National APM Data Collection

Frequently Asked Questions for 2020

Last updated on June 4, 2020

Please note this document may be updated and improved periodically based on feedback from health plans and other stakeholders.

LAN Measurement Effort

Definitions

Reporting

APM Categorization

Q1 – How is the LAN adjusting the 2020 Measurement Effort in light of the COVID-19 pandemic?

A1 – The LAN recognizes the national and global issues and uncertainty we face, and the impact the COVID-19 pandemic has on the health care industry and the partners to the HCP-LAN. To that end, the HCP-LAN is moving forward with the 2020 Measurement Effort in a way that gives maximum flexibility to health plans and participating states to respond to the survey on a timeline that makes sense for its business operations.

Specifically, participants can respond to the 2020 Measurement Effort survey anytime between June 26, 2020 and December 31, 2020. Should a health plan or state determine that this timeline is not feasible, there are other options that the HCP-LAN can discuss with plans on an individual basis. To learn more, please contact Andréa Caballero at acaballero@catalyze.org.

The HCP-LAN will resume its regular annual Measurement Effort in the Spring/Summer of 2021 (collecting 2020 APM data). Both 2019 APM results and 2020 APM results will be released in the Fall of 2021.

Q2 – Where can I find more information on the 2019 effort?

A2 – The full report and additional information can be found at the LAN Measurement Effort website.

Q3 – Where can I find the refreshed HCP-LAN APM Framework white paper?

A3 – Follow this link to the Refreshed APM Framework White Paper, published in 2017. The 2018

Measurement Effort marked the first time that the LAN used the Refreshed Framework. Please review this document for questions related to examples of subcategories or distinctions between categories.

Q4 – In the 2019 LAN Summit, the LAN announced new goals to accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models. Where can I find more information on the 2020 LAN Goals?

A4 – Please see the HCP-LAN website to learn more about the 2020 LAN Goals, including downloadable resources on the goals. https://hcp-lan.org/faqs/

Q5 – How is the commercial market segment defined?

A5 – For the purposes of this survey, the commercial market segment includes individual, small group, large group, fully insured, self-funded and exchange business. To the extent a health plan provides benefits for the Federal Employee Health Benefit (FEHB) program, state active employee programs, and/or an exchange, this business should be considered commercial and included in the survey. Responses to the survey will reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2019 or the most recent 12-month period for which data is available. Spending for dental and vision services are excluded. See "General Information" tab in the Excel workbook for more information.

Q6 – How is the Medicaid market segment defined?

A6 – For the purposes of this survey, the Medicaid market segment includes both business with a state to provide health benefits to Medicaid eligible individuals and state-run programs themselves. Data submitted for this survey should exclude the following: health care spending for dual-eligible beneficiaries, health care spending for long-term services and supports (LTSS), spending for dental and vision services. Responses to the survey will reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2019 or the most recent 12-month period for which data is available. See "General Information" tab in the Excel workbook for more information.

Q7 – How is the Medicare Advantage market segment defined?

A7 – For the purposes of this survey, the Medicare Advantage market segment includes a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, and Special Needs Plans. To the extent the Medicare Advantage plan has Part D or drug spending under its operations, it should include this information in its response. Responses to the survey will reflect dollars paid for

Medicare Advantage beneficiaries' (including dual eligible beneficiaries) medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2019 or the most recent 12-month period for which data is available. Dental and vision services are excluded. See "General Information" tab in the Excel workbook for more information.

Q8 – How is "providers" defined?

A8 – For the purposes of this survey, "providers" include all health care providers for whom there is health care spending. This includes, for example, pharmacy, behavioral health, and durable medical equipment (DME) spending in addition to physicians, hospitals and other traditional health care providers, and does not include dental and vision. If the plan does not provide a pharmacy benefit or behavioral health benefit (e.g. those services are provided by a different health plan or entity) and therefore does not spend dollars on these services, it should input 0 dollars for those services. There are cells on the "General Information" tab of the survey where the plan can indicate whether it is including the pharmacy benefit or behavioral health in their response and, if so, what percent of the spending either or both represent.

Q9 – What is a "legacy payment?"

A9 – For the purposes of this survey, "legacy payment" includes any payment that does not include a quality component. Examples include: traditional fee-for-service payment, diagnosis-related group (DRG) payments, and traditional capitation without quality. Following the Refreshed APM Framework, legacy payments fall into category 1.

Q10 – Should plans report just the incentive portion of the alternative payment model (APM) or all of the dollars going to the provider under that arrangement?

A10 – Plans should report the total dollars, which includes the underlying payment plus any incentive, such as fee-for-service with a bonus for performance (P4P), fee-for-service and savings that were shared with providers, etc. For APMs in which the provider is responsible for the total cost of a member or beneficiary's health care, the total costs incurred by the member or beneficiary covered under that plan should be included in the numerator. See Q12 for more detail.

Q11 – The survey says plans can report data from CY 2019 or the most recent 12-month period for which data is available. Does this mean plans will be reporting on different time periods?

A11 – Potentially. Given the timing of this survey, some plans may not have access to final CY 2019 data to report. Under these circumstances, the plan should report the most recent 12 months for which it has data (e.g., November 2017 – October 2019). Under the "General Information" tab, we ask plans whether they are using CY 2019 data or a different 12-month

period. If a plan reports data using the most recent 12-month approach, it must specify the term and use this same 12-month period for all metrics. Differing reporting periods will be addressed in communicating the findings of this measurement effort such that it is clear what proportion of spending was reported in any explicitly identified reporting period, and the range of reporting periods included in any more global statement.

Q12 – Should plans count payments on an annual basis or on an annualized basis?

A12 – Annual. For example, if the plan enters into a shared savings contract effective August 1, 2019, (and the reporting period is CY 2019) the plan should report the total dollars paid to that provider under the shared savings arrangement from August 1, 2019 – December 31, 2019 whereas it would report dollars paid to the provider between January 1, 2019 and July 30, 2019 under as Category 1. Remember, plans are to report ALL of the dollars flowing through that payment arrangement, not just the bonus or savings. The bonus or savings amounts may not be reconciled for some time, so it is acceptable for the plan to estimate the bonus or savings payment amount (if any).

Q13 – What is the preferred method for calculating the metrics?

A13 – The metrics should report actual dollars paid to providers through APMs in CY 2019 or during the specified time period. For example, if a provider is paid $120,000 for the entire year, but entered a shared savings contract with the plan on July 1, 2019, the payments the provider received from January 1, 2019 through June 31, 2019 ($60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2019 through December 31, 2019 ($60,000) would be reported as shared savings, if the reporting period is for CY 2019. Another acceptable approach is annualizing dollars paid in APMs based on a point in time, e.g. on a single day such as December 31, 2019, **only if** the APM contract existed for the **full 12-month period**. For example, a provider in a shared savings arrangement received $300 (a combination of $285 base payment plus $15 in shared savings), which, if multiplied by 365 (annualized), would be reported as $109,500 in shared savings CY 2019. An unacceptable approach is counting all of dollars paid to the provider as being in APMs for the entire year, regardless of when the contract was executed (e.g. considering the first example, counting $120,000 in shared savings even though the contract was only in place for half of the reporting year). NOTE: this method is much more vulnerable to variation from actual spending depending on the representativeness of the time period annualized.

Q14 – What should be counted in the numerator if an entity or provider is responsible for all of a patient's care?

A14 – If a plan (commercial, Medicaid, or MA) operates an APM where a physician group, primary care physician, or other physician is held responsible for ALL of the attributed member's

health care spending, including outpatient, inpatient, specialists, pharmacy, out-of- network, etc., all of the dollars associated with the attributed members can be included in the numerator.

Q15 – What are appropriateness of care metrics?

A15 – Appropriate care measures are metrics that are based on evidence-based guidelines and comparative effective research. Such measures assess how well providers avoid unnecessarily costly, harmful, and unnecessary procedures These measures also address patients' goals, prognoses, and needs; and they reflect the outcome of shared decision-making among patients, caregivers, and clinicians (e.g. Choosing Wisely measures). Some examples of appropriate care measures include, but are not limited to: unnecessary readmissions, preventable admissions, unnecessary imaging, appropriate medication use.
Measures of appropriate care are required in order for a payment method to qualify as a Category 3 or 4 APM to ensure providers are incentivized to reduce/eliminate care that is wasteful and potentially harmful to patients. Appropriate care measures also ensure providers do not withhold necessary care and are incentivized to provide necessary care.

Q16 – There are a lot of categories and subcategories. Is there an expectation that plans will have dollars to report in each category and subcategory?

A16 – No; however, most, if not all plans, will report some dollars under Category 1. In most cases, plans are experimenting with different payment methods that span across Categories 2 through 4. Plans should report the alternative payment models they had in effect in 2019. For example, a plan may have shared risk arrangements *planned* for 2019, but if they did not have any of those arrangements effective during the reporting period (CY 2019, for example), then the plan would report $0.00 under the shared risk item under Category 3.

Q17 – How would a pay-for-performance (P4P) contract that affects the future fee-for-service base payment be categorized?

A17 – According to the refreshed Framework (found here), this arrangement is aligned to Category 2C.

Q18 – What is the difference between traditional shared savings and utilization-based shared savings?

A18 – Both traditional shared savings and utilization-based shared savings allow providers to share in a portion of any savings they generate as long as they meet pre-established quality targets.

Traditional shared savings (3A): Requires that providers meet a pre-established set target for

spending. Traditional shared savings provides an upside only financial incentive for providers or provider entities to reduce unnecessary spending for a defined population or patients or an episode of care, and to meet quality targets.

Utilization-based shared savings (3A): Requires that providers meet pre-established utilization targets that produce savings (e.g., Medicare CPC+ Track 1 program). There are no financial targets in these arrangements; instead there are utilization targets that impact a significant portion of the total cost of care. Examples of utilization measures include, but are not limited to: emergency department utilization, inpatient admissions, and readmissions. Utilization-based shared savings provides an upside only financial incentive for providers or provider entities to reduce unnecessary care or utilization for a defined population of patients or an episode of care, and to meet quality targets.

The refreshed Framework notes that utilization measures can provide strong proxies for total cost of care (TCOC) and can take the place of formal financial benchmarks or spending targets. Improvement on utilization metrics, which could be either increased utilization where services are underutilized or decreased utilization where unnecessary services are over-utilized, is expected to improve quality while decreasing costs. To the extent the health plan has an APM program modeled after the CPC+ Track 1 program or has designed a similar program where utilization measures are a strong proxy for financial benchmarks, these programs can be categorized in the utilization-based shared savings payment method, in the 3A subcategory.

Q19 – What are the differences between the three population-based payment arrangement types?

A19 – All population-based payment methods are paid on a per member per month (PMPM) basis for a given time period, such as a month or year, and are tied to quality performance. However, there are several distinctions among the various population-based payment methods.

Full or percent of premium population-based payment tied to quality (4B): A per member per month (PMPM) payment for all of the care (e.g. inpatient, outpatient, specialists, pharmacy, out-of-network, etc.) that attributed members receive. The other two population-based payment arrangement types are not comprehensive and do not cover all of the health care that an attributed member receives.

Condition-specific population-based payment tied to quality (4A): A per member per month (PMPM) payment to providers for inpatient and outpatient care that an attributed member population may receive for a particular condition (e.g., diabetes) in a given time period, such as a month or year, including inpatient care and facility fees.
Capitation payments that exclusively cover primary care, such as those used to support Patient-

Centered Medical Home or similar delivery system models, are considered Condition-specific population-based payment tied to quality (4A).

Population-based payment that is not condition-specific tied to quality (4B): A per member per month (PMPM) payment to providers for outpatient or professional services that an attributed member population may receive in a given time period, such as a month or year. The services for which the payment coverage is predefined and could cover primary, acute and post-acute care that is not specific to any particular condition.

Q20 – What qualifies as a subcategory 4C, integrated finance and delivery system payments?

A20 – Payments in which the delivery system is integrated with the finance system and delivers comprehensive care. These integrated arrangements consist of either insurance companies that own provider networks, delivery systems that offer their own insurance products, or payer and provider organizations that share a common governance structure, or payer and provider organizations that are engaged in mutually exclusive relationships.

Integrated finance and delivery systems often share information to guide more efficient and effective care, work in tandem to ensure that savings are reinvested in enhancing care delivery and health improvement, align incentives and strategies between payer and provider organizations, cascade incentive payments to individual clinicians, and work in the community to address upstream and structural determinants of health.

For the purposes of this data collection, "provider networks" and "delivery systems" are synonymous. Health plans/insurance companies that own provider networks should count the total dollars paid to these providers by the health plan in 4C. However, if the insurance company owns a provider network and rents or leases the network to another insurer, those dollars would not be categorized as 4C. Delivery systems that offer a health insurance product should count all of the dollars paid to the delivery system through that insurance product in 4C. In addition, health plans and delivery systems who enter into joint ventures with shared ownership, should count all dollars flowing between the plan and providers in these arrangements in 4C.

If an insurance company acquires a provider network in the middle of the reporting period (CY 2019 or most recent 12-month period for which there is data), the company should only report the dollars paid to the provider network after which it was acquired as 4C. Payments to the provider network prior to the acquisition should be categorized under the appropriate payment category.

Q21 – Does the health plan count covered members and dollars in APMs that another health plan manages?

A21 – No. If the health plan does not directly manage those members, neither the lives nor dollars should be counted. The health plan that manages those lives should count those members and dollars, if it is participating in the data collection effort.
For example, Blue Cross Blue Shield Plan of State A has a national employer account with the majority of its covered lives in State A, as well as some covered lives in State B. Under these circumstances, the employer's covered lives in State B are reported by BCBS of State B; BCBS of State A reports dollars and covered lives that it manages for the employer in State A. BCBS of State B reports dollars and covered lives that it manages for the employer in State B, even if some of the State B lives originated as part of the relationship with the employer in State A.

Q22 – Will the health plan's specific data be shared with the public?

A22 – No. Data will be aggregated by line of business. It will not be shared on an individual plan basis.
Individual plan data will be collected and securely stored by MITRE and its sub-contractor, Catalyst for Payment Reform, for this measurement effort. The Center for Medicare and Medicaid Services, the Center for Medicare and Medicaid Innovation, LAN members, or participating payers will not have access to individual plan spending data.

Q23 – Which types of health care spending for long-term services and supports (LTSS) should be excluded?

A23 – All types of health care spending for long-term services and supports (LTSS) should be excluded. Examples of LTSS spending include, but are not limited to, dollars paid to providers or community-based organizations through Home & Community Based Services (HCBS) Waivers, adult day health services, habilitation (both day and residential), and respite care.

Q24 – Why is the LAN interested in measuring nominal risk?

A24 – In 2018, the LAN began aggregating spend in categories 3B and above because the payment models included in these categories require providers to take two-sided risk – meaning that providers hold financial liability if they are unable to achieve their contracted cost and quality goals. Evidence from CMS's program evaluation of the Medicare Shared Savings Program (MSSP) finds that ACOs in two-sided risk contracts are more likely to generate savings than ACOs whose contracts offer incentives (upside risk) only, "suggesting that greater financial accountability for cost is associated with a stronger commitment to, or more confidence in, making the care transformation necessary for success."[1]

However, two-sided risk can take many forms including the level of risk included and the design

[1] https://www.healthaffairs.org/do/10.1377/hblog20191024.65681/full/

of an APM contract. When CMS designed the Quality Payment Program (QPP) to determine qualifying characteristics of Advanced Alternative Payment Models (AAPMs), the agency created specifications to define a threshold level of two-sided risk. CMS calls this threshold *nominal risk.* The LAN seeks to measure whether dollars flowing through payment methods with provider two-sided risk would meet a modified version of CMS' definition of *nominal risk*, which we are calling the "LAN's nominal risk threshold" for the purposes of this survey. To explore the possibility of incorporating this analysis into future Measurement Efforts, the LAN engaged AHIP, BCBSA, CMMI, and approximately 15 national, regional, and public state payers in a workgroup tasked with developing a parsimonious set of metrics to measure the levels of two-sided risk in APM categories 3B, 4A, 4B, and 4C in all market segments (commercial, Medicaid, Medicare Advantage, Medicare FFS). The *Understanding Nominal Risk in 3B-FFS Shared Risk Arrangements* metric (which the LAN, along with committed partners, is piloting in the 2020 Measurement Effort) represents the output of this workgroup process.

Q25 – What APMs are considered to automatically meet the LAN's nominal risk threshold?

A25 – The questions on nominal risk will apply only to FFS-based Shared Risk in Category 3B, as these payments may or may not meet the standard. Population-based models in Category 4 are designed to confer full risk to the provider and therefore inherently meet any threshold of nominal risk. For the purposes of this 2020 pilot year, the LAN will consider procedure-based episode payments (3B) and condition-specific episode payments (4A) as automatically meeting the nominal risk threshold. This is in part out of a desire to avoid the complexity of parsing prospective and retrospective bundled payments within those categories, but also because of the relatively recent emergence of episode-based payment models. In future years – and depending on the results of this pilot – the LAN may apply the nominal risk standard to episode bundled payment programs as well FFS-based shared risk models.

Q26 – Why are procedure-based episodes (3B) deemed to meet the LAN's nominal risk threshold?

A26 – This is in part out of a desire to avoid the complexity of parsing prospective and retrospective bundled payments within those categories, but also because of the relatively recent emergence of episode-based payment models. In future years – and depending on the results of this pilot – the LAN may apply the nominal risk standard to episode bundled payment programs as well FFS-based shared risk models.