# HealthFacts RI

## Alternative Payment Model File

## Frequently Asked Submitter Questions

September 2023

## What is the objective of the Rhode Island Alternative Payment Model File?

To account for all healthcare related payments in Rhode Island each year – including alternative payment models and non-alternative payments models - by contract ID (APM002), line of business (APM010), and payment model (APM011) type, using the inclusion criteria of the annual NAIC/SERFF filings. These different types of healthcare expenditures are referred to as "payment models" and include both claims-related payments (fee-for-service) and non-claims related payments. Payers shall submit distinct information for each payment made to each contracted entity, by line of business and payment model type. For fee-for-service payments (i.e., payment models 1 & 1A), payers are asked to report both the total claims payments (payer and member cost-sharing amounts combined) as well as the payer portion only. With this information, Rhode Island should be able to sum up all payments made under the same Contract ID and capture total dollars paid under each contract.

## Who needs to submit the RI APM File?

A payer who has at least one policy/contract for healthcare services sold in Rhode Island ("situs") and who covers over 3,000 lives in Rhode Island combined, per Regulation 216-RICR-10-10-5.

## Will the Rhode Island APM File replace the data filed by carriers in current NAIC/SERFF filings?

No, this submission will not replace existing NAIC/SERFF filings sent to the Rhode Island Department of Business Regulation, Insurance Division.

## What is the difference between information submitted in the APM File vs. the Rhode Island All-Payer Claims Database (APCD)?

The inclusion criteria are different between APCD files (submitted monthly or quarterly) and the APM File (submitted annually). In the claims based APCD files, information is submitted for members residing in Rhode Island or employed by a Rhode Island small employer health insurance plan. The APM File collects data based on the state that the policy was sold or issued in ("situs") for group policies, and state of residence for policies sold on the individual market. For example, if a member resides in Florida but has commercial coverage through their large group private employer based in Rhode Island, information for this individual should be included in the APM File but not in the APCD. Conversely, if a Rhode Island resident works in Massachusetts and has insurance coverage through their employer, their data would be included in the APCD but not in the APM File.

## Should Payers submit separate files for dental and medical related payments?

No, medical and dental related payments shall be reported within the same APM File. Payers shall use the data element Contract Type (APM003) to report if each payment stratification is related to a medical ("M") or dental ("D") payment.

## What lines of business are required to be submitted in the Rhode Island APM File?

Payers shall submit the RI APM File for Commercial, Medicare Advantage, and Medicaid Managed Care Organization lines of business.

NOTE: Payments made to providers under a standalone pharmacy benefits contract should not be included in the APM file. Pharmacy Benefit Managers should not submit an APM File.

## How should payers report payments made to an Accountable Care Organization or Accountable Entity?

If a payment was made to a provider practicing under an Accountable Care Organization (ACO) or as an Accountable Entity (AE), the name of that ACO or AE should be reported in APM009, in addition to reporting payment information. If the provider is not participating under an ACO or as an AE, leave the field null.

## What payments must be included in the Rhode Island APM File?

Payers should report information for all payments made under insurance policies for which they are the primary payer and those that align with NAIC/SERFF inclusion criteria. All claims and non-claims payments should be submitted for each Contract ID (APM002), by line of business (APM010), and payment model (APM011).

## Should payers separate out pharmacy services delivered under a medical benefit?

No, payers are not required to separate out pharmacy services covered under a medical benefit. Payments made to providers under a standalone pharmacy benefits contract should not be included in the APM file. Pharmacy Benefit Managers should not submit an APM File.

## What is the timeframe ("performance period") of the payments included in the Rhode Island APM File?

The APM File shall include all payments made under insurance policies that align with NAIC/SERFF inclusion criteria, related to medical/dental care or contracts, during the reporting year being submitted (as identified in APM012).

Payments related to medical/dental care or contracts include:

- Fee-for-service based payments (for medical or dental services) **made** during the reporting year
- Contract payments for contract periods that **concluded** during the reporting year.

Submitters shall include the performance period start date (APM013) and performance period end date (APM014) for all reported payments.

For example, if a payer is reporting fee-for-service based payments or a contract based on the calendar year 2020 (CY 2020), the payer would submit details of the payment in the 2020 APM File submission with the following performance period start and end dates:

*Performance Period Start Date (APM013): 20200101*
*Performance Period End Date (APM014): 20201231*

When contracts fall partly outside of the reporting year, the payment should only be reported in the year in which the contract period is completed, and the payment is made. For example, for a Pay for Performance contract that goes from July 2019 through June 2020, the payer would submit the

following performance period start and end dates and report this payment in the 2020 APM File Submission only:

*Performance Period Start Date (APM013): 20190701*
*Performance Period End Date (APM014): 20200630*

Rhode Island will then prorate this payment information (and associated member months where applicable) for the portion of the contract that occurred in 2019.

NOTE: Payments made on a fee-for-service basis for medical/dental services should always be reported with a performance period start/end date that corresponds exactly to the reporting year (January 1 through December 31) and should include all fee-for-service payments made during that year.

## What if a given payment model includes multiple different components?

A single contract may consist of multiple payment model components. When this is the case, payers should stratify these payment models and report them on separate lines.

For example, payers should report the amount of the payment that was for fee-for-service, as well as the amount that was for pay-for-performance. These two payment categories would occupy two separate rows in the submission but be reported under same Contract ID.

Additionally, if a payer has a contract that is based on FFS and includes shared savings and shared risk, the payer shall report the amount of FFS payments on one row and report any shared savings or shared risk payments on another row.

## When would payers report a negative-dollar figure?

Negative payments should only be reported when a payer receives money from the contracted entity, as opposed to paying money out. For example, a penalty payment a contracted entity makes to the payer under a shared risk payment model.

## When would payers report a zero-dollar figure?

There are some situations where a payer should enter $0 for a given payment to convey important details about that contract.

For example, if a payer is under a shared savings arrangement with a fee-for-service foundation but the contracted entity did not achieve the necessary threshold to initiate the shared savings payment, the payer will enter the payment amount for fee-for-service with link to APM (APM011 = 1A) and enter $0 in another row reported under shared savings (where APM011 = 3A). The use of the payment model category 1A conveys that the Fee-For-Service payment had a link to the Shared Savings payment.

## What reporting stratifications should be used in the APM File?

All payments to contracted entities should be reported once per line of business (APM010), so that the sum of a payer's payments to the specified contracted entity – across all payment models - accurately reflects the total payments made to that contracted entity during the reporting year being submitted.

NOTE: Payments to a contracted entity may include multiple lines of business that are not easily distinguishable. In this case, payments must be apportioned across applicable lines of business to the best of the payer's ability. (e.g., plan membership distribution across lines of business).

## Should payers report provider NPI (APM004), provider tax ID (APM005), and entity type (APM008) for the organization a payment is sent to or the providers within that organization that receive the payment? For example, if a large payment is sent to the financial parent of a health system, should payers report what is sent to the financial parent, or should payers figure out how the financial parent distributed this payment to its providers?

Payers must provide the most granular payment data available. In the case where a financial parent receives a single payment for all their providers, the payer shall submit information about how the specified financial parent disbursed the single payment to the various providers under its umbrella. If this more granular information is unavailable, the payer shall include the payment made to the financial parent and no additional information.

## How are the different "payment" elements in the APM File defined and what is their relation to one another?

The APM File includes three payment elements total claims payments (APM016), total claims payments – payer portion (APM017), and total non-claims payments (APM018). APM016 and APM018 payment fields are mutually exclusive and when combined, should equal the total payment made to the contracted entity (for that line of business and payment model). Total claims payment – payer portion (APM017) is a subset of total claims payment (APM016).

## How should payers report Total Claims Payments – Payer Portion (APM017)?

Total claims payment – payer portion (APM017) is a subset of the amount reported in total claims payment (APM016). Payments reported in APM017 should only include the portion of claims payments paid for by the payer. Member cost sharing (for example, copays, deducible, coinsurance) dollars should not be included in this field. Both payer and member paid claims amounts should be reported under Total Claims Payments (APM016).

## How should a payer account for services associated with multiple APM payment models?

If a payment to a contracted entity could be included in more than one payment model, the payer may select which payment model they want to use. For example, a payer has a contract with Primary Care Physician A that includes a Fee-For-Service arrangement with a potential quality bonus if certain metrics are achieved. That same payer also has a shared savings arrangement with a medical group that Primary Care Physician A is a part of. In this case, the payer may select where Primary Care Physician A's contract payment will be reported – either in the arrangement with a quality bonus or the arrangement with shared savings. It is also important that the payer report these types of payments in a uniform way and that payers do not double count any payments reported.

A suggested approach may include reporting to the most advanced payment model, under the HCP-LAN category framework. For example, Shared Savings (category 3A) is more advanced than Pay for Quality (category 2C).

## How should payers handle payments made directly to subscribers as reimbursements for the subscribers' cost-sharing (e.g., copays)?

Payers should include these payments in their RI APM File submission under total claims payments (APM016) and total claims payments – payer portion (APM017), as this is a payer paid amount.

## What if a payer has no alternative model payments to report? For example, what if a provider only receives payments under a fee-for-service with no link to APM model?

The APM File collects both fee-for-service payments with no link to APM and alternative payment models. If the only payment made to the contracted entity was under a Fee-For-Service model with no link to an APM, then payers should only report the payment related to payment model 1 (fee-for-service without known link to APM) and populate the total claims payments (APM016) and total claims payments – payer portion (APM017) fields.

## How can payers ensure that fee-for-service payments that have a link to an APM are accurately reflected in the data?

Payers should use the payment arrangement type "FFS with link to APM" (1A) to reflect fee-for-service payments associated with an APM.

## How should member months (APM015) be reported in the APM File?

Member months (APM015) should always be reported for the following payment models:

- Condition-Specific Population-Based Payments (4A)
- Comprehensive Population-Based Payments (4B)
- Integrated Finance and Delivery System Payments (4C)
- Capitation Payments Not Linked to Quality (4N)

Member months should be reported for the following payment models only when the payment is attributed to a defined member population, and members months can be calculated. Otherwise, leave the member months field (APM015) null.

- Fee for Service with Link to APM (1A)
- Fee for Service Without Known Link to APM (1)
- Foundational Payments for Infrastructure and Operations (2A)
- Pay for Reporting (2B)
- Pay for Performance (2C)
- Alternative Payment Models with Shared Savings (3A)
- Alternative Payment Models with Shared Savings and Downside Risk (3B)
- Risk Based Payments Not Linked to Quality (3N)

Payers should include the total members (reported in member months APM015) that participated in each reported stratification, for the reportable payment models listed above. Payers are asked to identify the number of member months under each reportable payment model (APM011) and line of business (APM010), under each Contract ID (APM002).

For example, a condition-specific comprehensive populated-based payment (4A) paid for a single member from January through December of 2020 counts as 12 member months.

NOTE: Some contracts may include members that could be reported under multiple stratifications. For example, if the same individual received services from multiple providers in the same reporting year, all under non-claims payment models. Thus, the sum of all member months (APM015) reported for each payment model may exceed the total actual number of unique member months. For this reason, Rhode Island has included valid values A and V to report deduplicated total member months and its subset, deduplicated total alternative payment model member months, respectively.

## What are Payment Models A and V (valid values for APM011) and how should they be reported?

Although codes "A" and "V" are included as valid values for APM011, they are not HCP-LAN Framework payment models. Instead, these values are meant to capture enrollment, as specified below, during the reporting year for insurance policies issued in Rhode Island.

Valid value "A": Is meant to capture total enrollment for insurance policies issued in Rhode Island during the reporting year (reported in de-duplicated member months in field APM015). Total enrollment should only be reported for members for whom the payer was the primary payer.

Valid value "V": Is meant to capture total enrollment in alternative payment models only for insurance policies issued in Rhode Island during the reporting year (reported in de-duplicated member months in field APM015). Total APM enrollment should only be reported for members for whom the payer was the primary payer.

Both values A and V shall be reported once for each contract type (APM003) for each distinct line of business (APM010). If a payer does not contract with providers using alternative payment models, the payer should report '0' for the number of members months attributed to alternative payment models (i.e., for the rows of data where APM011 = 'V'). When reporting values A and V, only the following seven elements should be reported: submitter code (APM001), contract type (APM003), line of business (APM010), payment model using values A and V (APM011), reporting year (APM012), member months (APM015), and record type (APM019).

## What is the purpose of element contract type (APM003)?

This field is meant to distinguish payments made under a medical benefits contract, including all payments made to providers for medical, pharmacy, and dental services incurred under medical stand-alone coverage versus payments made under a dental benefits contract. Payers shall use "M" to report medical payments and "D" to report dental payments.

## What should the APM File look like when submitted?

Below is an example of a 2020 APM File submission. Actual APM file submissions should be **asterisk** delimited, would not have header rows, and would be far longer.

| APM001 | APM002 | APM003 | APM004 | APM005 | APM006 | APM007 | APM008 | APM009 | APM010 | APM011 | APM012 | APM013 | APM014 | APM015 | APM016 | APM017 | APM018 | APM019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Submitter Code* | *Contract ID* | *Contract Type* | *Provider NPI* | *Provider Tax ID* | *Last Name* | *First Name* | *Entity Type* | *ACO/AE* | *Line of Business* | *Payment Model* | *Reporting Year* | *Perf. Period Start* | *Perf. Period End* | *Member Months* | *Total Claims Payments* | *Total Claims Payments - Payer Portion* | *Total Non-Claims Payments* | *Record Type* |
| 12345678 | ABC123 | M | 1122334455 | 123456789 | Adams | Addy | 1 | | COMM | 2C | 2020 | 20200101 | 20201231 | 0 | 0 | 0 | 30000.00 | TC |
| 12345678 | ABC123 | M | 1122334455 | 123456789 | Adams | Addy | 1 | | COMM | 4B | 2020 | 20190701 | 20200630 | 10000 | 0 | 0 | 50000.00 | TC |
| 12345678 | ABC123 | M | 1122334455 | 123456789 | Adams | Addy | 1 | | COMM | 4B | 2020 | 20190701 | 20200630 | 30000 | 0 | 0 | 10000.00 | TC |
| 12345678 | ABC123 | M | 1122334455 | 123456789 | Adams | Addy | 1 | | COMM | 1 | 2020 | 20200101 | 20201231 | 0 | 80000.00 | 80000.00 | 0 | TC |
| 12345678 | ABC123 | M | 1122334455 | 123456789 | Adams | Addy | 1 | Good Health ACO | MADV | 1 | 2020 | 20200101 | 20201231 | 0 | 50000.00 | 40000.00 | 0 | TC |
| 12345678 | XYZ789 | M | 2435689021 | 432876543 | Live Long Hospital | | 2 | | COMM | 1 | 2020 | 20200101 | 20201231 | 50000 | 400000.00 | 300000.00 | 0 | TC |
| 12345678 | AAA111 | M | 3725497542 | 852222534 | Great Care LLC. | | 6 | | COMM | 1 | 2020 | 20200101 | 20201231 | 0 | 700000.00 | 600000.00 | 0 | TC |
| 12345678 | WWW777 | M | 3456789012 | 6655443322 | Darren | Dan | 1 | Healthy Kids Pediatrics | MMCO | 4N | 2020 | 20190201 | 20200131 | 10000 | 0.00 | 0.00 | 100000 | TC |
| 12345678 | BBB999 | D | 6789012345 | 9922556677 | Carry | Colleen | 1 | Super Teeth LLC. | MMCO | 1A | 2020 | 20200101 | 20201231 | 20000 | 100000.00 | 80000.00 | 0 | TC |
| 12345678 | BBB999 | D | 6789012345 | 9922556677 | Carry | Colleen | 1 | Super Teeth LLC. | MMCO | 2C | 2020 | 20200101 | 20201231 | 20000 | 0.00 | 0.00 | 10000 | TC |
| 12345678 | CCC555 | D | 9012345678 | 0123456789 | Clean Teeth Dental LLC. | | 2 | | COMM | 1 | 2020 | 20200101 | 20201231 | 0 | 2000000.00 | 1800000.00 | 0 | TC |
| 12345678 | | M | | | | | | | COMM | A | 2020 | | | 2000000 | | | | TC |
| 12345678 | | M | | | | | | | MADV | A | 2020 | | | 10000 | | | | TC |
| 12345678 | | M | | | | | | | MMCO | A | 2020 | | | 10000 | | | | TC |
| 12345678 | | M | | | | | | | COMM | V | 2020 | | | 35000 | | | | TC |
| 12345678 | | M | | | | | | | MADV | V | 2020 | | | 0 | | | | TC |
| 12345678 | | M | | | | | | | MMCO | V | 2020 | | | 10000 | | | | TC |
| 12345678 | | D | | | | | | | COMM | A | 2020 | | | 10000 | | | | TC |
| 12345678 | | D | | | | | | | MMCO | A | 2020 | | | 20000 | | | | TC |
| 12345678 | | D | | | | | | | COMM | V | 2020 | | | 0 | | | | TC |
| 12345678 | | D | | | | | | | MMCO | V | 2020 | | | 20000 | | | | TC |

The first five rows above all represent payments made to the same provider (Addy Adams), but for different lines of business (APM010), payment models (APM011), and performance periods (APM013 & APM014). Each of these stratifications under a Contract ID must be reported separately.

Blank fields represent elements that do not have to be reported for that stratification. For example, in the first row of data, member months (APM015) is blank because the pay for performance (2C) payment is not linked to a defined population and member months cannot be reported. Alternatively, for the second row, members months are populated because the payer has a defined population for the comprehensive population-based payment model (4B).

Payment amounts of $0 represent no payment made for that payment model. For example, in the first-row total claims payments is $0 because the payment model pay for performance (2C) is completely non-claims.

## What is the submission schedule for the Payment Arrangement Files?

The APM File will include all healthcare related payments related to medical/dental care or contracts, during the reporting year being submitted. Payers are provided 13 months of lag time from the end of the reporting year to when the APM file submission is due. For example, the 2023 APM File Submission shall include all payments related to 2023 fee-for-service payments or contracts that concluded in 2023 and shall be due January 31st, 2025 – 13 months following December 31st, 2023.

## What is the required file format and naming convention for the submission of the APM File?

The APM File submission shall be an **asterisk** delimited file, unless otherwise specified. The header rows, which include the data element names, should not be included and data elements must be organized in the order listed in the technical specification. Payers will use the same Hashing Application, submission portal account, and general formatting specifications used to submit files to the APCD.

File Naming Convention:

<File Type Code>_<Client Code><Submitter Code>_<Reporting Year Start>_<Reporting Year End>_<Date Submitted in YYYYMMDD>

Example: TC_RIRIC0000_202201_202212_20220825