APM.03 Introduction

The Health Care Payment Learning and Action Network's (LAN) goal is to bring together private payers, providers, employers, state partners, consumer groups, individual consumers, and other stakeholders to accelerate the transition to alternative payment models. New Hampshire DHHS has adopted this national HCP-LAN Assessment Metric as a reporting tool.

To measure the nation's progress, the LAN launched the National APM Data Collection Effort. This workbook will be used to collect health plan data according to the original APM Framework and line of business to be aggregated with other plan responses.

APM.03 Contents

If you have any questions about the national assessment, please view the Frequently Asked Questions or email Andrea Caballero at acaballero@catalyze.org; if you have questions specific to your New Hampshire response, please contact the NH DHHS MCO contracting team.

General Information

Question		Responses
Provide contact name, email and phone for the health plan respondent.	Name	
	E-mail	
	Phone	
What is the total number of members covered by the health plan by line of business?	Comm	
	MA	
	MCO	

Question		State
In which state(s) does the health plan have business? Please specify which line of business next to the state name. (C-commercial, MA – Medicare Advantage, MCO – Medicaid)		Alabama
		Alaska
		Arizona
		Arkansas
		California
		Colorado
		Connecticut
		Delaware
		Florida
		Georgia
		Hawaii
		Idaho
		Illinois
		Indiana
		Iowa
		Kansas
		Kentucky
		Louisiana
		Maine
		Maryland
		Massachusetts
		Michigan
		Minnesota

		Mississippi
		Missouri
		Montana
		Nebraska
		Nevada
		New Hampshire
		New Jersey
		New Mexico
		New York
		North Carolina
		North Dakota
		Ohio
		Oklahoma
		Oregon
		Pennsylvania
		Puerto Rico
		Rhode Island
		South Carolina
		South Dakota
		Tennessee
		Texas
		Utah
		Vermont
		Virginia
		Washington
		West Virginia
		Wisconsin
		Wyoming

Question	Information

Does your submission include the prescription drug claims data under the pharmacy benefit in denominator (total spend)? If yes, what percent of the pharmacy benefit spend is included?	
Does your submission include behavioral health claims data in the denominator (total spend)? If yes, what percent of the behavioral health spend is included?	
How many hours did it take your organization to complete this survey?	

APM.03 Medicaid Metrics

Goal/Purpose = Track total dollars paid through legacy payments and alternative payment methods (APMs) in the specified MCO contract year (CY), as specified.

The goal is NOT to gather information on a projection or estimation of where the plan would be if their contracts were in place the entire calendar year. Rather it is based on what the plan actually paid in claims for the specified time period.

Methods

The metrics should report actual dollars paid through APMs during the specified MCO CY 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, 2016, the payments the provider received from January 1, 2016 through June 31, 2016 ($60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2016 through December 31, 2016 ($60,000) would be reported as shared savings, if the reporting period is for the specified MCO CY. An acceptable approach is annualizing dollars paid in APMs based on a point in time, e.g. on a single day such as December 31, 2016, 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 during the specified MCO CY. 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.

Plans should report the total dollars paid, which includes the base 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.

To the extent payment to a provider includes multiple APMs, the plans should put the dollars in the dominant APM. For example, if a provider has a shared savings contract with a health plan and the provider is also eligible for performance bonuses for meeting quality measures (P4P), the health plan would report the FFS claims, shared savings payments (if any), and the P4P dollars in the shared savings subcategory (Category 3)

Metrics

Please note that the dollars paid through the various APMs (numerator) are actual dollars paid to providers during the specified MCO CY unless another method, such as annualizing, is used. Numerators should not be calculated based on beneficiaries attributed to APMs unless the provider is held responsible for all care (in network, out of network, inpatient, outpatient, behavioral health, pharmacy) the patient receives

Alternative Payment Model Framework - Category 1 (Metrics below apply to total dollars paid for Medicaid beneficiaries. Metrics are NOT linked to quality)						
#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value

1	NA	NA	Total dollars* paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY. *Reminder: Definition of total dollars has been changed to "total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in specified MCO contract year, including behavioral health and excluding directed payments."	0	Denominator to inform the metrics below	NA
2	Total dollars paid to providers through legacy payments (including FFS without a quality component and DRGs) payments in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Dollars under legacy payments (including FFS without a quality component and DRGs): Percent of total dollars paid through legacy payments (including FFS without a quality component and DRGs) in specified MCO CY.	#DIV/0!

Alternative Payment Model Framework - Category 2
(All methods below are linked to quality).

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
3	Dollars paid for foundational spending to improve care (linked to quality) in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in specified MCO CY.	NA
4	Total dollars paid to providers through FFS plus P4P payments (linked to quality) in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Dollars in P4P programs: Percent of total dollars paid through FFS plus P4P (linked to quality) payments in specified MCO CY. * CPR historic metric - trend.	#DIV/0!

5	Total dollars paid in Category 2 in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Payment Reform - APMs built on FFS linked to quality: Percent of total dollars paid in Category 2.	#DIV/0!
Alternative Payment Model Framework - Category 3 (All models below are linked to quality).						
#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
6	Total dollars paid to providers through FFS-based shared-savings (linked to quality) payments in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Dollars in shared-savings (linked to quality) programs: Percent of total dollars paid through FFS-based shared-savings payments in specified MCO CY.	NA
7	Total dollars paid to providers through FFS-based shared-risk (linked to quality) payments in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Dollars in shared-risk programs: Percent of total dollars paid through FFS-based shared-risk (linked to quality) payments in specified MCO CY.	#DIV/0!
8	Total dollars paid to providers through procedure-based bundled/episode payments (linked to quality) programs in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments in specified MCO CY.	#DIV/0!

9	Total dollars paid to providers through population-based payments that are not condition-specific (linked to quality) in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Population-based payments to providers that are not condition-specific and linked to quality: Percent of total dollars paid through population-based (linked to quality) payments that are not condition-specific in specified MCO CY.	#DIV/0!
10	Total dollars paid in Category 3 in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Payment Reform - APMs built on FFS architecture: Percent of total dollars paid in Category 3.	#DIV/0!

Alternative Payment Model Framework - Category 4
(All models below are linked to quality).

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
11	Total dollars paid to providers through population-based payments for conditions (linked to quality) in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Population-based payments for conditions (linked to quality): Percent of total dollars paid through condition-specific population-based payments linked to quality in specified MCO CY.	NA

12	Total dollars paid to providers through condition-specific, bundled/episode payments (linked to quality) in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Dollars in condition-specific bundled/episode payment programs (linked to quality): Percent of total dollars paid through condition-specific bundled/episode-based payments linked to quality in specified MCO CY.	#DIV/0!
13	Total dollars paid to providers through full or percent of premium population-based payments (linked to quality) in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Dollars in full or percent of premium population-based payment programs (linked to quality): Percent of total dollars paid through full or percent of premium population-based payments in specified MCO CY.	#DIV/0!
14	Total dollars paid in Category 4 in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Payment Reform - Population-based APMs: Percent of total dollars paid in Category 4.	#DIV/0!

Aggregated Metrics (Comparison between Category 1 and Categories 2-4)

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
15	Total dollars paid to providers through legacy payments (including FFS without a quality component and DRGs) payments in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Legacy payments not linked to quality: Percent of total dollars paid based through legacy payments (including FFS without a quality component and DRGs).	NA

16	Total dollars paid to providers through payment reforms in Categories 2C-4 in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Payment Reform Penetration Dollars in Categories 2C-4: Percent of total dollars paid through payment reforms in Categories 2C-4 in specified MCO CY.	#DIV/0!
17	Total dollars paid to providers through payment reforms in Categories 3 and 4 in specified MCO CY.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified MCO CY.	0	Payment Reform Penetration Dollars in Categories 3 and 4: Percent of total dollars paid through payment reforms in Categories 3 and 4 in specified MCO CY.	#DIV/0!

Cross-Checking		
Questions	Responses	
For the look back metrics only, what payment models were in effect during specified the period of reporting? Please specify the line of business (Comm, MA, MCO).	Select all that apply and include your MCO APM Identifier #s	
		Foundational spending to improve care
		FFS plus Pay for Performance
		FFS-based Shared Savings
		FFS-based Shared Risk
		Procedure-based Bundled/Episode Payments
		Population-based Payments not condition-specific
		Population-based Payments condition-specific
		Condition-Specific Bundled/Episode Payments
		Full or Percent of Premium Population-based Payment
For each program Identified in the prior question, Indicate When the program was launched. Please specify the line of business (Comm, MA, MCO).	Launch date (Month/Year)	
		Foundational spending to improve care
		FFS plus Pay for Performance
		FFS-based Shared Savings
		FFS-based Shared Risk
		Procedure-based Bundled/Episode Payments
		Population-based Payments not condition-specific
		Population-based Payments condition-specific
		Condition-Specific Bundled/Episode Payments
		Full or Percent of Premium Population-based Payment
For each program identified In the first question, describe its current stage Of implementation (Pilot, Expansion, Fully Implemented) *. Please specify the line of business (Comm, MA, MCO)	Indicate Pilot, Expansion, or Fully Implemented*in	
		Foundational spending to improve care
		FFS plus Pay for Performance
		FFS-based Shared Savings
		FFS-based Shared Risk
		Procedure-based Bundled/Episode Payments
		Population-based Payments not condition-specific
		Population-based Payments condition-specific
		Condition-Specific Bundled/Episode Payments
		Full or Percent of Premium Population-based Payment

*Pilot mode (e.g. only available for a subset of members and/or providers)
*Expansion mode (e.g. passed initial pilot stage)
*Fully implemented (e.g. generally available)

APM.03 Medicaid Metrics
Terms
Alternative Payment Model (APM)
Category 1
Category 2
Category 3
Category 4

Commercial members/ Medicare Advantage members/ Medicaid beneficiaries
Condition-specific bundled/episode payments
Specified MCO Contract Year (CY)
Diagnosis-related groups (DRGs)
Fee-for-service
Foundational spending
Full or percent of premium population-based payments
Legacy payments

Linked to quality
Pay for performance
Population-based payment for conditions
Population-based payment not condition-specific
Procedure-based bundled/episode payment
Provider
Shared risk

Shared savings
Total Dollars

Definitions
Health care payment methods that use financial incentives to promote or leverage greater value including higher quality care at lower costs -for patients, purchasers, payers and providers. This definition is specific to this exercise. If you are interested in MACRA's definition, please reference MACRA for more details.
Fee-for-service with no link to quality. These payments utilize traditional FFS payments that are not adjusted to account for infrastructure investments, provider reporting of quality data, for provider performance on cost and quality metrics. Diagnosis-related groups (DRGs) that are not linked to quality are in Category 1.
Fee-for-service linked to quality. These payments utilize traditional FFS payments, but are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well they perform on cost and quality metrics.
Alternative payment methods (APMs) built on fee-for-service architecture. These payments are based on FFS architecture, while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are based on cost performance against a target, irrespective of how the financial benchmark is established, updated, or adjusted. Providers that meet their cost and quality targets are eligible for shared savings, and those that do not may be held financially accountable.
Population-based payment. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality person level care within a defined or overall budget. This holds providers accountable for meeting quality and, increasingly, person centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, among other items. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care.

Health plan enrollees or plan participants.
A single payment to providers and/or health care facilities for all services related to a specific condition (e.g. diabetes). The payment considers the quality, costs, and outcomes for a patient-centered course of care over a longer time period and across care settings. Providers assume financial risk for the cost of services for a particular condition, as well as costs associated with preventable complications. [APM Framework Category **4A**]
The contract year for the health plan report payment information. This is the reporting period for which the health plan should report all of its "actual" spend data -a retrospective "look back."
A clinical category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients that are expected to have similar costs during a hospital stay -a form of case rate for a hospitalization. Each DRG is assigned a weight that reflects the relative cost of caring for patients in that category relative to other categories and is then multiplied by a conversion factor to establish payment rates.
Providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency. [APM Framework Category **1**]
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. 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. [APM Framework Category **2A**]
A fixed dollar payment to providers for all the care that a patient population may receive in a given time period, such as a month or year, (e.g. inpatient, outpatient, specialists, out-of-network, etc.) with payment adjustments based on measured performance and patient risk. [APM Framework Category **4B**]
Payments that utilize traditional payments and are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. This can include fee-for-service, diagnosis-related groups (DRGs) and per diems. [APM Framework Category **1**].

Payments that are set or adjusted based on evidence that providers meet a quality standards or improve care or clinical services, including for providers who report quality data, or providers who meet threshold on cost and quality metrics. The APM Framework does not specify which quality measures qualify for a payment method to be "linked to quality."
The use of incentives (usually financial) to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of a base payment, such as fee-for-service or population-based payment. In some cases, if providers do not meet quality of care targets, their base payment is adjusted downward the subsequent year. [APM Framework Categories **2C & 2D**].
A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period, such as a month or year, including inpatient care and facility fees. [APM Framework Category **4A**].
A per member per month (PMPM) payment to providers for outpatient or professional services that a patient population may receive in a given time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage is predefined and could be, for example, primary care services or professional services that are not specific to any particular condition. [APM Framework Category **3B**].
Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g. hip replacement). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular procedure and related services, as well as costs associated with preventable complications. [APM Framework Categories **3A & 3B**].
For the purposes of this workbook, provider includes all providers for which there is health care spending. For the purposes of reporting APMs, this includes medical, behavioral, pharmacy, and DME spending to the greatest extent possible.
A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets.

A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending. Shared savings provides an upside only financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets.
The total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in the specified MCO contract year, including behavioral health and excluding directed payments.