National APM Data Collection

Frequently Asked Questions for 2022

Last updated on March 16, 2022

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

LAN Measurement Effort

National APM Data Collection 1

Frequently Asked Questions for 2021 1

Q1 – Is the LAN still adjusting its annual Measurement Effort in light of the COVID-19 pandemic? 2

Q2 – Where can I find more information on the 2019 effort?..... 2

Q3 – Where can I find the refreshed HCP-LAN APM Framework white paper?..... 3

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? 3

Definitions

Q5 – How is the commercial market segment defined? 3

Q6 – How is the Medicaid market segment defined? 3

Q7 – How is the Medicare Advantage market segment defined? 3

Q8 – How is "providers" defined? 4

Q9 – What is a "legacy payment?" 4

Reporting

Q10 – Should stabilization and/or retainer payments to providers during the COVID-19 pandemic be included in the LAN APM data submission? For the purposes of the LAN 2022 data collection, stabilization and retainer payments refer to any type of payment paid to providers to mitigate provider loss of revenue during the COVID-19 Public Health Emergency. 4

Q11 – 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? 5

Q12 – The survey says plans can report data from a specific calendar year (CY 2020) or the most recent 12-month period for which data is available. Does this mean plans will be reporting on different time periods? 5

Q13 – Should payers count payments on an annual basis or on an annualized basis? 6

Q14 – Should payers use paid dates or date of service to determine whether to include payments to providers in designated reporting period? 6

Q15 – What is the preferred method for calculating the metrics? 6

Q16 – What should be counted in the numerator if an entity or provider is responsible for all of a patient's care? 6

Q17 – What are appropriateness of care metrics? 7

APM Categorization

Q18 – There are a lot of categories and subcategories. Is there an expectation that plans will have dollars to report in each one? 7

Q19 – How would a pay-for-performance (P4P) contract that affects the future fee-for-service base payment be categorized? 7

Q20 – What is the difference between traditional shared savings and utilization-based shared savings? 7

Q21 – What are the differences between the three population-based payment arrangement types? 8

Q22 - Does the LAN Framework have a minimum dollar threshold for prospective, population based payments (e.g., Per member per month [PMPM] payments) to classify as a Category 4 arrangement? 9

Q23 – What qualifies as a subcategory 4C, integrated finance and delivery system payments?..... 9

Health Plans Data

Q24 – Does the health plan count covered members and dollars in APMs that another health plan manages? 10

Q25 – Will the health plan's data be shared with the public?..... 10

Q26 – Which types of health care spending for long-term services and supports (LTSS) should be excluded? 11

Q27 – What does it mean if an entity "opts-in" or says "yes" to identify itself as a participant of the annual measurement effort? 11

Q1 – Is the LAN still adjusting its annual Measurement Effort in light of the COVID-19 pandemic?

A1 –

the LAN is resuming its regular annual Measurement Effort for the Spring of 2022 (collecting 2021 APM data). 2021 APM results will be released in Q4 2022.

Q2 – Where can I find more information on the 2020 and 2021 effort?

A2 – The full report and additional information on the 2020 and 2021 effort, based on 2019 and 2020 APM data, 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 2019 LAN APM Goals?

A4 – Please see the HCP-LAN website to learn more about the 2022 LAN APM 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 2021 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, and disproportionate share (DSH) payments for hospitals. Responses to the survey will reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2021 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 2021 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 stabilization payments and/or retainer payments to providers during the COVID-19 pandemic be included in the LAN APM data submission? For the purposes of the LAN 2022 data collection, stabilization and retainer payments refer to any type of payment paid to providers to mitigate provider loss of revenue during the COVID-19 Public Health Emergency.

A10 – Yes, please include stabilization and retainer payments to providers that were paid during the reporting period (Calendar Year 2021) in your 2022 LAN APM data submission.

The stabilization payments should be categorized according to the LAN APM Framework, to the extent possible. Based on public reports, the LAN suspects that stabilization payments are best categorized as 2A- Foundational Spending. According to the LAN's definitions, foundational spending includes, but is not limited to, payments to improve care delivery such as outreach and care coordination/management; after-hour availability; patient communication enhancements; health IT infrastructure use. Such payments may come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments and/or per episode fees for specialists.

While stabilization payments may not fit squarely into the examples in the LAN's definition (e.g., stabilization payments might have covered payroll or prevented practices from laying off staff), the LAN recognizes these payments as "foundational" because these payments were used to stabilize providers when there was a drop in utilization during the pandemic. Please reach out to the LAN Measurement team if you have questions about how to categorize the stabilization payments.

Additionally, please use the open answer field in the 2022 LAN Survey related to "assumptions, qualifications, considerations, or limitations" to provide additional details about the COVID-19 provider stabilization payments that your organization has included in its data submission. For example, if all your organization's 2A dollars were stabilization payments, please indicate this. If only a portion of your organization's 2A payments were stabilization payments, please provide the approximate percentage attributed to stabilization payments. Given the unprecedented public health events in 2021, the information provided in the open field question will help the LAN understand COVID-19's impact on provider payment in 2021.

Q11 – 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?

A11 – 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 Q16 for more detail.

Q12 – The survey says plans can report data from a specific calendar year (CY 2021) or the most recent 12-month period for which data is available. Does this mean plans will be reporting on different time periods?

A12 – Potentially. Given the timing of this survey, some plans may not have access to final CY 2020 data to report. Under these circumstances, the plan should report the most recent 12

months for which it has data (e.g., November 2020 – October 2021). Under the "General Information" tab, we ask plans whether they are using CY 2021 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.

Q13 – Should payers count payments on an annual basis or on an annualized basis?

A13 – Annual. For example, if the payer enters into a shared savings contract effective August 1, 2021, the plan should report the total dollars paid to that provider under the shared savings arrangement from August 1, 2021– December 31, 20201whereas it would report dollars paid to the provider between January 1, 2021 and July 30, 2021 under as Category 1. Remember, plans are to report ALL 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).

Q14 – Should payers use paid dates or date of service to determine whether to include payments to providers in designated reporting period?

A14 – Payers should use date of service if the claims are included in the designated reporting period.

Q15 – What is the preferred method for calculating the metrics?

A15 – The metrics should report actual dollars paid to providers through APMs in CY 2021 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, 2021, the payments the provider received from January 1, 2021 through June 31, 2021 ($60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2021 through December 31, 2021 ($60,000) would be reported as shared savings, if the reporting period is for CY 2021. 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, 2021, **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 2021. 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.

Q16 – What should be counted in the numerator if an entity or provider is responsible for all a patient's care?

A16 – 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 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.

Q17 – What are appropriateness of care metrics?

A17 – Appropriate care measures are metrics that are based on evidence-based guidelines and comparative effectiveness 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 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.

Q18 – There are a lot of categories and subcategories. Is there an expectation that plans will have dollars to report in each one?

A18 – 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 the specified reporting period. For example, a plan may have FFS-based shared risk arrangements *planned* for 2023, but if they did not have any of those arrangements effective during the reporting period (CY 2021, for example), then the plan would report $0.00 under the FFS-based shared risk item under Category 3.

Q19 – How would a pay-for-performance (P4P) contract that affects the future fee-for-service base payment be categorized?

A19 – According to the refreshed Framework (Page 25), this arrangement is aligned to Category 2C.

Q20 – What is the difference between traditional shared savings and utilization-based shared savings?

A20 – 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.

Q21 – What are the differences between the three population-based payment arrangement types?

A21 – 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.

Q22 - Does the LAN Framework have a minimum dollar threshold for prospective, population based payments (e.g., Per member per month [PMPM] payments) to classify as a Category 4 arrangement?

A22 - The LAN Framework does not include a dollar threshold for PMPMs to qualify as Category 4. Instead, the deciding factor is what services the PMPM payments cover.

The Refreshed LAN Framework states, "prospective payments are classified in Category 4A if they are prospective and population-based, and also cover all care delivered by particular types of clinicians" (page 28). An arrangement where a payer pays the provider prospective, population based payments (PMPM) for medical services signals a move away from the fee-for-service architecture and, therefore, has the quality of a Category 4 payment method.

By contrast, prospective payments in 2A are for infrastructure investments – not medical services. Understanding the distinction between the two (2A – infrastructure investments; 4A – care delivery) is the key to determining if a payment arrangement falls into Category 4.

Q23 – What qualifies as a subcategory 4C, integrated finance and delivery system payments?

A23 – 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 2021 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.

Q24 – Does the health plan count covered members and dollars in APMs that another health plan manages?

A24 – 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, Health Plan 1 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 Health Plan 2 of State B; Health Plan 1 of State A reports dollars and covered lives that it manages for the employer in State A. Health Plan 2 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.

Q25 – Will the health plan's data be shared with the public?

A25 – 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 Deloitte 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.

Q26 – Which types of health care spending for long-term services and supports (LTSS) should be excluded?

A26 – 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.

Q27 – The 2022 annual measurement survey administered directly by the LAN (i.e., not administered or fielded by AHIP or BCBSA) asks health plans and states if they want to be publicly recognized as a data contributor to the annual measurement effort. What does it mean if an entity "opts-in" or says "yes" to identify itself as a participant of the annual measurement effort?

A27 – Health plans and/or states that agree to be recognized as a data contributor means that the name of the organization will be shared with the LAN. Organization responses (e.g., APM data) will continue to be aggregated and remain deidentified.