant Record Detail
- CKCC/KCF Participant File Trailer

ACO-OS sends the Direct Contracting Participant file with the following information to the MCS at the CDS:

- Direct Contracting Participant File Header

- Direct Contracting Participant Record Detail
- Direct Contracting Participant File Trailer

ACO-OS sends the PCF Participant file with the following information to the MCS at the CDS:

- PCF Participant File Header
- PCF Participant Record Detail
- PCF Participant File Trailer

ACO-OS receives the CKCC Beneficiary Response file with the following information from the CWF:

- CKCC Beneficiary Response File Header
- CKCC Beneficiary Response Record Detail
- CKCC Beneficiary Response File Trailer

ACO-OS receives the KCF Beneficiary Response file with the following information from the CWF:

- KCF Beneficiary Response File Header
- KCF Beneficiary Response Record Detail
- KCF Beneficiary Response File Trailer

ACO-OS receives the Direct Contracting Beneficiary Response file with the following information from the CWF:

- Direct Contracting Beneficiary Response File Header
- Direct Contracting Beneficiary Response Record Detail
- Direct Contracting Beneficiary Response File Trailer

ACO-OS receives the PCF Beneficiary Response file with the following information from the CWF:

- PCF Beneficiary Response File Header
- PCF Beneficiary Response Record Detail
- PCF Beneficiary Response File Trailer

ACO-OS receives the CKCC/KCF Participant Response file with the following information from the MCS:

- CKCC/KCF Participant Response File Header
- CKCC/KCF Participant Response Record Detail
- CKCC/KCF Participant Response File Trailer

ACO-OS receives the Direct Contracting Participant Response file with the following information from the MCS:

- Direct Contracting Participant Response File Header
- Direct Contracting Participant Response Record Detail
- Direct Contracting Participant Response File Trailer

ACO-OS receives the PCF Participant Response file with the following information from the MCS:

- PCF Participant Response File Header
- PCF Participant Response Record Detail
- PCF Participant Response File Trailer

3 Assumptions, Constraints, and Risks

This section describes assumptions, constraints, and risks associated with the interface.

3.1 Assumptions

The following assumption applies to the project:

The ACO-OS delivers the data to the FFS SSMs with specified message formatting (or record layouts) and required protocols as per the agreed Interface Initiation.

3.2 Constraints

Operational success depends on the availability and quality of data from the ACO-OS to the FFS SSMs.

3.3 Risks

The following risk may impact achievement of project performance goals:

Changes to the baseline requirement/data file layout will impact the timely implementation of this interface.

4 General Interface Requirements

This section describes general interface requirements.

4.1 Interface Overview

1. The ACO-OS sends the Part A/Part B NGACO/VT APM Provider file to the MCS at the HP VDC. The MCS sends the Part A/Part B NGACO/VT APM Provider Response file back to the ACO-OS.
2. The ACO-OS sends the NGACO Beneficiary file to the CWF at the CWF HP Host. The CWF sends the NGACO Beneficiary Response file back to the ACO-OS.
3. The ACO-OS sends the VT APM Beneficiary file to the CWF at the CWF HP Host. The CWF sends the VT APM Beneficiary Response file back to the ACO-OS.
4. The ACO-OS sends will send Direct Contracting Beneficiary file to the CWF at the CWF HP Host. The CWF sends the Direct Contracting Beneficiary Response file back to the ACO-OS.
5. The ACO-OS sends the CKCC Beneficiary file to the CWF at the CWF HP Host. The CWF sends the CKCC Beneficiary Response file back to the ACO-OS.
6. The ACO-OS sends the KCF Beneficiary file to the CWF at the CWF HP Host. The CWF sends the KCF Beneficiary Response file back to the ACO-OS.

7. The ACO-OS sends the PCF Beneficiary file to the CWF at the CWF HP Host. The CWF sends the PCF Beneficiary Response file back to the ACO-OS.
8. The ACO-OS sends the Weekly AIPBP Reduction file (pass-through file) received from CWF to Entities via the Receipt and Control System (RACS) for the NGACO, VT APM, and Direct Contracting models. These files are sent through the Electronic File Transfer (EFT) platform and are available to Entities through Entity-specific mailboxes. (For the purposes of communicating with Entities, EFT is referred to as Managed File Transfer [MFT].) These files will contain all new AIPBP claims processed information during the week for any aligned beneficiary.
9. The ACO-OS will also store these weekly files for the system of record and redistribute them to the Entities upon request.
10. The ACO-OS sends the CEC Beneficiary file to the CWF at CWF HP Host. The CWF sends the CEC Beneficiary Response file back to the ACO-OS.
11. The ACO-OS sends the CEC Participant file to the MCS at HP VDC. The MCS sends the CEC Participant Response file back to the ACO-OS.

4.2 Functional Allocation

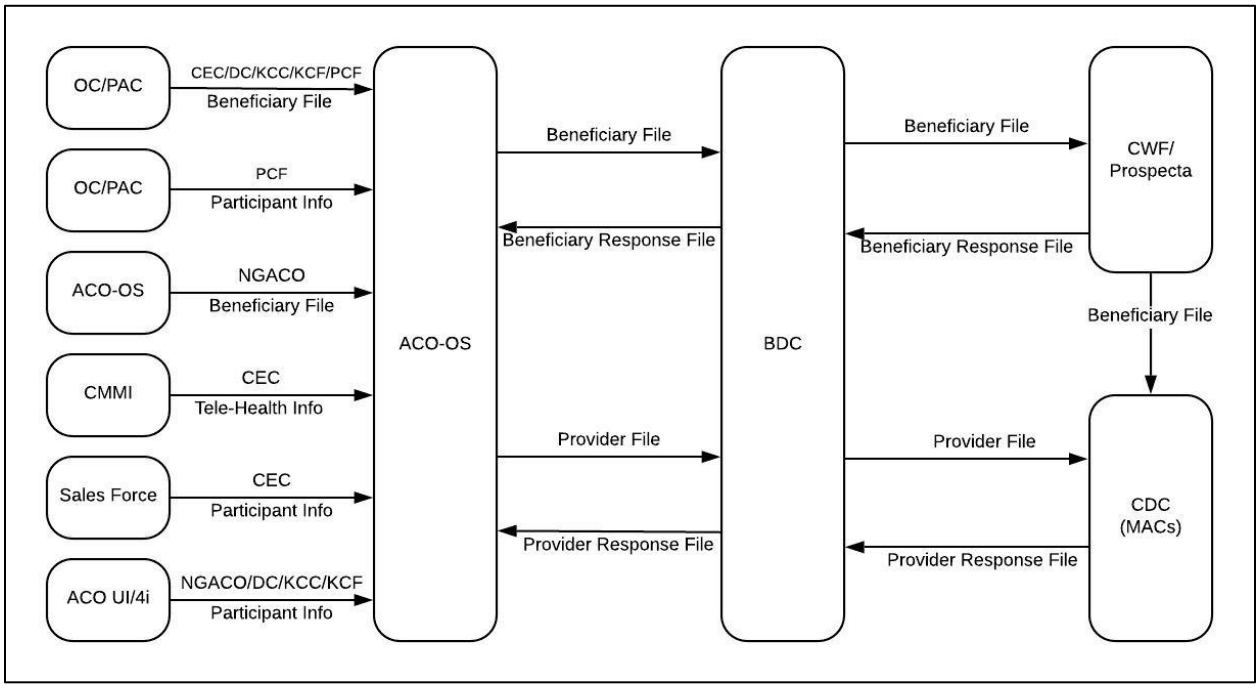
1. Based on Part A/Part B NGACO/VT APM Provider, NGACO Beneficiary information, and VT APM Beneficiary information maintained within the ACO-OS, the ACO-OS creates the following and sends the files to FFS SSMs:
    - Part A/Part B NGACO/VT APM Provider file
    - NGACO Beneficiary file
    - VT APM Beneficiary file
2. Based on CEC Participant and CEC Beneficiary information maintained within the ACO-OS, the ACO-OS creates the following and sends the files to FFS SSMs:
    - CEC Participant file
    - CEC Beneficiary file
3. Based on CKCC/KCF Participant and CKCC/KCF Beneficiary information maintained within the ACO-OS, the ACO-OS creates the following and sends the files to FFS SSMs:
    - CKCC/KCF Participant file
    - CKCC Beneficiary file
    - KCF Beneficiary file
4. Based on Direct Contracting Participant and Direct Contracting Beneficiary information maintained within the ACO-OS, the ACO-OS creates the following and sends the files to FFS SSMs:
    - Direct Contracting Participant file
    - Direct Contracting Beneficiary file
5. Based on PCF Participant and PCF Beneficiary information maintained within the ACO-OS, the ACO-OS creates the following and sends the files to FFS SSMs:
    - PCF Participant file

- PCF Beneficiary file

4.3 Data Transfer

The diagrams in the figures below display the data flow for the ACO-OS to FFS SSMs file transfers.

Figure 1: NGACO/VT APM /CKCC/KCF/Direct Contracting/PCF FFS SSM Data Flow



4.4 Transactions

1. The ACO-OS sends the following files to the CWF at the CWF HP Host:
   - NGACO Beneficiary file
   - VT APM Beneficiary file
   - CKCC Beneficiary file
   - KCF Beneficiary file
   - Direct Contracting Beneficiary file
   - PCF Beneficiary file
2. The ACO-OS sends the following file to the MCS at the HP VDC:
   - Part A/Part B NGACO/VT APM Provider file
   - Part A/Part B CKCC/KCF Provider file
   - Part A/Part B Direct Contracting Provider file
   - Part B PCF Provider file
3. The MCS sends a response file back to the ACO-OS for the Part A/Part B NGACO/VT APM Provider file received from the ACO-OS.

4. The CWF sends a response file back to the ACO-OS for the NGACO Beneficiary file received from the ACO-OS.
5. The CWF sends a response file back to the ACO-OS for the VT APM Beneficiary file received from the ACO-OS.
6. The CWF sends a response file back to the ACO-OS for the CKCC Beneficiary file received from the ACO-OS.
7. The CWF sends a response file back to the ACO-OS for the KCF Beneficiary file received from the ACO-OS.
8. The CWF sends a response file back to the ACO-OS for the Direct Contracting Beneficiary file received from the ACO-OS.
9. The CWF sends a response file back to the ACO-OS for the PCF Beneficiary file received from the ACO-OS.
10. If there are any errors identified on the Part A/Part B NGACO/VT APM/CKCC/KCF/Direct Contracting/PCF Provider Response file, the ACO-OS sends a full refresh Part A/Part B NGACO/VT APM/CKCC/ KCF/Direct Contracting/PCF Provider file back to the MCS at the HP VDC.
11. If there are any errors identified on the NGACO Beneficiary Response file, the ACO-OS sends a full refresh NGACO Beneficiary file back to the CWF at the CWF HP Host.
12. If there are any errors identified on the VT APM Beneficiary Response file, the ACO-OS sends a full refresh VT APM Beneficiary file back to the CWF at the CWF HP Host.
13. If there are any errors identified on the CKCC Beneficiary Response file, the ACO-OS sends a full refresh CKCC Beneficiary file back to the CWF at the CWF HP Host.
14. If there are any errors identified on the KCF Beneficiary Response file, the ACO-OS sends a full refresh KCF Beneficiary file back to the CWF at the CWF HP Host.
15. If there are any errors identified on the Direct Contracting Beneficiary Response file, the ACO-OS sends a full refresh Direct Contracting Beneficiary file back to the CWF at the CWF HP Host.
16. If there are any errors identified on the PCF Beneficiary Response file, the ACO-OS sends a full refresh PCF Beneficiary file back to the CWF at the CWF HP Host.
17. The ACO-OS sends the Weekly AIPBP Reduction File (pass-through file) received from CWF to Entities via RACS (specified in Appendix B). RACS logs the receipt of the pass-through file and then forwards the pass-through file to the NGACO/VT APM/CCKC/KCF/Direct Contracting Entities. The ACO-OS also stores these files for the system of record.
18. The ACO-OS sends the following file to the CWF at the CWF HP Host:
    - CEC Beneficiary file
19. The ACO-OS sends the following file to the MCS at the HP VDC:
    - CEC Participant file
20. The MCS sends a response file back to the ACO-OS for the CEC Participant file received from the ACO-OS.
21. The CWF sends a response file back to the ACO-OS for the CEC Beneficiary file received from the ACO-OS.

22. If there are any errors identified on the CEC Participant Response file, the ACO-OS sends a full refresh CEC Participant file back to the MCS at the HP VDC.
23. If there are any errors identified on the CEC Beneficiary Response file, the ACO-OS sends a full refresh CEC Beneficiary file back to the CWF at the CWF HP Host.

4.5 Security and Integrity

Files are transmitted using the CMS EFT process over a secure connection.

5 Detailed Interface Requirements

This section describes detailed interface requirements.

5.1 NGACO Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the NGACO Beneficiary file.

5.1.1 General Processing

The ACO-OS sends the NGACO Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the NGACO Beneficiary Response file to the ACO-OS.

5.1.2 Interface Processing Time Requirements

The NGACO Beneficiary data from the ACO-OS will routinely be sent monthly but could be sent more frequently if Business needs require. A full refresh file will be sent even if there is no change to the Beneficiary data. This full refresh file contains the NGACO Beneficiary data from 01/01/2016 onward.

The ACO-OS will include the most current Health Insurance Claim Number (HICN) and/or Railroad Retirement Board (RRB) Numbers associated with the beneficiary in NGACO Beneficiary file. The Delete Flag is available as of the ACO-OS December 2015 release for the excluded Beneficiaries based on program precedence exclusion.

5.1.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.1.4 File Layout

Each ACO-OS provided NGACO Beneficiary file and the corresponding CWF NGACO Beneficiary Response file has a header, record details, and trailer as described in section 5.1.4.2.

5.1.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.1.4.2.

5.1.4.2 Field/Element Definitions

All tables briefly describe a NGACO Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 1: NGACO Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the NGACO Beneficiary file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	40	CHAR	Blanks

Table 2: NGACO Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the NGACO Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	38	CHAR	As provided by the ACO-OS

Table 3: ACO-OS to NGACO Beneficiary Record Detail

Data Fields marked with an [I] contain Personally Identifiable Information (PII).

Data Fields marked with an [H] contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the NGACO Beneficiary file	1	7	CHAR	DTL_BEN
NGACO ACO Organization Identifier	Unique identifier for NGACO ACO	8	10	CHAR	V<nnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the NGACO alignment	18	1	CHAR	'D' or Blank
Beneficiary HICN/ Beneficiary RRB# [I] [H]	Beneficiary HICN/Beneficiary External RRB Number	19	12	CHAR	Alphanumeric characters
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the NGACO ACO	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a NGACO ACO	39	8	CHAR	CCYYMMDD
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M – Male F – Female U – Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
Filler		50	6	CHAR	Blanks

Table 4: FFS SSM to ACO-OS NGACO Beneficiary Response Record Detail

Data Fields marked with an I contain PII.

Data Fields marked with an H contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the NGACO Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As applicable
NGACO Organization Identifier	Unique identifier for NGACO ACO	10	10	CHAR	As provided by the ACO-OS
Delete Flag	Beneficiary who never should have been aligned, thus removed from the NGACO alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN/ Beneficiary RRB# I H	Beneficiary HICN/Beneficiary External RRB Number	21	12	CHAR	As provided by the ACO-OS
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with an NGACO ACO	33	8	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Effective End Date	Effective end date of the beneficiary's association with an NGACO ACO	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
Filler		52	4	CHAR	As provided by the ACO-OS

Table 5: NGACO Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the NGACO Beneficiary file	1	7	CHAR	TRL_BEN
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler		26	30	CHAR	Blanks

Table 6: NGACO Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the NGACO Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	28	CHAR	As provided by the ACO-OS

5.1.4.3 Filenames

The NGACO Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.BENE.Dyymmdd.Thhmmsst**. For example, an outbound file for December 15, 2019, at 10:00 AM would be:

P#EFT.ON.CWFHP.BENE.D191215.T1000000.

The file naming convention for the NGACO Beneficiary Response file sent by the CWF to the ACO-OS will be **P#EFT.ON.ACOT.BENE.CWFHP.Dyymmdd.Thhmmsst**. For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.BENE.CWFHP.D191215.T1000000.

5.1.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.1.5.1 Interface Initiation

The ACO-OS sends full refresh NGACO Beneficiary file to the CWF at the CWF HP Host on each month and as needed by CMS/CMMI.

5.1.5.2 Flow Control

The ACO-OS NGACO Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.1.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.2 VT APM Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the VT APM Beneficiary file.

5.2.1 General Processing

The ACO-OS sends the VT APM Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the VT APM Beneficiary Response file to the ACO-OS.

5.2.2 Interface Processing Time Requirements

The VT APM Beneficiary data from the ACO-OS will routinely be sent monthly but could be sent more frequently if Business needs require. A full refresh file will be sent even if there is no change to the Beneficiary data. This full refresh file contains the VT APM Beneficiary data from 01/01/2019 onward.

The ACO-OS will include the most current HICN and/or RRB Numbers associated with the beneficiary in VT APM Beneficiary file.

5.2.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.2.4 File Layout

Each ACO-OS provided VT APM Beneficiary file and the corresponding CWF VT APM Beneficiary Response file has a header, record details, and trailer as described in section 5.2.4.2.

5.2.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.2.4.2.

5.2.4.2 Field/Element Definitions

All tables briefly describe a VT APM Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 7: VT APM Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the VT APM Beneficiary file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Filler		16	40	CHAR	Blanks

Table 8: VT APM Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the VT APM Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	38	CHAR	As provided by the ACO-OS

Table 9: ACO-OS to VT APM Beneficiary Record Detail

Data Fields marked with an [I] contain Personally Identifiable Information (PII).

Data Fields marked with an [H] contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the VT APM Beneficiary file	1	7	CHAR	DTL_BEN
VT APM ACO Organization Identifier	Unique identifier for VT APM ACO	8	10	CHAR	F<nnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the VT APM alignment	18	1	CHAR	‘D’ or Blank

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary HICN/ Beneficiary RRB# I H	Beneficiary HICN/Beneficiary External RRB Number	19	12	CHAR	Alphanumeric characters
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the VT APM ACO	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a VT APM ACO	39	8	CHAR	CCYYMMDD
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M – Male F – Female U – Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
Filler		50	6	CHAR	Blanks

Table 10: FFS SSM to ACO-OS VT APM Beneficiary Response Record Detail

Data Fields marked with an [I] contain PII.

Data Fields marked with an [H] contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the VT APM Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As applicable
VT APM Organization Identifier	Unique identifier for VT APM ACO	10	10	CHAR	As provided by the ACO-OS
Delete Flag	Beneficiary who never should have been aligned, thus removed from the VT APM alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN/ Beneficiary RRB# [I] [H]	Beneficiary HICN/Beneficiary External RRB Number	21	12	CHAR	As provided by the ACO-OS
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with an VT APM ACO	33	8	CHAR	As provided by the ACO-OS
Beneficiary Effective End Date	Effective end date of the beneficiary's association with an VT APM ACO	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
Filler		52	4	CHAR	As provided by the ACO-OS

Table 11: VT APM Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the VT APM Beneficiary file	1	7	CHAR	TRL_BEN
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler		26	30	CHAR	Blanks

Table 12: VT APM Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the VT APM Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	28	CHAR	As provided by the ACO-OS

5.2.4.3 Filenames

The VT APM Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.VTBEN.Dyymmdd.Thhmmsst**. For example, an outbound file for December 15, 2019, at 10:00 AM would be:

P#EFT.ON.CWFHP.VTBEN.D191215.T1000000.

The file naming convention for the VT APM Beneficiary Response file sent by the CWF to the ACO-OS will be **P#EFT.ON.ACOT.VTBEN.CWFHP.Dyymmdd.Thhmmsst**. For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.VTBEN.CWFHP.D191215.T1000000.

5.2.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.2.5.1 Interface Initiation

The ACO-OS sends full refresh VT APM Beneficiary file to the CWF at the CWF HP Host on each month and as needed by CMS/CMMI.

5.2.5.2 Flow Control

The ACO-OS VT APM Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.2.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.3 Part A/Part B NGACO/VT APM Provider File for FFS SSMs

This section describes the information exchange between the ACO-OS and the MCS for the Part A/Part B NGACO/VT APM Provider File.

5.3.1 General Processing

The ACO-OS sends the Part A/Part B NGACO/VT APM Provider file to the MCS at the HP VDC. After MCS receives the Part A/Part B NGACO/VT APM Provider file from the ACO-OS, a response file is generated from the MCS along with a response code that the MCS then sends back to the ACO-OS.

5.3.2 Interface Processing Time Requirements

Part A/Part B NGACO/VT APM Provider data from the ACO-OS will be sent monthly. A full refresh file will be sent even if there is no change to the provider data. This full refresh file contains currently active and previously active benefit enhancement records for a Provider from 01/01/2016 forward for NGACO, and currently active and previously active benefit enhancement records for a Provider from 01/01/2019 for VT APM forward.

The ACO-OS will include the following Provider Types associated with an NGACO ACO on or after 01/01/2016 in the Part A/Part B NGACO/VT APM Provider File.

- Provider/Suppliers
- Preferred Providers

The ACO-OS will include the following Provider Types associated with an VT APM ACO on or after 01/01/2019 in the Part A/Part B NGACO/VT APM Provider File.

- Provider/Suppliers
- Preferred Providers

Every Provider record will have a base record accompanied by enhancement records if the provider participates in any benefit enhancements. Every enhancement will have its own record. A base record is required even when the Provider is not participating in any one of the benefit enhancements.

5.3.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.3.4 File Layout

Each ACO-OS provider file and corresponding MCS response file has a header, record details, and trailer as described in section 5.3.4.2.

5.3.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.3.4.2.

5.3.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACO-OS and a response by the MCS. The description column describes basic file elements. The response file returns exact field values provided by the ACO-OS with the addition of a response code.

Table 13: Part A/Part B NGACO/VT APM Provider File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B NGACO/VT APM Provider file	1	7	CHAR	HDR_PRV

Data Field	Description	Start Position	Length	Format	Valid Values
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	85	CHAR	Blanks

Table 14: Part A/Part B NGACO/VT APM Provider Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B NGACO/VT APM Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	83	CHAR	As provided by the ACO-OS

Table 15: ACO-OS to Part A/Part B NGACO/VT APM Provider Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an [I] contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part A/Part B NGACO/VT APM Provider file	1	7	CHAR	DTL_PRV
NGACO/VT APM Organization Identifier*	Unique identifier for NGACO/VT APM ACO	8	10	CHAR	V<nnn> F<nnn>
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	18	1	CHAR	P S A
Participant TIN* [I]	The Tax Identification Number (TIN) for the ACO Participant	19	9	NUM	Numbers
ACO Participant NPI*	The National Provider Identifier (NPI) for the ACO Participant (This field supports iNPI and oNPI)	28	10	NUM	Numbers
Participant CCN	The CMS Certification Number (CCN) for the ACO Participant	38	6	CHAR	Blank allowed

Data Field	Description	Start Position	Length	Format	Valid Values
Record Type*	Detail Record Type 0 = Base Record 1 = PBP 2 = NGACO/VTAPM TeleHealth 3 = Post Discharge Home Visit 4 = Skilled Nursing Facility (SNF) 3-Day Stay Waiver 5 = AIPBP 6 = CEC Telehealth 7 = Care Management Home Visit	44	1	CHAR	0 1 2 3 4 5 7
Participant/PBP /Enhancement Effective Start Date*	For the Base Record: Effective start date of the Provider's association with an NGACO/VT APM ACO. For PBP/AIPBP: Effective start date of the Provider utilizing PBP/AIPBP. For Benefit Enhancements: Effective start date of the Provider participating in the benefit enhancement.	45	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Provider/Enhancement Effective End Date*	For the Base Record: Effective end date of the Provider's association with an NGACO/VT APM ACO. For PBP/AIPBP: Effective end date of the Provider utilizing PBP/AIPBP. For Benefit Enhancements: Effective end date of the Provider participating in the benefit enhancement.	53	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Part A Percentage Reduction	Percentage of Part A Claims Reduction	61	3	DECIMAL	For the PBP Record: Value greater than (0) and less than (1) with two (2) implied decimals places. Ex. 0.75 will appear as 075. Value Zero is applicable for records other than PBP (or) when Part A Reduction Percentage is not available. For the AIPBP Record: Value is greater than “0” but less than or equal to (1) or 100% with two (2) implied decimal places when AIPBP is applicable. Ex. 1.00 will appear as 100. A zero value is applicable when Part A Reduction Percentage is not available.

Data Field	Description	Start Position	Length	Format	Valid Values
Part B Percentage Reduction	Percentage of Part B Claims Reduction	64	3	DECIMAL	For the PBP Record: Value greater than (0) and less than (1) with two (2) implied decimals places. Ex. 0.75 will appear as 075. Value Zero is applicable for records other than PBP (or) when Part B Reduction Percentage is not available. For the AIPBP Record: Value is greater than "0" but less than or equal to (1) or 100% with two (2) implied decimal places when AIPBP is applicable. Ex. 1.00 will appear as 100. A zero value is applicable when Part B Reduction Percentage is not available.
Filler		67	34	CHAR	Blanks

NOTES:

1. Record Type of AIPBP is not applicable for PY1.
2. Provider Type of Affiliate is not applicable for PY1.

Table 16: FFS SSM to ACO-OS Part A/Part B NGACO/VT APM Provider Response Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part A/Part B NGACO/VT APM Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	As applicable
NGACO/VT APM Organization Identifier*	Unique identifier for NGACO/VT APM ACO	10	10	CHAR	As provided by the ACO-OS
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	20	1	CHAR	As provided by the ACO-OS
Participant TIN* ǀ	The Tax Identification Number (TIN) for the ACO Participant	21	9	NUM	As provided by the ACO-OS
ACO Participant NPI*	The NPI for the ACO Participant (This field supports iNPI and oNPI).	30	10	NUM	As provided by the ACO-OS
Participant CCN	The CCN for the ACO Participant	40	6	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Record Type*	Detail Record Type 0 = Base Record 1 = PBP 2 = NGACO/VTAPM TeleHealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = AIPBP 6 = CEC Telehealth 7 = Care Management Home Visit	46	1	CHAR	As provided by the ACO-OS
Participant/PBP /Enhancement Effective Start Date*	For the Base Record: Effective start date of the Provider's association with an NGACO/VT APM ACO. For PBP/AIPBP: Effective start date of the Provider utilizing PBP/AIPBP. For Benefit Enhancements: Effective start date of the Provider participating in the benefit enhancement.	47	8	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Provide/Enhancement Effective End Date*	For the Base Record: Effective end date of the Provider's association with an NGACO/VT APM ACO. For PBP/AIPBP: Effective end date of the Provider utilizing PBP/AIPBP. For Benefit Enhancements: Effective end date of the Provider participating in the benefit enhancement.	55	8	CHAR	As provided by the ACO-OS
Part A Percentage Reduction	Percentage of Part A Claims Reduction	63	3	DECIMAL	As provided by the ACO-OS
Part B Percentage Reduction	Percentage of Part B Claims Reduction	66	3	DECIMAL	As provided by the ACO-OS
Filler		69	32	CHAR	As provided by the ACO-OS

Table 17: Part A/Part B NGACO/VT APM Provider File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the Part A/Part B NGACO/VT APM Provider file	1	7	CHAR	TRL_PRV
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of detail rows or records sent by ACO-OS	16	10	NUM	Numbers
Filler		26	75	CHAR	Blanks

Table 18: Part A/Part B NGACO/VT APM Provider Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B NGACO/VT APM Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of detail rows or records sent by ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	73	CHAR	As provided by the ACO-OS

5.3.4.3 Filenames

The file naming convention for the Part A/Part B NGACO/VT APM Provider file sent by the ACO-OS to the MCS at the HP VDC will be **P#EFT.ON.MCSHPVDC.PRV.Dyymmdd.Thhmmsst**. For example, an outbound file for December 15, 2011, at 10:00 AM to the MCS at the HP VDC would be:

P#EFT.ON.MCSHPVDC.PRV.D111215.T1000000

The file naming convention for the Part A/Part B NGACO/VT APM Provider Response file sent by the MCS to the ACO-OS will be **P#EFT.ON.ACOT.PRV.MCSHPVDC.Dyymmdd.Thhmmsst**. For example, an inbound file from the MCS corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.PRV.MCSHPVDC.D111215.T1000000

5.3.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.3.5.1 Interface Initiation

The ACO-OS sends the Part A/Part B NGACO/VT APM Provider file to the MCS at the HP VDC.

5.3.5.2 Flow Control

The ACO-OS Part A/Part B NGACO/VT APM Provider files are transferred to the MCS at the HP VDC using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.3.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.4 CEC Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the CEC Beneficiary file.

5.4.1 General Processing

The ACO-OS sends the CEC Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the CEC Beneficiary Response file to the ACO-OS.

5.4.2 Interface Processing Time Requirements

The CEC Beneficiary file from the ACO-OS will be sent monthly but could be sent more frequently if Business needs require. ACO-OS will not send the CEC Beneficiary file if there are no updates for a month.

The CEC Beneficiary file is a full replacement file and it contains CEC Beneficiary data from 01/01/2018 forward.

ACO-OS will include the most current HICN associated with the beneficiary in the CEC Beneficiary file. The Delete Flag will include a blank; it will be available for a future release.

5.4.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.4.4 File Layout

Each ACO-OS provided CEC Beneficiary file and the corresponding CWF CEC Beneficiary Response file has a header, record details, and trailer as described in section 5.4.4.2.

5.4.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.4.4.2.

5.4.4.2 Field/Element Definitions

All tables briefly describe a CEC Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 19: CEC Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CEC Beneficiary file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	40	CHAR	Blanks

Table 20: CEC Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CEC Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	38	CHAR	As provided by the ACO-OS

Table 21: ACO-OS to CEC Beneficiary Record Detail

Data Fields marked with an [I] contain Personally Identifiable Information (PII).

Data Fields marked with an [H] contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the CEC Beneficiary file	1	7	CHAR	DTL_BEN
ESCO Identifier	Unique identifier for CEC ESCO	8	10	CHAR	E<nnnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the CEC alignment	18	1	CHAR	'D' or Blanks
Beneficiary HICN/ Beneficiary RRB# [I] [H]	Beneficiary HICN/Beneficiary External RRB Number	19	12	CHAR	Alphanumeric characters
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the CEC ESCO	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a CEC ESCO	39	8	CHAR	CCYYMMDD
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific Blanks

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M – Male F – Female U – Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
Filler		50	6	CHAR	Blanks

Table 22: FFS SSM to ACO-OS CEC Beneficiary Response Record Detail

Data Fields marked with an I contain PII.

Data Fields marked with an H contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the CEC Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As Applicable
ESCO Identifier	Unique identifier for CEC ESCO	10	10	CHAR	As provided by the ACO-OS
Delete Flag	Beneficiary who never should have been aligned, thus removed from the CEC alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN/ Beneficiary RRB# I H	Beneficiary HICN/Beneficiary External RRB Number	21	12	CHAR	As provided by the ACO-OS
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with an CEC ESCO	33	8	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Effective End Date	Effective end date of the beneficiary's association with an CEC ESCO	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
Filler		52	4	CHAR	As provided by the ACO-OS

Table 23: CEC Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the CEC Beneficiary file	1	7	CHAR	TRL_BEN
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler		26	30	CHAR	Blanks

Table 24: CEC Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the CEC Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	28	CHAR	As provided by the ACO-OS

5.4.4.3 Filenames

The CEC Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.CECBEN.Dyymmdd.Thhmmsst**. For example, an outbound file for December 15, 2011, at 10:00 AM would be:

P#EFT.ON.CWFHP.CECBEN.D111215.T1000000.

The file naming convention for the CEC Beneficiary Response file sent by the CWF to the ACO-OS will be

P#EFT.ON.ACOT.CWFHP.CBNR.Dyymmdd.Thhmmsst.

For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.CWFHP.CBNR.D111215.T1000000.

5.4.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.4.5.1 Interface Initiation

The ACO-OS sends full replacement CEC Beneficiary file to the CWF at the CWF HP Host on each month and as needed by CMS/CMMI.

5.4.5.2 Flow Control

The ACO-OS CEC Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling

mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.4.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.5 CEC Participant File for FFS SSMs

This section describes the information exchange between the ACO-OS and the MCS for the CEC Participant File.

5.5.1 General Processing

The ACO-OS sends the CEC Participant file to the MCS at the HP VDC. After MCS receives the CEC Participant file from the ACO-OS, a response file is generated from the MCS along with a response code that the MCS then sends back to the ACO-OS.

5.5.2 Interface Processing Time Requirements

CEC Participant data from the ACO-OS will be sent monthly. ACO-OS will not send CEC Participant file if there are no updates for a month. The CEC Participant file is a full replacement file and it contains CEC Participant data from 01/01/2018 forward.

5.5.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.5.4 File Layout

Each ACO-OS CEC Participant file and corresponding MCS response file has a header, record details, and trailer as described in section 5.5.4.2.

5.5.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.5.4.2.

5.5.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACO-OS and a response by the MCS. The description column describes basic file elements. The response file returns exact field values provided by the ACO-OS with the addition of a response code.

Table 25: CEC Participant File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CEC Participant file	1	7	CHAR	HDR_PRV
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	85	CHAR	Blanks

Table 26: CEC Participant Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CEC Participant file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	83	CHAR	As provided by the ACO-OS

Table 27: ACO-OS to CEC Participant Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the CEC Participant file	1	7	CHAR	DTL_PRV
ESCO Identifier*	Unique identifier for CEC ESCO	8	10	CHAR	E<nnnn>
Provider Type*	Participant = P Provider/Supplier = S Affiliate = A	18	1	CHAR	P
Participant TIN* ǀ	The Tax Identification Number (TIN) for the ESCO Participant	19	9	NUM	Numbers

Data Field	Description	Start Position	Length	Format	Valid Values
Participant NPI*	The National Provider Identifier (NPI) for the ESCO Participant	28	10	NUM	Numbers
Participant CCN	The CMS Certification Number (CCN) for the ESCO Participant	38	6	CHAR	Blank allowed
Record Type*	Detail Record Type 0 = Base Record 1 = PBP 2 = NGACO/VT APM TeleHealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = AIPBP 6 = CEC TeleHealth 7 = Care Management Home Visit	44	1	CHAR	0 6
Participant/TeleHealth Effective Start Date*	Effective start date of the Participant's association with a CEC ESCO (or) Effective start date of the Participant's TeleHealth participation.	45	8	CHAR	CCYYMMDD
Participant/TeleHealth Effective End Date*	Effective end date of the Participant's association with an CEC ESCO (or) Effective end date of the Participant's TeleHealth participation.	53	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Part A Percentage Reduction	Percentage of Part A Claims Reduction	61	3	DECIMAL	000
Part B Percentage Reduction	Percentage of Part B Claims Reduction	64	3	DECIMAL	000
Filler		67	34	CHAR	Blanks

Table 28: FFS SSM to ACO-OS CEC Participant Response Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ı contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the CEC Participant file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	As Applicable
ESCO Identifier*	Unique identifier for CEC ESCO	10	10	CHAR	As provided by the ACO-OS
Provider Type*	Participant = P Provider/Supplier = S Affiliate = A	20	1	CHAR	As provided by the ACO-OS
Participant TIN* ı	The Tax Identification Number (TIN) for the ESCO Participant	21	9	NUM	As provided by the ACO-OS
Participant NPI*	The NPI for the ESCO Participant	30	10	NUM	As provided by the ACO-OS
Participant CCN	The CCN for the ESCO Participant	40	6	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Record Type*	Detail Record Type 0 = Base Record 1 = PBP 2 = NGACO/VT APM TeleHealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = AIPBP 6 = CEC TeleHealth 7 = Care Management Home Visit	46	1	CHAR	As provided by the ACO-OS
Participant/Tele Health Effective Start Date*	Effective start date of the Participant's association with a CEC ESCO (or) Effective start date of the Participant's TeleHealth participation.	47	8	CHAR	As provided by the ACO-OS
Participant/Tele Health Effective End Date*	Effective end date of the Participant's association with an CEC ESCO (or) Effective end date of the Participant's TeleHealth participation.	55	8	CHAR	As provided by the ACO-OS
Part A Percentage Reduction	Percentage of Part A Claims Reduction	63	3	DECIMAL	As provided by the ACO-OS
Part B Percentage Reduction	Percentage of Part B Claims Reduction	66	3	DECIMAL	As provided by the ACO-OS
Filler		69	32	CHAR	As provided by the ACO-OS

Table 29: CEC Participant File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the CEC Participant file	1	7	CHAR	TRL_PRV
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of detail rows or records sent by ACO-OS	16	10	NUM	Numbers
Filler		26	75	CHAR	Blanks

Table 30: CEC Participant Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CEC Participant file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of detail rows or records sent by ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	73	CHAR	As provided by the ACO-OS

5.5.4.3 Filenames

The file naming convention for the CEC Participant file sent by the ACO-OS to the MCS at the HP VDC will be **P#EFT.ON.MCSHPVDC.CECPRV.Dyymmdd.Thhmmsst**. For example, an outbound file for December 15, 2011, at 10:00 AM to the MCS at the HP VDC would be:

P#EFT.ON.MCSHPVDC.CECPRV.D111215.T1000000.

The file naming convention for the CEC Participant Response file sent by the MCS to the ACO-OS will be

P#EFT.ON.ACOT.MCSHPVDC.CPVR.Dyymmdd.Thhmmsst.

For example, an inbound file from the MCS corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.MCSHPVDC.CPVR.D111215.T1000000.

5.5.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.5.5.1 Interface Initiation

The ACO-OS sends the CEC Participant file to the MCS at the HP VDC.

5.5.5.2 Flow Control

The ACO-OS CEC Participant files are transferred to the MCS at the HP VDC using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.5.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.6 CKCC Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the CKCC Beneficiary file.

5.6.1 General Processing

The ACO-OS sends the CKCC Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the CKCC Beneficiary Response file to the ACO-OS.

5.6.2 Interface Processing Time Requirements

The CKCC Beneficiary data from the ACO-OS will routinely be sent quarterly but could be sent more frequently if Business needs require. A full refresh file will be sent even if there is no change to the Beneficiary data. This full refresh file contains CKCC Beneficiary data from 11/01/2020 forward.

The ACO-OS will include the most current HICN and/or RRB Numbers associated with the beneficiary in CKCC Beneficiary file. The Delete Flag is available in ACO-OS for the excluded Beneficiaries based on program precedence exclusion.

5.6.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.6.4 File Layout

Each ACO-OS provided CKCC Beneficiary file and the corresponding CWF CKCC Beneficiary Response file has a header, record details, and trailer as described in section 5.6.4.2.

5.6.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.6.4.2.

5.6.4.2 Field/Element Definitions

All tables briefly describe a CKCC Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 31: CKCC Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CKCC Beneficiary file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	40	CHAR	Blanks

Table 32: CKCC Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CKCC Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	38	CHAR	As provided by the ACO-OS

Table 33: ACO-OS (CKCC) to FFS SSM Beneficiary Record Detail

Data Fields marked with an I contain Personally Identifiable Information (PII).

Data Fields marked with an H contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the CKCC Beneficiary file	1	7	CHAR	DTL_BEN
CKCC ACO Organization Identifier	Unique identifier for CKCC Entity	8	10	CHAR	C<nnnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the CKCC alignment	18	1	CHAR	'D' or Blank
Beneficiary HICN/ Beneficiary RRB# I H	Beneficiary HICN/Beneficiary External RRB Number	19	12	CHAR	Alphanumeric characters
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the CKCC ACO	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a CKCC ACO	39	8	CHAR	CCYYMMDD 12319999 for open end date
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M = Male F = Female U = Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
QCP Indicator	Quarterly Capitated Payment Indicator	50	1	CHAR	Blank = Not Qualified for QCP payment "indicates ESRD beneficiary" Y = Qualified for QCP payment "indicates CKD beneficiary"
Filler		51	5	CHAR	Blanks

Table 34: FFS SSM to ACO-OS (CKCC) Beneficiary Response Record Detail

Data Fields marked with an [I] contain PII.

Data Fields marked with an [H] contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the CKCC Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As applicable
CKCC Organization Identifier	Unique identifier for CKCC ACO	10	10	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Delete Flag	Beneficiary who never should have been aligned, thus removed from the CKCC alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN/ Beneficiary RRB# IH	Beneficiary HICN/Beneficiary External RRB Number	21	12	CHAR	As provided by the ACO-OS
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with an CKCC ACO	33	8	CHAR	As provided by the ACO-OS
Beneficiary Effective End Date	Effective end date of the beneficiary's association with an CKCC ACO	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
QCP Indicator	Quarterly Capitated Payment Indicator	52	1	CHAR	As provided by the ACO-OS
Filler		53	3	CHAR	

Table 35: CKCC Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the CKCC Beneficiary file	1	7	CHAR	TRL_BEN

Data Field	Description	Start Position	Length	Format	Valid Values
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler		26	30	CHAR	Blanks

Table 36: CKCC Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the CKCC Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	28	CHAR	As provided by the ACO-OS

5.6.4.3 Filenames

The CKCC Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.CKCCBENE.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM would be:

P#EFT.ON.CWFHP.CKCCBENE.D210104.T1000000.

The file naming convention for the CKCC Beneficiary Response file sent by the CWF to the ACO-OS will be **P#EFT.ON.ACOT.CWFHP.CKCCBR.Dyymmdd.Thhmmsst**. For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.CWFHP.CKCCBR.D210104.T1000000.

5.6.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.6.5.1 Interface Initiation

The ACO-OS sends full refresh CKCC Beneficiary file to the CWF at the CWF HP Host on each month or quarterly and as needed by CMS/CMMI.

5.6.5.2 Flow Control

The ACO-OS CKCC Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.6.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.7 KCF Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the KCF Beneficiary file.

5.7.1 General Processing

The ACO-OS sends the KCF Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the KCF Beneficiary Response file to the ACO-OS.

5.7.2 Interface Processing Time Requirements

The KCF Beneficiary data from the ACO-OS will routinely be sent quarterly but could be sent more frequently if Business needs require. A full refresh file will be sent even if there is no change to the Beneficiary data. This full refresh file contains KCF Beneficiary data from 11/01/2020 onward.

The ACO-OS will include the most current HICN and/or RRB Numbers associated with the beneficiary in KCF Beneficiary file. The Delete Flag is available in ACO-OS for the excluded Beneficiaries based on program precedence exclusion.

5.7.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.7.4 File Layout

Each ACO-OS provided KCF Beneficiary file and the corresponding CWF KCF Beneficiary Response file has a header, record details, and trailer as described in section 5.7.4.2.

5.7.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.7.4.2.

5.7.4.2 Field/Element Definitions

All tables briefly describe a KCF Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 37: KCF Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the KCF Beneficiary file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	40	CHAR	Blanks

Table 38: KCF Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the KCF Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	38	CHAR	As provided by the ACO-OS

Table 39: ACO-OS (KCF) to FFS SSM Beneficiary Record Detail

Data Fields marked with an [I] contain Personally Identifiable Information (PII).

Data Fields marked with an [H] contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the KCF Beneficiary file	1	7	CHAR	DTL_BEN
KCF ACO Organization Identifier	Unique identifier for KCF ACO	8	10	CHAR	K<nnnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the KCF alignment	18	1	CHAR	'D' or Blank
Beneficiary HICN/ Beneficiary RRB# [I] [H]	Beneficiary HICN/Beneficiary External RRB Number	19	12	CHAR	Alphanumeric characters
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the KCF ACO	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a KCF ACO	39	8	CHAR	CCYYMMDD
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M = Male F = Female U = Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
QCP Indicator	Quarterly Capitated Payment Indicator	50	1	CHAR	Blank = Not Qualified for QCP payment “indicates ESRD beneficiary” Y = Qualified for QCP payment “indicates CKD beneficiary”
Filler		51	5	CHAR	Blanks

Table 40: FFS SSM to ACO-OS (KCF) Beneficiary Response Record Detail

Data Fields marked with an [I] contain PII.

Data Fields marked with an [H] contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the KCF Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As applicable
KCF Organization Identifier	Unique identifier for KCF ACO	10	10	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Delete Flag	Beneficiary who never should have been aligned, thus removed from the KCF alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN/ Beneficiary RRB# [1H]	Beneficiary HICN/Beneficiary External RRB Number	21	12	CHAR	As provided by the ACO-OS
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with an KCF ACO	33	8	CHAR	As provided by the ACO-OS
Beneficiary Effective End Date	Effective end date of the beneficiary's association with an KCF ACO	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
QCP Indicator	Quarterly Capitated Payment Indicator	52	1	CHAR	As provided by the ACO-OS
Filler		53	3	CHAR	

Table 41: KCF Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the KCF Beneficiary file	1	7	CHAR	TRL_BEN

Data Field	Description	Start Position	Length	Format	Valid Values
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler		26	30	CHAR	Blanks

Table 42: KCF Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the KCF Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	28	CHAR	As provided by the ACO-OS

5.7.4.3 Filenames

The KCF Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.KCFBENE.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM would be:

P#EFT.ON.CWFHP.KCFBENE.D210104.T1000000.

The file naming convention for the KCF Beneficiary Response file sent by the CWF to the ACO-OS will be **P#EFT.ON.ACOT.CWFHP.KCFBR.Dyymmdd.Thhmmsst**. For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.CWFHP.KCFBR.D210104.T1000000.

5.7.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.7.5.1 Interface Initiation

The ACO-OS sends full refresh KCF Beneficiary file to the CWF at the CWF HP Host on each month or quarterly and as needed by CMS/CMMI.

5.7.5.2 Flow Control

The ACO-OS KCF Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.7.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.8 Part A/Part B CKCC/KCF Provider File for FFS SSMs

This section describes the information exchange between the ACO-OS and the MCS for the Part A/Part B CKCC/KCF Provider File.

5.8.1 General Processing

The ACO-OS sends the Part A/Part B CKCC/KCF Provider file to the MCS at the HP VDC. After MCS receives the Part A/Part B CKCC/KCF Provider file from the ACO-OS, a response file is generated from the MCS along with a response code that the MCS then sends back to the ACO-OS.

5.8.2 Interface Processing Time Requirements

Part A/Part B CKCC/KCF Provider data from the ACO-OS will be sent monthly. A full refresh file will be sent even if there is no change to the provider data. This full refresh file contains currently active and previously active benefit enhancement records for a Provider from 11/01/2020 onward.

The ACO-OS will include the following Provider Types associated with a CKCC/KCF on or after 11/01/2020 in the Part A/Part B CKCC/KCF Provider File.

- Provider/Suppliers
- Preferred Providers

Every Provider record will have a base record accompanied by enhancement records if the provider participates in any benefit enhancements. Every enhancement will have its own record. A base record is required even when the Provider is not participating in any one of the benefit enhancements.

5.8.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.8.4 File Layout

Each ACO-OS provider file and corresponding MCS response file has a header, record details, and trailer as described in section 5.8.4.2.

5.8.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.8.4.2.

5.8.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACO-OS and a response by the MCS. The description column describes basic file elements. The response file returns exact field values provided by the ACO-OS with the addition of a response code.

Table 43: Part A/Part B CKCC/KCF Provider File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B CKCC/KCF Provider file	1	7	CHAR	HDR_PRV
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	85	CHAR	Blanks

Table 44: Part A/Part B CKCC/KCF Provider Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B CKCC/KCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	83	CHAR	As provided by the ACO-OS

Table 45: ACO-OS to Part A/Part B CKCC/KCF Provider Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an [I] contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part A/Part B CKCC/KCF Provider file	1	7	CHAR	DTL_PRV
CKCC/KCF Organization Identifier*	Unique identifier for CKCC/KCF ACO	8	10	CHAR	C<nnnn> K<nnnn>
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	18	1	CHAR	P S A
Participant TIN* [I]	The Tax Identification Number (TIN) for the ACO Participant	19	9	NUM	Numbers
ACO Participant NPI*	The National Provider Identifier (NPI) for the ACO Participant (This field supports iNPI and oNPI)	28	10	NUM	Numbers
Participant CCN	The CMS Certification Number (CCN) for the ACO Participant	38	6	CHAR	Blank allowed

Data Field	Description	Start Position	Length	Format	Valid Values
Record Type*	Detail Record Type 0 = Base Record 1 = APO 2 = Telehealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = TCC 6 = CEC Telehealth 7 = Care Management Home Visit 8 = PCC 9 = Home Health Homebound Waiver A = Diabetic Shoe Orders by Nurse Practitioners B = Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits C = Kidney Disease Education Benefit Enhancement D = SIP (Represents only the providers that can bill the G code) E = PCF (Represents all providers who can bill FVF codes) F = QCP	44	1	CHAR	**KCF BEs:** 0 = Base Record 2 = Telehealth 3 = Post Discharge Home Visits 5 = TCC B = Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits C = Kidney Disease Education Benefit Enhancement F = QCP *Note: QCP will only apply to nephrologists and nephrology practices and will not apply to all providers who are in CKCC.*

Data Field	Description	Start Position	Length	Format	Valid Values
					CKCC BEs: 0 = Base Record 2 = Telehealth 3 = Post-Discharge Home Visits 4 = SNF 5 = TCC 9 = Home Health Homebound Waiver B = Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits C = Kidney Disease Education F = QCP *Note: QCP will only apply to nephrologists and nephrology practices and will not apply to all providers who are in CKCC.*
Participant/ AMCP/QCP/ TCC Enhancement Effective Start Date*	For the Base Record: Effective start date of the Provider's association with an CKCC/KCF ACO. For QCP/TCC: Effective start date of the Provider utilizing QCP/TCC. For Benefit Enhancements: Effective start date of the Provider participating in the benefit enhancement.	45	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Provider/AMCP /QCP/TCC Enhancement Effective End Date*	For the Base Record: Effective end date of the Provider's association with an CKCC/KCF ACO. For QCP/TCC: Effective end date of the Provider utilizing QCP/TCC. For Benefit Enhancements: Effective end date of the Provider participating in the benefit enhancement.	53	8	CHAR	CCYYMMDD
Part A Percentage Reduction	Percentage of Part A Claims Reduction	61	3	DECIMAL	For the QCP Record: Value is always "100" or 100% with two (2) implied decimal places when QCP is applicable. Ex. 1.00 will appear as 100. For the TCC Record: Value is greater than "0" but less than or equal to (1) or 100% with two (2) implied decimal places when TCC is applicable. Ex. 1.00 will appear as 100.
Part B Percentage Reduction	Percentage of Part B Claims Reduction	64	3	DECIMAL	For the QCP Record: Value is always "100" or 100% with two (2) implied decimal places when QCP is applicable. Ex. 1.00 will appear as 100. For the TCC Record: Value is greater than "0" but less than or equal to (1) or 100% with two (2) implied decimal places when TCC is applicable. Ex. 1.00 will appear as 100.

Data Field	Description	Start Position	Length	Format	Valid Values
ETC_IND	associated with ESRD Treatment Choices (ETC) model.	67	1		Blank = Not an ETC participant Y = ETC participant
Filler		68	33	CHAR	Blanks

Table 46: FFS SSM to ACO-OS Part A/Part B CKCC/KCF Provider Response Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part A/Part B CKCC/KCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	As applicable
CKCC/KCF Organization Identifier*	Unique identifier for CKCC/KCF ACO	10	10	CHAR	As provided by the ACO-OS
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	20	1	CHAR	As provided by the ACO-OS
Participant TIN* ǀ	The Tax Identification Number (TIN) for the ACO Participant	21	9	NUM	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
ACO Participant NPI*	The NPI for the ACO Participant (This field supports iNPI and oNPI).	30	10	NUM	As provided by the ACO-OS
Participant CCN	The CCN for the ACO Participant	40	6	CHAR	As provided by the ACO-OS
Record Type*	Detail Record Type 0 = Base Record 1 = APO 2 = Telehealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = TCC 6 = CEC Telehealth 7 = Care Management Home Visit 8 = PCC 9 = Home Health Homebound Waiver A = Diabetic Shoe Orders by Nurse Practitioners B = Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits C = Kidney Disease Education Benefit Enhancement D = SIP (Represents only the providers who can bill the G code) E = PCF (Represents all providers who can bill FVF codes) F = QCP	46	1	CHAR	As provided by the ACO-OS **KCF BEs:** 0 = Base Record 2 = Asynchronous Telehealth 3 = Post Discharge Home Visits 5 = TCC B = Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits C = Kidney Disease Education Benefit Enhancement F = QCP *Note: QCP will only apply to nephrologists and nephrology practices and will not apply to all providers who are in CKCC.*

Data Field	Description	Start Position	Length	Format	Valid Values
					CKCC BEs: 0 = Base Record 2 = Telehealth 3 = Post-Discharge Home Visits 4 = SNF 5 = TCC (even though it is delayed to 2022) 9 = Home Health Homebound Waiver A = Home Health Services Certified by Nurse Practitioners B = Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits C = Kidney Disease Education F = QCP *Note: QCP will only apply to nephrologists and nephrology practices and will not apply to all providers who are in CKCC.*
ParticipantQCP/TCC Enhancement Effective Start Date*	For the Base Record: Effective start date of the Provider's association with an CKCC/KCF ACO. For QCP/TCC: Effective start date of the Provider utilizing QCP/TCC. For Benefit Enhancements: Effective start date of the Provider participating in the benefit enhancement.	47	8	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
ProvideQCP/TCC Enhancement Effective End Date*	For the Base Record: Effective end date of the Provider's association with an CKCC/KCF ACO. For QCP/TCC: Effective end date of the Provider utilizing QCP/TCC. For Benefit Enhancements: Effective end date of the Provider participating in the benefit enhancement.	55	8	CHAR	As provided by the ACO-OS
Part A Percentage Reduction	Percentage of Part A Claims Reduction	63	3	DECIMAL	As provided by the ACO-OS
Part B Percentage Reduction	Percentage of Part B Claims Reduction	66	3	DECIMAL	As provided by the ACO-OS
ETC_IND	associated with ESRD Treatment Choices (ETC) model.	69	1		Blank = Not an ETC participant Y = ETC participant
Filler		70	31	CHAR	As provided by the ACO-OS

Table 47: Part A/Part B CKCC/KCF Provider File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the Part A/Part B CKCC/KCF Provider file	1	7	CHAR	TRL_PRV
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Detail Record Count	Number of detail rows or records sent by ACO-OS	16	10	NUM	Numbers
Filler		26	75	CHAR	Blanks

Table 48: Part A/Part B CKCC/KCF Provider Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B CKCC/KCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of detail rows or records sent by ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	73	CHAR	As provided by the ACO-OS

5.8.4.3 Filenames

The file naming convention for the Part A/Part B CKCC/KCF Provider file sent by the ACO-OS to the MACS at the HP VDC will be **P#EFT.ON.MCSHPVDC.KCCPRV.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM to the MACS at the HP VDC would be:

P#EFT.ON.MCSHPVDC.KCCPRV.D210104.T1000000

The file naming convention for the Part A/Part B CKCC/KCF Provider Response file sent by the MCS to the ACO-OS will be **P#EFT.ON.ACOT.MCSHPVDC.KCPR.Dyymmdd.Thhmmsst**. For example, an inbound file from the MCS corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.MCSHPVDC.KCPR.D210104.T1000000

5.8.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.8.5.1 Interface Initiation

The ACO-OS sends the Part A/Part B CKCC/KCF Provider file to the MCS at the HP VDC.

5.8.5.2 Flow Control

The ACO-OS Part A/Part B CKCC/KCF Provider files are transferred to the MCS at the HP VDC using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.8.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.9 Direct Contracting Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the Direct Contracting Beneficiary file.

5.9.1 General Processing

The ACO-OS sends the Direct Contracting Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the Direct Contracting Beneficiary Response file to the ACO-OS.

5.9.2 Interface Processing Time Requirements

The Direct Contracting Beneficiary data from the ACO-OS will routinely be sent monthly but could be sent more frequently if Business needs require. A full refresh file will be sent even if there is no change to the Beneficiary data. This full refresh file contains the Direct Contracting Beneficiary data from 11/01/2020 onward.

The ACO-OS will include the most current HICN and/or RRB Numbers associated with the beneficiary in Direct Contracting Beneficiary file.

5.9.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.9.4 File Layout

Each ACO-OS provided Direct Contracting Beneficiary file and the corresponding CWF Direct Contracting Beneficiary Response file has a header, record details, and trailer as described in section 5.9.4.2.

5.9.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.9.4.2.

5.9.4.2 Field/Element Definitions

All tables briefly describe a Direct Contracting Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 49: Direct Contracting Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Direct Contracting Beneficiary file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	40	CHAR	Blanks

Table 50: Direct Contracting Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Direct Contracting Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	38	CHAR	As provided by the ACO-OS

Table 51: ACO-OS to Direct Contracting Beneficiary Record Detail

Data Fields marked with an I contain Personally Identifiable Information (PII).

Data Fields marked with an H contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the Direct Contracting Beneficiary file	1	7	CHAR	DTL_BEN
Direct Contracting Entity (DCE) Identifier	Unique identifier for DCE	8	10	CHAR	D<nnnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the Direct Contracting alignment	18	1	CHAR	'D' or Blank
Beneficiary HICN/ Beneficiary RRB# I H	Beneficiary HICN/Beneficiary External RRB Number	19	12	CHAR	Alphanumeric characters
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the DCE	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a DCE	39	8	CHAR	CCYYMMDD
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M = Male F = Female U = Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
Filler		50	6	CHAR	Blanks

Table 52: FFS SSM to ACO-OS Direct Contracting Beneficiary Response Record Detail

Data Fields marked with an I contain PII.

Data Fields marked with an H contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the Direct Contracting Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As Applicable
DCE Identifier	Unique identifier for a DCE	10	10	CHAR	As provided by the ACO-OS
Delete Flag	Beneficiary who never should have been aligned, thus removed from the Direct Contracting alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN/ Beneficiary RRB# I H	Beneficiary HICN/Beneficiary External RRB Number	21	12	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with a DCE	33	8	CHAR	As provided by the ACO-OS
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a DCE	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
Filler		52	4	CHAR	As provided by the ACO-OS

Table 53: Direct Contracting Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the Direct Contracting Beneficiary file	1	7	CHAR	TRL_BEN
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler		26	30	CHAR	Blanks

Table 54: Direct Contracting Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the Direct Contracting Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	28	CHAR	As provided by the ACO-OS

5.9.4.3 Filenames

The Direct Contracting Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.DCBENE.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM would be:

P#EFT.ON.CWFHP.DCBENE.D210104.T1000000.

The file naming convention for the Direct Contracting Beneficiary Response file sent by the CWF to the ACO-OS will be **P#EFT.ON.ACOT.CWFHP.DCBR.Dyymmdd.Thhmmsst**. For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.CWFHP.DCBR.D210104.T1000000.

5.9.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.9.5.1 Interface Initiation

The ACO-OS sends full refresh Direct Contracting Beneficiary file to the CWF at the CWF HP Host on each month and as needed by CMS/CMMI.

5.9.5.2 Flow Control

The ACO-OS Direct Contracting Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error

handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.9.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.10 Part A/Part B Direct Contracting Provider File for FFS SSMs

This section describes the information exchange between the ACO-OS and the MCS for the Part A/Part B Direct Contracting Provider File.

5.10.1 General Processing

The ACO-OS sends the Part A/Part B Direct Contracting Provider file to the MCS at the HP VDC. After MCS receives the Part A/Part B Direct Contracting Provider file from the ACO-OS, a response file is generated from the MCS along with a response code that the MCS then sends back to the ACO-OS.

5.10.2 Interface Processing Time Requirements

Part A/Part B Direct Contracting Provider data from the ACO-OS will be sent monthly. A full refresh file will be sent even if there is no change to the provider data. This full refresh file contains currently active and previously active benefit enhancement records for a Provider from 01/01/2021 forward for Direct Contracting records.

The ACO-OS will include the following Provider Types associated with a DCE on or after 01/01/2021 in the Part A/Part B Direct Contracting Provider File.

- Participant Providers
- Preferred Providers

Every Provider record will have a base record accompanied by enhancement records if the provider participates in any benefit enhancements. Every enhancement will have its own record. A base record is required even when the Provider is not participating in any one of the benefit enhancements.

5.10.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.10.4 File Layout

Each ACO-OS provider file and corresponding MCS response file has a header, record details, and trailer as described in section 5.10.4.2.

5.10.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.10.4.2.

5.10.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACO-OS and a response by the MCS. The description column describes basic file elements. The response file returns exact field values provided by the ACO-OS with the addition of a response code.

Table 55: Part A/Part B Direct Contracting Provider File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B Direct Contracting Provider file	1	7	CHAR	HDR_PRV
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	85	CHAR	Blanks

Table 56: Part A/Part B Direct Contracting Provider Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B Direct Contracting Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	83	CHAR	As provided by the ACO-OS

Table 57: ACO-OS to Part A/Part B Direct Contracting Provider Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part A/Part B Direct Contracting Provider file	1	7	CHAR	DTL_PRV
DCE Identifier*	Unique identifier for DCE	8	10	CHAR	D<nnnn>
Provider Type*	Preferred Provider = P Participant Provider = S Affiliate = A	18	1	CHAR	P S A
Provider TIN* ǀ	The Tax Identification Number (TIN) for the ACO Participant	19	9	NUM	Numbers
ACO Provider NPI*	The National Provider Identifier (NPI) for the ACO Provider (This field supports iNPI and oNPI)	28	10	NUM	Numbers
Provider CCN	The CMS Certification Number (CCN) for the ACO Provider	38	6	CHAR	Blank allowed

Data Field	Description	Start Position	Length	Format	Valid Values
Record Type*	Detail Record Type 0 = Base Record 1 = APO 2 = TeleHealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = TCC 6 = CEC Telehealth 7 = Care Management Home Visit 8 = PCC 9 = Home Health Homebound Waiver A = Diabetic Shoe Orders by Nurse Practitioners B = Concurrent Care for Beneficiaries who Elect the Medicare Hospice Benefits C = Kidney Disease Education Benefit Enhancement D = SIP (Represents only the providers who can bill the G code) E = PCF (Represents all providers who can bill FVF codes) F = QCP	44	1	CHAR	0 1 2 3 4 5 7 8 9 B

Data Field	Description	Start Position	Length	Format	Valid Values
Provider Effective Start Date in the DCE/Benefit*	For the Base Record, the Effective Start Date is the date the Provider was first aligned to the DCE. For all other BE records, the Effective Start Date is the date the provider started the Benefit Enhancement.	45	8	CHAR	CCYYMMDD
Provider Effective End Date in the DCE/Benefit*	For the Base Record, the Effective End Date is the date the Provider was last aligned to the DCE. For all other Benefit Enhancement records, the Effective End Date is the date the provider discontinued the Benefit Enhancement.	53	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Part A Percentage Reduction	Percentage of Part A Claims Reduction	61	3	DECIMAL	For the APO Record: Value greater than (0) and less than (1) with two (2) implied decimals places. Ex. 0.75 will appear as 075. Value Zero is applicable for records other than APO (or) when Part A Reduction Percentage is not available. For the TCC/PCC Record: Value is greater than “0” but less than or equal to (1) or 100% with two (2) implied decimal places when TCC/PCC is applicable. Ex. 1.00 will appear as 100. A zero value is applicable when Part A Reduction Percentage is not available.

Data Field	Description	Start Position	Length	Format	Valid Values
Part B Percentage Reduction	Percentage of Part B Claims Reduction	64	3	DECIMAL	For the APO Record: Value greater than (0) and less than (1) with two (2) implied decimals places. Ex. 0.75 will appear as 075. Value Zero is applicable for records other than APO (or) when Part B Reduction Percentage is not available. For the TCC/PCC Record: Value is greater than “0” but less than or equal to (1) or 100% with two (2) implied decimal places when TCC/PCC is applicable. Ex. 1.00 will appear as 100. A zero value is applicable when Part B Reduction Percentage is not available.
Filler		67	34	CHAR	Blanks

NOTE:

Provider Type of Affiliate is not applicable for PY1.

Table 58: FFS SSM to ACO-OS Part A/Part B Direct Contracting Provider Response Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part A/Part B Direct Contracting Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	As Applicable
DCE Identifier*	Unique identifier for Direct Contracting APM ACO	10	10	CHAR	As provided by the ACO-OS
Provider Type*	Preferred Provider = P Participant Provider = S Affiliate = A	20	1	CHAR	As provided by the ACO-OS
Provider TIN* ǀ	The Tax Identification Number (TIN) for the ACO Participant	21	9	NUM	As provided by the ACO-OS
ACO Provider NPI*	The NPI for the ACO Provider (This field supports iNPI and oNPI).	30	10	NUM	As provided by the ACO-OS
Provider CCN	The CCN for the ACO Provider	40	6	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Record Type*	Detail Record Type 0 = Base Record 1 = APO 2 = TeleHealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = TCC 6 = CEC Telehealth 7 = Care Management Home Visit 8 = PCC 9 = Home Health Homebound Waiver A = Diabetic Shoe Orders by Nurse Practitioners B = Concurrent Care for Beneficiaries who Elect the Medicare Hospice Benefits C = Kidney Disease Education Benefit Enhancement D = SIP (Represents only the providers who can bill the G code) E = PCF (Represents all providers who can bill FVF codes) F = QCP	46	1	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Provider Effective Start Date in the DCE/Benefit*	For the Base Record, the Effective Start Date is the date the Provider was first aligned to the DCE. For all other Benefit Enhancement records, the Effective Start Date is the date the provider started the Benefit Enhancement.	47	8	CHAR	As provided by the ACO-OS
Provider Effective End Date in the DCE/Benefit*	For the Base Record, the Effective End Date is the date the Provider was last aligned to the DCE. For all other Benefit Enhancement records, the Effective End Date is the date the provider discontinued the Benefit Enhancement.	55	8	CHAR	As provided by the ACO-OS
Part A Percentage Reduction	Percentage of Part A Claims Reduction	63	3	DECIMAL	As provided by the ACO-OS
Part B Percentage Reduction	Percentage of Part B Claims Reduction	66	3	DECIMAL	As provided by the ACO-OS
Filler		69	32	CHAR	As provided by the ACO-OS

Table 59: Part A/Part B Direct Contracting Provider File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the Part A/Part B Direct Contracting Provider file	1	7	CHAR	TRL_PRV
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of detail rows or records sent by ACO-OS	16	10	NUM	Numbers
Filler		26	75	CHAR	Blanks

Table 60: Part A/Part B Direct Contracting Provider Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B Direct Contracting Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of detail rows or records sent by ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	73	CHAR	As provided by the ACO-OS

5.10.4.3 Filenames

The file naming convention for the Part A/Part B Direct Contracting Provider file sent by the ACO-OS to the MCS at the HP VDC will be

P#EFT.ON.MCSHPVDC.DCPRV.Dyymmdd.Thhmmsst. For example, an outbound file for January 4, 2021, at 10:00 AM to the MCS at the HP VDC would be:

P#EFT.ON.MCSHPVDC.DCPRV.D210104.T1000000.

The file naming convention for the Part A/Part B Direct Contracting Provider Response file sent by the MCS to the ACO-OS will be **P#EFT.ON.ACOT.MCSHPVDC.DCPR.Dyymmdd.Thhmmsst**. For example, an inbound file from the MCS corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.MCSHPVDC.DCPR.D210104.T1000000.

5.10.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.10.5.1 Interface Initiation

The ACO-OS sends the Part A/Part B Direct Contracting Provider file to the MCS at the HP VDC.

5.10.5.2 Flow Control

The ACO-OS Part A/Part B Direct Contracting Provider files are transferred to the MCS at the HP VDC using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.10.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.11 PCF Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the PCF Beneficiary file.

5.11.1 General Processing

The ACO-OS sends the PCF Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the PCF Beneficiary Response file to the ACO-OS.

5.11.2 Interface Processing Time Requirements

The PCF Beneficiary data from the ACO-OS will routinely be sent monthly but could be sent more frequently if Business needs require. A full refresh file will be sent even if there is no change to the Beneficiary data. This full refresh file contains the PCF Beneficiary data from 10/01/2020 onward.

The ACO-OS will include the most current HICN and/or RRB Numbers associated with the beneficiary in PCF Beneficiary file.

5.11.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.11.4 File Layout

Each ACO-OS provided PCF Beneficiary file and the corresponding CWF PCF Beneficiary Response file has a header, record details, and trailer as described in section 5.11.4.2.

5.11.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.11.4.2.

5.11.4.2 Field/Element Definitions

All tables briefly describe a PCF Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 61: PCF Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the PCF file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler	Unused area filled with spaces.	16	40	CHAR	Blanks

Table 62: PCF Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the PCF Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler	Unused area filled with spaces.	18	38	CHAR	As provided by the ACO-OS

Table 63: ACO-OS to PCF Beneficiary Record Detail

Data Fields marked with an [I] contain Personally Identifiable Information (PII).

Data Fields marked with an [H] contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the PCF Beneficiary file, for PCF/SIP beneficiaries	1	7	CHAR	DTL_BEN Alphanumeric
PCF Model Identifier/Practice Location ID	Unique identifier for PCF Entity	8	10	CHAR	P<two character region cd><nnnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the PCF alignment	18	1	CHAR	'D' or Blank
Beneficiary HICN [I] [H]	Beneficiary Health Insurance Claim Number (HICN)	19	12	CHAR	Alphanumeric characters Health Insurance Claim Number (only format is validated by the MCS) (Field will not contain an MBI)
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the PCF Entity	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a PCF Entity	39	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M = Male F = Female U = Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
Filler/QCP Indicator	Unused area filled with spaces.	50	1	CHAR	Blanks
Population Indicator	Indicates whether the Beneficiary is in Seriously Ill Population (SIP)	51	1	CHAR	S = SIP Population or blank
Filler	Unused area filled with spaces.	52	4	CHAR	Blanks

Table 64: FFS SSM to ACO-OS PCF Beneficiary Response Record Detail

Data Fields marked with an [I] contain PII.

Data Fields marked with an [H] contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the PCF Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As Applicable
PCF Model Identifier/ Practice Location ID	Unique identifier for a PCF Entity	10	10	CHAR	As provided by the ACO-OS
Delete Flag	Beneficiary who never should have been aligned, thus removed from the PCF alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN [I] [H]	Beneficiary Health Insurance Claim Number (HICN)	21	12	CHAR	As provided by the ACO-OS
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with a PCF Entity	33	8	CHAR	As provided by the ACO-OS
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a PCF Entity	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
Filler/QCP Indicator	Unused area filled with spaces.	52	1	CHAR	As provided by the ACO-OS
Population Indicator	Indicates whether the Beneficiary is in Seriously Ill Population (SIP)	53	1	CHAR	As provided by the ACO-OS
Filler	Unused area filled with spaces.	54	2	CHAR	Blanks

Table 65: PCF Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the PCF Beneficiary file	1	7	CHAR	TRL_BEN
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler	Unused area filled with spaces.	26	30	CHAR	Blanks

Table 66: PCF Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the PCF Beneficiary file	1	7	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler	Unused area filled with spaces.	28	28	CHAR	As provided by the ACO-OS

5.11.4.3 Filenames

The PCF Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.PCFBENE.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM would be:

P#EFT.ON.CWFHP.PCFBENE.D210104.T1000000.

The file naming convention for the PCF Beneficiary Response file sent by the CWF to the ACO-OS will be **P#EFT.ON.ACOT.CWFHP.PCFBR.Dyymdd.Thhmmsst**. For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.CWFHP.PCFBR.D210104.T1000000.

5.11.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.11.5.1 Interface Initiation

The ACO-OS sends full refresh PCF Beneficiary file to the CWF at the CWF HP Host on each month and as needed by CMS/CMMI.

5.11.5.2 Flow Control

The ACO-OS PCF Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.11.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.12 Part B PCF Provider File for FFS SSMs

This section describes the information exchange between the ACO-OS and the MCS for the Part B PCF Provider File.

5.12.1 General Processing

The ACO-OS sends the Part B PCF Provider file to the MCS at the HP VDC. After MCS receives the Part B PCF Provider file from the ACO-OS, a response file is generated from the MCS along with a response code that the MCS then sends back to the ACO-OS.

5.12.2 Interface Processing Time Requirements

Part B PCF Provider data from the ACO-OS will be sent monthly. A full refresh file will be sent even if there is no change to the provider data. This full refresh file contains currently active and previously active benefit enhancement records for a Provider from 10/01/2020 forward for PCF records.

The ACO-OS will include the following Provider Types associated with a PCF Entity by December 31, 2020 in the Part B PCF Provider File.

- Provider/Suppliers

5.12.3 Message Format (or Record Layout) & Required Protocols

All the provider records under PCF/SIP model will carry benefit enhancements and every enhancement will have its own record. A base record is not required. The file is fixed-length format.

5.12.4 File Layout

Each ACO-OS provider file and corresponding MCS response file has a header, record details, and trailer as described in section 5.12.4.2.

5.12.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.12.4.2.

5.12.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACO-OS and a response by the MCS. The description column describes basic file elements. The response file returns exact field values provided by the ACO-OS with the addition of a response code.

Table 67: Part B PCF Provider File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part B PCF Provider file	1	7	CHAR	HDR_PRV
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Filler	Unused area filled with spaces	16	85	CHAR	Blanks

Table 68: Part B PCF Provider Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part B PCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler	Unused area filled with spaces	18	83	CHAR	As provided by the ACO-OS

Table 69: ACO-OS to Part B PCF Provider Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part B PCF Provider file	1	7	CHAR	DTL_PRV
PCF Model Identifier/ Practice ID*	Unique identifier for PCF Entity	8	10	CHAR	P<two character region cd><nnnn>
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	18	1	CHAR	S
Provider TIN* ǀ	TIN for the Entity Participant	19	9	NUM	Numbers
ProviderNPI*	NPI for the Entity Participant (This field supports iNPI and oNPI)	28	10	NUM	Numbers
Provider CCN	CCN for the Entity Participant	38	6	CHAR	Blank allowed, For PCF this will be initialized to spaces
Record Type*	Detail Record Type A = Diabetic Shoe Order by Nurse Practitioners D = SIP (Represents only the providers who can bill the G code) E = PCF (Represents all providers who can bill FVF codes)	44	1	CHAR	A D E Note: Do not send a 0 record
Provider / Enhancement Effective Start Date*	Provider Effective Start Date	45	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Provider/ Enhancement Effective End Date*	Provider Effective End Date	53	8	CHAR	CCYYMMDD
Part A Percentage Reduction	Percentage of Part A Claims Reduction	61	3	DECIMAL	Will be initialized to zeros
Part B Percentage Reduction	Percentage of Part B Claims Reduction	64	3	DECIMAL	Will be initialized to zeros
Filler	Unused area filled with spaces	67	34	CHAR	Blanks

Table 70: FFS SSM to ACO-OS Part B PCF Provider Response Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part B PCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	As Applicable
PCF Model Identifier/ Practice ID*	Unique identifier for PCF Entity	10	10	CHAR	As provided by the ACO-OS
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	20	1	CHAR	As provided by the ACO-OS
Provider TIN* ǀ	TIN for the ACO Provider	21	9	NUM	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Provider NPI*	NPI for the Entity Provider (This field supports iNPI and oNPI).	30	10	NUM	As provided by the ACO-OS
Provider CCN	CCN for the Entity Provider	40	6	CHAR	As provided by the ACO-OS
Record Type*	Detail Record Type A = Diabetic Shoe Order by Nurse Practitioners D = SIP (Represents only the providers who can bill the G code) E = PCF (Represents all providers who can bill FVF codes)	46	1	CHAR	As provided by the ACO-OS
Provider / Enhancement Effective Start Date*	Effective Start Date	47	8	CHAR	As provided by the ACO-OS
Provider/ Enhancement Effective End Date*	Effective End Date	55	8	CHAR	As provided by the ACO-OS
Part A Percentage Reduction	Percentage of Part A Claims Reduction	63	3	DECIMAL	As provided by the ACO-OS
Part B Percentage Reduction	Percentage of Part B Claims Reduction	66	3	DECIMAL	As provided by the ACO-OS
Filler	Unused area filled with spaces.	69	32	CHAR	As provided by the ACO-OS

Table 71: Part B PCF Provider File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the Part B PCF Provider file	1	7	CHAR	TRL_PRV
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of detail rows or records sent by ACO-OS	16	10	NUM	Numbers
Filler	Unused area filled with spaces	26	75	CHAR	Blanks

Table 72: Part B PCF Provider Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part B PCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of detail rows or records sent by ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler	Unused area filled with spaces	28	73	CHAR	As provided by the ACO-OS

5.12.4.3 Filenames

The file naming convention for the Part B PCF Provider file sent by the ACO-OS to the MCS at the HP VDC will be **P#EFT.ON.MCSHPVDC.PCFPRV.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM to the MCS at the HP VDC would be:

P#EFT.ON.MCSHPVDC.PCFPRV.D210104.T1000000.

The file naming convention for the Part B PCF Provider Response file sent by the MCS to the ACO-OS will be **P#EFT.ON.ACOT.MCSHPVDC.PCPR.Dyymmdd.Thhmmsst**. For example, an inbound file from the MCS corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.MCSHPVDC.PCPR.D210104.T1000000.

5.12.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.12.5.1 Interface Initiation

The ACO-OS sends the Part B PCF Provider file to the MCS at the HP VDC.

5.12.5.2 Flow Control

The ACO-OS Part B PCF Provider files are transferred to the MCS at the HP VDC using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.12.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.13 Durable Medical Equipment (DME) (Diabetic Shoe Order by Nurse Practitioner) PCF Provider File for FFS SSMs

This section describes the information exchange between the ACO-OS and the ViPS Medicare System (VMS) for the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider File.

5.13.1 General Processing

The ACO-OS sends the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file to the VMS via the BDC sweeped by the VDCs. After VMS receives the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file from the ACO-OS, a response file is generated from the VMS along with a response code that the VMS then sends back to the ACO-OS.

5.13.2 Interface Processing Time Requirements

DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider data from the ACO-OS will be sent monthly. A full refresh file will be sent even if there is no change to the provider data. This full refresh file contains currently active and previously active benefit enhancement records for a Provider.

The ACO-OS will include the following Provider Types associated with a PCF Entity by December 31, 2020 in the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider File.

- Provider/Suppliers (Participating Providers that are Nurse Practitioners)

5.13.3 Message Format (or Record Layout) & Required Protocols

All the provider records under PCF model will carry benefit enhancements and every enhancement will have its own record. A base record is not required. The file is fixed-length format.

5.13.4 File Layout

Each ACO-OS provider file and corresponding VMS response file has a header, record details, and trailer as described in section 5.13.4.2.

5.13.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.12.4.2.

5.13.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACO-OS and a response by the VMS. The description column describes basic file elements. The response file returns exact field values provided by the ACO-OS with the addition of a response code.

Table 73: DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file	1	7	CHAR	HDR_PRV
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler	Unused area filled with spaces	16	85	CHAR	Blanks

Table 74: DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part B PCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Filler	Unused area filled with spaces	18	83	CHAR	As provided by the ACO-OS

Table 75: ACO-OS to DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an [I] contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file	1	7	CHAR	DTL_PRV
PCF Model Identifier/ Practice ID*	Unique identifier for PCF Entity	8	10	CHAR	P<two-character region cd><nnnn>
Provider Type*	Preferred = P Provider/Supplier = S (Participating Providers) Affiliate = A	18	1	CHAR	S
Participant TIN* [I]	TIN for the Entity Participant	19	9	NUM	Numbers
Participant NPI*	NPI for the Entity Participant (This field supports iNPI and oNPI)	28	10	NUM	Numbers
Provider CCN	CCN for the Entity Participant	38	6	CHAR	Blank allowed For PCF this will be initialized to spaces
Record Type*	Detail Record Type A = Diabetic Shoe Order by Nurse Practitioners	44	1	CHAR	A *Note: Do not send a 0 record*

Data Field	Description	Start Position	Length	Format	Valid Values
Provider /Enhancement Effective Start Date*	Provider Effective Start Date	45	8	CHAR	CCYYMMDD
Provider/ Enhancement Effective End Date*	Provider Effective End Date	53	8	CHAR	CCYYMMDD
Part A Percentage Reduction	Percentage of Part A Claims Reduction	61	3	DECIMAL	Will be initialized to zeros
Part B Percentage Reduction	Percentage of Part B Claims Reduction	64	3	DECIMAL	Will be initialized to zeros
Filler	Unused area filled with spaces	67	34	CHAR	Blanks

Table 76: FFS SSM (VMC) to ACO-OS DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider Response Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	As Applicable
PCF Model Identifier/ Practice ID*	Unique identifier for PCF Entity	10	10	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	20	1	CHAR	As provided by the ACO-OS
Provider TIN* ǀ	TIN for the ACO Provider	21	9	NUM	As provided by the ACO-OS
Provider NPI*	NPI for the Entity Provider (This field supports iNPI and oNPI)	30	10	NUM	As provided by the ACO-OS
Provider CCN	CCN for the Entity Provider	40	6	CHAR	As provided by the ACO-OS
Record Type*	Detail Record Type A = Diabetic Shoe Order by Nurse Practitioners	46	1	CHAR	As provided by the ACO-OS
Provider /Enhancement Effective Start Date*	Provider Effective Start Date	47	8	CHAR	As provided by the ACO-OS
Provider/ Enhancement Effective End Date*	Provider Effective End Date	55	8	CHAR	As provided by the ACO-OS
Part A Percentage Reduction	Percentage of Part A Claims Reduction	63	3	DECIMAL	As provided by the ACO-OS
Part B Percentage Reduction	Percentage of Part B Claims Reduction	66	3	DECIMAL	As provided by the ACO-OS
Filler	Unused area filled with spaces	69	32	CHAR	As provided by the ACO-OS

Table 77: DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the DME PCF Provider file	1	7	CHAR	TRL_PRV
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of detail rows or records sent by ACO-OS	16	10	NUM	Numbers
Filler	Unused area filled with spaces	26	75	CHAR	Blanks

Table 78: DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the DME PCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of detail rows or records sent by ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler	Unused area filled with spaces	28	73	CHAR	As provided by the ACO-OS

5.13.4.3 Filenames

The file naming convention for the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file sent by the ACO-OS to the VMS at the HP VDC will be **P#EFT.ON.########.PCFPRD.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM to the VMS would be:

P#EFT.ON.########.PCFPRV.D210104.T1000000.

The file naming convention for the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider Response file sent by the MCS to the ACO-OS will be **P#EFT.ON.ACOT.#######.PCPR.Dyymmdd.Thhmmsst**. For example, an inbound file from the VMS corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.#######.PCPR.D210104.T1000000.

5.13.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.13.5.1 Interface Initiation

The ACO-OS sends the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file to the VMS.

5.13.5.2 Flow Control

The ACO-OS DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider files are transferred to the VMS using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.13.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

6 Qualification Methods

Developers perform initial data processing, cross-check testing, and system integration testing.

Appendix A: Response Codes and Explanations

The following table lists the Response/Error codes to be provided by the FFS SSMs when an error is encountered upon validation of files sent from the ACO-OS.

Table 79: Response Codes and Explanations

Code	Description	Explanation	Applies to Provider or Beneficiary or both
00	Success	The record was processed successfully.	Beneficiary or Provider
10	Header Record ID Error	The Header contains a Record ID but the last three characters are not PRV or BEN.	Beneficiary or Provider
11	Header Record Date Error	The Header Record date is missing or invalid.	Beneficiary or Provider
20	Detail Record ID Error	The data in the file does not conform to the file layout specified for the file transfer. The data format of the field or the data in the field does not conform to the list of valid values specified.	Beneficiary or Provider
21	Missing ACO Identifier applies to all ACO Program/models as follows: NGACO/VT APM/CEC/DC/KCC/KCF/PCF ACO/ESCO/Entity ID Error	The NGACO/VT APM/CEC/DC/KCC/KCF/PCF ID is missing or invalid.	Beneficiary or Provider
22	TIN Error	The Provider Taxpayer Identification Number (TIN) is invalid. **Note:** *The only validation MCS can perform is to ensure this is a numeric value.*	Provider
24	CCN Error	The Provider CCN is missing on the Part A file.	Provider
25	Effective Start Date Error	The Effective Start Date is missing or invalid.	Beneficiary or Provider
26	Effective End Date Error	The Effective End Date is missing or invalid.	Beneficiary or Provider

Code	Description	Explanation	Applies to Provider or Beneficiary or both
29	Beneficiary HICN Error	The Beneficiary HICN is missing or invalid.	Beneficiary
30	Trailer Record ID Error	The Trailer contains a Record ID but the last three characters are not PRV or BEN.	Beneficiary or Provider
31	Trailer Record Date Error	The Trailer Record Date is missing or invalid.	Beneficiary or Provider
32	Trailer Record Count Error	The error occurs when the record count does not equal the number of data records. (or) The trailer record is located before the end of the file. (or) There is a header and trailer, but no detail records.	Beneficiary or Provider
98	Header Record Missing	The Header record is missing or does not begin with HDR_.	Beneficiary or Provider
99	Trailer Record Missing	The Trailer record is missing or does not begin with TRL_.	Beneficiary or Provider

Appendix B: NGACO and VT APM Pass-Through File

NGACO Weekly AIPBP Reduction File:
The following file is prepared by CWF and provided to RACS utilizing EFT; this file is then moved from RACS via EFT to the Entities.

Table 80: NGACO Pass-Through Files

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date
Weekly AIPBP Reduction File	Weekly	P#EFT.ON.ACOT.V***.AIPBPRD.Dyymmdd.Thhmmsst	Text	800 Bytes	TBD	TBD

The file naming convention for the Weekly AIPBP Reduction File, sent by the CWF to Entities, will be P#EFT.ON.ACOT.V***.AIPBPRD.Dyymmdd.Thhmmsst for the NGACO Entities

The Weekly AIPBP Reduction filename in the ACO's mailbox will be P.V***.AIPBPRD.RP.Dyymmdd.Thhmmsst

Note: CWF will send both "CLMH-MBI" and "CLMH-HIC-NUM" as the beneficiary identifiers in the NGACO Weekly AIPBP Reduction file during the New Medicare Card Project transition period. After the end of the transition period (December 2019), only "CLMH-MBI" will be populated and "CLMH-HIC-NUM" will be populated as blanks.

VT APM Weekly AIPBP Reduction File:

The following file is prepared by CWF and provided to RACS utilizing EFT; this file is then moved from RACS via EFT to the Entities.

Table 81: VT APM Pass-Through Files

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date
Weekly AIPBP Reduction File	Weekly	P#EFT.ON.ACOT.F***.AIPBPRD.Dyymmdd.Thhmmsst	Text	800 Bytes	TBD	TBD

The file naming convention for the Weekly AIPBP Reduction File, sent by the CWF to Entities, will be P#EFT.ON.ACOT.F***.AIPBPRD.Dyymmdd.Thhmmsst for the VT APM Entities.

The Weekly AIPBP Reduction filename in the ACO's mailbox will be P.F***.AIPBPRD.RP.Dyymmdd.Thhmmsst.

Note: CWF will send both “CLMH-MBI” and “CLMH-HIC-NUM” as the beneficiary identifiers in the VTAPM Weekly AIPBP Reduction file during the New Medicare Card Project transition period. After the end of the transition period (December 2019), only “CLMH-MBI” will be populated and “CLMH-HIC-NUM” will be populated as blanks.

NGACO/VT APM Weekly AIPBP Reduction File Layout:

Table 82: NGACO/VT APM Weekly AIPBP Reduction File Header

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLMH-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: “CLMH” “CLML”
2	CLMH-CNTRCTR-NUM	Contractor Number	5	9	5	X(05)	Identification number of contractor submitting claim.
3	CLMH-ACO-ID	ACO ID	10	19	10	X(10)	ACO identification number.
4	CLMH-HIC-NUM	Beneficiary’s Health Insurance Claim Number	20	31	12	X(12)	Blanks
5	CLMH-MBI	Medicare Beneficiary Identifier	32	42	11	X(11)	MBI is a beneficiary identifier.
6	CLMH-DCN	DCN	43	65	23	X(23)	Carrier assigned Document Control Number for claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLMH-XREF-DCN	XREF DCN	66	88	23	X(23)	Cross-reference Document Control Number assigned to claim. Note: This field only applies to Part A.
8	CLMH-FROM-DT	From Date	89	96	8	YYYY MMDD	This date is the first day on the billing statement that covers services rendered to the beneficiary. This date is also known as “Statement Covers From Date”. Note: This applies only to Part A.
9	CLMH-THRU-DT	Thru Date	97	104	8	YYYY MMDD	This date is the last day on the billing statement that covers services rendered to the beneficiary. This date is also known as the “Statement Covers Through Date”. Note: This applies to only Part A.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
10	CLMH-PVDR-CCN	Provider CCN	105	110	6	X(06)	The CCN for the ACO Provider. This number verifies that a provider has been Medicare-certified for a particular type of services.
11	CLMH-PVDR-NPI	Provider NPI	111	120	10	X(10)	NPI Number is a unique identification number for covered health care providers. Covered health care providers must use the NPIs in administrative and financial transactions.
12	CLMH-TYPE-OF-BILL	Type of Bill	121	123	3	X(03)	A code that indicates the specific type of claim (Inpatient, Outpatient, adjustments, voids, etc.).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLMH-BILL-FACILITY	Bill Facility	121	121	1	X(01)	This code is the first digit of the type of bill (TOB1), and is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1= Hospital 2= SNF 3= Home Health Agency (HHA) 4= Religious non-medical (hospital) 5= Religious non-medical (extended care) 6= Intermediate care 7= Clinic or hospital-based renal dialysis facility 8= Specialty facility or Ambulatory Surgical Center (ASC) surgery 9= Reserved

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
14	CLMH-BILL-CATEGORY	Bill Category	122	122	1	X(01)	This code is the second digit of the type of bill (TOB2), and it is used to indicate with greater specificity where the service was provided (e.g. a department within a hospital) Claim Service Classification Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code).
15	CLMH-BILL-FREQUENCY	Bill Frequency	123	123	1	X(01)	This is the third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Claim Frequency Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Frequency-Code).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
16	CLMH-ADJSMT-TYPE-CD	Adjustment Type Code	124	124	1	X(01)	This code indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Credit 2=Debit
17	CLMH-PAYMENT-AMT	Claim Payment Amount	125	134	10	S9(08) V99	The amount that Medicare paid on the claim.
18	CLMH-AIPBP-RED-AMT	All Inclusive Population Based Payments Reduction Amount	135	144	10	S9(08) V99	Total payment amount with AIPBP reduction percent applied. Note: This will be the amount in Value Code 'Q1' for Part A.
19	CLMH-DRG-CODE	Diagnosis Related Group Code	145	147	3	9(03)	This code indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
20	CLMH-DGNS-ADMITTING	Admitting Diagnosis Code	148	154	7	X(07)	The ICD-9/10 diagnosis code identifying the illness or disability for which the beneficiary was admitted.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
21	CLMH-DGNS-EXTERNAL	DGNS External	155	161	7	X(07)	The ICD-9/ICD-10 diagnosis code which describes the external cause of the injury. Note: CWF is using external cause of injury first diagnosis code.
22	CLMH-PAT-VISIT-REAS1	Patient Visit Reason 1	162	168	7	X(07)	Diagnosis code for patient's first visit.
23	CLMH-PAT-VISIT-REAS2	Patient Visit Reason 2	169	175	7	X(07)	Diagnosis code for patient's second visit.
24	CLMH-PAT-VISIT-REAS3	Patient Visit Reason 3	176	182	7	X(07)	Diagnosis code for patient's third visit.
25	CLMH-PRCDR-DATA		183	557	375		
26	CLMH-PRCDR-ENTRY	Procedure Entry					Procedure Codes and Dates Occurs 25 times.
27	CLMH-PRCDR-CD	Procedure Code	183	189	7	X(07)	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
28	CLMH-PRCDR-DT	Procedure Date	190	197	8	YYYY MMDD	The date the indicated procedure was performed.
29	CLMH-DIAG-DATA		558	757	200		
30	CLMH-DIAG-ENTRY	Diagnosis Entry					Diagnosis Codes and POA indicators. Occurs 25 times.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
31	CLMH-DIAG-CODE	Diagnosis Code	558	564	7	X(07)	The patient's ICD-9/ICD-10 diagnosis code.
32	CLMH-DIAG-POA-IND	Diagnosis Code Present On Admission Indicator	565	565	1	X(01)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility.
33	CLMH-DETAIL-LINES	Detail Lines	758	760	3	S9(03)	Number of line items on claim.
34	CLMH-PATIENT-NUM	Patient Control Number	761	780	20	X(20)	Patient Control Number
35	FILLER1	Filler	781	800	20	X(20)	Filler

Table 83: NGACO/VT APM Weekly AIPBP Reduction File Detail

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLML-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: “CLMH” “CLML”
2	CLML-LINE-NUMBER	Claim Line Number	5	7	3	S9(03)	This number is a sequential number that identifies a specific claim line.
3	CLML-REV-CD	Revenue Code	8	11	4	9(04)	Claim Revenue center code identifies a specific accommodation, ancillary service, or billing calculation. Note: Include REV Code 0001.
4	CLML-RNDRG-PRVDR-TAX-NUM	Rendering Provider Tax Number	12	21	10	X(10)	The rendering provider’s Internal Revenue Employer Identification number or Social Security number. Note: Billing TIN is always the same as Rendering TIN for Part B.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
5	CLML-RNDRG-PRVDR-NPI-NUM	Rendering Provider National Provider Identifier Number	22	31	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI. Note: This will only apply to Part B.
6	CLML-DGNS-CD-1	Claim Line Diagnosis First Code	32	38	7	X(07)	The first of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLML-DGNS-CD-2	Claim Line Diagnosis Second Code	39	45	7	X(07)	The second of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	CLML-DGNS-CD-3	Claim Line Diagnosis Third Code	46	52	7	X(07)	The third of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLML-DGNS-CD-4	Claim Line Diagnosis Fourth Code	53	59	7	X(07)	The fourth of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
10	CLML-FROM-DATE	Claim Line From Date	60	67	8	YYYY MMDD	This is the date the service associated with the line item began. *UPDATE: CWF will carry the detail line item date for Part A in both the From and Thru Date.*
11	CLML-THRU-DATE	Claim Line Thru Date	68	75	8	YYYY MMDD	This is the date the service associated with the line item ended.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
12	CLML-SRVC-UNIT-QTY	Claim Line Service Unit Quantity	76	82	7	S9(07)	Total units associated with services needing unit reporting such as number of covered days in a particular accommodation, miles, Anesthesia times the units and number of oxygen or blood units.
13	CLML-TOT-CHRG-AMT	Claim Line Total Charge Amount	83	92	10	S9(08) V99	Total submitted charge for line item. Note: CWF will also be providing charges for non-covered and denied services.
14	CLML-ALOWD-CHRG-AMT	Claim Line Allowed Charge Amount	93	99	7	S9(05) V99	The amount Medicare approved for payment to the provider. Note: Part B only
15	CLML-CVRD-PD-AMT	Claim Line Covered Paid Amount	100	106	7	S9(05) V99	This is the amount Medicare reimbursed the provider for covered services associated with the claim-line and is based on the Total Charge minus the Non-Covered Charge.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
16	CLML-AIPBP-RED-AMT	All Inclusive Population Based Payments Reduction Amount	107	113	7	S9(05) V99	Total payment amount with AIPBP reduction percent applied. Note: This will be the Other Amount carried for 'L' for Part B. CWF will use Other Amount Indicator 'L' to calculate the AIPBP-reduced amount.
17	CLML-HCPC-CD	Healthcare Common Procedure Coding System (HCPCS) Code	114	118	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
18	CLML-HCPC-MODIFIER1	HCPCS First Modifier Code	119	120	2	X(02)	This is the first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
19	CLML-HCPC-MODIFIER2	HCPCS Second Modifier Code	121	122	2	X(02)	This is the second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
20	CLML-HCPC-MODIFIER3	HCPCS Third Modifier Code	123	124	2	X(02)	This is the third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
21	CLML-HCPC-MODIFIER4	HCPCS Fourth Modifier Code	125	126	2	X(02)	This is the fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
22	CLML-HCPC-MODIFIER5	HCPCS Fifth Modifier Code	127	128	2	X(02)	This is the fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. Note: This applies only to Part A.
23	FILLER	Filler	129	136	8	X(08)	

Appendix C: Direct Contracting Pass-Through File

Direct Contracting (Direct Contracting) Weekly APO/PCC/TCC Reduction File:
The following file is prepared by CWF from 01/01/2021 and provided to RACS utilizing EFT; this file is then moved from RACS via EFT to the Entities.

Table 84: Direct Contracting Pass-Through Files

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date
Weekly APO/PCC/TCC Reduction File	Weekly	P#EFT.ON.ACOT.D***.TCPCAPRC.Dyymmdd.Thhmmsst	Text	800 Bytes	TBD	TBD

The file naming convention for the Weekly APO/PCC/TCC Reduction File, sent by the CWF to Entities, will be **P#EFT.ON.ACOT.D***.TCPCAPRC.Dyymmdd.Thhmmsst** for the Direct Contracting Entities

The Weekly APO/PCC/TCC Reduction filename in the ACO's mailbox will be **P.D***.TCPCAPRC.RP.Dyymmdd.Thhmmsst**.

Note: CWF will send both "CLMH-MBI" and "CLMH-HIC-NUM" as the beneficiary identifiers in the Direct Contracting Weekly APO/PCC/TCC Reduction file during the New Medicare Card Project transition period. The field "CLMH-MBI" will be populated and "CLMH-HIC-NUM" will be populated as blanks.

Direct Contracting Weekly APO/PCC/TCC Reduction File Layout:

Table 85: Direct Contracting Weekly APO/PCC/TCC Reduction File Header

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
36	CLMH-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
37	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
38	CLMH-CNTRCTR-NUM	Contractor Number	6	10	5	X(05)	Identification number of contractor submitting claim.
39	FILLER	Delimiter	11	11	1	X(01)	; (Semi colon)
40	CLMH-ACO-IDENTIFIER		12	22	10	X(11)	ACO identification number.
41	CLMH-QUAL-ID	ACO ID	12	12	1	X(01)	
42	FILLER	Delimiter	13	13	1	X(01)	; (Semi colon)
43	CLMH-ACO-ID-NUMBER	ACO NUMBER	14	22	9	X(09)	
44	FILLER	Delimiter	23	23	1	X(01)	; (Semi colon)
45	CLMH-MEDICARE-PART	Claim Type	24	27	4	X(04)	FISS or MCS
46	FILLER	Delimiter	28	28	1	X(01)	; (Semi colon)
47	CLMH-MBI	Medicare Beneficiary Identifier	29	39	11	X(11)	MBI is a beneficiary identifier.
48	FILLER	Delimiter	40	40	1	X(01)	; (Semi colon)
49	CLMH-DCN	DCN	41	63	23	X(23)	Carrier assigned Document Control Number for claim.
50	FILLER	Delimiter	64	64	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
51	CLMH-XREF-DCN	XREF DCN	65	87	23	X(23)	Cross-reference Document Control Number assigned to claim. Note: This field only applies to Part A. This field will contain the same value as in DCN for part B claims.
52	FILLER	Delimiter	88	88	1	X(01)	; (Semi colon)
53	CLMH-FROM-DT	From Date	89	96	8	YYYY MMDD	This date is the first day on the billing statement that covers services rendered to the beneficiary. This date is also known as “Statement Covers From Date”. Note: This applies only to Part A.
54	FILLER	Delimiter	97	97	1	X(01)	; (Semi colon)
55	CLMH-THRU-DT	Thru Date	98	105	8	YYYY MMDD	This date is the last day on the billing statement that covers services rendered to the beneficiary. This date is also known as the “Statement Covers Through Date”. Note: This applies to only Part A.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
56	FILLER	Delimiter	106	106	1	X(01)	; (Semi colon)
57	CLMH-PVDR-CCN	Provider CCN	107	112	6	X(06)	The CCN for the ACO Provider. This number verifies that a provider has been Medicare-certified for a particular type of services.
58	FILLER	Delimiter	113	113	1	X(01)	; (Semi colon)
59	CLMH-PVDR-NPI	Provider NPI	114	123	10	X(10)	NPI Number is a unique identification number for covered health care providers. Covered health care providers must use the NPIs in administrative and financial transactions.
60	FILLER	Delimiter	124	124	1	X(01)	; (Semi colon)
61	CLMH-TYPE-OF-BILL	Type of Bill	125	130	6	X(06)	A code that indicates the specific type of claim (Inpatient, Outpatient, adjustments, voids, etc.).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
62	CLMH-BILL-FACILITY	Bill Facility	125	125	1	X(01)	This code is the first digit of the type of bill (TOB1), and is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1= Hospital 2= SNF 3= Home Health Agency (HHA) 4= Religious non-medical (hospital) 5= Religious non-medical (extended care) 6= Intermediate care 7= Clinic or hospital-based renal dialysis facility 8= Specialty facility or Ambulatory Surgical Center (ASC) surgery 9= Reserved
63	FILLER	Delimiter	126	126	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
64	CLMH-BILL-CATEGORY	Bill Category	127	127	1	X(01)	This code is the second digit of the type of bill (TOB2), and it is used to indicate with greater specificity where the service was provided (e.g. a department within a hospital) Claim Service Classification Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code).
65	FILLER	Delimiter	128	128	1	X(01)	; (Semi colon)
66	CLMH-BILL-FREQUENCY	Bill Frequency	129	129	1	X(01)	This is the third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Claim Frequency Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Frequency-Code).
67	FILLER	Delimiter	130	130	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
68	CLMH-ADJSMT-TYPE-CD	Adjustment Type Code	131	131	1	X(01)	This code indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Credit 2=Debit
69	FILLER	Delimiter	132	132	1	X(01)	; (Semi colon)
70	CLMH-ADJUST-REASON-CODE	Adjustment Reason Code	133	135	1	X(03)	Reason code for claim adjustment, for example: - Beneficiary Alignment Change (Value 'B') - Provider Alignment Change (Value 'P') - Other (Value 'O')
71	FILLER	Delimiter	136	136	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
72	CLMH-REIMB-AMT	Claim Payment Amount	137	147	11	X(11)	The amount that Medicare paid on the claim. $$$$$$$:99
73	FILLER	Delimiter	148	148	1	X(01)	; (Semi colon)
74	CLMH-BENE-PMT-COINSRNC-AMT	Claim Beneficiary Payment Coinsurance Amount	149	159	11	X(11)	An amount identifying the portion of cost that is the responsibility of a beneficiary for payment. $$$$$$$:99 Only for FISS (Part A) Value-code – ‘A2’
75	FILLER	Delimiter	160	160	1	X(01)	; (Semi colon)
76	CLMH-RCPNT-PMT-DDCTBL-PD-AMT	Claim Recipient Payment Deductible Paid Amount	161	168	8	X(08)	The amount of money the beneficiary paid towards an annual deductible. $$$$:99 Only for FISS (Part A) Value-code – ‘A1’
77	FILLER	Delimiter	169	169	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
78	CLMH-APO-RED-AMT	Advanced Payment Option Reduction Amount	170	177	8	X(08)	Total payment amount with PBP reduction percent applied. (For DC/KCC, Benefit Enhancement “1”). $$$$$:99 Only for FISS (Part A) Value-code – ‘Q1’
79	FILLER	Delimiter	178	178	1	X(01)	; (Semi colon)
80	CLMH-TCC-RED-AMT	Total Care Capitation Payment Reduction Amount	179	186	8	X(08)	(For DC/KCC, Benefit Enhancement “5”). $$$$$:99 Only for FISS (Part A) Value-code – ‘Q1’
81	FILLER	Delimiter	187	187	1	X(01)	; (Semi colon)
82	CLMH-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	188	195	8	X(08)	(For DC/KCC, Benefit Enhancement “8”). $$$$$:99 Only for FISS (Part A) Value-code – ‘Q1’
83	FILLER	Delimiter	196	196	1	X(01)	; (Semi colon)
84	CLMH-DRG-CODE	Diagnosis Related Group Code	197	199	3	9(03)	This code indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
85	FILLER	Delimiter	200	200	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
86	CLMH-DGNS-ADMITTING	Admitting Diagnosis Code	201	207	7	X(07)	The ICD-9/10 diagnosis code identifying the illness or disability for which the beneficiary was admitted.
87	FILLER	Delimiter	208	208	1	X(01)	; (Semi colon)
88	CLMH-DGNS-EXTERNAL	DGNS External	209	215	7	X(07)	The ICD-9/ICD-10 diagnosis code which describes the external cause of the injury. Note: CWF is using external cause of injury first diagnosis code.
89	FILLER	Delimiter	216	216	1	X(01)	; (Semi colon)
90	CLMH-PAT-VISIT-REAS1	Patient Visit Reason 1	217	223	7	X(07)	Diagnosis code for patient's first visit.
91	FILLER	Delimiter	224	224	1	X(01)	; (Semi colon)
92	CLMH-PAT-VISIT-REAS2	Patient Visit Reason 2	225	231	7	X(07)	Diagnosis code for patient's second visit.
93	FILLER	Delimiter	232	232	1	X(01)	; (Semi colon)
94	CLMH-PAT-VISIT-REAS3	Patient Visit Reason 3	233	239	7	X(07)	Diagnosis code for patient's third visit.
95	FILLER	Delimiter	240	240	1	X(01)	; (Semi colon)
96	CLMH-PRCDR-DATA		241	665	425		
97	CLMH-PRCDR-ENTRY	Procedure Entry	241	257	17		Procedure Codes and Dates Occurs 25 times.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
98	CLMH-PRCDR-CD	Procedure Code	241	247	7	X(07)	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
99	FILLER	Delimiter	248	248	1	X(01)	; (Semi colon)
100	CLMH-PRCDR-DT	Procedure Date	249	256	8	YYYY MMDD	The date the indicated procedure was performed.
101	FILLER	Delimiter	257	257	1	X(01)	; (Semi colon)
102	CLMH-DIAG-DATA		666	915	250		
103	CLMH-DIAG-ENTRY	Diagnosis Entry	666	675	10		Diagnosis Codes and POA indicators. Occurs 25 times.
104	CLMH-DIAG-CODE	Diagnosis Code	666	672	7	X(07)	The patient's ICD-9/ICD-10 diagnosis code.
105	FILLER	Delimiter	673	673	1	X(01)	; (Semi colon)
106	CLMH-DIAG-POA-IND	Diagnosis Code Present On Admission Indicator	674	674	1	X(01)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility.
107	FILLER	Delimiter	675	675	1	X(01)	; (Semi colon)
108	CLMH-DETAIL-LINES	Detail Lines	916	918	3	9(03)	Number of line items on claim.
109	FILLER	Delimiter	919	919	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
110	CLMH-PATIENT-NUM	Patient Control Number	920	939	20	X(20)	Patient Control Number
111	FILLER	Delimiter	940	940	1	X(01)	; (Semi colon)
112	FILLER1	Filler	941	985	45	X(45)	Filler

Table 86: Direct Contracting Weekly APO/PCC/TCC Reduction File Detail

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLML-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
2	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)
3	CLML-LINE-NUMBER	Claim Line Number	6	8	3	9(03)	This number is a sequential number that identifies a specific claim line.
4	FILLER	Delimiter	9	9	1	X(01)	; (Semi colon)
5	CLML-REV-CD	Revenue Code	10	13	4	9(04)	Claim Revenue center code identifies a specific accommodation, ancillary service, or billing calculation. Note: Include REV Code 0001.
6	FILLER	Delimiter	14	14	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLML-RNDRG-PRVDR-TAX-NUM	Rendering Provider Tax Number	15	24	10	X(10)	The rendering provider's Internal Revenue Employer Identification number or Social Security number. Note: Billing TIN is always the same as Rendering TIN for Part B.
8	FILLER	Delimiter	25	25	1	X(01)	; (Semi colon)
9	CLML-RNDRG-PRVDR-NPI-NUM	Rendering Provider National Provider Identifier Number	26	35	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI. Note: This will only apply to Part B.
10	FILLER	Delimiter	36	36	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
11	CLML-DGNS-CD-1	Claim Line Diagnosis First Code	37	43	7	X(07)	The first of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.
12	FILLER	Delimiter	44	44	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLML-DGNS-CD-2	Claim Line Diagnosis Second Code	45	51	7	X(07)	The second of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.
14	FILLER	Delimiter	52	52	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
15	CLML-DGNS-CD-3	Claim Line Diagnosis Third Code	53	59	7	X(07)	The third of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.
16	FILLER	Delimiter	60	60	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	CLML-DGNS-CD-4	Claim Line Diagnosis Fourth Code	61	67	7	X(07)	The fourth of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.
18	FILLER	Delimiter	68	68	1	X(01)	; (Semi colon)
19	CLML-FROM-DATE	Claim Line From Date	69	76	8	YYYY MMDD	This is the date the service associated with the line item began. UPDATE: CWF will carry the detail line item date for Part A in both the From and Thru Date.
20	FILLER	Delimiter	77	77	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
21	CLML-THRU-DATE	Claim Line Thru Date	78	85	8	YYYY MMDD	This is the date the service associated with the line item ended.
22	FILLER	Delimiter	86	86	1	X(01)	; (Semi colon)
23	CLML-SRVC-UNIT-QTY	Claim Line Service Unit Quantity	87	93	7	9(07)	Total units associated with services needing unit reporting such as number of covered days in a particular accommodation, miles, Anesthesia times the units and number of oxygen or blood units.
24	FILLER	Delimiter	94	94	1	X(01)	; (Semi colon)
25	CLML-TOT-CHRG-AMT	Claim Line Total Charge Amount	95	105	11	X(11)	Total submitted charge for line item. $$$$$$$$:99 Note: CWF will also be providing charges for non-covered and denied services.
26	FILLER	Delimiter	106	106	1	X(01)	; (Semi colon)
27	CLML-ALOWD-CHRG-AMT	Claim Line Allowed Charge Amount	107	114	8	X(08)	The amount Medicare approved for payment to the provider. $$$$$:99 Note: Part B only
28	FILLER	Delimiter	115	115	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
29	CLML-CVRD-PD-AMT	Claim Line Covered Paid Amount	116	126	11	X(11)	This is the amount Medicare reimbursed the provider for covered services associated with the claim-line and is based on the Total Charge minus the Non-Covered Charge. $$$$$$$:99
30	FILLER	Delimiter	127	127	1	X(01)	; (Semi colon)
31	CLML-BENE-PMT-COINSRNC-AMT	Claim Beneficiary Payment Coinsurance Amount	128	136	9	X(09)	An amount identifying the portion of cost that is the responsibility of a beneficiary for payment. $$$$$:99 (MCS Part B only)
32	FILLER	Delimiter	137	137	1	X(01)	; (Semi colon)
33	CLML-RCPNT-PMT-DDCTBL-PD-AMT	Claim Recipient Payment Deductible Paid Amount	138	145	8	X(08)	The amount of money the beneficiary paid towards an annual deductible. $$$$:99 (MCS Part B only)
34	FILLER	Delimiter	146	146	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
35	CLML-APO-RED-AMT	Advanced Payment Option Reduction Amount	147	154	8	X(08)	(For DC/KCC, Benefit Enhancement “1”). (MCS Part B only) $$$$$:99 Other-amts-ind - ‘L’
36	FILLER	Delimiter	155	155	1	X(01)	; (Semi colon)
37	CLML-TCC-RED-AMT	Total Care Capitation Reduced Amount	156	163	8	X(08)	(For DC/KCC, Benefit Enhancement “5”). (MCS Part B only) $$$$$:99 Other-amts-ind - ‘L’
38	FILLER	Delimiter	164	164	1	X(01)	; (Semi colon)
39	CLML-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	165	172	8	X(08)	Total payment amount with PCC reduction percent applied. (For DC/KCC, Benefit Enhancement “8”). (MCS Part B only) $$$$$:99 Other-amts-ind - ‘L’
40	FILLER	Delimiter	173	173	1	X(01)	; (Semi colon)
41	CLML-HCPC-CD	Healthcare Common Procedure Coding System (HCPCS) Code	174	178	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
42	FILLER	Delimiter	179	179	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
43	CLML-HCPC-MODIFIER1	HCPCS First Modifier Code	180	181	2	X(02)	This is the first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
44	FILLER	Delimiter	182	182	1	X(01)	; (Semi colon)
45	CLML-HCPC-MODIFIER2	HCPCS Second Modifier Code	183	184	2	X(02)	This is the second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
46	FILLER	Delimiter	185	185	1	X(01)	; (Semi colon)
47	CLML-HCPC-MODIFIER3	HCPCS Third Modifier Code	186	187	2	X(02)	This is the third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
48	FILLER	Delimiter	188	188	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
49	CLML-HCPC-MODIFIER4	HCPCS Fourth Modifier Code	189	190	2	X(02)	This is the fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
50	FILLER	Delimiter	191	191	1	X(01)	; (Semi colon)
51	CLML-HCPC-MODIFIER5	HCPCS Fifth Modifier Code	192	193	2	X(02)	This is the fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. Note: This applies only to Part A.
52	FILLER	Delimiter	194	194	1	X(01)	; (Semi colon)
53	FILLER	Filler	195	225	31	X(31)	

Appendix D: CKCC Pass-Through File

CKCC Weekly Capitated (TCC/QCP) Reduction File:

The following file is prepared by CWF from 01/01/2021 and provided to RACS utilizing EFT; this file is then moved from RACS via EFT to the Entities.

Table 87: CKCC Choices Pass-Through Files

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date
Weekly TCC/QCP Reduction File	Weekly	P#EFT.ON.ACOT.C***.TCCQCPRC.Dyymmdd.Thhmmsst	Text	800 Bytes	TBD	TBD

The file naming convention for the Weekly TCC/QCP Reduction File, sent by the CWF to Entities, will be P#EFT.ON.ACOT.C****.TCCQCPRC.Dyymmdd.Thhmmsst for the CKCC Entities

The Weekly TCC/QCP Reduction filename in the ACO's mailbox will be P.C****.TCCQCPC.RP.Dyymmdd.Thhmmsst.

Note: CWF will send both "CLMH-MBI" and "CLMH-HIC-NUM" as the beneficiary identifiers in the CKCC *Weekly TCC/QCP Reduction file during the New Medicare Card Project transition period. After the end of the transition period (December 2019), only "CLMH-MBI" will be populated and "CLMH-HIC-NUM" will be populated as blanks.*

Table 88: CKCC Entities Weekly TCC/QCP Reduction File Layout

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLMH-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
2	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
3	CLMH-CNTRCTR-NUM	Contractor Number	6	10	5	X(05)	Identification number of contractor submitting claim.
4	FILLER	Delimiter	11	11	1	X(01)	; (Semi colon)
5	CLMH-ACO-IDENTIFIER		12	22	10	X(11)	ACO identification number.
6	CLMH-QUAL-ID	ACO ID	12	12	1	X(01)	
7	FILLER	Delimiter	13	13	1	X(01)	; (Semi colon)
8	CLMH-ACO-ID-NUMBER	ACO NUMBER	14	22	9	X(09)	
9	FILLER	Delimiter	23	23	1	X(01)	; (Semi colon)
10	CLMH-MEDICARE-PART	Claim Type	24	28	5	X(05)	Part A or Part B paid for the claim.
11	FILLER	Delimiter	29	29	1	X(01)	; (Semi colon)
12	CLMH-MBI	Medicare Beneficiary Identifier	30	40	11	X(11)	MBI is a beneficiary identifier.
13	FILLER	Delimiter	41	41	1	X(01)	; (Semi colon)
14	CLMH-DCN	DCN	42	64	23	X(23)	Carrier assigned Document Control Number for claim.
15	FILLER	Delimiter	65	65	1	X(01)	; (Semi colon)
16	CLMH-XREF-DCN	XREF DCN	66	88	23	X(23)	Cross-reference Document Control Number assigned to claim. *Note: This field only applies to Part A.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	FILLER	Delimiter	89	89	1	X(01)	; (Semi colon)
18	CLMH-FROM-DT	From Date	90	97	8	YYYY MMDD	This date is the first day on the billing statement that covers services rendered to the beneficiary. This date is also known as “Statement Covers From Date”. *Note: This applies only to Part A.*
19	FILLER	Delimiter	98	98	1	X(01)	; (Semi colon)
20	CLMH-THRU-DT	Thru Date	99	106	8	YYYY MMDD	This date is the last day on the billing statement that covers services rendered to the beneficiary. This date is also known as the “Statement Covers Through Date”. *Note: This applies to only Part A.*
21	FILLER	Delimiter	107	107	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
22	CLMH-PVDR-CCN	Provider CCN	108	113	6	X(06)	The CCN for the ACO Provider. This number verifies that a provider has been Medicare-certified for a particular type of services.
23	FILLER	Delimiter	114	114	1	X(01)	; (Semi colon)
24	CLMH-PVDR-NPI	Provider NPI	115	124	10	X(10)	NPI Number is a unique identification number for covered health care providers. Covered health care providers must use the NPIs in administrative and financial transactions.
25	FILLER	Delimiter	125	125	1	X(01)	; (Semi colon)
26	CLMH-TYPE-OF-BILL	Type of Bill	126	131	6	X(06)	A code that indicates the specific type of claim (Inpatient, Outpatient, adjustments, voids, etc.).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
27	CLMH-BILL-FACILITY	Bill Facility	126	126	1	X(01)	This code is the first digit of the type of bill (TOB1), and is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1 = Hospital 2 = SNF 3 = Home Health Agency (HHA) 4 = Religious non-medical (hospital) 5 = Religious non-medical (extended care) 6 = Intermediate care 7 = Clinic or hospital-based renal dialysis facility 8 = Specialty facility or Ambulatory Surgical Center (ASC) surgery 9 = Reserved
28	FILLER	Delimiter	127	127	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
29	CLMH-BILL-CATEGORY	Bill Category	128	128	1	X(01)	This code is the second digit of the type of bill (TOB2), and it is used to indicate with greater specificity where the service was provided (e.g. a department within a hospital) Claim Service Classification Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code).
30	FILLER	Delimiter	129	129	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
31	CLMH-BILL-FREQUENCY	Bill Frequency	130	130	1	X(01)	This is the third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Claim Frequency Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Frequency-Code).
32	FILLER	Delimiter	131	131	1	X(01)	; (Semi colon)
33	CLMH-ADJSMT-TYPE-CD	Adjustment Type Code	132	132	1	X(01)	This code indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Credit 2=Debit
34	FILLER	Delimiter	133	133	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
35	CLMH-ADJUST-REASON-CODE	Adjustment Reason Code	134	136	1	X(03)	Reason code for claim adjustment, for example: • IUR • Beneficiary Alignment Change • Provider Alignment Change • Other
36	FILLER	Delimiter	137	137	1	X(01)	; (Semi colon)
37	CLMH-REIMB-AMT	Claim Payment Amount	138	148	11	X(11)	The amount that Medicare paid on the claim.
38	FILLER	Delimiter	149	149	1	X(01)	; (Semi colon)
39	CLMH-BENE-PMT-COINSRNC-AMT	Claim Beneficiary Payment Coinsurance Amount	150	155	6	X(6)	An amount identifying the portion of cost that is the responsibility of a beneficiary for payment.
40	FILLER	Delimiter	156	156	1	X(01)	; (Semi colon)
41	CLMH-RCPNT-PMT-DDCTBL-PD-AMT	Claim Recipient Payment Deductible Paid Amount	157	164	8	X(08)	The amount of money the beneficiary paid towards an annual deductible.
42	FILLER	Delimiter	165	165	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
43	CLMH-APO-RED-AMT	Advanced Payment Option Reduction Amount	166	173	8	X(08)	Total payment amount with PBP reduction percent applied. (For DC, Benefit Enhancement “1”).
44	FILLER	Delimiter	174	174	1	X(01)	; (Semi colon)
45	CLMH-TCC-RED-AMT	Total Care Capitation Payment Reduction Amount	175	182	8	X(08)	(For DC, Benefit Enhancement “5”).
46	FILLER	Delimiter	183	183	1	X(01)	; (Semi colon)
47	CLMH-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	184	191	8	X(08)	(For DC, Benefit Enhancement “8”).
48	FILLER	Delimiter	192	192	1	X(01)	; (Semi colon)
49	CLMH-DRG-CODE	Diagnosis Related Group Code	193	195	3	9(03)	This code indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
50	FILLER	Delimiter	196	196	1	X(01)	; (Semi colon)
51	CLMH-DGNS-ADMITTING	Admitting Diagnosis Code	197	203	7	X(07)	The ICD-9/10 diagnosis code identifying the illness or disability for which the beneficiary was admitted.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
52	FILLER	Delimiter	204	204	1	X(01)	; (Semi colon)
53	CLMH-DGNS-EXTERNAL	DGNS External	205	211	7	X(07)	The ICD-9/ICD-10 diagnosis code which describes the external cause of the injury. *Note: CWF is using external cause of injury first diagnosis code.*
54	FILLER	Delimiter	212	212	1	X(01)	; (Semi colon)
55	CLMH-PAT-VISIT-REAS1	Patient Visit Reason 1	213	219	7	X(07)	Diagnosis code for patient's first visit.
56	FILLER	Delimiter	220	220	1	X(01)	; (Semi colon)
57	CLMH-PAT-VISIT-REAS2	Patient Visit Reason 2	221	227	7	X(07)	Diagnosis code for patient's second visit.
58	FILLER	Delimiter	228	228	1	X(01)	; (Semi colon)
59	CLMH-PAT-VISIT-REAS3	Patient Visit Reason 3	229	235	7	X(07)	Diagnosis code for patient's third visit.
60	FILLER	Delimiter	236	236	1	X(01)	; (Semi colon)
61	CLMH-PRCDR-DATA		237	661	425		N/a
62	CLMH-PRCDR-ENTRY	Procedure Entry	237	243	8		Procedure Codes and Dates Occurs 25 times.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
63	CLMH-PRCDR-CD	Procedure Code	237	243	7	X(07)	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
64	FILLER	Delimiter	244	244	1	X(01)	; (Semi colon)
65	CLMH-PRCDR-DT	Procedure Date	245	252	8	YYYY MMDD	The date the indicated procedure was performed.
66	FILLER	Delimiter	253	253	1	X(01)	; (Semi colon)
67	CLMH-DIAG-DATA		662	911	250		
68	CLMH-DIAG-ENTRY	Diagnosis Entry	662	671	10		Diagnosis Codes and POA indicators. Occurs 25 times.
69	CLMH-DIAG-CODE	Diagnosis Code	662	668	7	X(07)	The patient's ICD-9/ICD-10 diagnosis code.
70	FILLER	Delimiter	669	669	1	X(01)	; (Semi colon)
71	CLMH-DIAG-POA-IND	Diagnosis Code Present on Admission Indicator	670	670	1	X(01)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility.
72	FILLER	Delimiter	671	671	1	X(01)	; (Semi colon)
73	CLMH-DETAIL-LINES	Detail Lines	912	914	3	9(03)	Number of line items on claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
74	FILLER	Delimiter	915	915	1	X(01)	; (Semi colon)
75	CLMH-PATIENT-NUM	Patient Control Number	916	935	20	X(20)	Patient Control Number
76	FILLER	Delimiter	936	936	1	X(01)	; (Semi colon)
77	FILLER1	Filler	937	981	45	X(45)	Filler

Table 89: CKCC Weekly TCC/QCP Weekly Reduction File Detail

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLML-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
2	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)
3	CLML-LINE-NUMBER	Claim Line Number	6	8	3	9(03)	This number is a sequential number that identifies a specific claim line.
4	FILLER	Delimiter	9	9	1	X(01)	; (Semi colon)
5	CLML-REV-CD	Revenue Code	10	13	4	9(04)	Claim Revenue center code identifies a specific accommodation, ancillary service, or billing calculation. Note: Include REV Code 0001.
6	FILLER	Delimiter	14	14	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLML-RNDRG-PRVDR-TAX-NUM	Rendering Provider Tax Number	15	24	10	X(10)	The rendering provider's Internal Revenue Employer Identification number or Social Security number. Note: Billing TIN is always the same as Rendering TIN for Part B.
8	FILLER	Delimiter	25	25	1	X(01)	; (Semi colon)
9	CLML-RNDRG-PRVDR-NPI-NUM	Rendering Provider National Provider Identifier Number	26	35	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI. Note: This will only apply to Part B.
10	FILLER	Delimiter	36	36	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
11	CLML-DGNS-CD-1	Claim Line Diagnosis First Code	37	43	7	X(07)	The first of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
12	FILLER	Delimiter	44	44	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLML-DGNS-CD-2	Claim Line Diagnosis Second Code	45	51	7	X(07)	The second of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
14	FILLER	Delimiter	52	52	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
15	CLML-DGNS-CD-3	Claim Line Diagnosis Third Code	53	59	7	X(07)	The third of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
16	FILLER	Delimiter	60	60	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	CLML-DGNS-CD-4	Claim Line Diagnosis Fourth Code	61	67	7	X(07)	The fourth of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
18	FILLER	Delimiter	68	68	1	X(01)	; (Semi colon)
19	CLML-FROM-DATE	Claim Line From Date	69	76	8	YYYY MMDD	This is the date the service associated with the line item began. UPDATE: CWF will carry the detail line item date for Part A in both the From and Thru Date.
20	FILLER	Delimiter	77	77	1	X(01)	; (Semi colon)
21	CLML-THRU-DATE	Claim Line Thru Date	78	85	8	YYYY MMDD	This is the date the service associated with the line item ended.
22	FILLER	Delimiter	86	86	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
23	CLML-SRVC-UNIT-QTY	Claim Line Service Unit Quantity	87	93	7	9(07)	Total units associated with services needing unit reporting such as number of covered days in a particular accommodation, miles, Anesthesia times the units and number of oxygen or blood units.
24	FILLER	Delimiter	94	94	1	X(01)	; (Semi colon)
25	CLML-TOT-CHRG-AMT	Claim Line Total Charge Amount	95	105	11	X(11)	Total submitted charge for line item. Note: CWF will also be providing charges for non-covered and denied services.
26	FILLER	Delimiter	106	106	1	X(01)	; (Semi colon)
27	CLML-ALOWD-CHRG-AMT	Claim Line Allowed Charge Amount	107	114	8	X(08)	The amount Medicare approved for payment to the provider. Note: Part B only
28	FILLER	Delimiter	115	115	1	X(01)	; (Semi colon)
29	CLML-CVRD-PD-AMT	Claim Line Covered Paid Amount	116	126	11	X(11)	This is the amount Medicare reimbursed the provider for covered services associated with the claim-line and is based on the Total Charge minus the Non-Covered Charge.
30	FILLER	Delimiter	127	127	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
31	CLML-APO-RED-AMT	Advanced Payment Option Reduction Amount	128	135	8	X(08)	(For DC, Benefit Enhancement “1”).
32	FILLER	Delimiter	136	136	1	X(01)	; (Semi colon)
33	CLML-TCC-RED-AMT	Total Care Capitation Reduced Amount	137	144	8	X(08)	(For DC, Benefit Enhancement “5”).
34	FILLER	Delimiter	145	145	1	X(01)	; (Semi colon)
35	CLML-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	146	153	8	X(08)	Total payment amount with PCC reduction percent applied. (For DC, Benefit Enhancement “8”).
36	FILLER	Delimiter	154	154	1	X(01)	; (Semi colon)
37	CLML-HCPC-CD	Healthcare Common Procedure Coding System (HCPCS) Code	155	159	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
38	FILLER	Delimiter	160	160	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
39	CLML-HCPC-MODIFIER1	HCPCS First Modifier Code	161	162	2	X(02)	This is the first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
40	FILLER	Delimiter	163	163	1	X(01)	; (Semi colon)
41	CLML-HCPC-MODIFIER2	HCPCS Second Modifier Code	164	165	2	X(02)	This is the second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
42	FILLER	Delimiter	166	166	1	X(01)	; (Semi colon)
43	CLML-HCPC-MODIFIER3	HCPCS Third Modifier Code	167	168	2	X(02)	This is the third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
44	FILLER	Delimiter	169	169	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
45	CLML-HCPC-MODIFIER4	HCPCS Fourth Modifier Code	170	171	2	X(02)	This is the fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
46	FILLER	Delimiter	172	172	1	X(01)	; (Semi colon)
47	CLML-HCPC-MODIFIER5	HCPCS Fifth Modifier Code	173	174	2	X(02)	This is the fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. *Note: This applies only to Part A.*
48	FILLER	Delimiter	175	175	1	X(01)	; (Semi colon)
49	FILLER	Filler	176	206	31	X(31)	

Appendix E: KCC Pass-Through File

KCC Weekly Capitated (QCP) Reduction File:

The following file is prepared by CWF from 01/01/2021 and provided to RACS utilizing EFT; this file is then moved from RACS via EFT to the Entities.

Table 90: KCC Pass-Through Files

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date
Weekly TCC/QCP Reduction File	Weekly	P#EFT.ON.ACOT.K****.QCPRC.Dyymmdd.Thhmmsst	Text	800 Bytes	TBD	TBD

The file naming convention for the Weekly AIPBP Reduction File, sent by the CWF to Entities, will be P#EFT.ON.ACOT.K****.QCPRC.Dyymmdd.Thhmmsst for the KCC Entities.

The Weekly QCP Reduction filename in the ACO's mailbox will be P.K****.QCPC.RP.Dyymmdd.Thhmmsst.

Note: CWF will send both "CLMH-MBI" and "CLMH-HIC-NUM" as the beneficiary identifiers in the KCC Weekly QCP Reduction file during the New Medicare Card Project transition period. After the end of the transition period (December 2019), only "CLMH-MBI" will be populated and "CLMH-HIC-NUM" will be populated as blanks.

Table 91: KCC Entities Weekly QCP Reduction File Layout

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLMH-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
2	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)
3	CLMH-CNTRCTR-NUM	Contractor Number	6	10	5	X(05)	Identification number of contractor submitting claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
4	FILLER	Delimiter	11	11	1	X(01)	; (Semi colon)
5	CLMH-ACO-IDENTIFIER		12	22	10	X(11)	ACO identification number.
6	CLMH-QUAL-ID	ACO ID	12	12	1	X(01)	
7	FILLER	Delimiter	13	13	1	X(01)	; (Semi colon)
8	CLMH-ACO-ID-NUMBER	ACO NUMBER	14	22	9	X(09)	
9	FILLER	Delimiter	23	23	1	X(01)	; (Semi colon)
10	CLMH-MEDICARE-PART	Claim Type	24	28	5	X(05)	Part A or Part B paid for the claim.
11	FILLER	Delimiter	29	29	1	X(01)	; (Semi colon)
12	CLMH-MBI	Medicare Beneficiary Identifier	30	40	11	X(11)	MBI is a beneficiary identifier.
13	FILLER	Delimiter	41	41	1	X(01)	; (Semi colon)
14	CLMH-DCN	DCN	42	64	23	X(23)	Carrier assigned Document Control Number for claim.
15	FILLER	Delimiter	65	65	1	X(01)	; (Semi colon)
16	CLMH-XREF-DCN	XREF DCN	66	88	23	X(23)	Cross-reference Document Control Number assigned to claim. *Note: This field only applies to Part A.*
17	FILLER	Delimiter	89	89	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
18	CLMH-FROM-DT	From Date	90	97	8	YYYY MMDD	This date is the first day on the billing statement that covers services rendered to the beneficiary. This date is also known as “Statement Covers From Date”. *Note: This applies only to Part A.*
19	FILLER	Delimiter	98	98	1	X(01)	; (Semi colon)
20	CLMH-THRU-DT	Thru Date	99	106	8	YYYY MMDD	This date is the last day on the billing statement that covers services rendered to the beneficiary. This date is also known as the “Statement Covers Through Date”. *Note: This applies to only Part A.*
21	FILLER	Delimiter	107	107	1	X(01)	; (Semi colon)
22	CLMH-PVDR-CCN	Provider CCN	108	113	6	X(06)	The CCN for the ACO Provider. This number verifies that a provider has been Medicare-certified for a particular type of services.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
23	FILLER	Delimiter	114	114	1	X(01)	; (Semi colon)
24	CLMH-PVDR-NPI	Provider NPI	115	124	10	X(10)	NPI Number is a unique identification number for covered health care providers. Covered health care providers must use the NPIs in administrative and financial transactions.
25	FILLER	Delimiter	125	125	1	X(01)	; (Semi colon)
26	CLMH-TYPE-OF-BILL	Type of Bill	126	131	6	X(06)	A code that indicates the specific type of claim (Inpatient, Outpatient, adjustments, voids, etc.).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
27	CLMH-BILL-FACILITY	Bill Facility	126	126	1	X(01)	This code is the first digit of the type of bill (TOB1), and is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1 = Hospital 2 = SNF 3 = Home Health Agency (HHA) 4 = Religious non-medical (hospital) 5 = Religious non-medical (extended care) 6 = Intermediate care 7 = Clinic or hospital-based renal dialysis facility 8 = Specialty facility or Ambulatory Surgical Center (ASC) surgery 9 = Reserved
28	FILLER	Delimiter	127	127	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
29	CLMH-BILL-CATEGORY	Bill Category	128	128	1	X(01)	This code is the second digit of the type of bill (TOB2), and it is used to indicate with greater specificity where the service was provided (e.g. a department within a hospital) Claim Service Classification Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code).
30	FILLER	Delimiter	129	129	1	X(01)	; (Semi colon)
31	CLMH-BILL-FREQUENCY	Bill Frequency	130	130	1	X(01)	This is the third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Claim Frequency Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Frequency-Code).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
32	FILLER	Delimiter	131	131	1	X(01)	; (Semi colon)
33	CLMH-ADJSMT-TYPE-CD	Adjustment Type Code	132	132	1	X(01)	This code indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Credit 2=Debit
34	FILLER	Delimiter	133	133	1	X(01)	; (Semi colon)
35	CLMH-ADJUST-REASON-CODE	Adjustment Reason Code	134	136	1	X(03)	Reason code for claim adjustment, for example: • IUR • Beneficiary Alignment Change • Provider Alignment Change • Other
36	FILLER	Delimiter	137	137	1	X(01)	; (Semi colon)
37	CLMH-REIMB-AMT	Claim Payment Amount	138	148	11	X(11)	The amount that Medicare paid on the claim.
38	FILLER	Delimiter	149	149	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
39	CLMH-BENE-PMT-COINSRNC-AMT	Claim Beneficiary Payment Coinsuranc e Amount	150	155	6	X(6)	An amount identifying the portion of cost that is the responsibility of a beneficiary for payment.
40	FILLER	Delimiter	156	156	1	X(01)	; (Semi colon)
41	CLMH-RCPNT-PMT-DDCTBL-PD-AMT	Claim Recipient Payment Deductible Paid Amount	157	164	8	X(08)	The amount of money the beneficiary paid towards an annual deductible.
42	FILLER	Delimiter	165	165	1	X(01)	; (Semi colon)
43	CLMH-APO-RED-AMT	Advanced Payment Option Reduction Amount	166	173	8	X(08)	Total payment amount with PBP reduction percent applied. (For DC, Benefit Enhancement “1”).
44	FILLER	Delimiter	174	174	1	X(01)	; (Semi colon)
45	CLMH-TCC-RED-AMT	Total Care Capitation Payment Reduction Amount	175	182	8	X(08)	(For DC, Benefit Enhancement “5”).
46	FILLER	Delimiter	183	183	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
47	CLMH-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	184	191	8	X(08)	(For DC, Benefit Enhancement “8”).
48	FILLER	Delimiter	192	192	1	X(01)	; (Semi colon)
49	CLMH-DRG-CODE	Diagnosis Related Group Code	193	195	3	9(03)	This code indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
50	FILLER	Delimiter	196	196	1	X(01)	; (Semi colon)
51	CLMH-DGNS-ADMITTING	Admitting Diagnosis Code	197	203	7	X(07)	The ICD-9/10 diagnosis code identifying the illness or disability for which the beneficiary was admitted.
52	FILLER	Delimiter	204	204	1	X(01)	; (Semi colon)
53	CLMH-DGNS-EXTERNAL	DGNS External	205	211	7	X(07)	The ICD-9/ICD-10 diagnosis code which describes the external cause of the injury. *Note: CWF is using external cause of injury first diagnosis code.*
54	FILLER	Delimiter	212	212	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
55	CLMH-PAT-VISIT-REAS1	Patient Visit Reason 1	213	219	7	X(07)	Diagnosis code for patient's first visit.
56	FILLER	Delimiter	220	220	1	X(01)	; (Semi colon)
57	CLMH-PAT-VISIT-REAS2	Patient Visit Reason 2	221	227	7	X(07)	Diagnosis code for patient's second visit.
58	FILLER	Delimiter	228	228	1	X(01)	; (Semi colon)
59	CLMH-PAT-VISIT-REAS3	Patient Visit Reason 3	229	235	7	X(07)	Diagnosis code for patient's third visit.
60	FILLER	Delimiter	236	236	1	X(01)	; (Semi colon)
61	CLMH-PRCDR-DATA		237	661	425		
62	CLMH-PRCDR-ENTRY	Procedure Entry	237	243	8		Procedure Codes and Dates Occurs 25 times.
63	CLMH-PRCDR-CD	Procedure Code	237	243	7	X(07)	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
64	FILLER	Delimiter	244	244	1	X(01)	; (Semi colon)
65	CLMH-PRCDR-DT	Procedure Date	245	252	8	YYYY MMDD	The date the indicated procedure was performed.
66	FILLER	Delimiter	253	253	1	X(01)	; (Semi colon)
67	CLMH-DIAG-DATA		662	911	250		
68	CLMH-DIAG-ENTRY	Diagnosis Entry	662	671	10		Diagnosis Codes and POA indicators. Occurs 25 times.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
69	CLMH-DIAG-CODE	Diagnosis Code	662	668	7	X(07)	The patient's ICD-9/ICD-10 diagnosis code.
70	FILLER	Delimiter	669	669	1	X(01)	; (Semi colon)
71	CLMH-DIAG-POA-IND	Diagnosis Code Present on Admission Indicator	670	670	1	X(01)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility.
72	FILLER	Delimiter	671	671	1	X(01)	; (Semi colon)
73	CLMH-DETAIL-LINES	Detail Lines	912	914	3	9(03)	Number of line items on claim.
74	FILLER	Delimiter	915	915	1	X(01)	; (Semi colon)
75	CLMH-PATIENT-NUM	Patient Control Number	916	935	20	X(20)	Patient Control Number
76	FILLER	Delimiter	936	936	1	X(01)	; (Semi colon)
77	FILLER1	Filler	937	981	45	X(45)	Filler

Table 92: KCC QCP Weekly Reduction File Detail

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLML-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
2	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)
3	CLML-LINE-NUMBER	Claim Line Number	6	8	3	9(03)	This number is a sequential number that identifies a specific claim line.
4	FILLER	Delimiter	9	9	1	X(01)	; (Semi colon)
5	CLML-REV-CD	Revenue Code	10	13	4	9(04)	Claim Revenue center code identifies a specific accommodation, ancillary service, or billing calculation. Note: Include REV Code 0001.
6	FILLER	Delimiter	14	14	1	X(01)	; (Semi colon)
7	CLML-RNDRG-PRVDR-TAX-NUM	Rendering Provider Tax Number	15	24	10	X(10)	The rendering provider's Internal Revenue Employer Identification number or Social Security number. Note: Billing TIN is always the same as Rendering TIN for Part B.
8	FILLER	Delimiter	25	25	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLML-RNDRG-PRVDR-NPI-NUM	Rendering Provider National Provider Identifier Number	26	35	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI. Note: This will only apply to Part B.
10	FILLER	Delimiter	36	36	1	X(01)	; (Semi colon)
11	CLML-DGNS-CD-1	Claim Line Diagnosis First Code	37	43	7	X(07)	The first of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
12	FILLER	Delimiter	44	44	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLML-DGNS-CD-2	Claim Line Diagnosis Second Code	45	51	7	X(07)	The second of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
14	FILLER	Delimiter	52	52	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
15	CLML-DGNS-CD-3	Claim Line Diagnosis Third Code	53	59	7	X(07)	The third of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
16	FILLER	Delimiter	60	60	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	CLML-DGNS-CD-4	Claim Line Diagnosis Fourth Code	61	67	7	X(07)	The fourth of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
18	FILLER	Delimiter	68	68	1	X(01)	; (Semi colon)
19	CLML-FROM-DATE	Claim Line From Date	69	76	8	YYYY MMDD	This is the date the service associated with the line item began. *UPDATE: CWF will carry the detail line item date for Part A in both the From and Thru Date.*
20	FILLER	Delimiter	77	77	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
21	CLML-THRU-DATE	Claim Line Thru Date	78	85	8	YYYY MMDD	This is the date the service associated with the line item ended.
22	FILLER	Delimiter	86	86	1	X(01)	; (Semi colon)
23	CLML-SRVC-UNIT-QTY	Claim Line Service Unit Quantity	87	93	7	9(07)	Total units associated with services needing unit reporting such as number of covered days in a particular accommodation, miles, Anesthesia times the units and number of oxygen or blood units.
24	FILLER	Delimiter	94	94	1	X(01)	; (Semi colon)
25	CLML-TOT-CHRG-AMT	Claim Line Total Charge Amount	95	105	11	X(11)	Total submitted charge for line item. *Note: CWF will also be providing charges for non-covered and denied services.*
26	FILLER	Delimiter	106	106	1	X(01)	; (Semi colon)
27	CLML-ALOWD-CHRG-AMT	Claim Line Allowed Charge Amount	107	114	8	X(08)	The amount Medicare approved for payment to the provider. Note: Part B only
28	FILLER	Delimiter	115	115	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
29	CLML-CVRD-PD-AMT	Claim Line Covered Paid Amount	116	126	11	X(11)	This is the amount Medicare reimbursed the provider for covered services associated with the claim-line and is based on the Total Charge minus the Non-Covered Charge.
30	FILLER	Delimiter	127	127	1	X(01)	; (Semi colon)
31	CLML-APO-RED-AMT	Advanced Payment Option Reduction Amount	128	135	8	X(08)	(For DC, Benefit Enhancement “1”).
32	FILLER	Delimiter	136	136	1	X(01)	; (Semi colon)
33	CLML-TCC-RED-AMT	Total Care Capitation Reduced Amount	137	144	8	X(08)	(For DC, Benefit Enhancement “5”).
34	FILLER	Delimiter	145	145	1	X(01)	; (Semi colon)
35	CLML-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	146	153	8	X(08)	Total payment amount with PCC reduction percent applied. (For DC, Benefit Enhancement “8”).
36	FILLER	Delimiter	154	154	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
37	CLML-HCPC-CD	Healthcare Common Procedure Coding System (HCPCS) Code	155	159	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
38	FILLER	Delimiter	160	160	1	X(01)	; (Semi colon)
39	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
40	CLML-HCPC-MODIFIER1	HCPCS First Modifier Code	161	162	2	X(02)	This is the first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
41	FILLER	Delimiter	163	163	1	X(01)	; (Semi colon)
42	CLML-HCPC-MODIFIER2	HCPCS Second Modifier Code	164	165	2	X(02)	This is the second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
43	FILLER	Delimiter	166	166	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
44	CLML-HCPC-MODIFIER3	HCPCS Third Modifier Code	167	168	2	X(02)	This is the third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
45	FILLER	Delimiter	169	169	1	X(01)	; (Semi colon)
46	CLML-HCPC-MODIFIER4	HCPCS Fourth Modifier Code	170	171	2	X(02)	This is the fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
47	FILLER	Delimiter	172	172	1	X(01)	; (Semi colon)
48	CLML-HCPC-MODIFIER5	HCPCS Fifth Modifier Code	173	174	2	X(02)	This is the fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. Note: This applies only to Part A.
49	FILLER	Delimiter	175	175	1	X(01)	; (Semi colon)
50	FILLER	Filler	176	206	31	X(31)	

Appendix F: Direct Contracting / KCC Weekly AIPBP Reduction File Layout

Table 93: Weekly DC / KCC Claims File extract Header Detail

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
78	CLMH-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
79	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)
80	CLMH-CNTRCTR-NUM	Contractor Number	6	10	5	X(05)	Identification number of contractors submitting claim.
81	FILLER	Delimiter	11	11	1	X(01)	; (Semi colon)
82	CLMH-ACO-IDENTIFIER		12	22	10	X(11)	ACO identification number.
83	CLMH-QUAL-ID	ACO ID	12	12	1	X(01)	
84	FILLER	Delimiter	13	13	1	X(01)	; (Semi colon)
85	CLMH-ACO-ID-NUMBER	ACO NUMBER	14	22	9	X(09)	
86	FILLER	Delimiter	23	23	1	X(01)	; (Semi colon)
87	CLMH-MEDICARE-PART	Claim Type	24	27	4	X(04)	FISS or MCS
88	FILLER	Delimiter	28	28	1	X(01)	; (Semi colon)
89	CLMH-MBI	Medicare Beneficiary Identifier	29	39	11	X(11)	MBI is a beneficiary identifier

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
90	FILLER	Delimiter	40	40	1	X(01)	; (Semi colon)
91	CLMH-DCN	DCN	41	63	23	X(23)	Carrier assigned Document Control Number for claim
92	FILLER	Delimiter	64	64	1	X(01)	; (Semi colon)
93	CLMH-XREF-DCN	XREF DCN	65	87	23	X(23)	Cross-reference Document Control Number assigned to claim. **Note:** *This field only applies to Part A.* This field will contain the same value as in DCN for part B claims.
94	FILLER	Delimiter	88	88	1	X(01)	; (Semi colon)
95	CLMH-FROM-DT	From Date	89	96	8	YYYY MMDD	This date is the first day on the billing statement that covers services rendered to the beneficiary. This date is also known as “Statement Covers From Date”. Note: This applies only to Part A.
96	FILLER	Delimiter	97	97	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
97	CLMH-THRU-DT	Thru Date	98	105	8	YYYY MMDD	This date is the last day on the billing statement that covers services rendered to the beneficiary. This date is also known as the “Statement Covers Through Date”. **Note:** *This applies to only Part A.*
98	FILLER	Delimiter	106	106	1	X(01)	; (Semi colon)
99	CLMH-PVDR-CCN	Provider CCN	107	112	6	X(06)	The CCN for the ACO Provider. This number verifies that a provider has been Medicare-certified for a particular type of services.
100	FILLER	Delimiter	113	113	1	X(01)	; (Semi colon)
101	CLMH-PVDR-NPI	Provider NPI	114	123	10	X(10)	NPI Number is a unique identification number for covered health care providers. Covered health care providers must use the NPIs in administrative and financial transactions.
102	FILLER	Delimiter	124	124	1	X(01)	; (Semi colon)
103	CLMH-TYPE-OF-BILL	Type of Bill	125	130	6	X(06)	A code that indicates the specific type of claim (Inpatient, Outpatient, adjustments, voids, etc.).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
104	CLMH-BILL-FACILITY	Bill Facility	125	125	1	X(01)	This code is the first digit of the type of bill (TOB1), and is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1= Hospital 2= SNF 3= Home Health Agency (HHA) 4= Religious non-medical (hospital) 5= Religious non-medical (extended care) 6= Intermediate care 7= Clinic or hospital-based renal dialysis facility 8= Specialty facility or Ambulatory Surgical Center (ASC) surgery 9= Reserved
105	FILLER	Delimiter	126	126	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
106	CLMH-BILL-CATEGORY	Bill Category	127	127	1	X(01)	This code is the second digit of the type of bill (TOB2), and it is used to indicate with greater specificity where the service was provided (e.g. a department within a hospital). Claim Service Classification Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code).
107	FILLER	Delimiter	128	128	1	X(01)	; (Semi colon)
108	CLMH-BILL-FREQUENCY	Bill Frequency	129	129	1	X(01)	This is the third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Claim Frequency Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Frequency-Code).
109	FILLER	Delimiter	130	130	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
110	CLMH-ADJSMT-TYPE-CD	Adjustment Type Code	131	131	1	X(01)	This code indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Credit 2=Debit
111	FILLER	Delimiter	132	132	1	X(01)	; (Semi colon)
112	CLMH-ADJUST-REASON-CODE	Adjustment Reason Code	133	135	1	X(03)	Reason code for claim adjustment, for example: • Beneficiary Alignment Change (Value 'B') • Provider Alignment Change (Value 'P') • Other (Value 'O')
113	FILLER	Delimiter	136	136	1	X(01)	; (Semi colon)
114	CLMH-REIMB-AMT	Claim Payment Amount	137	147	11	X(11)	The amount that Medicare paid on the claim. $$$$$$$$:99

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
115	FILLER	Delimiter	148	148	1	X(01)	; (Semi colon)
116	CLMH-BENE-PMT-COINSRNC-AMT	Claim Beneficiary Payment Coinsurance Amount	149	159	11	X(11)	An amount identifying the portion of cost that is the responsibility of a beneficiary for payment. $$$$$$$$:99 Only for FISS (Part A) Value-code – 'A2'
117	FILLER	Delimiter	160	160	1	X(01)	; (Semi colon)
118	CLMH-RCPNT-PMT-DDCTBL-PD-AMT	Claim Recipient Payment Deductible Paid Amount	161	168	8	X(08)	The amount of money the beneficiary paid towards an annual deductible. $$$$$:99 Only for FISS (Part A) Value-code – 'A1'
119	FILLER	Delimiter	169	169	1	X(01)	; (Semi colon)
120	CLMH-APO-RED-AMT	Advanced Payment Option Reduction Amount	170	177	8	X(08)	Total payment amount with PBP reduction percent applied. (For DC Benefit Enhancement "1"). $$$$$:99 Only for FISS (Part A) Value-code – 'Q1'
121	FILLER	Delimiter	178	178	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
122	CLMH-TCC-RED-AMT	Total Care Capitation Payment Reduction Amount	179	186	8	X(08)	(For DC/KCC, Benefit Enhancement “5”). $$$$$:99 Only for FISS (Part A) Value-code – ‘Q1’ Note: Benefit Enhancement ‘5’ will be delayed for KCC until 2022
123	FILLER	Delimiter	187	187	1	X(01)	; (Semi colon)
124	CLMH-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	188	195	8	X(08)	(For DC, Benefit Enhancement “8”). $$$$$:99 Only for FISS (Part A) Value-code – ‘Q1’
125	FILLER	Delimiter	196	196	1	X(01)	; (Semi colon)
126	CLMH-QCP-RED-AMT	Quarterly Capitated Payment	197	204	8	X(08)	(For KCC, Benefit Enhancement ‘F’) $$$$$:99
127	FILLER	Delimiter	205	205	1	X(01)	; (Semi colon)
128	CLMH-DRG-CODE	Diagnosis Related Group Code	206	208	3	9(03)	This code indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
129	FILLER	Delimiter	209	209	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
130	CLMH-DGNS-ADMITTING	Admitting Diagnosis Code	210	216	7	X(07)	The ICD-9/10 diagnosis code identifying the illness or disability for which the beneficiary was admitted.
131	FILLER	Delimiter	217	217	1	X(01)	; (Semi colon)
132	CLMH-DGNS-EXTERNAL	DGNS External	218	224	7	X(07)	The ICD-9/ICD-10 diagnosis code which describes the external cause of the injury. Note: CWF is using external cause of injury first diagnosis code.
133	FILLER	Delimiter	225	225	1	X(01)	; (Semi colon)
134	CLMH-PAT-VISIT-REAS1	Patient Visit Reason 1	226	232	7	X(07)	Diagnosis code for patient's first visit.
135	FILLER	Delimiter	233	233	1	X(01)	; (Semi colon)
136	CLMH-PAT-VISIT-REAS2	Patient Visit Reason 2	234	240	7	X(07)	Diagnosis code for patient's second visit.
137	FILLER	Delimiter	241	241	1	X(01)	; (Semi colon)
138	CLMH-PAT-VISIT-REAS3	Patient Visit Reason 3	242	248	7	X(07)	Diagnosis code for patient's third visit.
139	FILLER	Delimiter	249	249	1	X(01)	; (Semi colon)
140	CLMH-PRCDR-DATA		250	674	425		
141	CLMH-PRCDR-ENTRY	Procedure Entry	250	266	17		Procedure Codes and Dates Occurs 25 times.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
142	CLMH-PRCDR-CD	Procedure Code	250	256	7	X(07)	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
143	FILLER	Delimiter	257	257	1	X(01)	; (Semi colon)
144	CLMH-PRCDR-DT	Procedure Date	258	265	8	YYYY MMDD	The date the indicated procedure was performed.
145	FILLER	Delimiter	266	266	1	X(01)	; (Semi colon)
146	CLMH-DIAG-DATA		675	924	250		
147	CLMH-DIAG-ENTRY	Diagnosis Entry	675	684	10		Diagnosis Codes and POA indicators. Occurs 25 times.
148	CLMH-DIAG-CODE	Diagnosis Code	675	681	7	X(07)	The patient's ICD-9/ICD-10 diagnosis code.
149	FILLER	Delimiter	682	682	1	X(01)	; (Semi colon)
150	CLMH-DIAG-POA-IND	Diagnosis Code Present On Admission Indicator	683	683	1	X(01)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility.
151	FILLER	Delimiter	684	684	1	X(01)	; (Semi colon)
152	CLMH-DETAIL-LINES	Detail Lines	925	927	3	9(03)	Number of line items on claim.
153	FILLER	Delimiter	928	928	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
154	CLMH-PATIENT-NUM	Patient Control Number	929	948	20	X(20)	Patient Control Number
155	FILLER	Delimiter	949	949	1	X(01)	; (Semi colon)
156	FILLER1	Filler	950	994	45	X(45)	Filler

Table 94: Weekly DC/KCC Claims File Extract Line Detail

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
24	CLML-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
25	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)
26	CLML-LINE-NUMBER	Claim Line Number	6	8	3	9(03)	This number is a sequential number that identifies a specific claim line.
27	FILLER	Delimiter	9	9	1	X(01)	; (Semi colon)
28	CLML-REV-CD	Revenue Code	10	13	4	9(04)	Claim Revenue center code identifies a specific accommodation, ancillary service, or billing calculation. Note: Include REV Code 0001.
29	FILLER	Delimiter	14	14	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
30	CLML-RNDRG-PRVDR-TAX-NUM	Rendering Provider Tax Number	15	24	10	X(10)	The rendering provider's Internal Revenue Employer Identification number or Social Security number. **Note:** *Billing TIN is always the same as Rendering TIN for Part B.*
31	FILLER	Delimiter	25	25	1	X(01)	; (Semi colon)
32	CLML-RNDRG-PRVDR-NPI-NUM	Rendering Provider National Provider Identifier Number	26	35	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI. **Note:** *This will only apply to Part B.*
33	FILLER	Delimiter	36	36	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
34	CLML-DGNS-CD-1	Claim Line Diagnosis First Code	37	43	7	X(07)	The first of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. **Note:** *Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
35	FILLER	Delimiter	44	44	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
36	CLML-DGNS-CD-2	Claim Line Diagnosis Second Code	45	51	7	X(07)	The second of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. **Note:** *Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
37	FILLER	Delimiter	52	52	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
38	CLML-DGNS-CD-3	Claim Line Diagnosis Third Code	53	59	7	X(07)	The third of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. **Note:** *Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
39	FILLER	Delimiter	60	60	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
40	CLML-DGNS-CD-4	Claim Line Diagnosis Fourth Code	61	67	7	X(07)	The fourth of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. **Note:** *Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
41	FILLER	Delimiter	68	68	1	X(01)	; (Semi colon)
42	CLML-FROM-DATE	Claim Line From Date	69	76	8	YYYY MMDD	This is the date the service associated with the line item began. UPDATE: CWF will carry the detail line item date for Part A in both the From and Thru Date.
43	FILLER	Delimiter	77	77	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
44	CLML-THRU-DATE	Claim Line Thru Date	78	85	8	YYYY MMDD	This is the date the service associated with the line item ended.
45	FILLER	Delimiter	86	86	1	X(01)	; (Semi colon)
46	CLML-SRVC-UNIT-QTY	Claim Line Service Unit Quantity	87	93	7	9(07)	Total units associated with services needing unit reporting such as number of covered days in a particular accommodation, miles, Anesthesia times the units and number of oxygen or blood units.
47	FILLER	Delimiter	94	94	1	X(01)	; (Semi colon)
48	CLML-TOT-CHRG-AMT	Claim Line Total Charge Amount	95	105	11	X(11)	Total submitted charge for line item. $$$$$$$$:99 Note: CWF will also be providing charges for non-covered and denied services.
49	FILLER	Delimiter	106	106	1	X(01)	; (Semi colon)
50	CLML-ALOWD-CHRG-AMT	Claim Line Allowed Charge Amount	107	114	8	X(08)	The amount Medicare approved for payment to the provider. $$$$$:99 **Note:** *Part B only*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
51	FILLER	Delimiter	115	115	1	X(01)	; (Semi colon)
52	CLML-CVRD-PD-AMT	Claim Line Covered Paid Amount	116	126	11	X(11)	This is the amount Medicare reimbursed the provider for covered services associated with the claim-line and is based on the Total Charge minus the Non-Covered Charge. $$$$$$$$:99
53	FILLER	Delimiter	127	127	1	X(01)	; (Semi colon)
54	CLML-BENE-PMT-COINSRNC-AMT	Claim Beneficiary Payment Coinsurance Amount	128	136	9	X(09)	An amount identifying the portion of cost that is the responsibility of a beneficiary for payment. $$$$$$:99 (MCS Part B only)
55	FILLER	Delimiter	137	137	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
56	CLML-RCPNT-PMT-DDCTBL-PD-AMT	Claim Recipient Payment Deductible Paid Amount	138	145	8	X(08)	The amount of money the beneficiary paid towards an annual deductible. $$$$$:99 (MCS Part B only)
57	FILLER	Delimiter	146	146	1	X(01)	; (Semi colon)
58	CLML-APO-RED-AMT	Advanced Payment Option Reduction Amount	147	154	8	X(08)	(For DC, Benefit Enhancement “1”). (MCS Part B only) $$$$$:99 Other-amts-ind - ‘L’
59	FILLER	Delimiter	155	155	1	X(01)	; (Semi colon)
60	CLML-TCC-RED-AMT	Total Care Capitation Reduced Amount	156	163	8	X(08)	(For DC/KCC, Benefit Enhancement “5”). (MCS Part B only) $$$$$:99 Other-amts-ind - ‘L’ Note: Benefit Enhancement ‘5’ will be delayed for KCC until 2022
61	FILLER	Delimiter	164	164	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
62	CLML-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	165	172	8	X(08)	Total payment amount with PCC reduction percent applied. (For DC, Benefit Enhancement “8”). (MCS Part B only) $$$$$:99 Other-amts-ind - ‘L’
63	FILLER	Delimiter	173	173	1	X(01)	; (Semi colon)
64	CLML-QCP-RED-AMT	Quarterly Capitated Payment	174	181	8	X(08)	(For KCC, Benefit Enhancement ‘F’) $$$$$:99
65	FILLER	Delimiter	182	182	1	X(01)	; (Semi colon)
66	CLML-HCPC-CD	Healthcare Common Procedure Coding System (HCPCS) Code	183	187	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
67	FILLER	Delimiter	188	188	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
68	CLML-HCPC-MODIFIER1	HCPCS First Modifier Code	189	190	2	X(02)	This is the first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
69	FILLER	Delimiter	191	191	1	X(01)	; (Semi colon)
70	CLML-HCPC-MODIFIER2	HCPCS Second Modifier Code	192	193	2	X(02)	This is the second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
71	FILLER	Delimiter	194	194	1	X(01)	; (Semi colon)
72	CLML-HCPC-MODIFIER3	HCPCS Third Modifier Code	195	196	2	X(02)	This is the third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
73	FILLER	Delimiter	197	197	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
74	CLML-HCPC-MODIFIER4	HCPCS Fourth Modifier Code	198	199	2	X(02)	This is the fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
75	FILLER	Delimiter	200	200	1	X(01)	; (Semi colon)
76	CLML-HCPC-MODIFIER5	HCPCS Fifth Modifier Code	201	202	2	X(02)	This is the fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. **Note:** *This applies only to Part A.*
77	FILLER	Delimiter	203	203	1	X(01)	; (Semi colon)
78	FILLER	Filler	204	234	31	X(31)	N/A

Referenced Documents

Title	Document Number	Issued
CME Data Dictionary	CME Data Dictionary 20100715.xlsx	12/21/2017
ACO-OS Operations & Maintenance Manual (OMM)	3-ITSD-DCO-SOM-0063 V3.8	10/04/2018
Change Request ACO_0239: FFS SSM Bene File	ACO_0239 FFS SSM Bene File.docx	03/23/2015
Change Request ACO_0240: FFS SSM Provider File	ACO_0240 FFS SSM Provider File.docx	03/23/2015
Change Request ACO_0302: Addition of All-Inclusive Population Based Payment (AIPBP) to NGACO	ACO_0302	02/17/2016
Change Request ACO_0441: FFS SSM Bene and Provider File	ACO_0441	03/12/2018
Change Request ACO_0487: Generate a standalone VT APM Bene File to FFS SSM	ACO_0487	03/12/2018

Acronyms

Term	Definition
ACO	Accountable Care Organization
ACO-OS	Accountable Care Organization – Operational System
AIPBP	All Inclusive Population Based Payment
APO	Advanced Payment Option
ASC	Ambulatory Surgical Center
BENE	Beneficiary
CAH	Critical Access Hospital
CCN	CMS Certification Number
CDS	Companion Data Services
CEC	Comprehensive ESRD Care
CHAR	Character
CKCC	Comprehensive Kidney Care Contracting
CME	Common Medicare Environment
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
ConOps	Concept of Operations
CWF	Common Working File
DCE	Direct Contracting Entity
DME	Durable Medical Equipment
EFT	Electronic File Transfer
ESCO	ESRD Care Organization
FFS	Fee-For-Service
GTL	Government Team Lead
HHA	Home Health Agency
HICN	Health Insurance Claim Number
HP	Hewlett Packard
IC	Innovation Center
ICD	Interface Control Document
ID	Identifier
IDR	Integrated Data Repository

Term	Definition
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facilities
KCC	Kidney Care Choice
KCF	Kidney Care First
LILS	Legislative IT Lifecycle Support
MA OEP	Medicare Advantage Open Enrollment Period
MAC	Medicare Administrative Contractor
MBD	Medicare Beneficiary Database
MCS	Multi-Carrier System
NGACO	Next Generation Accountable Care Organization
NGD	Next Generation Desktop (1-800-Medicare)
NPI	National Provider Identifier
OMM	Operations & Maintenance Manual
PBA	Performance-Based Adjustment
PBP	Population-Based Payment
PCC	Primary Care Capitation
PCF	Primary Care First
PHI	Protected Health Information
PII	Personally Identifiable Information
POC	Point of Contact
PY	Performance Year
QCP	Quarterly Capitative Payment
RACS	Receipt and Control System
RRB	Railroad Retirement Board
RTI	Research Triangle Institute
SDD	System Design Document
SIP	Seriously Ill Population
SNF	Skilled Nursing Facility
SSM	Shared System Maintainer
TBD	To be determined
TCC	Total Care Capitation
TIN	Tax Identification Number

Term	Definition
TPCP	Total Primary Care Payment
VDC	Virtual Data Center
VMS	ViPS Medicare System
VT APM	Vermont All Payer Model

Glossary

Term	Definition
Advanced Payment Option	An adjusted percentage of the Medicare FFS revenues earned by each Direct Contracting/Entity. The adjustment is based on submitted and payable claims for the services delivered to aligned beneficiaries.
All Inclusive Population Based Payment	Each year, NGACO/VT APM/Direct Contracting/CKCC/KCF Entities will select a payment mechanism for the upcoming performance year. If an ACO selects AIPBP, the ACO will have written agreements regarding capitation with AIPBP-participating Participants and Preferred Providers.
Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits	CMS will make available to qualified Direct Contracting and KCF/CKCC Entities, a waiver of the requirement that beneficiaries who elect the Medicare Hospice Benefit give up their right to receive curative care (sometimes referred to as “conventional care”) as a condition of electing the hospice benefit. All expenditures incurred by Medicare on behalf of such beneficiaries, whether for hospice or other non-hospices services, would be included as part of Total Cost of Care for the relevant performance year.
Entity	Unique for Direct Contracting/KCC. This is a synonym to ACO/ESCO.
Home Health Homebound Waiver	CMS will make available to qualified Direct Contracting and KCF Entities, a waiver of the homebound requirement to allow for modified application for beneficiaries aligned to the entity in order to receive home health services. The entity will have greater flexibility to ensure special populations (as specified in the Direct Contracting and KCF Participation Agreement) have access to home health services in appropriate cases. Given the risk borne by the entity, the entity would be incentivized only to do so where such care would improve quality and be cost-effective from a Total Cost of Care perspective. This flexibility would aid Direct Contracting and KCF Practices in reaching their own alternative payment arrangements with home health agencies and promote innovation and greater ability of beneficiaries to return to, remain in, and receive care in their home.
Kidney Disease Education Benefit Enhancement	CMS will make available to qualified KCF Entities, the KDE waiver that would: • Waive the requirement that the KDE be performed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and allow qualified clinicians not currently allowed to bill for the benefit to furnish the services incident to the services of a participating KCF or CKCC nephrologist. • Waive the requirement that a beneficiary have Stage 4 CKD in order to test furnishing the KDE benefit to beneficiaries with CKD stage 5 and those in the first 6 months of ESRD, who can also benefit from KDE.

Term	Definition
	• Waive the requirement that KDE sessions cover the topic of delaying initiation of dialysis to allow participating nephrologists to cover this topic as “as applicable” rather than mandated, as it is not 28 Name Description relevant to beneficiaries with ESRD who have already begun dialysis. • Waive the requirement that an outcomes assessment be conducted during one of the KDE sessions; and instead to test the provision of this assessment during a subsequent evaluation and management visit with the nephrologist.
Performance-Based Adjustment	A payment methodology for the Primary Care First model based on performance in five quality and patient experience of care measures, as well as, a measure of acute hospital utilization that is calculated and applied on a quarterly basis.
Population-Based Payments	An adjusted percentage of the Medicare FFS revenues earned by each NGACO/VT APM Entity. The adjustment is based on submitted and payable claims for the services delivered to aligned beneficiaries.
Post Discharge	CMS will make available to qualified NGACO/VT APM/Direct Contracting/CKCC/KCF Entities waivers to allow “incident to” claims for home visits to non-homebound aligned beneficiaries by licensed clinicians under the general supervision—instead of direct supervision—of NGACO/VT APM/Direct Contracting/CKCC/KCF Providers/Suppliers or Preferred Providers. Licensed clinicians may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform the ordered services under physician (or other practitioner) supervision. Claims for post discharge home visits will only be allowed following discharge from an inpatient facility (including, e.g., inpatient prospective payment system (IPPS) hospitals, CAHs, SNFs, Inpatient Rehabilitation Facilities (IRF)) and will be limited to no more than one visit in the first 10 days following discharge and no more than two visits in the first 30 days following discharge. Payment of claims for these visits will be allowed as services and supplies that are incident to the service of a physician or other practitioner.
Primary Care Capitation	Each year, Direct Contracting Entities will select a payment mechanism for the upcoming performance year. If an Entity selects PCC, the Entity will have written agreements regarding capitation on certain primary care claims with PCC-participating Participants and Preferred Providers.
Primary Care First–General Component	Identifies beneficiaries who are in the non-SIP category and receive care from a PCF practitioner who is accountable for coordination and management of their care.
Professional Population-Based Payment	A payment mechanism available to PCF participants based on a group-based risk adjustment to reduce practice focus on individual risk scores.

Term	Definition
Quarterly Capitation Payments	Alternate payment/risk sharing mechanism available for CKCC and KCF entities paid out quarterly for the services performed for the CKD4, CKD5 aligned beneficiaries.
Seriously Ill Population (SIP) Component	Identifies seriously ill beneficiaries who are experiencing fragmented, uncoordinated care under Medicare FFS, deliver an intensive, episodic intervention to stabilize their clinical condition, and establish a meaningful relationship between the beneficiary and a PCF practitioner who is accountable for coordinating and managing their care in the longer term.
Telehealth Benefit enhancement for DC and KCC	CMS will make available to qualified KCF and Direct Contracting Entities, a conditional waiver that eliminates the rural geographic component of originating site requirements, allows the originating site to include a beneficiary's home, and for the use of asynchronous ("store and forward") telehealth services in the specialties of teledermatology and teleophthalmology. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunication systems in single media format do not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Payment will be permitted for services including dermatology and ophthalmology services furnished to eligible beneficiaries using asynchronous telehealth in single or multimedia formats and distant site practitioners will bill for these services using CMMI specific asynchronous telehealth codes. The distant site practitioner must be a KCE/DCE participant who has elected to participate in this benefit enhancement.
TeleHealth Benefit Enhancement for NGACO and VT APM	CMS will make available to qualified NGACO/VT APM Entities, a waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site in order to be eligible to receive TeleHealth services. The benefit enhancement will allow payment of claims for TeleHealth services delivered by NGACO/VT APM Providers/Suppliers (Participant Providers) or Preferred Providers to aligned beneficiaries in specified facilities or at their residence regardless of the geographic location of the beneficiary.

Term	Definition
Three-day stay SNF waiver	CMS will make available to qualified NGACO/VT APM/Direct Contracting/CKCC/KCF Entities, a waiver of the three-day inpatient stay requirement prior to admission to a SNF or acute-care hospital or Critical Access Hospital (CAH) with swing-bed approval for SNF services ("swing-bed hospital"). This benefit will allow beneficiaries to be admitted to qualified Providers/Suppliers if a SNF or swing-bed hospital is on the NGACO/VT APM/Direct Contracting/CKCC/KCF Provider/Supplier list directly or with an inpatient stay of fewer than three days. The waiver will apply only to eligible aligned beneficiaries admitted to NGACO/VT APM/Direct Contracting/CKCC/KCF Providers/Suppliers or Preferred Providers.
Total Care Capitation	Each year, Direct Contracting/CKCC Entities will select a payment mechanism for the upcoming performance year. If an Entity selects TCC, the Entity will have written agreements regarding capitation with TCC-participating Participants and Preferred Providers.
Total Primary Care Payment	A payment methodology for the Primary Care First model that is designed to move away from traditional fee-for-service (FFS) payment incentives. In order to balance these incentives, this methodology includes two payment types: (1) a professional population-based payment (professional PBP) paid on a quarterly basis; and (2) a flat fee for each primary care visit, paid on a claim-by-claim basis.

Approvals

The undersigned acknowledge that they have reviewed this document and agree with the information presented within this document. Changes to this document will be coordinated with, and approved by, the undersigned, or their designated representatives.

Signature:

Date:

Print Name: Vivek Trehan

Title: Softrams IDDOC Project Manager

Role: Submitting Organization's Approving Authority

Signature:

Date:

Print Name: Tamar Zelcer

Title: OIT/ESSG/DADS – CMS ACO-OS Government Task Lead (GTL)

Role: CMS' Approving Authority

Signature:

Date:

Print Name: Pauline Lapin

Title: Group Director, Seamless Care Models Group

Role: CMS Business Owner

Revision History

Version	Date	Organization/POC	Description of Changes
0.1	06/01/2015	NGC/Subhaker Chigurula	Initial draft for September 2015 ACO-OS Release based on Change Request ACO_0239 (FFS SSM Bene File) and ACO_0240 (FFS SSM Provider File).
0.2	06/11/2015	NGC/Subhaker Chigurula	Updated ICD based on comments from Office of Technology Solutions (OTS), Common Working File (CWF) Application, and Multi-Carrier System (MCS) for September 2015 ACO-OS Release. Impacted CRs are ACO_0239 (FFS SSM Bene File) and CR ACO_0240 (FFS SSM Provider File).
0.3	07/01/2015	NGC/Subhaker Chigurula	Updated ICD based on comments from OTS, CWF and MCS. • Used CWF at CWF HP Host for sending NGACO Beneficiary File. • Used CWF for receiving Response File. • Used MCS at HP VDC for sending Part A/Part B NGACO Provider File • Used MCS for receiving Response File.
1.0	07/08/2015	NGC/Geoff Cummings	Baselined as Final for September 2015 Release.

Version	Date	Organization/POC	Description of Changes
1.1	05/25/2016	NGC/Subhaker Chigurula	• Updated Referenced Documents • Updated ICD Overview • Updated General Interface Requirements • Updated section 8.1.2: Interface Processing Time Requirements. • Updated Table 4: ACO-OS to NGACO Beneficiary Record Detail. • Updated Table 5: FFS SSM to ACO-OS NGACO Beneficiary Response Record Detail. • Updated Section 8.1.5.1: Interface Initiation. • Updated Table 10: ACO-OS to Part A/Part B NGACO Provider Record Detail. • Updated Table 11: FFS SSM to ACO-OS Part A/Part B NGACO Provider Response Record Detail. • Updated Glossary. • Updated Acronyms. Added Appendix B: Pass-through files
2.0	08/29/2016	NGC/Kristina Kriss	Revised to indicate “CWF” in place of “FISS” where appropriate, per FISS feedback. • Baselined as Final for September 2016 Release.
2.1	11/29/2016	NGC/Daric Bossman/ Subhaker Chigurula	For System Requirements Project: • Updated Tables 2 – 13 to include the “Start Position” column. • Updated Tables 4, 5, 10, and 11 to denote fields that contain PII/PHI. Added Weekly AIPBP Reduction File to Appendix B.
3.0	12/07/2016	NGC/Daric Bossman/ Subhaker Chigurula	• Updated Appendix B based on feedback from CMS. • Revised to indicate “CWF” in place of “FISS” where appropriate, per FISS feedback. Baselined as Final.

Version	Date	Organization/POC	Description of Changes
3.1	01/10/2018	NGC/Subhaker Chigurula	For March 2018 Release: • Changed the title to CMMI • Updated for CEC Program • Added Section 6.3: CEC Beneficiary File for FFS SSMs • Added Section 6.4: CEC Participant File for FFS SSMs
3.2	02/07/2018	Team Halfaker/Subhaker Chigurula and Aftaan White	For March 2018 Release: Updated Part A/Part B NGACO Provider File and file naming conventions.
4.0	03/07/2018	Team Halfaker/Nima Eslami and Chris Zahn	• Updated Appendix B: AIPBP Reduction File header layout • Updated CEC Participant File for FFS SSMs, valid values for record detail in Part A/B Percentage Reduction as 000. Baselined as Final for March 2018 Release.
4.1	03/26/2018	Team Halfaker/Aftaan White	For June 2018 Release: • Updated valid values for the Care Management Home Visits Benefit Enhancement for the Part A/Part B NGACO Provider File.
4.2	04/19/2018	Team Halfaker/Aftaan White	For March 2018 Release: Updated Part A/Part B NGACO Provider File and file naming conventions.
5.0	06/04/2018	Team Halfaker/Nima Eslami	Update to AIPBP pass-through file field name based on CWF feedback. Finalized for June 2018 release.

Version	Date	Organization/POC	Description of Changes
5.1	07/06/2018	Team Halfaker/ Subhaker Chigurula	For September 2018 Release: • Updated Part A/Part B NGACO/VT APM Provider File. • Updated NGACO/VT APM Beneficiary File. • Updated Response Codes and Explanations • Updated Table 14: CEC Beneficiary File Header • Updated Table 16: ACO-OS to CEC Beneficiary Record Detail Updated Table 18: CEC Beneficiary File Trailer
6.0	09/05/2018	Team Halfaker/ Subhaker Chigurula	• Updated Table 10: ACO-OS to Part A/Part B NGACO/VT APM Provider Record Detail Baselined as Final for the September 2018 release.
6.1	10/19/2018	Team Halfaker/ Subhaker Chigurula	For December 2018 Release: • Updated Appendix B: Pass-Through File • Updated NGACO Beneficiary File for FFS SSMs • Added VT APM Beneficiary File for FFS SSMs
7.0	12/06/2018	Team Halfaker/Kristina Kriss	Baselined as Final for the December 2018 release.
7.1	10/08/2019	Team Halfaker/ Subhaker Chigurula	Appendix: Pass-Through File section was updated for HICN/MBI changes.
8.0	10/22/2019	Team Halfaker/ Subhaker Chigurula	Baselined as Final for the October 2019 release.

Version	Date	Organization/POC	Description of Changes
8.1	04/09/2020	Softrams/ Raajita Tangirala	Added new Payment models for June 2020 release: • Comprehensive Kidney Care Contract Beneficiary File • Kidney Care First Beneficiary File • CKCC/KCF Provider File • Direct Contracting Beneficiary File • Direct Contracting Provider File
8.2	04/21/2020	Softrams/ Raajita Tangirala/ Lakiesha Stanley	Updated per feedback from CMMI, including adding appendices for CKCC and KCC Pass-Through Files.
8.3	05/04/2020	Softrams/ Lakiesha Stanley	Updated CKCC/KCF BE language, glossary terms, and Direct Contracting file details based on feedback from CMMI. Also added updates based on new model (PCF).
8.4	06/18/2020	Softrams/ Lakiesha Stanley/ Hema Parasuramuni	Updated the document based on Business Owner comments on V8.3. For PCF: Added the Diabetic Shoe order component benefit enhancement code as “A” in a new file DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider File that will be sent to VMS. Appendix A Response Codes are distinguished to apply to beneficiary or provider or both.
8.5	06/11/2020	Softrams/ Hema Parasuramuni	Updated the document based on PCF Business Owner comments on V8.4. For KCC AMCP Benefit Enhancement Code G must be removed per KCC business owners.

Version	Date	Organization/POC	Description of Changes
8.6	06/19/2020	Softrams/ Hema Parasuramuni	• Per KCC Business Owner's feedback, updated the valid values for ETC and QCP to indicate Blank/Y instead of 0/1 • Per DC Business owner comments removed "missing" in TIN Error and CCN Error in Appendix A. Added Appendix F Direct Contracting and KCC weekly AIPBP Reduction File Layout.