# COLORADO ALTERNATIVE PAYMENT MODEL REPORT METHODOLOGY, April 2021

# BACKGROUND

In September 2019, the Center for Improving Value in Health Care (CIVHC) began receiving Alternative Payment Model (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 on Colorado’s movement towards adopting APMs in an effort to lower health care costs and improve care.

CIVHC collects an annual APM file from submitters in September of each year. This year’s report is based on files submitted in September of 2020 and contains APM information for 2017, 2018, and 2019. The public report available at [www.civhc.org](http://www.civhc.org) shows the progress Colorado has made towards adoption of APMs. An [interactive report, along with a downloadable Excel file and Issue Brief](https://www.civhc.org/get-data/public-data/focus-areas/alternative-payment-models/) are available for users to understand various aspects of APMs including trends over time, types of APMs being utilized according to the Health Care Payment Learning and Action Network ([HCP LAN](https://hcp-lan.org/)) categories, and breakouts by payer type (Medicare Advantage, Commercial, and Medicaid).

This document provides an overview of the methodology that was used to calculate the information in the report and caveats that users should be aware of when viewing and interpreting the information.

OVERVIEW OF METHODS

The calculation of medical and primary care spending utilized claim payments and non-claim payments collected through the APM files as well as 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 spending in the CO APCD was informed by the [Primary Care Payment Reform Collaborative](https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-legislation/primary-care-payment-reform) (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](https://hcp-lan.org/). More information on the submission instructions payers receive can be found [here.](https://www.civhc.org/wp-content/uploads/2020/10/Colorado-APCD-2020-APM-Data-Submission-Manual_09.08.2020.pdf)

# REPORT DEFINITIONS

**All Payers:** All payers in this report includes Medicaid 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.

**All Payers without Integrated Payer-Provider Systems:** Includes Medicaid and Commercial payers, but removes APM payments from several integrated health system payers in Colorado. Please see the caveats and considerations section below for more information.

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

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

**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](https://hcp-lan.org/) for more information.

**Total Medical Payments:** Combination of all APM and FFS payments for medical spending only, not including pharmacy or dental spending.

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

**Proportion of Payments by Model Type:** Shows the distribution of types of payments as a percentage of the total for both Fee for Service and APMs by category type.

**Total Primary Care Payments:** Total Primary Care Payments is a subset of Total Medical Payments and includes all payments that were made for primary care services, including FFS and APMs. Primary Care Payments include both claims and non-claims payments.

**Total APM Primary Care Payments:** All APM payments made for primary care services.

**Average % APM of Total Primary Care Payments**: APM payments for primary care services as a percent of total primary care payments, averaged across all three years.

**% Primary Care Payments by LAN**: Shows the percentage that individual APM LAN category payments represent compared to total APM payments for primary care.

# CAVEATS AND CONSIDERATIONS

To facilitate the adoption of the HCP LAN framework to define the APM data submission, CIVHC and DOI held several multi-payer calls, received expert consultation from Catalyst for Payment Reform, and engaged in one-on-one discussions and technical assistance with payers. Though CIVHC made a great effort into ensuring this report contains high-quality information, it is important to note that this is the first year CIVHC collected APM data under the current specifications. As time progresses, CIVHC and the payers will inevitably gain more expertise about APM arrangements and the appropriate LAN categorizations, and apply this knowledge to future collection of these files.

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 spending 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.
* **Data available in the** [Primary Care Spending and Alternative Payment Model Use Report](https://drive.google.com/file/d/1LTvjvQlwg0xUqcJ6xnodKez-6o_akJP6/view?usp=sharing) **does not include LAN categories 3N and 4N in the total APM spending calculations** per the request of the Collaborative since they do not involve a measure of quality and are therefore not considered “value-based.” Therefore, totals in the report submitted to the Collaborative report differ from totals presented in report available at civhc.org which does include categories 3N and 4N. Visit the [DOI website](https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-legislation/primary-care-payment-reform) for more information.
* **Payers were instructed to categorize the FFS payments associated with a larger APM** (i.e. pay for performance) into the associated APM and *not* to report FFS payments separately. However, some payers did not do this, and **as a result, FFS % of total spending is likely artificially inflated**.
* To reduce the risk of “double counting” payments submitted by Medicaid and the Medicaid Regional Accountable Entities (RAEs), CIVHC asked RAEs only to report payments to providers. **Payments from HCPF to the RAE/MCOs (i.e., payments from one payer entity to another) were not included in the APM calculations.** This eliminates “double counting” the payments HCPF made, and eliminates the primary source of data redundancies, however, it makes HCPF’s reported spending through APMs appear lower.
* **Humana did not submit an APM file to CIVHC in time for this analysis and is not included in the results.** Humana’s CO APCD submissions only account for approximately 3% of total medical spending and therefore we estimate that their claims would not have a material impact on the APM data. We do estimate that the percentage of total medical spending paid under APMs 2C (Pay for Performance), 3A (Shared Savings – Upside Only), and 3B (Shared Savings with Downside and Upside Risk) would likely increase with Humana submissions.
* Though CIVHC and the DOI spent considerable time sharing and discussing the new HCP LAN framework to categorize payment models with payers, **payers continue to refine their submissions based on their understanding of the categories and their ability to categorize their payments using their individual systems**. CIVHC and the DOI will continue working with Colorado payers to enhance consistency in category submissions across payers.
* **The definition of primary care relies heavily on provider taxonomy requirements**. CIVHC could not validate some payer’s claims-based primary care spending data against claims submitted to the CO APCD due to payer differences in associated taxonomy codes for providers. In future iterations, CIVHC is planning to use an additional external source to validate providers’ primary care designation.

LAN ALTERNATIVE PAYMENT MODEL CATEGORIES

Health Care Payment Learning & Action Network. [Alternative Payment Models APM Framework](https://hcp-lan.org/). 2017

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| **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 patient 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 Shared Savings** | 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 Downside Risk** | 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-Based Payment** | 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) |
| **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 systems that 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. |

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# PRIMARY CARE DEFINITION & EXCLUSIONS

CIVHC used the definition of primary care established by the [Colorado Primary Care Payment Reform Collaborative](https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-legislation/primary-care-payment-reform) 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 are instructed to sum to produce total claim-based primary care payments:

### 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.

1. **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.** For more information on the claims-based and non-claims based methodology that was used, including a list of CPT codes and Primary Care provider taxonomies, download the [Primary Care Spending and Alternative Payment Model Use Report](https://drive.google.com/file/d/1LTvjvQlwg0xUqcJ6xnodKez-6o_akJP6/view?usp=sharing).

PRIMARY CARE CALCULATION

The calculation of primary care spending as a percentage of total health care spending is as follows:



**Claims-Based Payments for Primary Care:** Payments for primary care services as defined in the [Data Submission Guide](https://www.civhc.org/wp-content/uploads/2020/10/Colorado-APCD-2020-APM-Data-Submission-Manual_09.08.2020.pdf) that are tied to a claim. The calculation includes both the plan portion and the member portion. The numbers for this calculation come from two sources: 1) the claim-based spending identified as primary care from payers that were required to submit an APM file, and 2) claims that qualify as primary care in the CO APCD for payers exempt from submitting an APM file.

**Non-Claims-Based Payments for Primary Care:** Payments made to primary care providers (providers associated with taxonomies in the DSG primary care definition), outside of the claim transaction. This calculation is sourced only from the APM submissions. Please note that claims payments are *not* synonymous with traditional fee-for-service payments. Claims payments are often an essential part of the structure of an APM.

**Total Claims-Based Payments:** All medical services payments that are tied to a claim. This calculation includes both the plan portion and the member portion. The numbers for this calculation come from two sources: 1) the total claim-based spending from payers that were required to submit an APM file, and 2) claims that qualify as primary care in the CO APCD for payers exempt from submitting an APM file.

**Total Non-Claims-Based Payments:** All payments to medical providers made outside of the claim transaction. This calculation is sourced only from the APM submissions. Please note that claims payments are *not* synonymous with traditional fee-for-service payments. Claims payments are often an essential part of the structure of an APM.

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 alternative payment model 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. Spending for these payers is calculated using the CO APCD and reported separately. Below is the list of medical submitters that only reimburse providers on a FFS basis or only submit Medicare Supplemental data:

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