

National APM Data Collection Frequently Asked Questions

Last updated on 5/13/2016

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

Q1 - How is the commercial market segment defined?

A1 - 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, this business should be considered commercial and included in the survey. Responses to the survey will reflect (1) dollars paid CY 2015 or most recent 12 months and (2) dollars paid based on executed contracts in place on January 1, 2016. See “General Information” tab in the Excel workbook for more information.

Q2 - How is the Medicaid market segment defined?

A2 - 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 and health care spending for long-term care (LTC). Responses to the survey will reflect (1) dollars paid CY 2015 or most recent 12 months and (2) dollars paid based on executed contracts in place on January 1, 2016. See “General Information” tab in the Excel workbook for more information.

Q3 - How is the Medicare Advantage market segment defined?

A3 - 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 (1) dollars paid CY 2015 or most recent 12 months and (2) dollars paid based on executed contracts in place on January 1, 2016. See “General Information” tab in the Excel workbook for more information.

Q4 - How is “providers” defined?

A4 - 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. 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.

Q5 - What is a “legacy payment?”

A5 - 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 [APM Framework](#), legacy payments fall into category 1.

Q6 - What Does it mean to be a Premium Level or Primary Level Contributor?

A6 - Plans have different options to report data based on their circumstances. Therefore, plans can report either “full details” or “partial details.” However, there is a desire to understand the prominence of particular alternative payment models available across the nation. Thus, plans that report the “full details” will receive recognition as a *Premium Level Contributor* to the LAN data collection effort, while plans that report the “partial details” will receive recognition as a *Primary Level Contributor* to the LAN data collection effort.

Premium Level Contributor: A *premium level contributor* will report full details, including all four categories and subcategories related to the 2015 look back metrics and categories 3 and 4 and subcategories for the 2016 point-in-time metrics. This includes rows 12-32 and 56-71 in the tabs for which plan has information (commercial, Medicare Advantage, and/or Medicaid).

Primary Level Contributor: A *primary level contributor* will report partial details on categories 1, 2, 3, and 4 related to the 2015 look back metrics only and categories 3 and 4 separately related to the 2016 point-in-time metrics. This includes rows 12, 13, 17, 23, 28, 57, 63, 68, and 71 in the tabs for which plan has information (commercial, Medicare Advantage, and/or Medicaid). Plans reporting partial details will report dollars paid in the rows that are highlighted in yellow.

Q7 - Should plans report just the incentive portion of the alternative payment model or all of the dollars going to the provider under that arrangement?

A7 - 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 (full or percent of premium population-based payment), the total cost of each member or beneficiary covered under that plan should be included in the numerator. See Q12 for more detail.

Q8 - The survey says plans can report data from CY 2015 or the most recent 12 months. Does this mean plans will be reporting on different time periods?

A8 - Potentially. Given the timing of this survey, some plans may not have access to final CY 2015 data to report. Under these circumstances, the plan should report the most recent 12 months for which it has data. Under the “General Information” tab, we ask plans whether they are using CY 2015 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.

Q9 - For the “look back”, should plans count payments on an annual basis or on an annualized basis?

A9 - Annual. For example, if the plan enters into a shared savings contract effective August 1, 2015, (and the reporting period is CY 2015) the plan should report the total dollars paid to that provider under the shared savings arrangement from August 1, 2015 – December 31, 2015 whereas it would report dollars paid to the provider between January 1, 2015 and July 30, 2015 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).

Q10 - What is the preferred method for calculating “look back” metrics?

A10 - The “2015 look back” metrics should report actual dollars paid through APMs CY 2015 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, 2015, the payments the provider received from January 1, 2015 through June 31, 2015 (\$60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2015 through December 31, 2015 (\$60,000) would be reported as shared savings, if the reporting period is for CY 2015. An acceptable but less preferable approach is annualizing dollars paid in APMs based on a point in time, e.g. on a single day such as December 31, 2015, as long as 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 2015. 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.

Q11 - Is it acceptable for plans to calculate the “point in time” metrics using an average cost per member per month?

A11 - Yes. It is acceptable under certain circumstances. If a particular provider (*e.g.*, primary care physician) is held responsible for ALL of their attributed member’s health spending, then an average total cost per member covered under such an arrangement can be used to calculate the total cost of care for the attributed members for providers in that APM category.

Q12 - What should be counted in the numerator if an entity or provider is responsible for all of a patient’s care?

A12 - If a plan (commercial, Medicaid, or MA) operates a full or percent of premium population-based payment 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.

Q13 - There are a lot of categories and subcategories. Is there an expectation that plans will have dollars to report in each category and subcategory?

A13 - No; however, most, if not all plans, will report some dollars under Category 1. In fact, the majority of a plan’s spending could be in this category. In most cases, plans are experimenting with different payment methods that span across Categories 2 through 4. For the “look back”, plans should report the alternative payment models they had in effect in 2015. For example, a plan may have shared-risk arrangements *planned* for 2016, but if they did not have any of those arrangements effective during the reporting period (CY 2015, for example), then the plan would report \$0.00 under the shared-risk item under Category 3, Question 7. Similarly, for the “point-in-time estimate,” there isn’t any expectation that plans report dollars in all categories. Plans should only report APM executed contracts in place on January 1, 2016, and not any anticipated future contracts expected to be signed later in 2016.

Q14 - How would a pay for performance (P4P) contract that affects the future fee-for-service base payment be categorized?

A14 - Under the APM Framework, this arrangement is aligned to Category 2D. This survey combined 2C and 2D. Dollars paid under this scenario would be reported under Category 2, Question 4.

Q15 - What are the differences between the three population-based payment arrangement types?

A15 - 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.

Population-based payment for conditions 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 in a given time period, such as a month or year, including inpatient care and facility fees.

Population-based payment not condition-specific tied to quality (3B): 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 covers are predefined and not specific to any particular condition.

Q16 - What does “based on contracts in place on January 1, 2016” mean?

A16 - In addition to the “look back” metrics, plans will report a January 1, 2016 metric. Based on executed contracts in place on 1/1/16, plans will report the dollars flowing through APMs and annualize for an entire year. This metric is not a projection or future estimation and therefore should not adjust for anticipated growth or attrition in membership, contracts, or dollars in APMs throughout 2016. For example, even if a plan knows that a contract will be in place on August 1, 2016, it should not include the dollars or associated members/beneficiaries in the 1/1/16 metric.

Q17 - Does the health plan count covered members and dollars in APMs that another health plan manages?

A17 - No. If the health plan does not directly manage those members, neither the lives nor dollars should not 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.

Q18 - Will the health plan’s specific data be shared with the public?

A18 - 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.

Q19 – Where can I find the HCP-LAN White Paper?

A19 – Here is a link to the [HCP - LAN White Paper](#). Please review this document for questions related to examples of subcategories or distinctions between categories.