CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

COLORADO ALTERNATIVE PAYMENT MODEL ANALYSIS

METHODOLOGY, June 2022

BACKGROUND

Alternative Payment Models (APMs) are ways health insurance payers pay providers outside of the traditional Fee-for-Service (FFS) payment model. APMs are nationally regarded as a way to improve health and lower health care costs by incentivizing providers to focus on health outcomes. In September 2019, the Center for Improving Value in Health Care (CIVHC) began collecting APM information from health insurance payers in Colorado for the first time. This data, coupled with traditional Fee-for-Service (FFS) claims being submitted to the Colorado All Payer Claims Database (CO APCD), enables important insights into Colorado's movement toward adopting APMs, aimed at lowering health care costs and improving care.

CIVHC collects an annual APM file from health insurance payers in September of each year. This report is based on files submitted in September of 2021 and contains APM information for 2018, 2019, and 2020. The public report available at www.civhc.org shows Colorado payer progress toward paying through APMs. An interactive report and a downloadable Excel file are available for users to understand various aspects of APMs. The report includes:

- Trends over time.
- Categories of APMs utilized according to the Health Care Payment Learning and Action Network (HCP LAN) categories.
- Breakouts by payer type (Medicare Advantage, Medicaid, CHP+ and commercial payers).

This document provides an overview of the methodology used to calculate the information in the report and caveats that users should keep in mind when viewing and interpreting the data.

OVERVIEW OF METHODS

Medical and primary care payments were calculated utilizing non-claim payments collected through the APM files and claim payments submitted through the CO APCD by payers who were exempt from submitting an APM file (see below for payer exemptions). The approach to defining primary care payments in the CO APCD was informed by the Primary Care Payment Reform Collaborative (the Collaborative) and operationalized with input from the Collaborative members and the Division of Insurance (DOI). The Collaborative also recommended collecting APM data using the nationally recognized Health Care Payment Learning and Action Network (HCP LAN) Alternative Payment Model framework. More information on the HCP LAN initiative and the APM framework can be found here. More details on the submission instructions for payers can be found here.

WHAT MAKES UP PRIMARY CARE PAYMENTS?

CIVHC used the definition of primary care established by the Collaborative for this report and the report delivered to the Primary Care Collaborative. Primary care payments represent payments made to primary care providers for primary care services and includes services delivered by behavioral health providers who practice in an integrated primary care setting.

The primary care definition consists of two components that payers add together to produce total claim-based primary care payments:

a. **Outpatient services delivered *by primary care providers* (which includes OB/GYN providers),** defined by a combination of primary care provider taxonomy and primary care CPT-4 procedure codes**.**
b. **Outpatient services delivered *by behavioral health providers, nurse practitioners and physician assistants* (other provider taxonomies)**, defined by a combination of the "other "provider taxonomies and primary care CPT-4 procedure codes AND billed by a primary care provider (defined by primary care taxonomy).

Primary care calculations include services delivered in an outpatient setting and **excludes facility claims and inpatient services.**

DEFINITIONS

All APM Payments: All medical service payments sourced only from the APM submissions.

- Please note that alternative payment models can include some fee-for-service. See example below.

Total Payments: All medical services payments. This calculation includes both the health plan portion and the member (patient) portion. The sources for this calculation are the following: 1) the total APM payments spending from payers that were required to submit an APM file, and 2) FFS claims in the CO APCD for payers exempt from submitting an APM file.

Total payments do not include Medicare FFS or ERISA based self-insured payments.

APM Payments for Primary Care: Payments made to primary care providers (providers associated with taxonomies in the DSG primary care definition), sourced only from the APM submissions.

- Please note that alternative payment models can include some fee-for-service payments. An example of this is LAN category 2C: Pay for Performance. This model rewards providers who perform well on quality metrics or penalizes providers who do not perform well by increasing or decreasing their FFS baseline. For example, suppose the provider is treating a patient with asthma. In that case, the quality measure tied to the provider's performance could be reducing emergency room visits. A provider who can teach an asthma patient how to treat their condition effectively at home and thus reduce the number of trips the patient takes to the emergency department can

increase their FFS baseline payments.

- **Total Payments for Primary Care:** Payments for primary care services as defined in the Data Submission Guide that are tied to a FFS claim or an APM. The calculation includes both the health plan portion and the member (patient) portion. The numbers for this calculation come from two sources: 1) FFS claim-based and APM spending identified as primary care from payers that were required to submit an APM file, and 2) FFS claims that qualify as primary care in the CO APCD for payers exempt from submitting an APM file.

- **All Payers:** All payers in this report include Medicare Advantage, Medicaid, CHP+ and commercial payers in the CO APCD. Please see below for a list of commercial payers who are exempt from reporting APMs to the CO APCD.

- **Integrated Payer-Provider Systems:** Filters are available in the report to enable users to understand how Colorado is doing on APMs with and without integrated payer-provider systems payments. Several Colorado payers are structured as integrated payer-provider systems and have a high proportion of APM payments compared to other commercial payers. These payers represent around a quarter of the commercially insured lives in Colorado but drive a large portion of the APM spending in the state.

- **Fee for Service (FFS):** Payments made to providers on a per-service basis.

- **Alternative Payment Models (APM):** Payments made to providers outside an FFS model that are intended to incentivize cost-effective, high quality care.

- **HCP LAN APM Categories:** Nationally recognized categories of APMs based on the Health Care Payment Learning and Action Network (HCP LAN). See below for definitions or click here for more information.

- **Value Based APM Payments:** Excludes non-value-based payments, LAN categories 3N and 4N, which are not linked to quality and are therefore not considered value-based.

- **% APM of Total Payments:** Total dollars spent on APMs (provided by payers through an annual APM file), divided by Total Payments (combination of payments received by *all* payers through monthly claim-level submissions to the CO APCD, AND APM files).

- **% APM of Total Primary Care Payments**: APM payments for primary care services as a percent of total primary care payments.

- **% of APM Payments by LAN Category Type:** APM categories as a percentage of total APM spending.

CALCULATIONS

Measure	Calculation
Total Payments (All Medical)	ALL APM payments + FFS payments (includes Primary Care claims, but excludes Pharmacy and Dental claims)
Total Primary Care Payments	APM payments for Primary Care Services + FFS payments for Primary Care Services +
All APMs Payments	Includes ALL LAN categories: 2A + 2b + 2C+ 3A+ 3B + **3N** + 4A + 4B+ 4C+ **4N**
Value Based (VB) APM Payments	Excludes non-value-based categories **(3N and 4N):** 2A + 2b + 2C+ 3A+ 3B +4A + 4B+ 4C
% All APM of Total Payments (All Medical)	All APM total ÷ Total Payments (All Medical)
% Total Primary Care Payments of Total Payments	APM payments for Primary Care Services + FFS payments for Primary Care Services + ÷ Total Payments (All Medical)
% APM VB of Total Medical Payments	APM VB total ÷ Total Payments (All Medical)
% All APM of Total Primary Care Payments	All APM total for primary care services ÷ All Primary Care Payments
% APM VB of Total Primary Care Payments	APM VB total for primary care services ÷ All Primary Care Payments
% of APM Payments by LAN Category Type	LAN Category ÷ ALL APMs

CONSIDERATIONS AND CAVEATS

To facilitate the adoption of the HCP LAN framework to define the APM data submission, CIVHC and DOI held several calls with payers, received expert consultation from Catalyst for Payment Reform, and engaged in one-on-one discussions and technical assistance with payers. In order to validate payer submissions, CIVHC evaluated submissions by payer compared to last year's submissions and also provided a summary of the submissions to payers and asked the CEO/CFO at each organization to attest to their data as submitted. The attestation process helps payers ensure that their data when summarized and analyzed is reflective of what they would expect, and provides an additional level of validation to ensure data quality, integrity, and accuracy. All payers attested to the information submitted in their APM files for the current analysis. The validation process helps ensure the data submitted by the payers provides the most accurate representation of APMs possible. However, because this is self-reported data, CIVHC is unable to ensure 100% accuracy of the results.

Beyond the broad limitations, readers of this report should consider the following:

- **Several Colorado payers are structured as integrated payer-provider systems and have a high proportion of APM** payments compared to other commercial payers. These payers represent around a quarter of the commercially insured lives in Colorado but drive a large

portion of the APM payments in the state. Filters are available in the report to enable users to understand how Colorado is doing on APMs with and without integrated payer-provider system payments.

- CIVHC receives claims and non-claims submissions from both, the Medicaid State Agency, and the Medicaid Regional Accountable Entities organizations. To eliminate redundant payments submitted by Medicaid and the Medicaid Regional Accountable Entities (RAEs), CIVHC asked RAEs only to report non-claim payments made directly to providers. **Payments from Medicaid to the RAE/MCOs (i.e., payments from one payer entity to another) were not included in the APM calculations.** This eliminates the primary source of data redundancies; however, it makes Medicaid's reported payments through APMs appear lower.
- **The definition of primary care relies heavily on provider taxonomy requirements**. CIVHC could not validate some payer's claims-based primary care payments data against claims submitted to the CO APCD due to payer differences in associated taxonomy codes for providers. In future iterations, CIVHC plans to use an additional external source to validate providers' primary care designation.

PAYER EXEMPTIONS

A handful of active medical claims submitters to the CO APCD were exempt from submitting an APM file because they are not involved in APM payments to providers. Further, some medical claims submitters only administrate claims on behalf of Medicare Supplemental members, and Medicare Supplemental data is not intended to be included in the APM submission. Payments for these payers are calculated using the CO APCD and reported separately. Below is the list of medical submitters that only reimburse providers on an FFS basis or only submit Medicare Supplemental data:

Carrier	Exemption Reason
United Health Care (Individual, student, and Med Sup submitter codes)	FFS only
UMR	FFS only
American Enterprise	FFS only
Friday Health Plans	FFS only
AmeriBen/IEC Group	FFS only
UCHealth Plan Administrators	FFS only
Meritain Health	FFS only
HealthSmart Benefit Solutions	FFS only
HealthScope Benefits	FFS only
Allegiance Benefit Plan Management	FFS only
State Farm	Med Sup
Physicians Mutual	Med Sup
USAA Enterprise	Med Sup
Carrier	**Exemption Reason**
Insurance Administration	Med Sup
C.S.I. Life	Med Sup
Aflac	Med Sup

LAN PAYMENT ARRANGEMENT CATEGORIES

Health Care Payment Learning & Action Network. Alternative Payment Models APM Framework.

Category Code	Value	Definition/Example
01	**Fee for Service**	Payments made on a traditional fee-for-service model, no link to quality and value. These are traditional FFS payments that are not adjusted to account for infrastructure investments, provider reporting of quality data, for provider performance on cost and quality metrics. Diagnosis- related groups (DRGs) that are not linked to quality are included in Category 1.
2A	**Foundational Payments for Infrastructure and Operations**	Payments for infrastructure investments that can improve the quality of patients care (e.g., payments designated for staffing a care coordination nurse or upgrading to electronic health records).
2B	**Pay for Reporting**	Payments (incentives or penalties) to report quality measurement results.
2C	**Pay-for-Performance**	Payments (incentives or penalties) based on performance in meeting goals for quality measures (e.g. bonuses for quality performance).
3A	**APMs with SharedSavings**	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Does not include penalties when cost or utilization targets are not met (e.g., shared savings with upside risk only).
3B	**APMs with Shared Savings and DownsideRisk**	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Includes penalties representing a portion of the losses that result when a cost or utilization target is not met (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk).
3N	**Risk Based Payments NOT Linked to Quality**	Payments representing a share of savings generated when a cost or utilization target is met and no quality targets exist (e.g., episode-based payments for procedures without quality measures and targets).
4A	**Condition-Specific Population-Based Payment**	Payments for the comprehensive treatment of specific conditions (e.g., payments for specialty services, such as oncology or mental health). Bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering only chemotherapy payments. Also, payments that are prospective and population-based and cover all care delivered by particular types of clinicians (e.g., orthopedics).
4B	**Comprehensive Population-BasedPayment**	Payments that are prospective and population-based, and cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct, (e.g. global budgets or full/percent of premium payments).

Category Code	Value	Definition/Example
4C	**Integrated Finance and Delivery System**	Payments that also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, while in other cases they consist of delivery systemsthat offer their own insurance products (e.g. global budgets or full/percent of premium payments in integrated systems)
4N	**Capitated Payments NOT linked to Quality**	Payments that are prospective and population-based, but not linked to quality.

For more information about this report, please contact us at info@civhc.org