

CENTER FOR HEALTH  
INFORMATION AND ANALYSIS

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**METHODOLOGY PAPER**  
**ALTERNATIVE PAYMENT METHODOLOGIES**

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**AUGUST 2015**





## INTRODUCTION

Alternative Payment Methods (APMs) are methods of payment used by payers to reimburse providers not solely based on a fee-for-service (FFS) basis in which some of the financial risk associated with both the occurrence of medical conditions as well as the management of those conditions is shifted from payers to providers to incentivize efficiency and quality of health care delivery. With the enactment of Chapter 224 of the Acts of 2012, the Center for Health Information and Analysis (CHIA) is statutorily mandated to collect and report APM data from private and public health care payers operating in the Massachusetts health care market.<sup>1</sup>

CHIA's objective in collecting APM data is to monitor year-over-year changes in the proportion of members<sup>2</sup> covered by APMs, as well as the types of payment methods implemented by payers and physician groups.

This paper provides an overview of the data elements collected and describes CHIA's methodology used in calculating APM utilization levels and trends.

## DATA COLLECTION

### Timeline

APM data files are collected in May of each year and contain data from the previous calendar year (CY). APM data was first collected in May 2013 for CY2012 information. APM supplemental data files are collected in June of each year and contain data from the previous calendar year. APM supplemental data was first collected in June 2015 for CY2014 information.

### Data Submitters

CHIA collects APM data from major commercial payers in the Massachusetts commercial health insurance market,<sup>3</sup> as well as commercial payers that offer Medicare Advantage plans, MassHealth Managed Care Organization (MCO) plans, and Commonwealth Care plans.<sup>4</sup> CHIA also collects APM data from MassHealth, Massachusetts' Medicaid program for its Primary Care Clinician (PCC) Plan. Payers must report data for all Massachusetts residents based on zip code of residence as of the last day of the reported year (December 31), or the resident's last day of enrollment in the payer's plan.

### Data Elements

Payers submit three APM data files: one at the member zip code level, one at the managing physician group level and one supplemental file. Payers include only information pertaining to members for which they are the primary payer, and exclude any paid claims for which they are the secondary or tertiary payer.

<sup>1</sup> CHIA is required by M.G.L. c. 12C to collect from private and public health care payers "data on changes in the type of payment methods implemented by payers and the number of members covered by alternative payment methodologies" and "the proportion of health care expenditures reimbursed under fee-for-service and alternative payment methodologies." Regulation 957 CMR 2.00 governs the methodology and filing requirements for health care payers to report this data to CHIA.

<sup>2</sup> Members are measured in member months, defined as the number of members participating in a plan over a specified period of time expressed in months of membership.

<sup>3</sup> These payers account for approximately 99% of the Massachusetts commercial market.

<sup>4</sup> A full list of payers required to submit APM data to CHIA can be found here: <http://chiamass.gov/list-of-payers-required-to-report-data>.

In the managing physician group file, for members whose insurance products require the selection of a primary care physician (PCP) such as HMO-type products, payers allocate members based on the provider organizations that their PCPs are associated with. For members whose insurance products do not require the selection of PCPs (such as PPO-type products), if applicable based on the contract between payers and provider groups, payers would allocate members to appropriate provider organizations based on the payer's own member attribution/assignment logic. Currently, there are two levels of managing physician groups: parent physician groups and local practice groups. Parent physician groups are the provider groups with whom the payer contracts. These parent physician groups are sometimes comprised of several subsidiary local practice groups. APM data is also reported at the local practice group level if the group meets a membership threshold of 36,000 member months.<sup>5</sup> Going forward, payers will also report managing physician groups at the registered provider organization (RPO) level, once the provider organizations complete the RPO registration with the Health Policy Commission.<sup>6</sup>

In both the managing physician group and member zip code files, member months and payment amounts<sup>7</sup> are collected by insurance category, product type, and payment method.<sup>8</sup> Aggregate member health status scores are also reported by zip code and managing physician group. Members and payments are assigned to one of five payment method categories in a mutually exclusive, hierarchical order: global payments, limited budget, bundled payments, other non-fee-for-service, or fee-for-service (FFS). The first four payment methods are considered APMs, since managing physician groups generally need to bear certain levels of financial risk. Members are assigned to each type of APM based on the contractual arrangement between a payer and a provider organization; members do not choose to be part of an APM. The payment method hierarchy is based on the comprehensiveness of health services in an APM contract between payers and provider organizations, from most comprehensive (global payments) to least (FFS). The definition of each payment method is described as follows:

- **Global Payment:** The global payment method is a type of payment arrangement between payers and providers that establishes a spending target for a comprehensive set of health care services to be delivered to a specified population during a defined time period. Global payment arrangements may shift some financial risk from payers to providers. In these cases, if costs exceed the budgeted amounts, providers must absorb those costs, subject to negotiated risk sharing agreements. On the other hand, providers may share in, or retain, the savings if costs are lower than the budgeted amounts and health care quality performance targets are met.

It is important to note that within the framework of a global payment arrangement with a managing physician group, payments to service providers at the transactional level are generally made on a FFS basis. Also, global payments as defined here do not consider the extent of risk, if any, borne by the managing physician group. It is difficult to capture levels of risk, as there is currently no standardized approach to risk classification or reporting.

- **Limited Budget:** Limited budgets, like global payments, represent a move away from FFS-based payments. Limited budgets are payment arrangements whereby payers and providers, either prospectively or retrospectively, agree to pay for a specific set of services to be delivered by a single provider. This could include, for instance, capitated primary care or oncology services. Limited budgets also shift some financial risk from payers to providers.

<sup>5</sup> Reporting thresholds are established in 957 CMR 2.00. Available from: <http://chiamass.gov/assets/docs/g/chia-regs/957-2-00-payer-data-emergency-adopted-reg.pdf>

<sup>6</sup> The Health Policy Commission's website provides more information on RPO registration: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/registration-of-provider-organizations/>.

<sup>7</sup> In the physician group file only, payments paid for financial and quality performance-based contracts are collected for each insurance category, product type, and payment method combination.

<sup>8</sup> Please refer to the APM Data Specification Manual for detailed information on collected data fields: <http://chiamass.gov/data-specification-manuals>.

- **Bundled Payment:** Bundled payments are a method of reimbursing providers, or a group of providers, for providing multiple health care services associated with defined “episodes of care” (e.g. knee surgery, pregnancy and delivery, and etc.) for a patient or set of patients. These payments may include services developed based upon clinical guidelines, severity adjustments to account for the general health status of a patient and comorbidities (other related ailments), and even designated “profit” margins and allowances for potential complications.
- **Other, non-FFS-based:** This category includes all other payment arrangements that are not based on a FFS model, but that also do not easily fit into any of the other categories. This category includes members whose managing groups participate in the Patient-Centered Medical Home (PCMH) arrangement with payers, for instance.
- **Fee-for-service (FFS):** Under this model, health care providers are reimbursed by payers at negotiated rates for individual services delivered to patients. A variety of FFS payment arrangements exist, including, but not limited to, Diagnosis Related Groups (DRGs), per-diem payments, claims-based payments adjusted by performance measures, and discounted charge-based payments. This category also includes pay-for-performance incentives that accompany FFS payments.

For further details on APM data collection and data elements, please visit: <http://chiamass.gov/information-for-data-submitters-payer-data-reporting/>.

### APM Supplemental File

In the supplemental file, payers report member months at the plan and provider level by insurance category, product type, payment method, market segment (for commercial populations), risk type and carved-out benefit type. For commercial populations, payers assign members to one of the five following market segments: individual (insurance purchased directly from payer), small group (employer groups with 1-50 eligible employees), mid-size group (51-100 employees), large group (101-499 employees) or jumbo group (500 or more employees). For global budget contracts, payers assign the services carved-out from the contract to one of the seven following categories: pharmacy only, behavioral health only, other services, pharmacy and behavioral health, pharmacy and other, behavioral health and other or pharmacy, behavioral health and other.

For global payment contracts, payers allocate members to one of two risk types which indicate the nature of the financial contract between the payer and provider:

- **Global Payment - Shared Savings Only:** A payment arrangement in which providers share in cost savings at a pre-negotiated rate if they stay below a target budget for their population’s care, but face no financial risk if their costs exceed it.
- **Global Payment- Upside and Downside Risk:** In a two-sided risk model, providers share in cost savings if they stay below a target budget for their population’s care and share in the losses at a pre-negotiated rate if their costs exceed the target budget. Providers are often eligible to keep a larger proportion of savings if they agree to share in any costs above the target amount.

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## METHODOLOGY

Payers attribute members and payments to payment methods based on the hierarchy as defined above, from most to least comprehensive. CHIA's metric used to measure APM adoption is the proportion of members whose care is paid for under global payments, limited budgets, bundled payments, and/or other, non-FFS-based payment methods. While the proportion of spending attributed to each payment method is sometimes displayed in CHIA's data appendices, it is not the primary measure of APM adoption. Since most payers' total spending amounts are not final at the time data is submitted to CHIA due to pending claims reconciliations, APM payment data can be used as a measure of the scale of APM adoption but not as a measure of actual spending for each type of payment method. Unlike in CHIA's Total Medical Expenses (TME) filings, payers are not asked to apply factors to their APM payments to estimate completed spending amounts.

## CONCLUSION

APM data provides critical information for monitoring the adoption of alternative payment methodologies in the Massachusetts health care market. CHIA will regularly update this document to reflect any changes to APM data collection and methodology. CHIA will continue to monitor and report on APM implementation across all segments of the Massachusetts health care market.

*For CHIA's latest APM report, please visit: [chiamass.gov/alternative-payment-methods-2/](http://chiamass.gov/alternative-payment-methods-2/).*

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