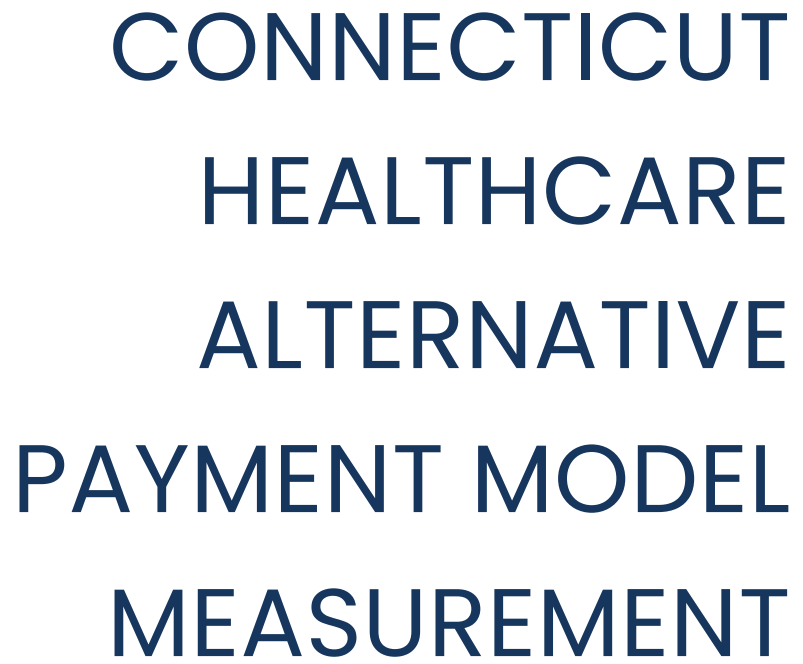


CONNECTICUT HEALTHCARE ALTERNATIVE PAYMENT MODEL MEASUREMENT

Implementation Manual

Version 2.0

June 18, 2024

Version History

<table>
<tr><th>Version Number</th><th>Release Date</th><th>Summary of Changes</th></tr>
<tr><td>1.0</td><td>July 25, 2023</td><td></td></tr>
<tr><td>2.0</td><td>June 18, 2024</td><td>Clarified that payments that could be categorized in HCP-LAN's 3N and 4N categories should be reported in Category 1 (legacy payments), because they are not linked to quality.
Updated the payment period definition to reflect that, if necessary, plans may deviate from OHS' calendar year payment period specification and submit for the most recent 12-month period; however, plans must indicate the start and end dates of the payment period in their data submission.
Clarified that if a payer does not engage in value-based contracting with a given provider type, the payer should still include that provider's spending in the plan's total expenditures (denominator).
Added new Appendix B with Department of Social Services (DSS) data specifications.</td></tr>
</table>

Table of Contents

I. Overview 5

II. Definitions of Key Terms 6

III. Alternative Payment Model (APM) Data Collection and Reporting Methodology 15

APM Categories 15

Insurers Required to Submit APM Data 17

Public Reporting of APM Adoption 18

Appendix A: Insurance Carrier APM Data Specification 19

A. APM Excel File Submission Instructions and Schedule 19

B. HCP-LAN Categories 20

C. Payment Period 20

D. Market Segments 22

E. Providers to Include/Exclude 22

F. Providers Participating in Multiple APMs 23

G. Allocating Health Plan Members to an Accountable Care APM 23

H. APM Excel File Specifications 24

General Information 24

Commercial and Medicare Advance Payments 24

Commercial and Medicare Advantage Covered Lives 26

I. File Submission 26

Appendix B: Department of Social Services (DSS) APM Data Specification 28

A. APM Excel File Submission Instructions and Schedule 28

B. HCP-LAN Categories 29

C. Payment Period 29

D. Market Segments 30

E. Providers to Include/Exclude 31

F. Providers Participating in Multiple APMs 31

G. Allocating Medicaid Members to an Accountable Care APM 31
H. APM Excel File Specifications 32
General Information 32
Medicaid Payments 32
Medicaid Covered Lives 33
I. File Submission 34

I. Overview

On January 22, 2020, Governor Lamont signed Executive Order No. 5 directing the Office of Health Strategy (OHS) to monitor the adoption of alternative payment models (APMs). During the 2022 legislative session, Connecticut General Statute 19a-754g et. Seq. codified Executive Order No. 5's provisions into law. The primary goal of tracking total dollars paid through APMs is to monitor the progress of healthcare organizations in shifting from traditional fee-for-service payment models to value-based approaches. The adoption of APMs is a critical component of a needed shift towards value-based care, which aims to improve patient outcomes and reduce growth in overall healthcare costs. By accurately tracking and reporting APM-related payments, plans can contribute to a better understanding of the adoption of these models and help identify areas for improvement and further expansion.

This manual contains the technical and operational procedures that OHS will employ to assess the adoption of APMs. This manual also provides technical specifications for data reporting and collection.

OHS Contact Information: For questions about this manual or the data submission template, please contact Lisa Sementilli at Lisa.Sementilli@ct.gov.

Attachment 1. Insurance Carrier CY23 APM Data Submission Template:
https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Alternative-Payment-Model-Measurement-Implementation-Manual

Attachment 2. DSS CY23 APM Data Submission Template:
https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Alternative-Payment-Model-Measurement-Implementation-Manual

II. Definitions of Key Terms

Accountable care arrangement: An accountable care arrangement is a payment model that incorporates accountability for total cost of care (TCOC) for attributed patients. See TCOC definition and further clarification along with examples below.

Accountable care organization (ACO): An ACO is a group of healthcare providers, such as physicians, hospitals, and other healthcare professionals, that voluntarily come together to provide coordinated, high-quality care to a specific group of patients. The main goals of an ACO are to improve health outcomes, enhance patient experiences, and reduce healthcare cost growth.

Alternative payment model (APM): Healthcare payment methods that use financial incentives to promote greater value - including higher quality care, equity and cost efficiency – for patients, purchasers, payers and providers. OHS' APM definitions and categories are based on the Health Care Payment Learning Action Network (HCP-LAN) Framework.

Appropriate care measures: 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 preventable or unnecessary procedures. Some examples of appropriate care measures include, but are not limited to: potentially avoidable readmissions, potentially preventable admissions, medically unnecessary imaging, and 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.

Assign/assigned/assignment: The method by which health plans associate members (individual patients, regardless of product – commercial Medicaid or Medicare Advantage) to a contracted, in-network primary care provider (PCP) or a primary care group (PCG) for the purposes of an accountable care contract. This term includes a health plan member who chooses (voluntarily, self-designates) a contracted, in-network PCP or PCG or is assigned to a PCP or PCG by the state or plan based on utilization. The PCP or PCG is charged with caring for the patients for whom they have been delegated by the contracted health plan.

Attributed/attribution: Refers to a statistical or administrative methodology that attributes a patient population prospectively or retrospectively to a provider for a particular APM (which must include consideration of cost AND quality). "Attributed" patients include those who choose to enroll in, or do not opt out of, an accountable care organization (ACO), patient-centered medical home (PCMH), or other delivery models in which patients are attributed to a provider who is accountable for a patient's total cost of care for six months or longer. The HCP-LAN Framework is agnostic to the attribution method (e.g., prospective or concurrent).

Category 1: Fee-for-service payments with no link to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service) that are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. Diagnosis-related group payments (DRGs) that are not linked to quality are in Category 1.

Category 2 APM: Fee-for-service payments linked to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service) but these payments are subsequently adjusted for infrastructure investments to improve care or clinical services, based on whether providers report quality data, or based on how well providers perform on cost and quality metrics. Examples include:

- 2A: Foundational Payments for Infrastructure and Operations to improve care delivery such as care coordination fees and payments for health information technology investments.
- 2B: Pay for Reporting: Bonus payments/rewards for reporting on specified quality measures, including those paid in DRG systems.
- 2C: Pay for Performance: Bonuses for demonstrated performance on quality measures.

Category 3 APM: APMs built 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 (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. Providers that meet their quality, and cost or utilization targets are eligible to share in savings, and those that do not may be held financially accountable. Category 3 APMs must hold providers financially

accountable for performance on quality measures, including appropriate care measures. Examples include:

- 3A: APMs with upside gain sharing based on a budget target: retrospective bundled payments with upside risk only, retrospective episode-based payments with shared savings (no shared risk); PCMH with retrospective shared savings (no shared risk); specialty Center of Excellence (COE) with retrospective shared savings (no shared risk).
- 3B: APMs with upside gain sharing and downside loss sharing based on a budget target: retrospective bundled payments with upside and downside risk, retrospective episode-based payments with shared savings and losses, PCMH with retrospective shared savings and losses, specialty COE with retrospective shared savings and losses).

Category 4 APM: Prospective population-based payment. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality, person-centered care within a defined scope of practice, a comprehensive collection of care or a highly integrated finance and delivery system. These models hold providers accountable for meeting quality 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, as well as acute and chronic care services. These payments require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Category 4 APMs require accountability for quality measures, including appropriate care measures as a safeguard against incentives to limit necessary care. Examples include:

- 4A: Condition-specific population-based payments, e.g., via an ACO, PCMH or Center of Excellence (COE), partial population-based payments for primary care, and episode-based payments for clinical conditions such as diabetes.
- 4B: Comprehensive population-based payments - full or percentage of premium population-based payment, e.g., via an ACO, PCMH or COE, integrated comprehensive population-based payment and delivery system, comprehensive population-based payment for pediatric or geriatric care.
- 4C: Integrated Finance and Delivery System – population-based payments to organizations that tightly integrate care delivery and financing using global budgets or fully/percentage of premium payments in integrated systems.

Center of excellence (COE): Specialized programs within healthcare institutions which supply exceptionally high concentrations of expertise and related resources centered on particular medical areas and deliver care in a comprehensive, interdisciplinary fashion.

Commercial market: For the purposes of this report, the commercial market 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 Benefits (FEHB) program, state active employee programs, and/or an exchange, this business is considered commercial.

Condition-specific bundled/episode payments: A single payment to providers and/or healthcare 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]

Condition-specific population-based payment: A prospective 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].

Diagnosis-related groups (DRGs): 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.

Fee-for-service (FFS): A negotiated or payer-specified payment rate for every unit of service providers deliver, without regard to quality, outcomes or efficiency. [APM Framework Category 1]

Fee-for-service- (FFS) based shared risk: 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. [APM Framework 3B]

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. 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]

Full or percentage of premium population-based payments: 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]

Integrated finance and delivery system payments: 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, or 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. [APM Framework Category 4C]

Insurance carrier (Carrier): A private health insurance company that offers one or more of the following: commercial insurance, benefit administration for self-insured employers, and Medicare Advantage plans.

Legacy payments: Payments that are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. These can include fee-for-service, diagnosis-related group (DRG) and per diem payments. [APM Framework Category 1]

Linked to quality: Payments that are set or adjusted based on evidence that providers meet quality standards or have improved care, including for providers who report quality data, or providers who meet a threshold on quality metrics. The APM Framework does not specify which quality measures qualify for a payment method to be "linked to quality" in Category 2. In order to qualify as a Category 3 or 4 APM, the

link to quality must include “appropriate care measures.” See definition of “appropriate care measures” for a description and examples.

Longitudinal relationship: This is defined as a care relationship where the provider has attributed patients from whom they serve as a coordinator of overall care.

At minimum, this longitudinal relationship needs to be six (6) months and often can be determined on a yearly basis in alternative payment models. A provider-patient relationship for an episode of care for a chronic condition or cancer treatment regimen that is six months or longer also qualifies as a longitudinal relationship.

Exclusions: A three-month episode for a hip/knee replacement or other such service does not qualify as a longitudinal relationship.

Medicaid market: The Medicaid market segment includes spending by the Connecticut Department of Social Services (DSS). Medicaid data submitted by DSS for this survey should exclude the following: healthcare spending for dual-eligible beneficiaries, healthcare spending for long-term services and supports (LTSS), spending for dental and vision policies, and disproportionate share (DSH) payments for hospitals and directed payments that are not part of service-based payments. Responses to the survey will reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in the payment period.

Medicare Advantage market: For the purposes of this survey, the Medicare Advantage market 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, such spending is included.

Patient-centered medical home (PCMH): A model of primary care delivery that emphasizes patient-centered, comprehensive, coordinated, accessible, and quality care. The primary goals of the PCMH model are to improve health outcomes, enhance the patient experience, and reduce healthcare cost growth.

Pay for performance: 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 Category 2C]

Payment period: The 12-month calendar year period applicable to the specified APM report, (e.g., CY2023: January 1 - December 31, 2023 or the most current 12-month period).

Population-based payments that are not condition-specific: 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 cover primary, acute and post-acute care that is not specific to any particular condition. [APM Framework Category 4B]

Procedure-based bundled/episode payment: A single price for all services to providers and/or healthcare 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 3B]

Provider: For the purposes of this report, provider means an entity with which an insurance carrier or the Department of Social Services (DSS) contracted for the delivery of covered services and which received payment for services delivered during the payment period. For the purposes of reporting APMs, this includes medical, behavioral, pharmacy, long-term care and DME spending, and excludes dental and vision policies.

Total cost of care (TCOC): A measure that encompasses all costs associated with delivering healthcare services to a patient population over a specific period. It includes all payments associated with provision of medical care to the defined population, and is used to assess the financial efficiency and effectiveness of healthcare delivery. TTCOC, as defined by the HCP-LAN and as used in this report, is intended to indicate there is significant financial accountability for the patient's care; however, it does NOT mean that every claim related to a patient must fall under the TCOC arrangement. In other words, TCOC does not need to include ALL of the patient's costs; it can be a significant subset of a patient's costs.

TCOC may cover inpatient and outpatient services (e.g., Medicare Part A and B) and can potentially include drug costs (e.g., Medicare Part B and D) or long-term services and supports, as desired. Providers do not need to be in a capitated payment arrangement or at financial risk for TCOC spending but have some measure(s) that they are assessed on for TCOC as part of their overall performance (e.g., CMS' Primary Care First model has a measure of Total Per Capita Cost for aligned beneficiaries), however, capitation arrangements or financial risk for TCOC would also count as accountability for TCOC.

- Example 1: A TCOC arrangement that excludes drug-benefit-related costs can still be considered a TCOC arrangement.
- Example 2: A TCOC arrangement that is for a patient's primary care services, but not the patient's specialty or facility-related costs can still be considered a TCOC arrangement.
- Example 3: An episode-based model of 6-months or longer that excludes un-related services, outliers, and other select exclusionary criteria (e.g., major traumas) can still be considered a TCOC arrangement.
- Example 4: An arrangement that only covers wellness or preventive care is not considered a TCOC arrangement.

Total dollars: The total estimated in- and out-of-network healthcare spend (e.g., annual payment amount) made to providers in the applicable payment period.

Traditional shared savings: A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a pre-established set target for spending, as long as they meet quality targets. Traditional 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.

Utilization-based shared savings: A payment arrangement that allows providers to share in a portion of any savings they generate due to meeting quality and utilization targets that produce savings (e.g., Medicare's former 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 target.

III. Alternative Payment Model (APM) Data Collection and Reporting Methodology

This section contains details about how OHS will collect and report the payments made through alternative payment model (APM) arrangements and the members covered under accountable care APMs in Connecticut.

APM Categories

OHS will collect data on total payments made to providers during the payment period by market (commercial, Medicare Advantage and Medicaid) within the APM categories in **Table 1** below. OHS will also collect data on the total number of members included in accountable care APMs during the payment period by market. OHS' APM tracking methodology is based on the Healthcare Payment Learning and Action Network (HCP-LAN) Framework, which categorizes payment models into four major categories based on the degree of provider financial risk and the potential for care coordination.

Table 1. Alternative Payment Model (APM) Categories

Category #	Category Description
Category 1	Fee-for-service payments with no link to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service) that are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. Diagnosis-related group payments (DRGs) that are not linked to quality are in Category 1.
Category 2 APM (must be linked to quality) [1]	Fee-for-service payments linked to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service) but these payments are subsequently adjusted for infrastructure investments to improve care or clinical services, based on whether providers report quality data, or based on how well providers perform on cost and quality metrics. Examples include: • **2A**: Foundational Payments for Infrastructure and Operations to improve care delivery such as care coordination fees and payments for HIT investments.

[1] Please note that whereas the LAN only requests payments in Categories 2A and 2C in its annual survey (and not 2B), OHS is requesting payments in Categories 2A, 2B and 2C.

Category #	Category Description
	• **2B:** Pay for Reporting: Bonus payments/rewards for reporting on specified quality measures, including those paid in DRG systems. • **2C**: Total dollars paid to (or collected from) providers in pay-for-performance APMs.
Category 3 APM (excludes risk-based payment models that are NOT linked to quality)	APMs built 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 (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. Providers that meet their quality, and cost or utilization targets are eligible to share in savings, and those that do not may be held financially accountable. Category 3 APMs must hold providers financially accountable for performance on appropriate care measures. Examples include: • **3A**: APMs with upside gain sharing based on a budget target/shared savings: retrospective bundled payments with upside risk only, retrospective episode-based payments with shared savings (no shared risk); PCMH with retrospective shared savings (no shared risk); specialty Center of Excellence (COE) with retrospective shared savings (no shared risk). • **3B:** APMs with upside gain sharing and downside risk (retrospective bundled payments, retrospective episode-based payments, PCMH, specialty COE).
Category 4 APM (excludes capitated payment models that are NOT linked to quality)	Population-based payment. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality, person-centered care within a defined scope of practice, a comprehensive collection of care or a highly integrated finance and delivery system. These models hold 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, as well as acute and chronic care services. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Category 4 APMs require accountability for appropriate care measures as a safeguard against incentives to limit necessary care. Examples include: • **4A:** Condition-specific population-based payments, e.g., via an ACO, PCMH or Center of Excellence (COE), partial population-

Category #	Category Description
	based payments for primary care, and episode-based payments for clinical conditions such as diabetes. • **4B:** Comprehensive population-based payments - full or % of premium population-based payment, e.g., via an ACO, PCMH or COE, integrated comprehensive population-based payment and delivery system, comprehensive population-based payment for pediatric or geriatric care. • **4C**: Integrated Finance and Delivery System - move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. e.g., global budgets or fully/percent of premium payments in integrated systems.

Insurers Required to Submit APM Data

Annually, OHS will direct identified insurance carriers and DSS to report total payments made to providers, APM-specific payment data, total covered lives, and members included in accountable care APMs, all using the specifications outlined in **Appendix A** and the template provided as **Attachment 1** (specifications for DSS to submit its data are included in **Appendix B** with the DSS template provided as **Attachment 2**). **Table 2** below lists which insurance carriers should report for their commercial and Medicare Advantage markets.[2]

Table 2. Insurance Carriers Requested to Report APM Data by Market

Carrier	Commercial Fully and Self-Insured	Medicare Advantage
Aetna Health & Life	X	X
Anthem	X	X
Cigna	X	
ConnectiCare	X	X
UnitedHealthcare	X	X
Wellcare		X

[2] Because the market may change, this table may need to be updated over time.

Public Reporting of APM Adoption

OHS reports APM adoption at the market-level (commercial, Medicare Advantage, Medicaid) for each APM category. For each market, OHS reports the percentage of payments made through each of the APM categories and subcategories in **Table 1** above. OHS reports payments in each category as a whole (e.g., Category 2 in total) and each subcategory (e.g., Categories 2A, 2B and 2C separately).

Similarly, OHS uses payer-submitted membership data to report the percentage of members in each market attributed, aligned, or assigned to a primary care physician (PCP), primary care group (PCG), or a non-PCP (i.e., specialist) participating in a total cost of care (TCOC) accountable care APM of six months or longer in the payment period. OHS reports the percentage of members covered under Category 3 and 4 accountable care APMs for each market.

Beginning in 2025, OHS plans to report APM adoption and covered lives at the payer level by market (commercial, Medicare Advantage). For each payer for each market, OHS plans to report the percentage of payments made through each of the APM categories and subcategories in **Table 1** above. OHS also plans to report each payer's percentage of members in each market attributed, aligned, or assigned to a PCP, PCG or non-PCP participating in a TCOC accountable care APM (Categories 3 and 4) of six months or longer in the payment period.

Appendix A: Insurance Carrier APM Data Specification

This insurance carrier APM specification provides technical details to assist carriers in reporting and filing data that will enable OHS to assess APM adoption and members covered under accountable care APMs.

OHS will annually request APM data files with dates of service during the payment period (e.g., OHS is requesting payment period 2023 data in 2024). Insurance carriers will submit one Excel file with multiple record types in each tab, including:

- **General Info tab** which collects background information about the health plan's data submission.
- **Commercial and Medicare Advantage Payments tabs**, which collects Numerator and Denominator values by HCP-LAN APM category for the commercial and Medicare Advantage markets.
- **Commercial and Medicare Advantage Covered Lives tabs,** which collects plan members attributed to Connecticut providers participating in APMs by HCP-LAN category for the commercial and Medicare Advantage markets.
- **Definitions tab**, which includes relevant definitions for terms used in the APM submission template.
- **LAN APM Framework tab**, which includes a figure depicting APM categories according to the LAN framework.

This insurance carrier APM data specification appendix is informed by the LAN's APM Measurement Survey and by other state value-based payment reporting tools, including the Michigan Department of Health and Human Services' Medicaid APM Data Collection Tool. OHS may periodically update and revise these data specifications in subsequent versions.

A. APM Excel File Submission Instructions and Schedule

The APM data submission file layout for insurance carriers is included in this Appendix. Carriers will submit APM data using the Excel template provided by OHS according to the schedule outlined in **Table A-1**. Carriers will submit APM data annually.

Table A-1. Insurance Carriers' APM Data Filing Schedule

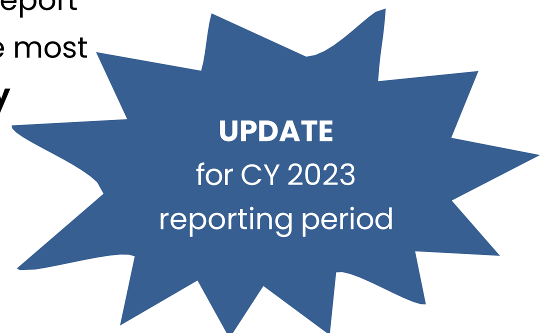
Date	Files Due
August 15, 2024	CY 2023
August 15, 2025	CY 2024
August 15, 2026	CY 2025
August 15, 2027	CY 2026

B. HCP-LAN Categories

OHS' APM tracking methodology is based on the HCP-LAN Framework, which categorizes payment models into four major categories based on the degree of provider financial risk and the potential for care coordination. The four categories and their sub-categories are detailed in **Table 1** above.

C. Payment Period

Insurance carriers will submit APM data for the payment period (i.e., calendar year) applicable to the specified APM report (e.g., CY 2023: January 1 – December 31, 2023). **Note:** OHS' payment period definition differs from the LAN's annual survey specifications, which allow insurance carriers to report payment information for the calendar year *or* the most current 12-month period. **If necessary, plans may deviate from OHS' calendar year payment period specification and submit for the most recent 12-month period; however, plans must indicate the start and end dates of the payment period in their data submission**.



In completing its APM reporting, an insurance carrier should only count an APM payment arrangement for the time period in which it was effective. For example, if an APM payment arrangement became effective with a provider beginning April 1st of a payment period, the insurance carrier should include the pro-rated portion of the contract between April 1st and December 31st of the reporting year. The portion of the contract paid between January 1st and March 31st should not be included in that particular APM model reporting.

It is crucial for plans to provide accurate information on their payments to providers within specified time periods, particularly those operating under contracts that include one or more APMs. The intention is to gather actual payment data rather than projections or estimations based on hypothetical scenarios or incomplete contracts. Please see the inset below for how to handle provider payments not yet paid out during the payment period.

"Look back" or retrospective metrics are essential in this process, as they report the actual dollars paid to providers through APMs for the applicable payment period. For instance, if a plan paid a provider $120,000 for the entire year, but only entered into a shared savings contract with the provider on June 1, six months into the payment period, half of the payments the provider received ($60,000) would be reported as being linked to a contract that includes shared savings (Category 3).

How to Handle Provider Payments Not Yet Paid Out During the Payment Period

OHS requests that insurance carriers use a **"date of payment"** approach. Actual payments to providers between January 1st and December 31st should be reported in the APM Data Submission Template. Carriers should not estimate payments that providers may receive in the following payment period(s) related to APM arrangements or dates of service within the reporting year.

This "date of payment" or "cash" approach to reporting APM payments made to providers has the advantage of offering a more immediate snapshot of plan performance on APM use without waiting for claims run off or relying on carrier projections of future provider payments. Using the same "date of payment" approach in consecutive 12-month periods, should provide a comparable snapshot of each plan's relative APM usage and changes over time.

NOTE: OHS' "date of payment" approach for APM reporting differs from OHS' Cost Growth Benchmark data specifications, which request that insurance carriers submit allowed amounts on an incurred basis (not paid basis).

D. Market Segments

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 Benefits (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 the payment period (e.g., CY 2023). Spending for dental and vision policies are excluded.

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 as covered services, 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 the payment period (e.g., CY 2023). Dental and vision policies are excluded.

E. Providers to Include/Exclude

For the purposes of this survey, "providers" include all Connecticut healthcare providers to which the insurer made payments for covered services. This includes, for example, providers of pharmacy, behavioral health, and durable medical equipment (DME) covered services in addition to physicians, hospitals and other traditional healthcare covered services, and **does not** include providers specifically associated with spending for dental and vision policies. **If a payer does not engage in value-based contracting with a given provider type, the payer should still include that provider's spending in the plan's total expenditures (denominator).**

F. Providers Participating in Multiple APMs

In cases where a provider participates in multiple APMs, carriers should allocate the payment amounts to the "highest" category APM. For example, if a provider has a shared savings contract with a health plan and is also eligible for performance bonuses for meeting quality measure performance targets (P4P), the health plan would report the fee-for-service claims, shared savings payments (if any), and the P4P dollars in the shared savings subcategory (Category 3).

G. Allocating Health Plan Members to an Accountable Care APM

As part of this survey, OHS is requesting that insurance carriers submit total covered lives by market and covered lives attributed to Connecticut providers participating in accountable care APMs in the payment period. Health plans typically attribute health plan members included in accountable care APM arrangements to a PCP/PCG. In some situations, health plans/states may attribute members to both a PCP/PCG and a non-PCP (i.e., specialist). In these instances, health plans should attribute members to either the PCP/PCG or the non-PCP focused accountable care APM categories but not both.

If your organization attributes members to only PCP/PCG accountable care APMs, the following applies:

1. **Allocating health plan member lives to Category 3A and/or Category 3B accountable care APM arrangements.** If your organization attributes health plan members to the PCP/PCG focused accountable care APM categories, please attribute your organization's covered lives to Category 3A, Category 3B, or both (i.e., 3A and 3B).
2. **Allocating health plan member lives to Category 4 (i.e., all of Category 4 combined) accountable care APM arrangements**. If your organization has covered lives in any of Category 4 (i.e., 4A, 4B, 4C), OHS assumes all of those covered lives are in a TCOC accountable care APM, and therefore should be counted and captured in Category 4.

If your organization attributes members to only the non-PCP (i.e., specialist) accountable care APMs, the following applies:

1. **Allocating health plan member lives to non-PCPs (i.e., specialists) who participate in accountable care APM arrangements.** If your organization attributes members to non-PCP (e.g., specialist) focused accountable care arrangements, please attribute your organization's member lives to any of Category 3 (i.e., 3A and 3B combined) and/or any of Category 4 (i.e., 4A, 4B, 4C).

For additional guidance on measuring covered lives in accountable care APM arrangements, including examples and further inclusion/exclusion criteria, please reference the LAN's guidance document or please contact Lisa Sementilli at Lisa.Sementilli@ct.gov.

H. APM Excel File Specifications

Insurance carriers must submit one Excel template provided by OHS that includes its APM data. The Excel template includes multiple tab types, only two of which require data entry by insurance carriers. The subsections below describe the information that carriers must submit within each tab.

General Information

The "General Info" tab collects background information from the insurance carrier about its submission, including contact information, lines of business in which the health plan operated in the payment period, and the total number of members covered by the insurance carrier by line of business during the payment period.

Commercial and Medicare Advance Payments

The "Commercial Payments" and "Medicare Payments" tabs collect total payments made by insurance carriers to providers and total payments made through APMs in the commercial and Medicare Advantage markets for the payment period. The tabs contain several columns requiring specific information or calculations related to APMs as defined by the HCP-LAN. Only the cells in this tab that are shaded yellow require data entry. The other cells in the tab will automatically calculate.

Category #: This column is already populated with the HCP-LAN APM category numbers, which correspond to different APM types. No data entry is needed from insurance carriers for this column.

Numerator Description: This column contains detailed definitions of the data that should be input in the corresponding "Numerator Value" column. No data entry is needed from insurance carriers for this column.

Numerator Value: When filling in the highlighted cells in the "Numerator Value" column, please provide the total dollar amount of payments made under contracts that include the defined APMs. This should be an aggregate amount across the specified market (commercial or Medicare Advantage) and should align with the market segment, payment period and provider specifications described above.

Denominator Description: This column contains detailed definitions of the data that should be input in the corresponding "Denominator Value" column. No data entry is needed from insurance carriers for this column.

Denominator Value: When filling in the highlighted cell in the "Denominator Value" column, insurance carriers should input total dollars paid to providers (in or out of network) for members in the specified payment period, regardless of whether these were under an APM or a traditional fee-for-service model. This should be an aggregate amount across the specified market (commercial or Medicare Advantage) and should align with the market segment, payment period and provider specifications described above.

Metric: This column is pre-populated with descriptions of the calculated metric. This provides insurance carriers with an understanding of what each calculated metric will represent. No data entry is needed from insurance carriers for this column.

Metric Calculation: This column is automated to calculate the proportion of total payments made through APMs for each category, based on the values insurance carriers provide in the "Numerator Value" and "Denominator Value" columns. No data entry is needed from insurance carriers for this column.

Notes: This column is available for insurance carriers to include any additional details, clarifications, or context related to the data insurance carriers have entered. This could include explanatory notes about any significant changes in payment policies or other factors influencing the values reported.

Commercial and Medicare Advantage Covered Lives

The “Commercial Covered Lives” and “Medicare Covered Lives” tabs collect total members by line of business and total members covered under accountable care APMs by line of business for the payment period. The tabs contain several columns requiring specific information or calculations related to members covered under accountable care APMs as defined by the HCP-LAN. Only the cells in this tab that are shaded yellow require data entry. The other cells in the tab will automatically calculate.

Category #: This column is already populated with the HCP-LAN APM category numbers, which correspond to different APM types. No data entry is needed from insurance carriers for this column.

Covered Lives Description: This column contains detailed definitions of the data that should be input in the corresponding “Covered Lives” column. No data entry is needed from insurance carriers for this column.

Covered Lives: When filling in the highlighted cells in the “Covered Lives “ column, please provide the total number of health plan members attributed to a Connecticut PCP, PCG or non-PCP participating in the defined APMs. Values input into the highlighted cells should align with the guidance above on how to allocate health plan members to an accountable care APM differently depending on whether the insurance carrier attributes members to only PCP/PCG accountable care APMs or if the insurance carrier attributes members to only the non-PCP (i.e., specialist) accountable care APMs.

Metric: This column is pre-populated with descriptions of the calculated metric. This provides insurance carriers with an understanding of what each calculated metric will represent. No data entry is needed from insurance carriers for this column.

Metric Calculation: This column is automated to calculate the percentage of plan members included in accountable care APMs in the payment period as per each category, based on the values insurance carriers provide in the “Covered Lives” column. No data entry is needed from insurance carriers for this column.

I. File Submission

File Submission Naming Conventions

Data submissions should follow the following naming conventions:

Insurance Carrier Name_APM_YYYY_Version.xls

YYYY is the four-digit year of submission (which will generally be one year later than the year of the data reflected in the report).

Version is optional and indicates the submission number.

The file extension must be .xls or .xlsx

Below are examples of valid file names:

CARRIER A_APM_2023_01.xlsx or CARRIER A_APM_2023_1.xlsx or CARRIER A_APM_2023.xlsx

Submitting Files to OHS

Electronic files are to be submitted through the State's secure file transfer (SFT) server at https://sft.ct.gov/ to OHS.

OHS will provide a form at https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Implementation-Manual for the carrier's contact(s) to fill out and email to OHS. This information is required:

- To facilitate user access to the State's SFT Web Client;
- To confirm the user is the authorized and designated contact for the carrier at registration;
- To facilitate securing and protecting confidential data;
- To enable OHS to communicate with the contact about data error correction and validation, system or process changes and updates.

The contact will fill out the form and email it to OHS@ct.gov. OHS will acknowledge receipt of the filled form, credential and grant the contact/new user access to the State's network within two business days. Upon receiving the credentials to access the server, the authorized user will upload the required data files. The contact must alert OHS through email after uploading the file(s).

Appendix B: Department of Social Services (DSS) APM Data Specification

This Department of Social Services (DSS) APM specification provides technical details to assist DSS in reporting and filing data that will enable OHS to assess APM adoption and members covered under accountable care APMs.

OHS will annually request APM data files with dates of service during the payment period (e.g., OHS is requesting payment period 2023 data in 2024). DSS will submit one Excel file with multiple record types in each tab, including:

- **General Info** which collects background information about DSS's data submission.
- **Medicaid Payments tabs**, which collects Numerator and Denominator values by HCP-LAN APM category for the Medicaid market.
- **Medicaid Covered Lives tabs,** which collects plan members attributed to providers participating in APMs by HCP-LAN category for the Medicaid market.
- **Definitions Tab**, which includes relevant definitions for terms used in the APM submission template.
- **LAN APM Framework Tab**, which includes a figure depicting APM categories according to the LAN framework.

This DSS APM data specification appendix is informed by the LAN's APM Measurement Survey and by other state value-based payment reporting tools, including the Michigan Department of Health and Human Services' Medicaid APM Data Collection Tool. OHS may periodically update and revise these data specifications in subsequent versions.

A. APM Excel File Submission Instructions and Schedule

The APM data submission file layout for DSS is included in this Appendix. OHS requests that DSS submit APM data using the Excel template provided by OHS according to the schedule outlined in **Table B-1**. OHS asks that DSS submit APM data annually.

Table B-1.DSS APM Data Filing Schedule

Date	Files Due
August 15, 2024	CY 2023
August 15, 2025	CY 2024
August 15, 2026	CY 2025
August 15, 2027	CY 2026

B. HCP-LAN Categories

OHS' APM tracking methodology is based on the HCP-LAN Framework, which categorizes payment models into four major categories based on the degree of provider financial risk and the potential for care coordination. The four categories and their sub-categories are detailed in **Table 1** above.

C. Payment Period

OHS requests DSS submit APM data for the payment period applicable to the specified APM report (e.g., CY 2023: January 1 – December 31, 2023). **Note:** OHS' payment period definition differs from the LAN's annual survey specifications, which allow payers to report payment information for the calendar year *or* the most current 12-month period. If necessary, DSS may deviate from OHS' calendar year payment period specification and submit for the most recent 12-month period; however, DSS is asked to indicate the start and end dates of the payment period in its data submission.

In completing its APM reporting, DSS should only count an APM payment arrangement for the time-period in which it was effective. For example, if an APM payment arrangement became effective with a provider beginning April 1st of a payment period, DSS should include the pro-rated portion of the contract between April 1st and December 31st of the reporting year. The portion of the contract paid between January 1st and March 31st should not be included in that particular APM model reporting.

OHS seeks to gather accurate information on DSS payments to providers within specified time periods, particularly those operating under contracts that include one or more APMs. The intention is to gather actual payment data rather than projections

or estimations based on hypothetical scenarios or incomplete contracts. Please see the inset below for how to handle provider payments not yet paid out during the payment period.

"Look back" or retrospective metrics are essential in this process, as they report the actual dollars paid to providers through APMs for the applicable payment period. For instance, if DSS paid a provider $120,000 for the entire year, but only entered into a shared savings contract with the provider on June 1, six months into the payment period, half of the payments the provider received ($60,000) would be reported as being linked to a contract that includes shared savings (Category 3).

How to Handle Provider Payments Not Yet Paid Out During the Payment Period

OHS requests that DSS use a **"date of payment"** approach. Actual payments to providers between January 1st and December 31st should be reported in the APM Data Submission Template. DSS should not estimate payments that providers may receive in the following payment period(s) related to APM arrangements or dates of service within the reporting year.

This "date of payment" or "cash" approach to reporting APM payments made to providers has the advantage of offering a more immediate snapshot of DSS performance on APM use without waiting for claims run off or relying on DSS' projections of future provider payments. Using the same "date of payment" approach in consecutive 12-month periods, should provide a comparable snapshot of each plan's relative APM usage and changes over time.

D. Market Segments

For the purposes of this survey, the **Medicaid market segment** includes spending by the Connecticut Department of Social Services (DSS). Medicaid data submitted by DSS for this survey should exclude the following: healthcare spending for dual-eligible beneficiaries, healthcare spending for long-term services and supports (LTSS), spending for dental and vision covered services, disproportionate share (DSH) payments for hospitals and directed payments that are not part of service-based payments. Responses to the survey will reflect dollars paid for medical, behavioral

health, and pharmacy covered services (to the extent possible) in the payment period.

E. Providers to Include/Exclude

For the purposes of this survey, “providers" include all healthcare providers for whom there is healthcare spending. This includes, for example, providers of pharmacy, behavioral health, and durable medical equipment (DME) covered services in addition to physicians, hospitals and other traditional healthcare services, and **does not** include spending for dental and vision policies.

F. Providers Participating in Multiple APMs

In cases where a provider participates in multiple APMs, DSS should allocate the payment amounts to the "highest" category APM. For example, if a provider has a shared savings contract with DSS and is also eligible for performance bonuses for meeting quality measure performance targets (P4P), DSS should report the fee-for-service claims, shared savings payments (if any), and the P4P dollars in the shared savings subcategory (Category 3).

G. Allocating Medicaid Members to an Accountable Care APM

As part of this survey, OHS requests that DSS submit total covered lives by market and covered lives attributed to providers participating in accountable care APMs in the payment period. Payers typically attribute members included in accountable care APM arrangements to a PCP/PCG. In some situations, health plans/states may attribute members to both a PCP/PCG and a non-PCP (i.e., specialist). In these instances, DSS should attribute members to either the PCP/PCG or the non-PCP focused accountable care APM categories but not both.

If DSS attributes members to only PCP/PCG accountable care APMs, the following applies:

3. **Allocating Medicaid member lives to Category 3A and/or Category 3B accountable care APM arrangements.** If DSS attributes members to the PCP/PCG focused accountable care APM categories, please attribute DSS' covered lives to Category 3A, Category 3B, or both (i.e., 3A and 3B).
4. **Allocating Medicaid member lives to Category 4 (i.e., all of Category 4 combined) accountable care APM arrangements**. If DSS has covered lives in

any of Category 4 (i.e., 4A, 4B, 4C), OHS assumes all of those covered lives are in a TCOC accountable care APM, and therefore should be counted and captured in the Category 4 accountable care APM question.

If DSS attributes members to only the non-PCP (i.e., specialist) accountable care APMs, the following applies:

2. **Allocating Medicaid member lives to non-PCPs (i.e., specialists) who participate in accountable care APM arrangements.** If DSS attributes members to non-PCP (e.g., specialist) focused accountable care arrangements, please attribute DSS' member lives to any of Category 3 (i.e., 3A and 3B combined) and/or any of Category 4 (i.e., 4A, 4B, 4C).

For additional guidance on measuring covered lives in accountable care APM arrangements, including examples and further inclusion/exclusion criteria, please reference the LAN's guidance document or please contact Lisa Sementilli at Lisa.Sementilli@ct.gov.

H. APM Excel File Specifications

OHS requests that DSS submit one Excel template provided by OHS that includes its APM data. The Excel template includes multiple tab types, only two of which require data entry by DSS. The subsections below describe the information that DSS must submit within each tab.

General Information

The "General Info" tab collects background information from DSS about its submission, including contact information, and the total number of members covered by DSS during the payment period.

Medicaid Payments

The "Medicaid payments" tab collects total payments made by DSS to providers and total payments made through APMs for the payment period. The tab contains several columns requiring specific information or calculations related to APMs as defined by the HCP-LAN. Only the cells in this tab that are shaded yellow require data entry. The other cells in the tab will automatically calculate.

Category #: This column is already populated with the HCP-LAN APM category numbers, which correspond to different APM types. No data entry is needed from DSS for this column.

Numerator Description: This column contains detailed definitions of the data that should be input in the corresponding "Numerator Value" column. No data entry is needed from DSS for this column.

Numerator Value: When filling in the highlighted cells in the "Numerator Value" column, please provide the total dollar amount of payments made under contracts that include the defined APMs. This should be an aggregate amount and should align with the market segment, payment period and provider specifications described above.

Denominator Description: This column contains detailed definitions of the data that should be input in the corresponding "Denominator Value" column. No data entry is needed from DSS for this column.

Denominator Value: When filling in the highlighted cell in the "Denominator Value" column, DSS should input total dollars paid to providers (in or out of network) for members in the specified payment period, regardless of whether these were under an APM or a traditional fee-for-service model. This should be an aggregate amount and should align with the market segment, payment period and provider specifications described above.

Metric: This column is pre-populated with descriptions of the calculated metric. This provides DSS with an understanding of what each calculated metric will represent. No data entry is needed from DSS for this column.

Metric Calculation: This column is automated to calculate the proportion of total payments made through APMs for each category, based on the values DSS provide in the "Numerator Value" and "Denominator Value" columns. No data entry is needed from DSS for this column.

Notes: This column is available for DSS to include any additional details, clarifications, or context related to the data DSS has entered. This could include explanatory notes about any significant changes in payment policies or other factors influencing the values reported.

Medicaid Covered Lives

The "Medicaid Covered Lives" tab collects total Medicaid members and total members covered under accountable care APMs for the payment period. The tabs contain several columns requiring specific information or calculations related to members covered under accountable care APMs as defined by the HCP-LAN. Only the cells in this tab that are shaded yellow require data entry. The other cells in the tab will automatically calculate.

Category #: This column is already populated with the HCP-LAN APM category numbers, which correspond to different APM types. No data entry is needed from DSS for this column.

Covered Lives Description: This column contains detailed definitions of the data that should be input in the corresponding "Covered Lives" column. No data entry is needed from DSS for this column.

Covered Lives: When filling in the highlighted cells in the "Covered Lives " column, please provide the total number of members attributed to a PCP, PCG or non-PCP participating in the defined APMs. Values input into the highlighted cells should align with the guidance above on how to allocate members to an accountable care APM differently depending on whether DSS attributes members to only PCP/PCG accountable care APMs or if DSS attributes members to only the non-PCP (i.e., specialist) accountable care APMs.

Metric: This column is pre-populated with descriptions of the calculated metric. This provides DSS with an understanding of what each calculated metric will represent. No data entry is needed from insurance carriers for this column.

Metric Calculation: This column is automated to calculate the percentage of members included in accountable care APMs in the payment period as per each category, based on the values DSS provided in the "Covered Lives" column. No data entry is needed from DSS for this column.

I. File Submission

File Submission Naming Conventions

Data submissions should follow the following naming conventions:

DSS_APM_YYYY_Version.xls

YYYY is the four-digit year of submission (which will generally be one year later than the year of the data reflected in the report).

Version is optional and indicates the submission number.

The file extension must be .xls or .xlsx

Below are examples of valid file names:

DSS_APM_2023_01.xlsx or DSS_APM_2023_1.xlsx or DSS_APM_2023.xlsx

Submitting Files to OHS

Electronic files are to be submitted through the State's secure file transfer (SFT) server at https://sft.ct.gov/ to OHS.

OHS will provide a form at https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Implementation-Manual for DSS' contact(s) to fill out and email to OHS. This information is required:

- To facilitate user access to the State's SFT Web Client;
- To confirm the user is the authorized and designated contact for the carrier at registration;
- To facilitate securing and protecting confidential data;
- To enable OHS to communicate with the contact about data error correction and validation, system or process changes and updates.

The contact will fill out the form and email it to OHS@ct.gov. OHS will acknowledge receipt of the filled form, credential and grant the contact/new user access to the State's network within two business days. Upon receiving the credentials to access the server, the authorized user will upload the required data files. The contact must alert OHS through email after uploading the file(s).