ROADMAP

for Driving High Performance in Alternative Payment Models

Data Collection Tool

ADP Roadmap Data Collection Tool Specifications

Overview

The Data Collection tool is designed to collect a variety of performance and descriptive information from plans about their APMs. Separate tabs are available to report information about population-based and specialty APMs. If plans submit information on more than one of either type of APM, they can copy the appropriate tab and create a new label (e.g., "PBP APM 2" or "Specialty APM 3").

Population-Based Payment APMs

I. Contact Information

a. Contact information for plan POC: Provide the name, title, email, and phone number for the individual who the Roadmap team can contact with questions and to schedule interviews about best practices.

b. Contact information for provider POC: Provide the name, organization, title, email, and phone number for the individual who the Roadmap team can contact to schedule interviews about best practices. The Roadmap team requests at least one contact for each of the following types of providers:

- High-Performers: Provider organizations that had the highest performance on cost and quality among all APM participants.
- Rapid-Improvers: Provider organizations that demonstrated the most rapid improvement on cost and quality among all APM participants, irrespective of their baseline performance.
- Less Successful: Provider organizations that struggled to achieve high performance on cost and quality.

If possible, it would be ideal to connect with a variety of providers (e.g. providers who live in different parts of the country, providers in physician groups as well as hospitals/health systems, and providers in small and large practices).

II. Performance Information

a. Overview: In the interest of reducing the burden of reporting performance information, there are three options for reporting.

- Provider-Cohort Specific: Pull data according to cohorts of providers that entered the APM in the same year, and report cost and quality ratios according to each provider cohort.
- All Provider Cohorts: Pull data for all providers that ever participated in the APM, and report aggregated cost and quality ratios for all providers.
- Initial Provider Cohort: Pull data for all providers that entered into the APM during the first years, and report cost and quality ratios for this initial provider cohort.

It is only necessary to report according to one of these three options. The preferred approach is to report according to provider-cohorts, and the least favored approach is to report according to initial provider cohort.

b. Cost:

- Market-Normalized Cost Ratios*:* Calculate, but do not report, the following numerators and denominators for the past four years of operation. For each year, report the results of the ratio based on the following calculations for numerators and denominators:
  1. Numerator ("Actual TCOC"): Aggregated total cost of care, as you are currently calculating it, of all participating providers within the APM.
  2. Denominator ("TCOC Benchmark"): Applying the same calculations used in the numerator, aggregated total cost of care for peer providers in the same market who are not participating in the APM.

$$\text{Market-Normalized Total Costs} = \frac{\text{Actual Total Costs}}{\text{Total Cost Benchmarks}}$$

- Cost Units: Indicate whether you assess cost performance of the model in terms of total cost of care (TCOC) or medical loss ratio (MLR).

c. Quality:

- Measure: List the name of the measure that was used to assess quality performance in the APM.
- Market-Normalized Quality Ratios: Calculate, but do not report, the following numerators and denominators for the past four years of operation. For each year, report the results of the ratio based on the following calculations for numerators and denominators:
  1. Numerator ("Actual TCOC"): Aggregated quality of care performance of all participating providers within the APM.
  2. Denominator ("TCOC Benchmark"): Aggregated quality of care performance for peer providers in the same market who are not participating in the APM.

$$\text{Market-Normalized Quality} = \frac{\text{Actual Quality}}{\text{Quality Benchmarks}}$$

- *Specification:* In the "specification" field, report which measure specifications were used (e.g., NQF, HEDIS, CMS, other in-house specification).

d. Method for establishing peer group for cost and quality ratios: Describe the method used to assign providers that did not participate in the APM to the denominator of the cost and quality ratios.

III. Descriptive Information

a. APM attributes:

- Market: Report the census region of the market(s) in which the APM is operating.
- Line of Business: Report line of business (e.g., MA, Medicaid, commercial, or Medicare FFS).
- Product Line: Report product line (e.g., HMP, PPO, or POS).
- Percent of Network Participating in APM: Report the percent of your provider network in the specified line of business that is participating in the APM.
- Provider Composition: Indicate types of providers participating in the APM (e.g., primary care, hospital, specialty, post-acute care) by checking boxes to the left of provider types that participate.
- Percent of Attributed Members/Beneficiaries: Report the percent of members or beneficiaries within the specified line of business who are attributed to the APM.
- Years in Operation: Report the number of years the APM has been in operation.
- Average Duration of Provider Contracts: Report roughly how many years an APM contract with a provider organization lasts, on average.
- Multi-payer Model: Indicate whether the APM is multi-payer.
- LAN APM Category: Specify which category and subcategory in the LAN APM Framework that this APM falls into.
- Type and Level of Risk: Estimate the range (as percentages) of shared savings and shared risk that participating providers take on, as applicable.
- Payment Mechanism: Report types of payments included in the APM, such as up-front or PMPM payments to support infrastructure development, bonus payments for cost or quality performance, shared savings with upside or downside risk, and prospective, population-based payments.
- Provider Selection Criteria: Report the high-level criteria you look for when entering into a contract with a provider organization.
- APM Criteria for Success: Describe the approach you use to determine if an APM is successful.

IV. Total Cost of Care or Medical Loss Ratio Calculations

This section provides additional information on total cost of care or Medical Loss Ratio calculations.

a. Behavioral health carve-in: Indicate "yes" if behavioral health costs are carved into total cost of care calculations, and "no" if they are not. Additional information (e.g., services covered and proportion of TCOC) can be added to the "Please Explain" field.

b. Pharmacy spend carve-in: Indicate "yes" if pharmacy costs are carved into total cost of care calculations, and "no" if they are not. Additional information (e.g., services covered and proportion of TCOC) can be added to the "Please Explain" field.

c. **Incentive payments:** Indicate "yes" if performance incentive payments are included in total cost of care calculations, and "no" if they are not. Additional information (e.g., services covered and proportion of TCOC) can be added to the "Please Explain" field.
d. **Other carve-ins included:** Indicate "yes" if other, non-traditional health care costs (e.g., spending on transportation, housing, and other social support services) are included in total cost of care calculations and "no" if they are not. Additional information about the types of costs that are carved-in can be added to the "Please Explain" field.
e. **Risk-adjustment methodology:** Provide information on the risk-adjustment methodology used in calculating total cost of care (e.g., general methodology, variables accounted for).
f. **Method for addressing outlier payments:** Provide information on the methodology used to address outlier payments (e.g., general methodology, variables accounted for).

V. Best Practices

The primary objective of the Roadmap is to develop an implementation guide that payers can use to collaborate with other stakeholders to implement successful APMs – i.e., APMs that demonstrate high performance on cost and quality across all participating providers. We are interviewing payers to identify the best practices they used to implement successful APMs, and the implementation guide will be heavily based on the best practices identified in the course of the interviews. These practices may pertain to the way the APM was designed at the outset, or they may have to do with the activities the plan used to help support providers as the APM was implemented. Based on your experience, can you explain at a high level (i.e., 1-2 sentences each) the top contributors to your success? Possible examples of best practices may include analytic support for providers or using regional cost trends to set financial benchmarks.

VI. Supplemental Information

Provide additional information not captured elsewhere in the data collection tool that the Roadmap should take into account when considering the success of the APM.

VII. Additional Questions

a. **Patient experience:** Check the box to report that the APM assesses patient experience, and demonstrates high levels of achievement in this domain. Additional information about assessments and accomplishments (e.g., shared decision-making, active patient engagement, positive experience of care, whether patient experience assessment is tied to payments) can be reported in the "Please Explain" field.
b. **Provider experience:** Check the box to report that the APM assesses provider experience, and demonstrates high levels of achievement in this domain. Additional information about assessments and accomplishments (e.g., timely data exchange, low administrative burden, proactive technical assistance, financial support) can be reported in the "Please Explain" field.
c. **Health equity:** Check the box to report that the APM assesses health equity, and demonstrates high levels of achievement in this domain. Additional information about

assessments and accomplishments (e.g., lowering disparities in access and health outcomes, and cultural competence) can be reported in the "Please Explain" field.

Specialty APMs

I. Contact Information

a. Contact information for plan POC: Provide the name, title, email, and phone for the individual who the Roadmap team can contact with questions and to schedule interviews about best practices.

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- Less Successful: Provider organizations that struggled to achieve high performance on cost and quality.

If possible, it would be ideal to connect with a variety of providers (e.g., providers who live in different parts of the country, providers in physician groups as well as hospitals/health systems, and providers in small and large practices).

II. Performance Information

a. Overview: In the interest of reducing the burden of reporting performance information, there are three options for reporting.

- Provider-Cohort Specific: Pull data according to provider cohorts that entered the APM in the same year, and report cost and quality ratios according to each provider cohort.
- All Provider Cohorts: Pull data for all providers that ever participated in the APM, and report cost and quality ratios according to each provider cohort.
- Initial Provider Cohort: Pull data for all providers that entered into the APM during the first years, and report cost and quality ratios for this initial provider cohort.

It is only necessary to report according to one of these three options. The preferred approach is to report according to provider-cohorts, and the least favored approach is to report according to initial provider cohort.

b. Cost:

- Market-Normalized Cost Ratios: Calculate, but do not report, the following numerators and denominators for the past four years of operation. For each year, report the results of the ratio based on the following calculations for numerators and denominators:

1. Numerator ("Actual TCOC"): Aggregated cost per episode, as you are currently calculating it, of all participating providers within the APM.
2. Denominator ("TCOC Benchmark"): Applying the same calculations used in the numerator, aggregated cost per episode for peer providers in the same market who are not participating in the APM.

$$\text{Market-Normalized Cost per Episode} = \frac{\text{Actual Cost per Episode}}{\text{Cost per Episode Benchmark}}$$

- Volume of Episodes: Report the number of episodes performed by providers in the APM during the past four years of operation.

c. Quality:

- Measure: List the name of the measure that was used to assess quality performance in the APM.
- Market-Normalized Quality Ratios: Calculate, but do not report, the following numerators and denominators for the past four years of operation. For each year, report the results of the ratio based on the following calculations for numerators and denominators:
  1. Numerator ("Actual TCOC"): Aggregated quality of care performance of all participating providers within the APM.
  2. Denominator ("TCOC Benchmark"): Aggregated quality of care performance for peer providers in the same market who are not participating in the APM.

$$\text{Market-Normalized Quality} = \frac{\text{Actual Quality}}{\text{Quality Benchmarks}}$$

- Specification: In the "specification" field, report which measure specifications were used (e.g., NQF, HEDIS, CMS, other in-house specification).

d. Method for establishing peer group for cost and quality ratios: Describe the method used to assign providers that did not participate in the APM to the denominator in the cost and quality ratios.

III. Descriptive Information

a. APM attributes:

- Market: Report the census region of the market(s) in which the APM is operating.
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- Product Line: Report product line (e.g., HMP, PPO, or POS).
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- Provider Composition: Indicate types of providers participating in the APM (e.g., primary care, hospital, specialty, post-acute care) by checking boxes to the left of provider types that participate.
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- Provider Selection Criteria: Report the high-level criteria you look for when entering into a contract with a provider organization.
- APM Criteria for Success: Describe the approach you use to determine if an APM is successful.

b. Episode parameters:

- Episode Type: Report episode type (e.g., cardiac, hip and knee, or oncology).
- Episode Duration: Report duration of episode (e.g., 30-, 60-, or 90-day for hip and knee bundles, or from cancer diagnosis through termination of treatment for oncology bundles).
- Risk Adjustment: Provide information on the risk-adjustment methodology used in calculating cost per episode.
- Patient Population: Report patient population.
- Services/costs Included: Report the services and costs included in the APM (e.g., acute, post-acute, drugs).

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c. **Health equity:** Check the box to report that the APM assesses health equity, and demonstrates high levels of achievement in this domain. Additional information about assessments and accomplishments (e.g., lowering disparities in access and health outcomes, and cultural competence) can be reported in the "Please Explain" field.