CONNECTICUT HEALTHCARE ALTERNATIVE PAYMENT MODEL MEASUREMENT

Implementation Manual

Version 1.0

July 25, 2023

Version History

Version Number	Release Date	Summary of Changes
1.0	July 25, 2023	

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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, §§217-223 of Public Act 22-118 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 more value-based approaches. The adoption of APMs is a critical component of the broader 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 Hanna Nagy at Hanna.Nagy@ct.gov

Attachment 1. Insurance Carrier CY22 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: Accountable Care centers on the patient and aligns their care team to support shared decision-making and help realize the best achievable health outcomes for all through comprehensive, high quality, affordable, equitable, longitudinal care. For the purposes of this report, accountable care must include two elements or dimensions: 1) the care is longitudinal with a duration of six months or longer; and 2) the payment model incorporates accountability for total cost of care (TCOC) for aligned patients. See TCOC definition and further clarification along with examples below.

Alternative Payment Model (APM): Healthcare payment methods that use financial incentives to promote or leverage greater value - including higher quality care 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.[1]

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 unnecessary procedures. These measures also address patients' goals, prognoses, and needs; and they reflect the outcome of shared decision-making among patients, caregivers, and clinicians (e.g., Choosing Wisely measures). Some examples of appropriate care measures include, but are not limited to: unnecessary readmissions, preventable admissions, unnecessary imaging, 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 or Align/Aligned/Alignment: 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 physician (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. The PCP or PCG is charged with caring for the patients for whom they have been delegated by the contracted health plan.

NOTE: Some health plans may have specialty models that assign patients to a specialist based on the model instead of a PCP or PCG. In such cases, the health plan should count these members under the Non-PCP/PCG-Focused Accountable Care Metric. However, if the member is assigned to a specialist and a PCP, the health plan should only count that member one time under either PCP/PCG or non-PCP/PCG, but not both.

[1] The HCP-LAN APM framework categories are articulated in the Refreshed APM Framework White Paper available here (accessed May 2023) and in the graphics included in OHS' APM data submission template in the tab labeled "7. LAN APM Framework".

See examples of assign/assigned/assignment from the perspective of a health plan or health plan member below.

Health Plan Example: Health plans may take this action when the product in which the member enrolls requires the member to select a PCP or PCG. If the member does not select a PCP or PCG at the time of enrollment, the health plan allocates – or assigns – the member to a PCP or PCG within the health plans' preferred provider network. The health plan may consider the PCP or PCG's current panel size, geographic location, member claims' history, and other factors when identifying an appropriate PCP or PCG for the member.

Health Plan Member Example: A health plan member may voluntarily select a PCP or PCG at the time of enrollment or at other times while enrolled in the health plan.

Attributed/Attribution: Refers to a statistical or administrative methodology that attributes a patient population to a provider for a particular APM (which must include consideration of cost AND quality). "Attributed" patients can 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).

Empanel/Empaneled/Empanelment: This term is typically used in a provider-facing manner; however, some health plans may use this term internally to describe the act the health plan takes to assign individual patients to individual primary care providers (PCP) or primary care groups (PCG) and care teams with sensitivity to patient and family preference.[2] This act or process results in a provider having a "patient panel." The patient panel is a group of patients assigned to one PCP or primary care group (PCG). The physician and/or group is accountable for the care of the patients within the panel. Also known as paneled or paneling. See also assign/assigned/assignment.

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 <u>not</u> 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): 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.
- 2B: Pay for Reporting: Bonus payments/rewards for reporting on specified quality measures, including those paid in DRG systems.

[2] https://www.ahrq.gov/sites/default/files/wysiwyg/evidencenow/tools-and-materials/executive-summary-empanelment.pdf

- 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): Alternative payment methods (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); Oncology Center of Excellence (COE) with retrospective shared savings (no shared risk).
- 3B: APMs with upside gain sharing (retrospective bundled payments with upside risk, retrospective episode-based payments with shared savings, PCMH with retrospective shared savings, Oncology COE with retrospective shared savings) and APMs with downside risk (retrospective bundled payments with downside risk, retrospective episode-based payments with losses, PCMH with retrospective losses, Oncology COE with retrospective losses).

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-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.

Commercial market: For the purposes of this report, 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. Spending for dental and vision policies are excluded.

Condition-specific bundled/episode payments: 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]

Condition-specific population-based payment: 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. See Frequently Asked Questions for more information. [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 percent 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 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]

Linked to quality: Payments that are set or adjusted based on evidence that providers meet quality standards or improve care or clinical services, including for providers who report quality data, or providers who meet a 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" 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 aligned patients in which they serve as a coordinator for their 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. Plans are asked to exclude these patients from the accountable care count UNLESS the patient is in an accountable care relationship with another provider that is six months or longer.

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: health care spending for dual-eligible beneficiaries, health care spending for long-term services and supports (LTSS), spending for dental and vision policies, and disproportionate share (DSH) payments for hospitals. Responses to the survey will reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in the payment period.

Medicare Advantage market: For the purposes of this survey, the Medicare Advantage market segment includes a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, and Special Needs Plans. To the extent the Medicare Advantage plan has Part D or drug spending under its operations, it should include this information in its response. Responses to the survey will reflect dollars paid for Medicare Advantage beneficiaries’ (including dual eligible beneficiaries) medical, behavioral health, and pharmacy benefits (to the extent possible) in the payment period. Dental and vision policies are excluded.

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., CY2022: January 1 - December 31, 2022). **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.

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: 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 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, and DME spending to the greatest extent possible, and excludes dental and vision policies.

Total Cost of Care: Total cost of care (TCOC) 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.

Additionally, TCOC covers 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 other 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 on Total Per Capita Cost for aligned beneficiaries), however, capitation arrangements or financial risk for TCOC would also count as accountability for TCOC. See TCOC examples below.

- 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 targets.

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 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) [3]	Fee-for-service 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. • **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:

[3] 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
	• **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); Oncology Center of Excellence (COE) with retrospective shared savings (no shared risk). • **3B:** APMs with upside gain sharing (retrospective bundled payments with upside risk, retrospective episode-based payments with shared savings, PCMH with retrospective shared savings, Oncology COE with retrospective shared savings) and APMs with downside risk (retrospective bundled payments with downside risk, retrospective episode-based payments with losses, PCMH with retrospective losses, Oncology COE with retrospective losses).
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-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.[4]

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

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

Public Reporting of APM Adoption

OHS will report APM adoption for CY 2022 at the market-level (commercial, Medicare Advantage, Medicaid) for each APM category. For each market, OHS will report the percentage of payments made through each of the APM categories and subcategories in **Table 1** above. OHS will report 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 will use payer-submitted membership data to report the percentage of members in each market attributed, aligned, assigned, or empaneled 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 will report the percentage of members covered under Category 3 and 4 accountable care APMs for each market.

Although OHS plans to report CY 2022 APM adoption solely at the market-level, OHS may report APM adoption and covered lives at the payer-level in future years.

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 2022 data in 2023). 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 but aims to update this manual no more frequently than once per payment period.

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
September 30, 2023	CY 2022
August 15, 2024	CY 2023
August 15, 2025	CY 2024
August 15, 2026	CY 2025

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 applicable to the specified APM report (e.g., CY 2022: January 1 – December 31, 2022). **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.

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 2022). 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 under its operations, it should include this information in its response. Responses to the survey will reflect dollars paid for Medicare Advantage beneficiaries' (including dual eligible beneficiaries) medical, behavioral health, and pharmacy benefits (to the extent possible) in the payment period (e.g., CY 2022). Dental and vision policies are excluded.

E. Providers to Include/Exclude

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

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 Hanna Nagy with questions at Hanna.Nagy@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_2022_01.xlsx or CARRIER A_APM_2022_1.xlsx or CARRIER A_APM_2022.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/Payer-Data-Portal 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 Service (DSS) APM Data Specification

To be added in a subsequent version of this manual.