COMAR 10.25.06 – *Maryland Medical Care Data Base and Data Collection*

MCDB

2023 Medical Care Data Base

Alternative Payment Model File Frequently Asked Submitter Questions

Maryland Health Care Commission

CENTER FOR ANALYSIS AND INFOMRATION SYSTEMS
4160 PATTERSON AVENUE
Baltimore, Maryland 21215
(410) 764-3460

MHCC.MARYLAND.GOV

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This Frequently Asked Questions document (FAQ) was developed to provide detail and clarify information in Appendix H – Alternative Payment Model (APM) Data Submission Manual of the Medical Care Data Base Data Submission Manual (MCDB DSM). Please refer to the APM Data Submission Manual or reach out to Shankar Mesta, shankar.mesta@maryland.gov for additional information.

General Information

What is the objective of the Maryland Alternative Payment Model (APM) File?

The Maryland Health Care Commission (MHCC) is seeking APM data to meet requirements of COMAR 10.25.06.14, to develop a non-fee-for-service expenses report. Collecting non-fee-for-service data now will provide a baseline to monitor cost, utilization, and quality trends as the share of non-fee-for-service payment models grows in the Maryland commercial health care market.

Who needs to submit the APM File?

MHCC seeks to collect data on medical claims administered through the medical benefit for the APM File. The following entities are defined in COMAR 10.25.06.03 and designated by the Commission to provide data to the MCDB:

(1) Each payor whose total lives covered exceeds 1,000, as reported to the Maryland Insurance Administration;
(2) Each payor offering a qualified health plan, qualified dental plan, or qualified vision plan certified by the Maryland Health Benefit Exchange (MHBE), Insurance Article, §31-115, Annotated Code of Maryland; and
(3) Each payor that is a managed care organization participating in the Maryland Medical Assistance Program in connection with the enrollment of an individual in the Maryland Medical Assistance Program or the Maryland Children's Health Program; The Commission will post known reporting entities on its website at https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb_data_submission.aspx. Entities who meet the specifications in COMAR 10.25.06.03 are required to report, even if they are not explicitly listed on the website. A glossary of reporting entity definitions can be found in Appendix B of the MCDB DSM.

What if a payor has no alternative model payments to report during the requested timeframe? For example, what if a provider only receives payments under a fee-for-service with no link to APM model?

If your organization does not have any medical benefit APM arrangements, please request a waiver and/or submit questions to shankar.mesta@maryland.gov.

What is the difference between the population required to be submitted in the APM File vs. the claims submissions?

The populations required to be submitted differs between the claims files (submitted quarterly) and the APM File (submitted annually). The quarterly claims submissions to the MCDB are transactions submitted at the member level, whereas the annual APM File requires submission of contract level payments to provider organizations for a set of attributes members. Data for self-insured plans, Medicare Advantage plans or other plans **is not required**. Please see the table below for information on which populations are required and optional for each submission. R denotes required and O denotes optional.

Residency	Fully Insured Plans	Self-Insured Plans	Medicare Advantage, and Medicare Supplemental Plans
Maryland	R MCDB R APM	O MCDB O APM	R MCDB O APM
Non-Maryland	R MCDB	O MCDB	O MCDB

	O APM	O APM	O APM

Why would a data submitter choose to provide optional information in the APM File?

MHCC appreciates that some value-based payment arrangements may include members covered under self-insured plans, Medicare Advantage plans, Medicare Supplemental plans or other plans. Payors may include or exclude this information pertaining to members not covered by a fully-insured plan situsted in Maryland. Use the multi-choice drop down menus to identify the insurance category included in the row. MHCC also appreciates that some value-based arrangements may include attributed members who do not live in Maryland. Payors may include or exclude members attributed to these arrangements who do not live in Maryland. Payors shall indicate the number of member months for Maryland residents and Maryland non-residents in the appropriate column. Please indicate in the "E. Notes" worksheet whether data provided includes data for residents outside of Maryland.

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

For the 2023 Reporting Cycle, MHCC requests that all payors include data for calendar year 2022. Please report any contractual arrangement that spans any part of the year. For example, if the payor enters into a shared savings contract effective August 1, 2022 (and the reporting period is CY 2022), the payor shall report the associated member months and total dollars (including FFS payments and bonus/savings incentives) paid for that population of members from August 1, 2022 – December 31, 2022.

Should dollars reflect payments made during the performance period or for contracts existing during the performance period?

For the 2023 Reporting Cycle, MHCC requests that only payments associated with the 2022 contract be reported regardless of when they are made. MHCC is collecting data in September of the following year to account for reconciliation periods of APM contracts. Payments made in calendar year 2022 for a 2021, earlier, or later (prospective) performance period should not be included. For example:

- If a reconciliation payment for a 2020 contract is made in April 2022, it should not be included.
- If a reconciliation payment for a 2022 contract is made in July 2023, it should be included.
- If a prospective infrastructure payment for a 2023 contract is made in December 2022, it should not be included.

Should allowed or incurred and paid payments be reported?

All payments for all worksheets in the APM file should be made on an allowed basis.

What is the submission schedule?

The performance period is CY 2022 (January 1st, 2022 – December 31st 2022). Please submit the APM file to the Chief, Cost and Quality at the MHCC Center for Analysis and Information Systems at shankar.mesta@maryland.gov no later than September 30, 2023.

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

The required file format and naming convention for the submission is similar to the quarterly claims file with a few differences. The Excel templates should be submitted using the following naming convention:

PayorID_FileType_PeriodStartDate_PeriodEndDate _Create Date

Each variable in the above format must be populated as follows:

- PayorID = MHCC-assigned submitter code
- FileType = APM
- PeriodStartDate (YYYYMM format)
- PeriodEndDate (YYYYMM format)

- CreateDate (YYYYMMDD)

Example: MDP020A_APM_202201_202212_ 20230925

Financial Data

What payments must be included in the APM File?

Worksheets "A.1 Financial" and "A.2 Financial – Episodes" collect financial information associated with APM contracts, defined as HCP-LAN Category 2A, 2B, 2C, 3A, 3B, 4B and 4C and HCP-LAN Category 4A, respectively. Note: Financial information related to HCP-LAN Category 1 is not collected on these worksheets.

Are fee-for-service payments included anywhere in this data submission?

Worksheet "D. Summary" should also include one row of summary information for Maryland residents enrolled in fully-insured Maryland-situsedplans who are not attributed to one of the HCP-LAN categories above and thus are paid for via a fee-for-service arrangement with no link to quality or value.

Should payors separate out pharmacy services delivered under a medical benefit?

No, payors 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 if a given payment model includes multiple different components?

Reporting shall occur in the HCP-LAN category furthest along the continuum of financial and clinical risk for the provider organization.

> **Example 1:** If a member was attributed to a billing provider with an HCP-LAN Category 2B value-based payment arrangement and a billing provider with an HCP-LAN Category 3A value-based payment arrangement, the member and all their spend and member months would be attributed to the billing provider with the HCP-LAN Category 3A arrangement.
>
> **Example 2:** If a billing provider is participating in multiple value-based payment arrangements, payors should submit a separate row for each value-based payment arrangement. Members attributed to multiple value-based payment arrangements with the same provider shall have all of their spend and member months attributed to the HCP-LAN Category farthest along the continuum of financial and provider risk.
>
> **Example 3:** If a member is attributed to a billing provider under an HCP-LAN Category 4A episode-based payment arrangement and attributed to the same billing provider under a HCP-LAN Category payment arrangement (2A, 2B, 2C, 3A, 3B, 4B and 4C), the total spending would be reported on A.1 Financial. Spending related to the episode would be reported on A.2 Financial Episodes.

How should a payor differentiate contract-level payments between Maryland and non-Maryland residents?

Payors should report the total contract-level payment, such as a foundational payment for infrastructure and operation (HCP-LAN Category 2A), in the appropriate field and report the total member months for Maryland residents and non-Maryland residents. MHCC will apportion the payment to Maryland residents based on the member month distribution.

How should a payor report Maryland and Non-Maryland Resident Member Months for prospective, contract-level payments, such as HCP-LAN Category 2A payments for infrastructure and operations?

Payors should report the total contract-level payment and associated member months in the appropriate field. Some payments, such as Category 2A payments, may not be tied to a specific patient population. In these instances, payors should run their attribution methodology for providers participating in the arrangement. The resulting list of members should serve as the patient population for the APM. MHCC will footnote this process when sharing aggregate results.

How should a payor report when a payor receives money from the contracted

entity?

When a payor receives money from the contracted entity in the form of a recoupment, as opposed to paying money out, the payor should report the net payments made to the contracted entity in the appropriate HCP-LAN Category. For example, a recoupment payment a contracted entity makes to the payor under a shared risk payment model.

When would payors report a zero-dollar figure?

All dollars associated with an APM contract should be reported to the HCP-LAN category furthest along the continuum of financial and provider risk. Each row of data should have an assigned HCP-LAN category and dollars associated with that contract, therefore zero-dollar figures should not be reported.

Should payors report payments to Billing Providers or providers within a provider organization when the provider-level data is available?

Payors must report each row of data with the Billing Provider Tax ID and Billing Provider Name. MHCC requests that the National Billing Provider ID is also included, but this is not required. Payments to individual providers part of an APM contract with a parent Billing Provider Organization should not be reported separately.

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

Payors should report the fee-for-service payments associated with an APM contract in the HCP-LAN category furthest along the continuum of financial and provider risk coinciding with the APM payment in the contract.

How should payors report APM arrangements that do not have a link to quality and value (HCP-LAN Categories 3N and 4N)?

For the 2023 data collection cycle, MHCC is only collecting data on APM arrangements with a link to quality and value. Therefore, payors do not need to submit data on arrangements classified as HCP-LAN Category 3N and 4N. If the payor is uncertain on the classification, please reach out to MHCC to discuss.

When should payors report an Age/Gender Factor? How should this be calculated?

Payors should report the Age/Gender Factor for each row for an APM contract reported in worksheets "A1. Financial" and "A2. Financial – Episodes". Payors should follow the guidance below and contact their pricing teams for additional information on development of the age/gender factor.

Payors should use their unique census factors for gender by age group and the populations in these groups to calculate the adjusted populations attributed to the different types of APM arrangements. These factors may vary depending on the number of tiers included in the calculation. Tiers include: self, self and child, self and spouse and self and family.

AgeGenderFactorExample is an additional spreadsheet linked on the MHCC Website. It offers a framework for each payor to calculate the age/gender factors for the populations enrolled in its APM arrangements.

Note: Census factors for self and spouse are the same as those as self and family and therefore can be used as a three-tier calculation as needed.

Membership Data

Which data elements should be consistent between a claims file submission and the APM file submission?

Payors should report an Encrypted Enrollee's Identifier (E002 in APCD Eligibility File), Enrollee Year and Month of Birth (E004 in APCD Eligibility File), and Enrollee Sex (E005 in APCD Eligibility File) in worksheet "B1. Billing Provider Membership" for each provider group/APM contract combination reported in worksheets "A1. Financial" and "A2. Financial – Episodes". These data elements will be used by MHCC to determine performance on a set of select quality measures as defined in the APM Data Submission Manual.
Note: If a member is in more than one APM arrangement, the member's information must be submitted for each provider/HCP-LAN arrangement.

Example: Individual with a primary care physician participating in an accountable care organization that has a shared savings contract with the payor and is also attributed to a population-based cancer care treatment bundle with another provider. Their total spend would be attributed to the shared savings provider in the HCP-LAN category furthest along the continuum of financial and provider risk in worksheet "A1. Financial" and the spend associated with their cancer care treatment would be attributed to the population-based clinical bundled payment to the provider and be reported in the "A2. Financial – Episode" worksheet.

How should member months be reported in the APM File?

Member months should always be reported for APM contracts, defined as HCP-LAN Category 2A, 2B, 2C, 3A, 3B, 4B and 4C in worksheet "A1. Financial".

In worksheet "A2. Financial – Episodes", Maryland (and Non-Maryland, if the submitter chooses to provide this information) Resident Number of Episodes should be submitted with the associated APM contract for all episode-based payment arrangements categorized as HCP-LAN Category 4A.

Total Unduplicated Member Months should be reported for all HCP-LAN categories, including fee-for-service only contracts, category 1, for all contracts in the "D. Summary" worksheet.

Contract Information

Which contracts should be included in worksheet "C. Contract Information"?

Information on existing and new contract arrangements during the performance period defined as HCP-LAN Category 2A, 2B, 2C, 3A, 3B, 4A, 4B and 4C should be included.

Summary Data

How should payors summarize data on provider organizations in worksheet "D. Summary"?

Please submit one aggregate row for each HCP-LAN Category that the payor has with any entity/provider. If there are pediatric arrangements for an HCP-LAN Category, please submit a separate row aggregating the data for the pediatric arrangements. Note no provider information is collected in worksheet "D. Summary" and that data should be aggregated across contracts.

Example Worksheets

What should the APM File look like when submitted?

See examples below.

Below is an example of a 2023 APM File submission for worksheet "A1. Financial". Actual APM file submission would be far longer.

Reporting Year	Billing Provider (Organization /Entity) Tax ID	Billing Provider (Organization/Entity) Name	National Billing Provider (Organization /Entity) ID	Practitioner /Supplier ID *(optional)*	Pediatric Indicator	Insurance Category or Categories	Maryland Resident Member Months	Non-Maryland Resident Member Months	Age/Gender Factor	HCP-LAN Payment Category	Total Medical Expense for Member Months Reported in H, I
2022	123456789	Provider Org Name 1			0	1	134235	0	1.07	2C	$ 75,225,660
2022	124456788	Provider Org Name 2			0	1	30000	0	0.94	3A	$ 15,745,122
2022	321456798	Provider Org Name 3			0	1	12445	0	1.03	2C	$ 6,934,567
2022	986721456	Provider Org Name 4			0	1	30000	0	1.05	3B	$ 15,834,560
2022	984214357	Provider Org Name 5			0	1	26666	1234	0.89	2C	$ 15,199,999
2022	675378932	Provider Org Name 6			0	3	7666	6543	0.91	3B	$ 11,000,000
2022	342534564	Provider Org Name 7			0	1	1123	7754	0.96	3A	$ 4,634,235
2022	234235642	Provider Org Name 8			0	1	36664	0	1.02	2B	$ 19,967,321
2022	457456452	Provider Org Name 9			0	3	4432	0	0.91	2C	$ 3,620,000

Below is an example of a 2023 APM File submission for worksheet "A2. Financial - Episodes". Actual APM file submission would be far longer.

Reporting Year	Billing Provider (Organization/ Entity) Tax ID	Billing Provider (Organization/Entity) Name	National Billing Provider (Organization/ Entity) ID *(optional)*	Practitioner/ Supplier ID *(optional)*	Pediatric Indicator	Insurance Category or Categories	Maryland Resident Number of Episodes	Non-Maryland Resident Number of Episodes	Age/Gender Factor	Episode Type	HCP-LAN Payment Category	Total Medical Expense for Episodes Reported in Column G, H
2022	123456789	Provider Org Name 1			0	1	15	0	1.07	Cardiology	4A	$ 300,000
2022	124456788	Provider Org Name 2			0	1	12	0	0.94	Cardiology	4A	$ 405,670
2022	321456798	Provider Org Name 3			0	1	200	0	1.03	Gastroenterol	4A	$ 8,200,000
2022	986721456	Provider Org Name 4			0	1	200	0	1.05	Orthopedics	4A	$ 2,600,000
2022	984214357	Provider Org Name 5			0	1	100	0	0.89	Cardiology	4A	$ 2,768,000
2022	675378932	Provider Org Name 6			0	1	200	0	0.91	Gastroenterol	4A	$ 9,800,000
2022	342534564	Provider Org Name 7			0	1	200	0	0.96	Gastroenterol	4A	$ 8,967,000
2022	234235642	Provider Org Name 8			0	1	200	0	1.02	Orthopedics	4A	$ 2,000,000
2022	457456452	Provider Org Name 9			0	1	320	0	0.91	Orthopedics	4A	$ 2,780,000

Below is an example of a 2023 APM File submission for worksheet "B.1 Billing Provider Membership". Actual APM File submission would be far longer.

Reporting Year	Encrypted Enrollee's Identifier (E002)	Enrollee Year and Month of Birth (E004)	Enrollee Sex (E005)	Billing Provider (Organization/Entity) Tax ID	HCP-LAN Payment Category
2022	F120542	19820600	2	123456789	2C
2022	G12307	19650600	2	123456789	2C
2022	K86723	20020800	2	123456789	2C
2022	L09682	19880400	1	123456789	2C
2022	J94127	19601200	1	123456789	2C
2022	B4921934	19581000	2	123456789	2C
2022	O93841	19910400	1	123456789	2C
2022	U8374591	19760900	1	986721456	3B
2022	D23419	19970300	2	986721456	3B
2022	F19238	19901000	2	986721456	3B
2022	G48174	19891200	1	986721456	3B
2022	A238237	19890100	1	986721456	3B
2022	R485721	20030300	2	986721456	3B

Below is an example of a 2023 APM File submission for worksheet "C. Contract Information". Actual APM File submission would be far longer.

Reporting Year	Billing Provider (Organization/ Entity) Tax ID	Billing Provider (Organization/ Entity) Name	Pediatric Indicator	Contract Type Name	Contract Description	Total Non-Claims Payments	Involves Both Claims and Non-Claims	Services Covered	Involves Measurement of Quality (Y/N)	Involves Measurement of Spending Targets (Y/N)	Payments are Prospective or Retrospective	Payment is Population-Based (Y/N)	Risk to Provider	HCP-LAN Payment Category	Comments
2022	123456789	Bethesda Physician Group	0	Quality Compass	Providers can earn pay for performance payments based on their performance relative to providers within the state on select quality measures. Measures include breast cancer screening, emergency department utilization and risk of continued opioid use. Payments are tiered based on performance and provided to attainment and relative improvement over time.	$3,400,000	B	S	Y	Y	RT	Y	N/A	2C	Program has been in place since 2018.
2022	986721456	Baltimore Community Hospital	0	Diabetes Care Plus	Providers are paid a prospective bundled payment for all diabetes care provided within primary care. Benchmark is set on historical claims data and risk adjusted based on the patient population.	$12,400,000	N	M	Y	Y	PR	Y	N/A	4A	Contract initiated in September 2022, only partial data.

Below is an example of a 2023 APM File submission for worksheet "D. Summary". Actual APM File submission would include all HCP-LAN categories, separating pediatric arrangements.

Reporting Year	Pediatric APM Indicator	Insurance Category or Categories	Total Unduplicated Member Months	Total Number of Episodes	HCP-LAN Payment Category	Total Medical Expense	Total Non-Claims Payments
2022	0	1	1036324543	0	1	$518,162,272,000	$ -
2022	0	1	1230567	0	2B	$ 676,811,850	$ 24,611,340
2022	0	1	1450645	0	2C	$ 783,348,300	$ 37,345,012