

**Alternative Payment Methods**  
**Semi-Weekly TAG Call Notes**  
March 1, 2013

**I. Differences between Legacy TME and APM Filings [Handout 1]**

<b>Total Medical Expenses (TME)</b>	<b>Alternative Payment Methods (APM)</b>
Provides reported based on CHIA OrgID list (posted on the Center's website)	Providers reported based on Payer contracting structure
Largest level group reported is Parent Physician Group	Largest level group reported is Contracting Entity
Reporting threshold = 36,000 member months	Reporting threshold = 36,000 member months*

\*For Handout 3, submit all contracting entity IDs that have at least one physician group

**II. Provider Payment Methods [Handout 2]**

- Payment classification is based on the overarching payment method attributed to the member on whose behalf the payment was made.
- Payers should list the dollar amount of payments to Massachusetts-based providers, regardless of member residence. For payments made to Massachusetts-based providers for non-MA residences for whom the payer has no further payment structure information, report these payments as Fee-for-Service.
- Please see the example on the following page for how to report global payment and limited budget amounts.

**Example 1: Global Payment**

**Physician Group A under Global Payment Arrangement**

Number of Member	2
Member Months	24
Capitated PMPM	\$1,000
<b>Capitated Budget</b>	<b>\$24,000</b>

**Member 1**

Service	FFS Value	Note
Hospital Services	\$5,000 (A1)	Member 1 received hospital care from Hospital B. Report this amount in Handout 2 under Hospital B for "global payment"
Specialty Services	\$2,000 (B3)	Member 1 received specialty services (e.g. seeing an ophthalmologist) from Physician Group C. Report this amount in Handout 2 under Physician Group C for "global payment"
Ambulatory Surgical Services	\$1,000 (D1)	Member 1 had an outpatient surgery at a freestanding ambulatory surgical center (Provider D). Report this amount in Handout 2 under the Provider D as "global payment"

**Total Service Payments \$8,000**

\* Total Budget for Member 1 is \$12,000 (i.e. \$1,000\*12=\$12,000)

**Member 2:**

**FFS Value**

Hospital Services	\$10,000 (A1)	Member 2 received hospital care from Hospital B. Report this amount in Handout 2 under Hospital B for "global payment"
Specialty Services	\$1,500 (B3)	Member 2 received specialty services (e.g. seeing an oncologist) from Physician Group C. Report this amount in Handout 2 under Physician Group C for "global payment"
Diagnostic Imaging Services	\$500 (D3)	Member 2 had an imaging service at a freestanding diagnostic imaging center (Provider G). Report this amount in Handout 2 under the Provider G as "global payment"

**Total Service Payments \$12,000**

\* Total Budget for Member 2 \$12,000

**Total Expenses for these two members**

**\$20,000**

\$8,000+\$12,000=\$20,000

**Net Amount Received by Physician Group A**

**\$4,000 (C1)**

\$24,000-\$20,000=\$4,000

Report this amount in Handout 2 under the Physician Group A as "global payment"

**Example 2: Limited Budget**

**Physician Group Y under Limited Budget Payment Arrangement (primary care capitation)**

Number of Member	2
Member Months	24
Capitated PMPM	\$300
<b>Capitated Budget</b>	<b>\$7,200</b>

**Member 3**

Service	FFS Value	Note
Hospital Services	\$5,000 (A2)	Member 3 received hospital care from Hospital B. Report this amount in Handout 2 under Hospital B for "Fee for Service"
Specialty Services	\$2,000 (B4)	Member 3 received specialty services (e.g. seeing an ophthalmologist) from Physician Group C. Report this amount in Handout 2 under Physician Group C for "Fee for Service"
Ambulatory Surgical Services	\$1,000 (D2)	Member 3 had an outpatient surgery at a freestanding ambulatory surgical center (Provider D). Report this amount in Handout 2 under the Provider D as "Fee for Service"

**Total Service Payments \$8,000**

\* Total Limited Budget for Member 3 is \$3,600 (i.e. \$300\*12=\$3,600)

**Member 4:**

**FFS Value**

Hospital Services	\$10,000 (A2)	Member 4 received hospital care from Hospital B. Report this amount in Handout 2 under Hospital B for "Fee for Service"
Specialty Services	\$1,500 (B4)	Member 4 received specialty services (e.g. seeing an oncologist) from Physician Group C. Report this amount in Handout 2 under Physician Group C for "Fee for Service"
Diagnostic Imaging Services	\$500 (D4)	Member 4 had an imaging service at a freestanding diagnostic imaging center (Provider G). Report this amount in Handout 2 under the Provider G as "Fee for Service"

**Total Service Payments \$12,000**

\* Total Limited Budget for Member 4 is \$3,600 (i.e. \$300\*12=\$3,600)

<b>Total Expenses for these two members</b>	<b>\$20,000</b>	\$8,000+\$12,000=\$20,000
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<b>Net Amount Received by Physician Group Y</b>	<b>\$7,200 (C2)</b>	Report this amount in Handout 2 under the Physician Group Y as "limited budget"
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<b>Hospital Inpatient</b>						A	
Hospital OrgID	Hospital Type Code	Insurance Category Code	Product Type Code	Payment Method	Total Claims Payments	Total Non-Claims Payments	Total Payments
####	1,2,3,4	1,2,3,4	1,2,3,4	1,2,3,4,5	\$\$\$	\$\$\$	\$\$\$
1 Hospital B (22)	Acute (1)	Commercial (4)	HMO (1)	Global (1)	\$15,000		\$15,000
2 Hospital B (22)	Acute (1)	Commercial (4)	HMO (1)	Fee For Service (5)	\$15,000		\$15,000

<b>Physician Group</b>							
Provider Group OrgID-OR- Payer's Internal Provider Number (if no OrgID)	Local Practice Group OrgID-OR- Payer's Internal Provider Number (if no OrgID)	Insurance Category Code	Product Type Code	Payment Method	B Total Claims Payments	C Total Non-Claims Payments	Total Payments
####	#####	1,2,3,4	1,2,3,4	1,2,3,4,5	\$\$\$	\$\$\$	\$\$\$
1 Physician Group A		Commercial (4)	HMO (1)	Global (1)		\$4,000	
2 Physician Group Y		Commercial (4)	HMO (1)	Limited Budget (2)		\$7,200	
3 Physician Group C		Commercial (4)	HMO (1)	Global (1)	\$3,500		
4 Physician Group C		Commercial (4)	HMO (1)	Fee For Service (5)	\$3,500		

<b>Other Providers</b>								
Provider Group OrgID-OR- Payer's Internal Provider Number (if no OrgID)	Local Practice Group OrgID-OR- Payer's Internal Provider Number (if no OrgID)	Organization Type	Insurance Category Code	Product Type Code	Payment Method	D Total Claims Payments	Total Non-Claims Payments	Total Payments
####	####	3,4,5,6,7,8,9	1,2,3,4	1,2,3,4	1,2,3,4,5	\$\$\$	\$\$\$	\$\$\$
1 Provider D		ASC (3)	Commerc	HMO (1)	Global (1)	\$1,000		
2 Provider D		ASC (3)	Commerc	HMO (1)	Fee For Service (5)	\$1,000		
3 Provider G		Diagnostic Imaging (7)	Commerc	HMO (1)	Global (1)	\$500		
4 Provider G		Diagnostic Imaging (7)	Commerc	HMO (1)	Fee For Service (5)	\$500		

## Reporting Information

CHIA File	Report only MA residents*	Report only MA providers
TME – Physician Groups**	X	X
TME – Zip Codes	X	
Relative Price – All files		X
Alternative Payment Methods – Physician Groups (Handout 1)**	X	
Alternative Payment Methods – Zip Codes (Handout 1)	X	
Provider Payment Methods (Handout 2)		X
Contracting Entity Mapping (Handout 3)		X
RP Network Average Dollar (Handout 4)		X

\* As determined by the member’s residence on the last day of the calendar year (December 31<sup>st</sup>), or the last day in the payer’s network.

\*\* Provider groups must meet reporting threshold of 36,000 member months of MA residents.

### Data Specification Manual and Handout Names

File Name (Former Names)	Data Specification Manual Name	Handout
Alternative Payment Methods (Supplemental TME)	APM	Handout 1
Provider Payment Methods (RP Supplemental)	Provider Payment Methods	Handout 2
Contracting Entity Mapping	N/A	Handout 3
Relative Price Network Average Dollar (Standard Fee Schedule Change)	RP Nt Avg Dollar	Handout 4