

# Advancing the Development of a Framework to Capture Non–Fee-for-Service Health Care Spending for Primary Care

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## Preface

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Primary care spending as a percentage of total health care spending is a relatively new measure that allows end users to assess the degree to which a health system is oriented toward primary care delivery. The Milbank Memorial Fund recently supported RAND Corporation and Bailit Health to develop a methodology to calculate primary care spending as a percentage of total health care spending by commercial health plans and supported RAND in adapting this methodology for use in examining primary care spending in fee-for-service (FFS) Medicare. However, there is concern that calculation of primary care spending and total health care spending using FFS payment data alone underestimates both primary care spending and total health care spending by excluding non-FFS payments (e.g., capitation payments, alternative payment model payments) made to providers, particularly in states that emphasize managed care. Several states and other multistakeholder entities have begun to collect non-FFS spending data from insurers in their state to measure primary care spending or total health care spending and changes in these over time, but the mechanisms in use to collect these data vary. At present, states or state-specific entities are collecting these data and establishing the varied mechanisms for data collection currently in use. While states' iterative innovations in developing approaches for collecting non-FFS payments are an important first step, developing a well-specified, common national standard approach to collecting these data is essential for facilitating greater advancement of the capture of these data by all states and being able to make comparisons between states and over time. Doing so can ensure that conclusions about differences between delivery systems and over time reflect true differences in spending patterns.

This report describes work conducted by RAND, with funding from the Milbank Memorial Fund and the California Health Care Foundation, to understand the landscape of what non-FFS payment data are being collected by states and other stakeholders. It represents a preliminary step toward advancing the development of a standardized methodology for collecting non-FFS payment data.

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## Summary

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Health systems that are more oriented toward primary care delivery have been demonstrated to deliver higher-quality and more-efficient care (Friedberg, Hussey, and Schneider, 2010). Most previously used measures of health system orientation toward primary care are based on local area counts of physicians by specialty, which are incomplete proxies for investment in primary care and are challenging for policymakers to use as levers for near-term change to reorient the health care system or the care it delivers toward primary care, or for payers, purchasers, or insurers to alter spending to meet primary care spending percentage targets being implemented or considered by some states (Baicker and Chandra, 2004).

Primary care spending as a percentage of total health care spending is a new measure of the degree to which a health system is oriented toward or invested in primary care. This measure is easily understood by varied audiences, can be measured at different levels of the health system, and is readily modifiable through policy changes, such as minimum primary care spending rates (Koller and Khullar, 2017). The Milbank Memorial Fund recently supported RAND Corporation and Bailit Health to develop a methodology to calculate primary care spending as a percentage of total health care spending by commercial health plans and supported RAND in adapting this methodology for use in examining primary care spending in fee-for-service (FFS) Medicare (Bailit, Friedberg, and Houy, 2017; Reid, Damberg, and Friedberg, 2019).

States and other entities have enacted or are considering laws, regulations, or other efforts to measure and report on primary care spending as a proportion of total medical spending, and in some instances set targets for increased relative spending on primary care (e.g., Colorado, Connecticut, Delaware, Maine, Oregon, Rhode Island, Vermont, West Virginia, Massachusetts, and Washington) (Colorado Health Institute, 2019; Delaware Primary Care Collaborative, 2019; Green Mountain Care Board, 2020; Maine Quality Forum, 2020; Milbank Memorial Fund, 2020; Office of Financial Management, 2019; Office of the Health Insurance Commissioner, 2014; Primary Care Collaborative, 2020). Methods currently in use to measure primary care spending as a percentage of total health care spending vary widely among states and analyses, reflecting variation in measured population, in providers designated as primary care providers, and in services identified as primary care services. Some are limited to FFS-payments only, whereas others are starting to incorporate other types of payments related to primary care. Accordingly, estimates of the percentage of total spending on primary care vary widely from 2.12 percent in a national analysis of 2015 FFS Medicare claims to 15.2 percent in an analysis of 2018 Medicaid coordinated care organizations that included payments outside the traditional FFS framework (Oregon Health Authority, 2020; Reid, Damberg, and Friedberg, 2019).

At the same time, payers and policymakers have implemented reforms to provider payments to drive improvements in health care quality and spending, with providers receiving other types

of payment arrangements that are often accounted for outside the traditional FFS payment framework. These may include payments for infrastructure (e.g., medical home payments, health information technology), performance (e.g., pay-for-performance, shared savings), or risk-bearing arrangements (e.g., capitation payments, bundled payments, global payments, shared savings). Many non-FFS payment models disproportionately affect payment and care delivery in the primary care setting. Thus, to fully understand primary care spending as a percentage of total health care spending, it is important to account for non-FFS payments both to primary care and other aspects of the health care delivery system. Failing to accurately, completely, and consistently account for non-FFS payments could lead to underestimation of cumulative investment in primary care and in health care spending overall, make it difficult to implement policies seeking to measure and report on primary care spending, and make it challenging to know whether progress toward primary care spending targets is real.

RAND was asked by the Milbank Memorial Fund to describe current methods being used to collect non-FFS payment data across states and define features of a potential standardized approach for collecting non-FFS data to support more complete assessment of primary care spending as a proportion of total health care spending. To understand current approaches to collecting non-FFS payments to providers, we reviewed documentation on data being collected by states in their all-payer claims databases (APCDs) and spoke with representatives from states with APCDs or other multipayer databases and other key stakeholders who are working to collect non-FFS payment data. Having summarized what we learned, the Milbank Memorial Fund convened an expert panel where RAND presented initial findings and elicited input on key considerations and features of non-FFS data collection models and mechanisms. Both the interviews and this expert panel discussion informed the considerations and recommendations that we present in this report. We identified four key dimensions and decisions that states and other entities interested in collecting non-FFS payment data should consider in designing their data collection strategy. We present insights from the expert panel members on goals and considerations for the collection of non-FFS payment data and primary care spending data. We close by presenting preliminary considerations and recommendations for data collection standards and discuss additional work that is needed to refine and build consensus around the recommendations, as well as to put them into action. This report represents an initial step to advance discussions toward a broad multistakeholder effort to build consensus on establishing a standardized approach for non-FFS payment data collection.

## Methods

To assess the current landscape of non-FFS payment data collection, we conducted six interviews of staff from state agencies and other state-specific multistakeholder entities that currently collect non-FFS payment data to understand the features of the data they are collecting. We focused on states and state-specific entities because these are currently the entities engaged

in establishing mechanisms for data collection and collecting these data. States are often well-positioned to collect such multipayer data and get a more complete population-based picture through their regulatory and value-based payment-related activities. To understand the features, we asked about the types of payment data they collect, the structure of data, whether it was possible to identify which non-FFS payments were for primary care, and the interactions between the state and payers who were submitting data. We also spoke with several payers who submit non-FFS payment data about the data that their organizations maintain regarding non-FFS payments made to providers and to learn about their experiences submitting non-FFS payment data. In addition to the interview, when documentation about current data collection procedures and data fields collected was available, we also reviewed these documents.

After we completed the interviews, the Milbank Memorial Fund and RAND convened an expert panel to solicit reflections on the findings from the interviews. Panel members included 36 representatives from primary care policy organizations, payers, state government (including APCD administrators), and primary care researchers and other stakeholders with knowledge in the area of primary care spending. Panel members were provided with a memorandum prepared by RAND that summarized relevant background information and synthesized key insights from the interviews. RAND presented this information and led a structured discussion to gain stakeholder perspectives on data collection standards.

## Findings

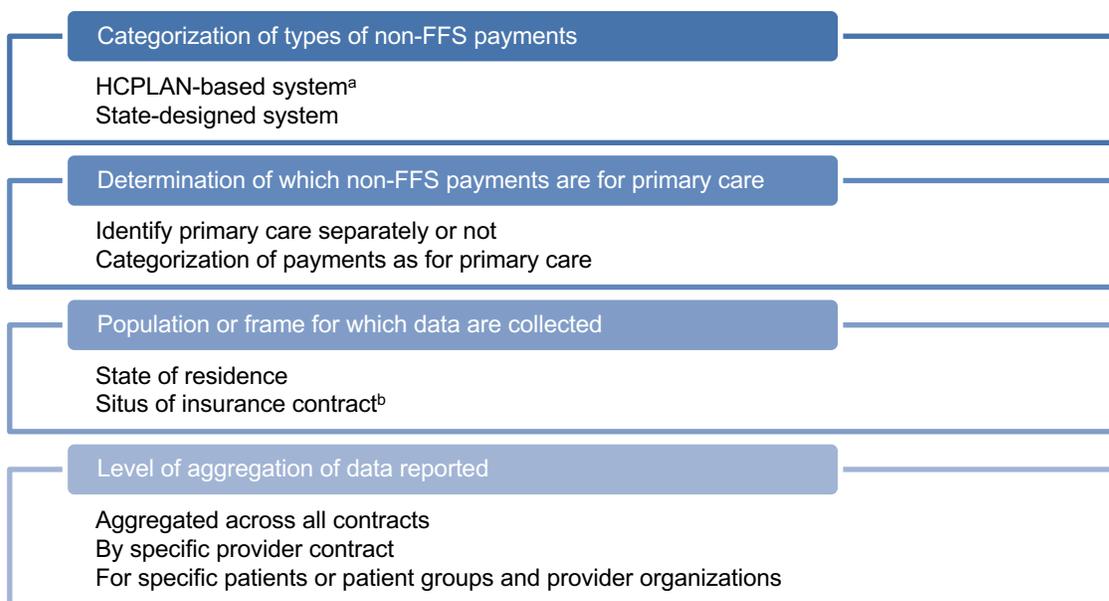
States varied in their approaches to collecting non-FFS payment data. Whether only commercial (Rhode Island) or also noncommercial (all other states), the set of payers required to report data differed across states. Some states (Vermont and Rhode Island) are collecting high-level total non-FFS payment data from each payer, and others (Oregon, Colorado, and Massachusetts) collect disaggregated payments at the level of the provider group. In voluntary submission to the Integrated Healthcare Association in California, capitation payments are collected at the level of the patient. No two states used precisely the same scheme for categorizing non-FFS payments, and few states actually required the flagging of primary care payments in the payment data submitted. Discussion with our expert panel suggested that there were many varied viewpoints around how to categorize different types of non-FFS payments (e.g., capitation payments, alternative payment model [APM] payments) and how to identify the full range of potential primary care payments. Furthermore, discussion with our expert panel suggested that different audiences have different use cases in mind for these data, and these various use cases require differing degrees of aggregation; for some use cases, cumulative non-FFS payments from each payer may be sufficient, whereas for others provider- or patient-level data may be needed.

As states consider approaches for collecting non-FFS payment data, it is important to recognize that compiling and reporting these data may be time consuming and burdensome for payers who may not have their internal data organized in a way that facilitates meeting reporting

requirements, particularly for payers operating in multiple states who potentially face disparate sets of reporting requirements. As state policymakers and other multistakeholder entities weigh potential standardized approaches, they should bear in mind the burden placed on payers and the feasibility of the reporting requirements. What works well in one state, with a specific population, mix of payers, set of norms about different payment types (e.g., capitation), and set of additional priorities beyond estimation of primary care spending as a percentage of total health care spending, may work less well in another state. Across payers, there is currently no standardized approach for administering non-FFS payment schemes, further complicating the collection of data. Furthermore, payers have highly variable payment infrastructures and data systems that affect the structure and content of the data they maintain. For payers that operate in multiple states, variation in reporting requirements across states creates increased burden. Furthermore, many payers do not currently have processes and systems in place that make tracking of non-FFS payment easy. States that have been most successful in collecting non-FFS payment data have worked closely with payers in their state to develop requirements that the payers are actually capable of fulfilling; furthermore, this collaboration has provided opportunities for regular dialogue and updating of different types of payments captured as the APM landscape evolves.

Based on our interviews, review of documentation, and expert panel, we found that reporting requirements for non-FFS payment data can be characterized by four key decisions (shown in Figure S.1 below).

**Figure S.1. Four Key Decisions for Non-FFS Payment Data Reporting Requirements**



**NOTES:**

<sup>a</sup> HCPLAN reflects the categorizations reflected in Health Care Payment Learning & Action Network.

<sup>b</sup> Situs refers to the legal location of the insurance contract.

## Conclusions

As non-FFS payments continue to grow and represent an increasing share of total health care expenditures, collection of non-FFS payment data is increasingly important to policymakers who seek to accurately track total health care spending and the portion of total health care spending allocated to primary care. In this work, we investigated and summarized the approaches that states and other state-specific entities currently use to collect non-FFS payment data. We then solicited expert and stakeholder input. Finally, we identified key considerations and recommendations to move the discussion forward toward development of a standardized method for collecting these data.

While states' iterative innovations in developing approaches for collecting non-FFS payments are an important first step, developing a well-specified, common national standard approach to collecting these data is essential for facilitating greater advancement of the capture of these data by all states and being able to make comparisons between states and over time. Developing a standard approach that can be used across states will improve the comparability of estimates of total spending for primary care and non-FFS spending across states and among payers and ease the burden placed on payers who operate in multiple states because they can apply the same methods in all states to aggregate and report data. However, challenges are certain to arise because the categories and nature of non-FFS payments vary across states and any standard is not likely to meet the needs of all states.

To promote a single standard, we preliminarily recommend the following:

1. Develop a single approach for categorizing types of non-FFS payments.
2. Select a common approach for identifying what types of non-FFS payments are considered primary care payments.
3. Define a uniform population or frame for data collection on the basis of situs of insurance contracts<sup>1</sup> as is most feasible for payers.
4. Work toward disaggregated data reporting by provider organization and patient zip code, as opposed to cumulative payments from each payer.

While this work is a first step toward defining what is needed to develop a standardized approach for reporting non-FFS payment data in the context of primary care, significant additional work is needed to further develop the standards and to build consensus on the approach. Critically important is convening key stakeholders and building consensus around seminal features of non-FFS payment data collection definitions. To facilitate comparable data across states and over time for calculation of primary care spending as a proportion of total health care spending as well as other potential use cases, such stakeholder engagement efforts should aim to build consensus around the four points above.

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<sup>1</sup>Situs refers to the legal location of a contract.

Future work in this area should also empirically assess whether different approaches for collection of non-FFS payment data and primary care spending data meaningfully affect primary care spending as a percentage of total health care spending and other spending metrics of interest to policymakers. Additional work is also needed to understand how measures of primary care spending, with and without inclusion of non-FFS spending, correlate with desired outcomes of care delivery. This is particularly important in an evolving health care landscape that is increasingly shaped by ongoing provider consolidations and increased prevalence of non-FFS payment. Identifying ways to integrate non-FFS spending data into APCDs has the potential to open many future opportunities for research and analysis. As non-FFS payment data collection standards are developed and formalized, a broad set of potential use cases should be considered.

## Acknowledgments

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## Abbreviations

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ACO	accountable care organization
APCD	all-payer claims database
APM	alternative payment model
FFS	fee-for-service
HCPLAN	Health Care Payment Learning & Action Network
HIT	health information technology
HMO	health maintenance organization
IHA	Integrated Healthcare Association
PCP	primary care provider
PMPM	per member per month
PPO	preferred provider organization

# 1. Background

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## Primary Care Spending

Health systems that are more oriented toward primary care deliver higher-quality and more-efficient care (Friedberg, Hussey, and Schneider, 2010). Most previously used measures of health system primary care orientation are based on local area counts of physicians by specialty, which are incomplete proxies for investment in primary care and are challenging for policymakers to use as levers for near-term change to reorient the health care system or the care it delivers toward primary care (Baicker and Chandra, 2004).

Primary care spending as a percentage of total health care spending is a new measure of the degree to which the health system is oriented toward or invested in primary care. The value of this measure of primary care investment is more understandable to varied audiences, can be measured at multiple levels of the health system, and is readily modifiable through policy changes, such as minimum primary care spending rates (Koller and Khullar, 2017). The Milbank Memorial Fund recently supported RAND Corporation and Bailit Health to develop a methodology to calculate primary care spending as a percentage of total health care spending by commercial health plans and supported RAND in adapting this methodology for use in examining primary care spending in fee-for-service (FFS) Medicare (Bailit, Friedberg, and Houy, 2017; Reid, Damberg, and Friedberg, 2019).

Several states have enacted or are considering laws or regulations to measure and report on primary care spending as a proportion of total medical spending and in some instances set targets for increased relative spending on primary care. Such laws or regulations are in place in Colorado, Connecticut, Delaware, Maine, Oregon, Rhode Island, Vermont, and West Virginia, and legislation is pending in Massachusetts and Washington (Milbank Memorial Fund, 2020; Primary Care Collaborative, 2020). Reports on primary care spending as a proportion of total medical spending have been published in Colorado, Delaware, Maine, Oregon, Rhode Island, Vermont, and Washington (Colorado Health Institute, 2019; Delaware Primary Care Collaborative, 2019; Green Mountain Care Board, 2020; Maine Quality Forum, 2020; Milbank Memorial Fund, 2020; Office of Financial Management, 2019; Office of the Health Insurance Commissioner, 2014; Primary Care Collaborative, 2020). States are interested in tracking the proportion of primary care spending as an initial indicator of their overall health care system's quality and efficiency.

Methods currently in use to measure primary care spending as a percentage of total health care spending vary widely among states and analyses, reflecting variation in measured population, in providers designated as primary care providers (PCPs), and in services identified as primary care. Some are limited to FFS-payments only, whereas others are starting to

incorporate other types of payments related to primary care. Accordingly, estimates of the percentage of total spending on primary care spending vary widely from 2.12 percent in a national analysis of 2015 FFS Medicare claims to 15.2 percent in an analysis of 2018 Medicaid coordinated care organizations data that included payments outside the traditional FFS framework (Oregon Health Authority, 2020; Reid, Damberg, and Friedberg, 2019). To enable complete and accurate calculation of both the numerator (primary care spending) and denominator (total health care spending) of this measure, and to facilitate valid comparisons across states and settings, a standardized approach to including non-FFS payment data is needed, in addition to coordinated approaches to defining providers and services considered to be primary care. RAND was asked by the Milbank Memorial Fund to describe current methods being used to collect non-FFS payment data across states and define features of a potential standardized approach for collecting non-FFS data to support more complete assessment of primary care spending as a proportion of total health care spending.

## Non-Fee-for-Service Health Care Payments

Over the past decade, payers and policymakers have implemented reforms to provider payments to drive improvements in health care quality and spending, with providers receiving other types of payments for such things as infrastructure (e.g., medical home payments, health information technology [HIT]) and performance (e.g., pay-for-performance, shared savings), which are often accounted for outside the traditional FFS payment framework. Some providers are entering into shared-savings arrangements and risk-bearing payment arrangements (e.g., bundled payments, capitation payments, or global payments) that are also often accounted for outside the traditional FFS payment framework. With an aim of encouraging practice patterns that are more aligned with quality improvement, cost containment, and overall value, payers' use of non-FFS payment mechanisms continues to grow and evolve. Many non-FFS payment models disproportionately affect payment and care delivery in the primary care setting. Thus, to fully understand primary care spending as a percentage of total health care spending, it is important to account for non-FFS payments to primary care as well as to other aspects of the health care delivery system.

Non-FFS payments take a wide variety of forms, many of which are commonly used across states and contexts. These include both alternative payment model (APM) provider payments (e.g., shared savings, pay-for-performance, bundled payments), other provider payments for care delivery (e.g., capitation payments), and other payments to provider organizations (e.g., health information technology investments, payments or in-kind investments in workforce or staffing). Uses and combinations of these different non-FFS payment types vary both across payers and across a given payers' different provider contracts. To help policymakers and the provider community consider different provider payments and the evolution of payment to greater financial risk exposure, the Health Care Payment Learning & Action Network (HCPLAN)

created the APM framework to categorize different types of payments to health care providers (Table 1.1) (Health Care Payment Learning & Action Network, 2017; Nussbaum, McClellan, and Metlay, 2018).

**Table 1.1. HCPLAN APM Framework**

<b>CATEGORY 1</b> <b>FFS—No Link to Quality and Value</b>	<b>CATEGORY 2</b> <b>FFS—Link to Quality and Value</b>	<b>CATEGORY 3</b> <b>APMs Built on FFS Architecture</b>	<b>CATEGORY 4</b> <b>Population-Based Payment</b>
	<b>A</b> Foundational payments for infrastructure and operations (e.g., care coordination fees and payments for HIT investments)	<b>A</b> APMs with shared savings (e.g., <i>shared savings with upside risk only</i> )	<b>A</b> Condition-specific population-based payment (e.g., <i>per member per month payments, payments for specialty services, such as oncology or mental health</i> )
	<b>B</b> Pay for reporting (e.g., <i>bonuses for reporting data or penalties for not reporting data</i> )	<b>B</b> APMs with shared savings and downside risk (e.g., <i>episode-based payments for procedures and comprehensive payments with upside and downside risk</i> )	<b>B</b> Comprehensive population-based payment (e.g., <i>global budgets or full/percent of premium payments</i> )
	<b>C</b> Pay-for-performance (e.g., <i>bonuses for quality performance</i> )		<b>C</b> Integrated finance and delivery systems (e.g., <i>global budgets or full/percent of premium payments in integrated systems</i> )
		<b>3N</b> Risk-based payments NOT linked to quality	<b>4N</b> Capitated payments NOT linked to quality

SOURCE: Health Care Payment Learning & Action Network, 2017.

These categories of payments provide a starting point for accounting for the various types of non-FFS payments made to providers; however, states and payers may use other means to categorize payments and these categories may not capture all primary care investment. The specific recipient of a non-FFS payment depends on the type of payment, the payer, the line of business, and the contract. In some cases, it may be possible to tie a payment to a specific patient and primary care physician (e.g., a capitation fee for a patient covered by a health maintenance organization [HMO] product who must select a PCP). In other cases, a non-FFS payment for performance could be tracked only at the level of a group of providers who all contract together with a payer. Relatedly, some types of non-FFS payments to provider groups or health systems are inclusive of primary care as well as a broad array of other services across the continuum of care (e.g., shared savings payments, global budgets); determination of what proportion of these

payments is applicable to primary care is not straightforward. Because non-FFS payments are an increasingly important part of primary care and total health care spending, data collection systems need to be updated to reflect these changes.

## Collecting Health Care Spending Data

Collection of both FFS and non-FFS payment data is important to enable a complete assessment of both primary care spending and total health care spending, and to set accurate and credible benchmarks for future primary care spending targets and allocations. This is particularly true in settings where APMs such as risk-based contracting, pay-for-performance, medical home payments, and bundled payments are used and where additional non-FFS payment types including capitation are used. Failing to accurately, completely, and consistently account for non-FFS payments could lead to underestimation of cumulative investment in primary care and in health care spending overall, make it difficult to implement policies seeking to measure and report on primary care spending, and make it challenging to know whether progress toward primary care spending targets is real. Further, complete and accurate accounting for non-FFS spending can also enable states to assess the influence of APMs and to gain a more comprehensive assessment of overall health care payments.

Health care payment data that are currently available for assessing primary care spending and total health care spending in most cases reflect only payments made under FFS arrangements. At the state level, all-payer claims databases (APCDs) have been gaining traction as a way to aggregate claims and encounter data across a state's public and private payers to support a range of analyses related to health care spending, quality, and disparities. APCDs capture FFS claims payments to providers but miss other types of provider payments including professional and full-risk capitation payments and APM payments such as shared savings, performance-based incentives, and bundled payments. Several organizations that seek to measure health care spending and assess the value of care delivered, including several states with APCDs, other multistakeholder entities, and Medicare, have considered how to collect non-FFS payment data. Currently, no standardized approach exists for how to categorize these types of payments or for how to collect these data in a uniform fashion to allow comparisons across payers and across states. Among states that are collecting non-FFS payment data, most are not publicly releasing their findings, making it difficult to assess how the different strategies that states are using to categorize non-FFS payments and payment to primary care affect the data that are collected.

Policymakers in several states have begun to develop and implement requirements for payers to submit non-FFS payments data to state APCDs or other data collection efforts to enable more complete assessment of primary care spending as a proportion of total health care spending, as well as for analyses of total health care spending. However, the current mechanisms different states and multistakeholder entities use to collect non-FFS payment data vary widely. One major dimension of variability is the level of aggregation of the non-FFS payment data collected: either

aggregated by payer versus disaggregated at the level of the provider organization, patient or patient groups, or payer lines of business (e.g., HMO, preferred provider organization [PPO]). Different levels of data aggregation support different types of analysis. Data aggregated at the payer level that reflect non-FFS payments toward primary care spending and total health care spending can help inform discussion of whether health systems as a whole are evolving to promote and support primary care; these are also essential data for states that have set minimum primary care spending targets for payers. Disaggregated data at the level of the provider organization can provide further information about which providers are receiving different non-FFS payments. Disaggregated data by patient or patient group can provide information about how non-FFS payments toward primary care and total health care spending are distributed across a state's population. Disaggregated data provide potential to support analyses that may explore the association between non-FFS payments toward primary care and total health care spending with other features of health care delivery.

## Contributions of This Report

For this report, we conducted interviews with states and other key stakeholders, reviewed documentation, and convened an expert panel to better understand how data are being collected and how they might be used. In what follows, we describe current methods being used to collect non-FFS payment data across states and define features of a potential standardized method for collecting non-FFS data. We identified four key dimensions and decisions that states and other entities interested in collecting non-FFS spending data should consider in designing their data collection strategy. We also present key broader insights from experts on goals and considerations for collection of non-FFS data. Finally, in the Conclusions section, we present preliminary recommendations for data collection standards and discuss additional work that is needed to build consensus around and refine those recommendations, as well as to put them into action.

## 2. Methods

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To assess the current landscape of states' collection of non-FFS payment data, we conducted semistructured interviews with state organizations currently collecting non-FFS payment data, to solicit stakeholder perspectives. During these interviews, we asked about the types of data collected, the structure of data collected, whether it was possible to flag primary care payments, and the interaction between the state and payers who were submitting data. We also spoke with several payers who have submitted data about the underlying data they maintain on non-FFS payments and their experiences submitting these data to states. Interview guides are available in the Appendix. We conducted a total of ten interviews with individuals from Colorado, Oregon, Massachusetts, Rhode Island, Vermont, and California.<sup>1</sup> To our knowledge, these are the only states currently collecting these data. In addition to the interview, when documentation about current data collection procedures was available, we also reviewed these documents. Two researchers attended each interview and both took notes. The interviews were also recorded. After the interviews, we used the recordings to reconcile the notes. The research team synthesized the results from the interviews to identify common themes and procedures across states.

After the interviews, the Milbank Memorial Fund convened an expert panel to solicit reflections and insights on primary care data collection. Panel members included 36 representatives from primary care policy organizations, representatives from payers and payer organizations, representatives from states and APCDs, as well as primary care researchers and other stakeholders in the area of primary care spending. Both RAND and Milbank made suggestions of panel members to be invited to participate. RAND provided panel members with a memorandum that provided relevant background information, synthesized key insights from the interviews, and posed the following discussion questions:

1. What are important goals to consider for a single standard for non-FFS payment data collection?
2. What are the key use cases for capturing non-FFS payment data? Which use cases should be prioritized?
3. Are there elements of data collection that are not represented in the materials presented above that should be considered?
4. What process should be used to designate whether a non-FFS payment or portion thereof is primary care spending?

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<sup>1</sup> California is currently collecting non-FFS spending through an effort led by IHA (the Integrated Healthcare Association). Their efforts differ significantly from those in other states, primarily because participation is voluntary and organized by a nongovernmental organization. As a result, we are not reporting additional details about their efforts in this report.

5. What are relative benefits and drawbacks for each of the data collection decisions described above?
6. States have not currently allowed linkages between non-FFS data (usually organized by contract) and APCD data (usually limited to state residents). Are concerns about situs<sup>2</sup> not overlapping with residency sufficient to warrant this? Or should these linkages be allowed for some well-specified research questions?
7. With regard to key decision points described above, should our final report make recommendations or only present options?

RAND moderated the expert panel discussion. As with the interviews, notes were taken during the expert panel and the meeting was also recorded. After the panel, we used the recording to reconcile the notes. The research team synthesized the results from the expert panel meeting.

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<sup>2</sup> Situs refers to the location of a contract.

## 3. Findings

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### Current State Requirements for Reporting Non-FFS Payment Data

Although the use of non-FFS payments in health care is growing, few states have formal methods for tracking non-FFS payments being made to providers. Below we summarize the approaches used in the six states—Rhode Island, Vermont, Massachusetts, Oregon, Colorado, and California—that collect data on non-FFS spending.

#### *Rhode Island*

In Rhode Island, the Office of the Health Insurance Commissioner collects data on non-FFS payments. All commercial health plans in Rhode Island with more than 10,000 lives in fully insured plans are required to report payment data; reporting is based on the legal location, situs, of the insurance contract. Noncommercial plans, such as Medicare and Medicaid, do not submit information. Each payer submits a high-level Excel file that summarizes total spending for each type of non-FFS payment, aggregated across all providers. Data are collected about all payment types included in our interview guide.<sup>1</sup> Payers submit data in five mutually exclusive categories of non-FFS payments, some of which have applicable subcategories and all of which have fields to allow for netting out excluded or duplicated services or payments: (1) APMs—population-based contracts (subcategories including shared savings model upside gain only, shared savings model upside and downside risk, full risk model), (2) APMs—bundled payments, (3) APMs—limited capitation, (4) pay-for-performance, and (5) APMs—other (including a subcategory for patient-centered medical home supplemental payments). Because the reporting of non-FFS data is at an aggregated level, there is no payment information for specific encounters or by individual providers. Primary care spending is tracked under a separate reporting mechanism; this makes it not readily linkable with these non-FFS payment data. Payers submit non-FFS data twice per year.

#### *Vermont*

Vermont collects non-FFS payment data through the Green Mountain Care Board, a state-appointed independent group charged with promoting changes in the health system that improve quality while stabilizing costs. The data submitted cover the following payers: Medicare,

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<sup>1</sup> Each state was asked whether they collected data on the following types of non-FFS payments: capitation payments (i.e., full-, partial- or professional-risk), risk-based contracting payments (e.g., hospital gainsharing, shared savings), bundled/episode-based payments, medical home payments, pay-for-performance), payments for infrastructure expenditures or investment (e.g., HIT Incentives), payments for workforce expenditures or investment (e.g., nurse care managers, community health workers, and others).

Medicaid, and the large commercial health plans that participate in the state's accountable care organization (ACO) model. Vermont tracks non-FFS spending using a high-level Excel file that summarizes total spending for each type of non-FFS payment, aggregated across all providers, similar to the level of aggregation used in Rhode Island. Non-FFS payments are tracked according to categories that are specific to APMs and non-FFS payment models in the state, which vary by payer type. For commercial payers, the two categories are medical service incentive programs (includes payments made for Blueprint Primary Care Medical Home and Community Health Team, but excludes other bonuses and incentive like pay-for-performance bonuses, HIT incentives, and other infrastructure payments) and capitation and risk settlements (includes payments made in the ACO shared savings program and capitation payments). For Medicaid, the categories are ACO per member per month (PMPM) payments, medical home payments under the Blueprint PMPM payout amount, PMPM capitation payment, Medicare Community Health Teams payment, Medicare Blueprint payment, Women's Health Initiative, and Women's Health Initiative Primary Care. Encounter data are tracked separately. Primary care spending is not separately flagged, though some categories of payment are readily distinguishable (i.e., the state's Blueprint medical home payments). Payers submit reports once per year.

### *Massachusetts*

The Commonwealth of Massachusetts collects data on non-FFS payments through the Center for Health Information and Analysis, an independent state agency. Data are collected from commercial plans (including those that offer Medicare Advantage plans) that are among the state's 14 largest plans and/or participate in the state's individual health insurance exchange, as well as Medicaid managed care. Each payer submits detailed files that document non-FFS payments for all covered lives in each ZIP code; this represents a more disaggregated approach than that used by Vermont or Rhode Island. Data are only reported for state residents. Data are reported about all payment types covered in our interview guide. Data are collected for the following categories of nonpayment types: (1) global budget/payments (full benefits), (2) global budget/payments (partial benefits; applies when a set of services are carved out, e.g., behavioral health or pharmacy), (3) limited budget (e.g., primary care or oncology capitation), (4) bundled payments, and (5) other non-FFS-based payments (e.g., patient-centered medical home payments). Payers are required to apportion all payments across ZIP codes using an averaging method that takes into account the number of member months covered in that ZIP code. These data are also broken down by line of business (e.g., commercial, Medicare Advantage). Payers are required to report non-FFS payments to provider groups. Encounter data are tracked separately. Primary care spending is not currently tracked, but Massachusetts is developing methods to do so. Payers submit data annually not only for the previous year but also resubmitting data for the one year prior to that, refreshing data to reflect changes once accounts are settled between payers and providers.

## *Oregon*

Oregon collects non-FFS payment data through the Oregon Health Authority, a public agency with authority over health care in the state of Oregon. Data are submitted by commercial plans, Medicare Advantage plans, and Medicaid plans. Reporting is based on the situs of the insurance contract. Each payer submits a detailed payment file that describes all payments and payment types made to each provider entity with which they contract. The provider entities can vary in their size: some are large hospital systems that include many individual doctors; others may represent small medical groups that contract directly with insurers. Payers submit data for all payment types covered in our interview guide and classify payments according to a system modified from the HCPLAN framework. These payment types include FFS with link to APM, FFS without known link to APM, payments based on patient-centered primary care home tier level, foundational payments for infrastructure and operations that are not based on primary care home tier level, pay-for-reporting, pay-for-performance, APMs with shared savings, APMS with shared savings and downside risk, risk-based payments not linked to quality, condition-specific population-based payments, comprehensive population-based payment, integrated finance and delivery system, and capitation payments not linked to quality. Their categorization focuses on actual payments being made to providers and, as such, excludes in-kind payments and direct staff support, but this can be harder to parse in integrated delivery systems. The APCD collects encounter data for capitated contracts and claims data for FFS contracts, but these data cannot be linked to the non-FFS spending data. Primary care spending is tracked separately from these non-FFS payments. Each payer submits high-level spending information about total primary care spending in a more aggregated format with distinct submission specifications; this includes some non-FFS payments, but the data are more aggregated and the specifications are distinct. Payers submit non-FFS reports annually.

## *Colorado*

Colorado collects data on non-FFS payments through the Center for Improving Value in Health Care, a nonprofit agency that administers Colorado's APCD under the authority of the State's Department of Health Care Policy and Financing. Data are submitted by commercial, Medicare Advantage, and Medicaid plans. Reporting is based on the situs of the insurance contract. At the time of our interview, Colorado was considering making changes to their reporting requirements that may apply to submissions made in fall 2020. Each payer submits a detailed payment file that describes all payments and payment types made to each billing provider. The provider entities can vary in their size: some are large hospital systems that include many individual doctors; others may represent small groups that contract directly with insurers. Data are collected about all payment types and categorized according to a system modified from the HCPLAN framework in an approach similar to Oregon's. Categories of non-FFS payment data collected include FFS, foundational payments for infrastructure and

operations, pay-for-reporting, pay-for-performance, APMs with shared savings, APMS with shared savings and downside risk, risk-based payments not linked to quality, condition-specific population-based payments, comprehensive population-based payment, integrated finance and delivery system, and capitation payments not linked to quality. Encounter data are collected in the APCD, but these data cannot be linked to the non-FFS spending data. Primary care spending is tracked and payers must identify which payments are specific to primary care. Payers submit non-FFS reports annually, submitting data not only for the previous year but also resubmitting data for the two years prior to that, refreshing data to reflect changes once accounts are settled between payers and providers. If changes are made to reporting requirements (e.g., new categories are required), payers must update the two years of historical data that are resubmitted to reflect new reporting requirements.

### *California*

In California, data are collected by the Integrated Healthcare Association (IHA), an independent nonprofit organization made up of payers, providers, and other stakeholders that provides a forum for cross-industry collaboration. Unlike other efforts discussed here, the IHA effort is voluntary. Data are collected for California residents from all of the major commercial plans, including those that offer Medicare Advantage plans, as well as one managed Medicaid plan. Data on capitation payments are currently collected annually at the level of the plan-member-provider organization. Capitation for the member is split out by professional capitation, facility capitation, and global capitation. IHA also collects other member attributes like ACO attribution and type of financial risk contract. IHA is working with payers to implement processes to collect data on other types of non-FFS payments and is also developing a methodology for measuring primary care spending. In addition, IHA collects value-based pay-for-performance payments (upside only shared savings, adjusted for quality performance) at the plan level. Encounter data are collected separately, along with claims data, and can be linked to the capitation data at the member level. Payers have been submitting data annually and are transitioning to quarterly submission in 2020.

### *Summary of State Efforts*

Table 3.1 summarizes the data collection efforts by each state. The different goals of states and policymakers currently designing data collection efforts have led to significant differences in the implementation of ongoing data collection efforts. In terms of the structure of the data, there are similarities across some states. Rhode Island and Vermont follow similar models, with high-level aggregate totals to be submitted by each payer. Colorado and Oregon use similar models, with both requiring reporting of spending disaggregated by each payer at the level of the non-FFS contract with providers. Massachusetts has taken a different approach that requires data disaggregated at the level of the ZIP code of the covered lives. California collects payment data at the level of the patient and is beginning to collect other types of payments at an aggregated

level. However, there are many differences on other levels. Each state uses their own method for categorizing non-FFS payments, and there is little alignment in those methods. Even Colorado, which largely followed Oregon's method for data collection in other regards, made some changes to the categorization of non-FFS payments. Furthermore, states differ in the payers covered (particularly around the inclusion of Medicare Advantage and Medicaid Managed Care), and whether and how they are tracking primary care spending.

**Table 3.1. Summary of State Data Collection Models**

State	Agency Collecting Data	Payers Covered	Level of Aggregation	Payment Types <sup>a</sup>	Encounter Data	Primary Care	Frequency of Submission
Rhode Island <sup>b</sup>	Office of the Health Insurance Commissioner	Commercial payers covering more than 10,000 fully insured lives	Total spending by payer for each payment type, with details about payment types	All: grouped by APMs—population-based contracts, APMs—bundled payments, APMs—limited capitation, pay-for-performance, and APMs—other	No	Tracked separately	Twice per year
Vermont	Green Mountain Care Board	Medicaid and commercial payers who participate in the state's ACO model	Total spending aggregated by payment type	Varies by payer	Tracked separately	Not tracked	Annual
Massachusetts	Center for Health Information and Analysis	Commercial (limited to largest plans and those in the exchange), Medicaid Managed Care	Aggregated at ZIP code of residence of covered lives or at level of provider	All; grouped by global budget/payments (full benefits), global budget/payments (partial benefits), limited budget, bundled payments, and other non-FFS based	Tracked separately	Not tracked (under development)	Annual
Oregon <sup>b</sup>	Oregon Health Authority	Commercial and Medicare Advantage payers with at least 5,000 lives, and Medicaid	Total payments by each payment type for each contract, may aggregate across multiple providers	All using modified HCPLAN framework	Tracked separately	Tracked separately, aggregate level by payer	Annual
Colorado	Center for Improving Value in Health Care	Commercial (limited to largest plans), Medicaid, Medicare Advantage	Payments by type aggregated at the level of the billing provider	All using modified HCPLAN framework	Tracked separately	Flag payments for primary care	Annually
California	IHA	Commercial, Medicare Advantage, voluntary submission	Payments attributed to specific patients, not aggregated	Capitation payments (professional, facility, global) collected, working to collect other types of data value-based P4P payments collected at plan level	Yes	Beginning to identify by provider specialty and procedure codes	Annually, transitioning to quarterly

**NOTES:**

<sup>a</sup> States were asked about collection of data related to the following payment types: capitation (i.e., full, partial, or professional risk), risk-based contracting payments (e.g., hospital gainsharing, shared savings), bundled/episode-based payments, medical home payments, pay-for-performance, payments for infrastructure expenditures or investment (e.g., HIT incentives), payments for workforce expenditures or investment (e.g., nurse care managers, community health workers, and others).

<sup>b</sup> Oregon and Rhode Island have multiple data collection procedures that may include non-FFS payments; we discuss their more granular methods for accounting for non-FFS payments in this report.

## Payer Perspectives

As states consider models for non-FFS payment data collection, it is important to recognize that compiling and reporting these data is time consuming for payers. Regulators should bear in mind the burden placed on payers and the feasibility of the reporting requirements. An approach that works well in one state, with a given population, mix of payers, set of norms about payment types, and set of use case priorities, may work less well in another state with a different population, mix of payers, norms about payment types, and use case priorities. For payers that operate in multiple states, standards that vary across states create increased burden on payers. National standards would ease the burden on payers that operate across states, because they would be able to implement a single reporting structure. Furthermore, even within one state, payers may have difficulty determining how best to fit their existing non-FFS payments into a state's payment categories. States that have been most successful have worked closely with payers active in their state to develop requirements that the payers are actually capable of fulfilling, and they provide opportunities for regular dialogue with payers as the APM landscape evolves.

The data that payers are tracking and collecting in their internal accounting and reporting systems may not be systematic across (or even within) payers. In many instances, payers may be providing these payments outside their standard operational systems. The mechanism for non-FFS payments' interaction with existing FFS-oriented operational systems may vary widely as well, including payments made completely independent of FFS payments, non-FFS payments triggered by specific nonbilling procedure codes (e.g., specific G-codes), non-FFS payments made outside the FFS-system accompanied by zeroed-out FFS-claims, or enhanced-FFS payments encompassing the non-FFS payment amount.

There exists a common infrastructure for providers to submit FFS claims to insurers and payers for the purposes of reimbursement. This has allowed APCDs to develop common structures for collecting FFS claims data. However, there is currently no common structure for tracking non-FFS payments. Thus, as new requirements and regulations are built at the state level, payers must adapt and build new systems and processes to meet these requirements. It takes time for payers to do this.

Both payer interviewees and members of our expert panel noted that assembling these data may require interactions across departments within payer organizations that may not regularly interact otherwise, may involve team members who may not fully understand non-FFS payments or APMs, and may be impacted by staff turnover. Payers also noted that requirements for included payments, population frame, and timing for non-FFS data collection may differ from those used in their own internal operational work and in other outside reporting requirements. The expert panel discussed whether a more aggregated high-level spreadsheet versus disaggregated provider- or patient-level data was more burdensome. An aggregated, high-level spreadsheet represents a simpler form to fill-out and requires less information from payers.

However, some members of the expert panel noted that more aggregated data are not always less burdensome for payers than disaggregated data, because more judgment and data manipulation may be required to produce high-level aggregations that do not reflect the way data are operationally collected or stored by a payer.

Payers may need time to develop new systems to meet reporting requirements. Even complex reporting requirements may be possible if payers are given sufficient advanced notice to build the necessary systems. Among the states from which we gathered data about non-FFS payment reporting, Massachusetts has the most complex reporting requirements but has also been collecting non-FFS data for over a decade. Payers in Massachusetts have had many years to build and refine the systems necessary to fulfill the detailed reporting requirements.

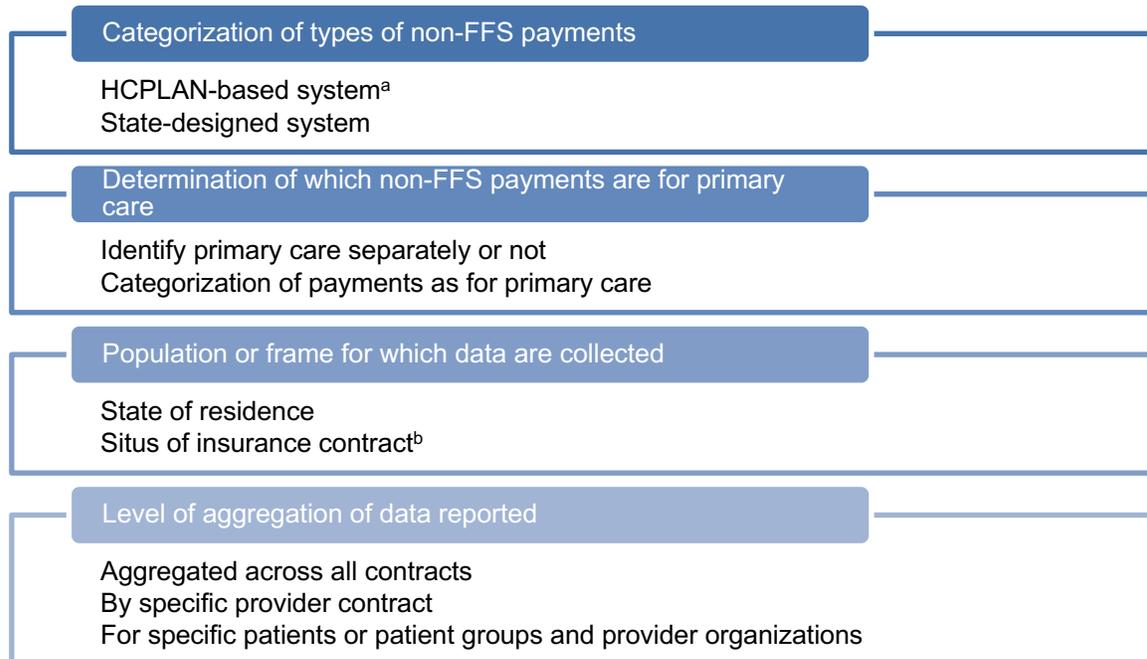
Finally, a payer interviewee also noted that the conversation around collection of and requirements for non-FFS payment data is particularly important as APMs and primary care payments continue to move further away from an FFS chassis as the basis of payment. This individual felt that conversations about data systems for non-FFS payments should be linked to conversations around what clinical documentation requirements would look like in a non-FFS-based payment system.

## Key Decisions and Dimensions for Non-FFS Payment Data Collection

Based on our interviews, we determined that reporting requirements for non-FFS payment data can be characterized by four key decisions (shown in Figure 3.1). These key decisions formed the outline for our discussion with the expert panel.

The decisions that states make about each of these requirements are independent of each other; for example, for any level of aggregation, a state can select any method of categorization of non-FFS payments. The choices made around each of these decisions depends crucially on the intended use cases of the data. While the primary interest of this report is to better understand primary care spending, other potential use cases for these data are discussed in more detail below.

**Figure 3.1. Four Key Decisions for Non-FFS Payment Data Reporting Requirements**



**NOTES:**

<sup>a</sup> HCPLAN reflects the categorizations reflected in Health Care Payment Learning & Action Network.

<sup>b</sup> Situs refers to the legal location of the insurance contract.

*Categorization of Types of Non-FFS Payments*

Most states require that all non-FFS payments be broken down into key categories describing the type of non-FFS payment (such as capitation, pay-for-performance, or risk-based contracting, etc.). Although the HCPLAN framework is a commonly used method for categorizing different types of provider payments, some states use other categorizations or may modify HCPLAN to better fit the needs of payers in their state or to bring attention to specific programs that are of interest in their state. States may have already had payment categories in place before the HCPLAN framework was introduced. Payers may not be familiar with the HCPLAN framework and may be using other means to categorize their own non-FFS payments. The proliferation of different non-FFS payment programs across payers and the innovation that continues to occur makes the categorization of types of non-FFS payments particularly difficult; what works well today may not work well in the future.

*Determination of Which Non-FFS Payments Are for Primary Care*

States have adopted different definitions of what is included in primary care spending based on type of clinical specialty (e.g., inclusion of geriatric, obstetrics and gynecology, behavioral health, naturopathic, homeopathic providers), payment codes (e.g., varying breadth of include procedure codes versus all professional payments to identified providers), and other criteria (i.e., whether total spending includes or excludes pharmacy spending); an overview of

definitions in use is provided in Table A.1 in the Appendix. Some states have required payers to either separately report payments that are related to primary care or indicate what proportion of each payment or payment type was for primary care. Furthermore, some states (Vermont and Massachusetts) are currently tracking non-FFS payments but not separately identifying primary care. We found that identification of payments for primary care can be challenging, particularly for payments made to multispecialty provider groups. States we talked to have had to work closely with payers to support determination of what payments should be considered primary care and what payments should not be considered primary care. However, a key conclusion of the experts in our panel was that achieving consensus around defining which payees and which activities should be included in any future measure is particularly daunting and will require additional stakeholder engagement and consensus building.

### Included Payees

In our interviews with states and payers, identifying primary care payments was not noted as a particularly challenging issue. However, in our expert panel, several panel members expressed that one key element of determining whether a non-FFS payment is for primary care may be determined based on to whom the payment is directed. This is straightforward for a single specialty primary care group but becomes more complicated when payments are made to multispecialty physician organizations or large health systems. Panel members noted uncertainty in how to categorize certain types of non-FFS payments as primary care when they are made to such entities that provide primary care among a broader array of other health services. Because large multispecialty physician organizations and health systems may have relatively greater participation in APMs, understanding payments to these organizations is crucial to calculating total non-FFS spending toward primary care.

There were conflicting viewpoints among panel members about the feasibility of identifying payments to primary care within large physician organizations. Some panel members noted that a key policy goal should be to determine what money is actually going to the PCPs performing clinical decisionmaking and interacting with patients in the exam room. Others panel members cited challenges with this approach or alternatives to this perspective. In large, complex, multispecialty provider organizations, there can be a disconnect between dollars paid to the broader provider organization for primary care delivery and the actual financial resources that the provider organization directs to PCPs and practices within the organization. It was noted that the payers themselves have no insight into what provider organizations do with payments once they are made to the organization, and thus payers would not be able to report on the actual resources a provider organization ultimately directs toward primary care. This is true for all payments made to large provider organizations or health systems but is of particular concern for types of non-FFS payments that reflect overall care delivery and total cost of care inclusive of primary care (e.g., shared savings payments, global budget arrangements); determination of what

proportion of these broad non-FFS payments made to provider organizations and health systems should be proportioned to primary care is not straightforward.

Others panel members pointed out that the landscape of primary care delivery is changing, noting that policies and delivery system innovations are encouraging care to become more team-based and less exam room-based. Panel members noted roles for other nonphysician providers, clinicians, and team members who may or may not provide the type of visit-based care that is traditionally billable under FFS, noting that contributions of these team members to managing a primary care panel is substantive and valuable. These could include nurse practitioners, physician assistants, nurses, social workers, pharmacists, nutritionists, patient educators, psychologists, behavioral health providers, as well as medical assistants, practice assistants, population health managers, patient coaches, and navigators. Several panel members suggested, and most agreed, that a narrow definition that counts only dollars directed toward providers engaged in active clinical decisionmaking in the exam room may miss or discount this broader evolving conception of primary care as a team-based and nonvisit-based activity.

Although panel members expressed a variety of viewpoints about which payees should be included, there was consensus that additional stakeholder engagement would be needed to develop standards for identifying primary care payments.

#### Included Activities Paid for by Non-FFS Payments

The expert panel also discussed the types of activities potentially paid for under non-FFS payments and whether those constituted primary care payments. Panel members commented that a wide variety of payments made outside standard FFS-based transactions could potentially be considered non-FFS payments related to health care or to primary care. These might include investments related to addressing social determinants of health, supporting health care infrastructure, or supporting nonvisit-based care or nonprovider members of the team. Panel members noted roles for nonvisit-based functions, be they virtual visits, telephone encounters, telemedicine, or asynchronous care coordination. These payments are becoming increasingly important as more health care visits are moved to virtual visits during the COVID-19 pandemic.

Although areas of ambiguity exist (e.g., supporting the development of a primary care practice in a housing development), there was consensus among panel members that any definition of primary care payments should be limited to services provided through the auspices of a PCP's office or provider organization, and panel members felt it should not include those provided directly by the insurer or payer themselves (i.e., care management hotlines or nurses provided through the payer, rather than through the primary care practice).

Many panel members expressed agreement with the idea of having more than one definition of what constitutes primary care payments or investments: from payments made to primary care physicians for their billable clinical work to the financial resources a large multispecialty provider organization ultimately directs to the provision of visit- and nonvisit-based primary care

services to their patient population. These definitions of varying breadth would provide a range of primary care spending estimates.

Although panel members expressed a variety of viewpoints about which activities should be included, there was consensus that additional stakeholder engagement would be needed to develop standards for identifying primary care payments.

### *Population for Which Data Are Collected*

States must also consider whether required reporting of non-FFS payment data should be based on residency of patients, the legal location (or situs) of the insurance contract, or location of the provider. This issue is of particular importance if a state is considering linking reported non-FFS payments to an APCD. Reporting of claims for APCDs are typically required for all residents of a state, but this may not be appropriate for reporting of non-FFS contracts. Non-FFS contracts between a payer and a provider organization may relate to the care of all patients covered by that payer (or all patients covered by some subset of insurance products sold by that payer), but some of those patients may not live within the state. Some states we spoke with said that payers found it challenging to report payments from contracts only for residents. Instead, some entities have required reporting of non-FFS payment data that reflect on situs of the insurance contract. If different populations are covered, it may be inappropriate to combine these data sources for aggregate statistics or for calculating the share of spending through APMs.

### *Level of Aggregation*

Non-FFS payment data can be collected at three principal levels of aggregation: aggregated across all contracts, aggregated at the level of the contract, or disaggregated at the level of the patient or patient group, described in more detail below. Although more aggregated reporting may be less burdensome for states or entities and in some cases for payers, more granular reporting offers more opportunities for analysis and for data validation. In this report, we focus on understanding non-FFS payments for the purposes of assessing primary care spending as a proportion of total health care spending. This requires both assessment of total primary care spending and total health care spending. Discussion with our expert panel suggested that different audiences have different use cases in mind for these data, and these various use cases require differing degrees of aggregation; for some use cases, cumulative non-FFS payments from each payer may be sufficient, whereas for others provider- or patient-level data may be needed. In addition to measuring primary care spending as a proportion of total health spending, states and researchers may also be interested in other use cases such as measurement of APM payments, enabling complete spending estimates for specific health care services, and assessment of the relationship between non-FFS payments to providers and their performance on measures of cost, access, low-value care, and clinical quality. States or other entities may have interest in assessing these use cases for different units of analysis (i.e., payers, insurance product types, patient populations, provider organizations, provider types, or geographic regions,

including at the aggregate state level). Potential users of the data could include, but are not limited to, state policymakers, health plans, provider organizations, patient groups, professional and specialty societies, and researchers.

#### Reporting Non-FFS Payments Aggregated Across All Contracts

Some states (i.e., Rhode Island, Vermont) require commercial payers to report non-FFS payments broken down by payment type category (e.g., capitation payments) but aggregated across all providers and all contracts the payer holds. This model is designed for a macro-level accounting of the total cost of care within a state. Aggregation across all contracts, providers, and patients does not allow the study of the effect of non-FFS payments on the practice patterns of providers, the outcomes of covered patients, or other similar micro-level analyses. This model places relatively limited burden on payers because they typically must only report total spending by category. This level of aggregation limits the potential use cases of the data.

#### Reporting Payments by Provider Contract

Other states (i.e., Oregon, Colorado) require commercial payers to report non-FFS payments broken down by contract or billing entity and payment type category (such as HCPLAN category 2A or capitation payment). In these states, payers report payments made to each provider or provider organization that they contract with. This model provides detailed data that can be aggregated to produce macro-level accounting of the total cost of care within a state. Reporting at the level of the provider contract (e.g., plan A, HMO contract with provider A) also allows greater understanding of the different types of contracts that are being used and how different payment types are being combined.

Furthermore, there may be interest in studying how contractual relationships affect primary care practice patterns, utilization, and outcomes. Linking data to utilization as reported to an APCD could allow for deeper research into the relationship between contracting mechanisms and primary care practice patterns, utilization, and outcomes. However, Oregon, Colorado, and members of the expert panel cited significant concerns with these types of linkages because the reporting requirements of the APCD are based on enrollee residency, which may not overlap with the patients covered by contracts reported to the state based on situs. As a result, both Oregon and Colorado currently have decided that because the populations do not overlap perfectly, non-FFS payment data and APCD claims data should not be linkable to patients and providers. Therefore, these data cannot be used to study how contractual relationships affect primary care practice patterns, utilization, or outcomes. States using this model emphasized that reporting based on contract situs, as opposed to enrollee residence (the norm for APCD data), was important for feasibility of this reporting model for payers.

## Reporting Payments for Specific Patients or Patient Groups and Provider Organizations

A single data source combining non-FFS payment data reported for individual patients linked to individual provider organizations by insurer and product type would enable the greatest opportunities for data analysis and research. This model provides detailed data that can be aggregated to produce macro-level accounting of the total cost of care within a state. But it would also allow for studies of the effect of non-FFS contractual arrangements on the provision of primary care at the level of the patient group or provider (for example). IHA in California, which is a voluntary reporting system, currently uses a version of this approach to capture capitation and some other non-FFS payments to physician organizations by enrollee. The Massachusetts model does not report payments at the individual patient level but requires that all payments be apportioned to individual patients at a member-month level to be aggregated up to a ZIP code level.

Challenges with applying this model to APM payments broadly include that patients may seek care from many provider organizations (particularly outside HMO insurance products) and that many non-FFS payment types are not directly tied to any specific patient (e.g., HIT infrastructure payments, shared saving payments) but rather to the health system or physician organization. For these difficult to apportion non-FFS payments, Massachusetts requires that payers make an assumption that payments are evenly distributed across ZIP codes; this means that such payments are averaged across the providers' attributed or assigned members' ZIP codes proportionately. This fundamentally assumes that non-FFS payments that go to providers but that are not directly tied to specific patients should be attributed equally across all patients of those providers. Within large provider organizations, it may not be clear how to assign a given non-FFS payment to an individual provider. Furthermore, it may not be clear how to assign a given non-FFS payment to an individual patient, particularly given the concerns reported by some states related to non-FFS contracts that cover patient lives not reported to APCDs. This model's granular data collection would place a higher burden on payers. States not currently collecting these data expressed concerns about the acceptability, feasibility, and support required. However, Massachusetts's experience suggests that this model can be implemented.

## Validation of Data Received

Multiple panel members noted that the idea of collecting non-FFS payment data at the state level was a relatively novel concept. Others noted that consistency of definitions over time and across states may be more important than perfection or precise delineation of all facets of the definition, if the goal is to track trends across time and patterns across geography. It is, however, important to note that comparability of one year to another and one state to another may be compromised if firm definitions for included patients, payees, and payment type are not decided a priori and validation strategies for the data received are not in place. Variation in aspects of the definition of non-FFS spending across years and across states could lead to false conclusions or trends that reflect differences in the underlying data, rather than true differences in primary care

spending. This is of particular importance in states where policies are in place or under consideration to establish minimum primary care spending targets by payers; firm definitions and validation procedures will be essential to be sure that improvements relative to targets or relative to a prior year reflect true changes in payments, rather than changes in data submission.

Members of our expert panel agreed that the ability to validate data collected would be important to its credibility but noted that such validation efforts are a challenge and a burden for states with limited budget or staff available for analytics, particularly when significant efforts were simultaneously needed to educate payers about data submission and categorizations of non-FFS payments or when many payers are submitting data. Interviewees and panel members noted that building confidence in the data through validation is an ongoing process that plays out over years. Disaggregated data, either at the level of the provider group, individual patient, or patient group, can provide relatively more opportunities for data validation than more aggregated data. In Massachusetts, one reported validation mechanism was directly verifying specific reports of payments from payers to provider groups with the providers themselves. Panel members from payer organizations also recommended that there be as much specificity and guidance in the definitions of non-FFS payment categories and what constitutes a primary care payment as possible, minimizing the amount of judgment required by payers assembling the information. It was also acknowledged that guidance, categorization, and validation approaches may need to be modified and continually refined to reflect current and future models in a state, given the wide variety of possible ways that non-FFS payments may be designed and executed across payers.

## 4. Conclusions

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As non-FFS payments continue to grow and represent an increasing share of total health care expenditures, collection of data reflecting these payments is increasingly important to accurately track total health care spending and total spending toward primary care. In this work, we investigated how states that are currently collecting information about non-FFS payments are doing so and sought to move the discussion forward toward development of a standardized method for collecting these data by identifying key considerations and decisions.

### Synthesis and Recommendations

While states' iterative innovation in developing mechanisms for reporting non-FFS payments and primary care spending is an essential first step, developing a well-specified, common national standard definition is essential for making comparisons between states and for tracking trends over time. Developing a standard that can be used across states will improve the comparability of total spending for primary care and non-FFS spending across states and ease the burden placed on payers who operate in multiple states because they can apply the same methods in all states to aggregate and report data. However, challenges are certain to arise because the categories and nature of non-FFS payments vary across states and any single standard is not likely to meet the needs of all states. Furthermore, any standards will need to be flexible to allow for future changes that may occur in the market; payers are introducing new non-FFS contracts each year, and any standards will need to be able to accommodate the changes and innovations in payment models that are certain to take place. Accordingly, a multistakeholder consensus building process incorporating input from a variety of states and payers will be an essential and ongoing process. Analysis to understand the implications of different standards under consideration will also be critical, to fully understand and weigh the potential trade-offs of decisions regarding sampling frames, categorization schema, and the levels at which data are collected and aggregated. Our research has found that there is meaningful variation in the data collection efforts currently occurring, suggesting that reaching a consensus about standardization will take significant additional investment. The different goals of states and policymakers currently designing data collection efforts have led to significant differences in the implementation of ongoing data collection efforts.

To promote a single standard, we recommend the following next steps to further the development of data collection standards:

1. **Develop a single standard for categorizing types of non-FFS payments.** Because states are currently using a variety of approaches to categorize non-FFS payment methods, the approach ultimately selected may be better aligned with some existing

standards than others. Although HCPLAN offers an extant structure, it may not have the level of granularity needed to be functional for states' needs and payers' payment models, and may need additional modification to specifically address which payments apply to primary care spending. Further, because HCPLAN may be unfamiliar to some payers, significant investment in coordinating and educating payers will be necessary. Our research made clear that developing and implementing a standard for categorizing non-FFS payments is difficult for states, and achieving agreement on a potential standardized methodology across states will present additional challenges. This step is likely to be particularly difficult; there is limited standardization for how non-FFS payments are structured or implemented, with many different models and methods being used by a multitude of payers across all states and variation in how payments are tracked both between and within payers. To develop a single standard for categorizing types of non-FFS payments, the following steps will need to be taken:

- a. A careful environmental scan will be needed to catalogue the full scope of non-FFS payments currently on offer, as well as the practical mechanisms by which payments are determined, paid, and tracked by payers to more completely understand the non-FFS payment environment and the potential future evolution of new contract types.
  - b. Additional consensus building and stakeholder engagement efforts will be needed to determine how best to categorize the payments. Stakeholder engagement must include payers to ensure that any standard is implementable and relevant to the realities of non-FFS payments, as well as policymakers and researchers who seek to better regulate and understand the market.
  - c. As new options are considered, careful empirical analysis will be needed to assess the effects of different categorization schemes.
2. **Select a common approach for identifying what types of non-FFS payments are considered primary care payments.** Within this approach, a continuum of definitions may exist, as is currently common among states and researchers (i.e., a narrow and a broad definition of providers and payment types). As with categorizing non-FFS payments, determining what should be considered primary care payments will require a number of steps. A narrow definition may focus on payments made to providers for care delivery, whereas a broader definition might incorporate some portion of payments made to large multispecialty provider organizations and health systems for performance across the continuum of care (e.g., shared savings, global payment arrangements). To develop a common approach for identifying primary care non-FFS payments, the following steps will need to be taken:
- a. Additional stakeholder engagement and consensus building will be needed. This stakeholder engagement should seek to identify the needs and goals of different user groups. Potential areas of focus might include consensus building regarding which providers are classified as primary care and a consistent mechanism to apportion broad payments (e.g., shared savings, global payment arrangements) made to large multispecialty provider organizations and health systems.
  - b. Again, empirical analysis to better understand the effect of different approaches is needed. Without such analysis, we cannot directly assess how big of an effect different approaches to categorization of providers and payments will have on the

overall estimate of the proportion of total spending toward primary care across states, payers, or settings.

3. **Define a uniform population or frame for data collection on the basis of situs of insurance contracts as is most feasible for payers.** This uniform population or frame refers to the set of patients, payers, or lines of business for which non-FFS payments will be collected. Although this situs-based population frame differs from the state-residency frame that is used in APCDs, this is the standard by which most states are currently collecting these data and the mechanism most feasible for payers. To develop a single standard for inclusion of patients, payers, and lines of business, the following steps will need to be taken:
  - a. As a first step, we recommend that any standards focus on collection on the basis of situs of the insurance contract because this will be most feasible for payers.
  - b. As a later step, coupling situs reporting with ZIP code level reporting could facilitate an additional focus on state residents. This will open up the use of data to a broader set of use cases.
4. **Work toward disaggregated data collection.** While several states and members of the expert panel expressed concerns about the situs of insurance contracts, Massachusetts' experience suggests that these hurdles can be overcome with sufficiently disaggregated data. Although disaggregated data are not necessary to track total primary spending, they afford the greatest possibilities for additional use cases, allow for more validation opportunities, and may be more straightforward for payers to construct. If new standards cannot be set to collect disaggregated data in the near term, then we recommend that plans be made from the outset to collect disaggregated data at a later date. Given the investments that will be needed to be made by payers to begin tracking non-FFS payments in a systematic way, any standards set today should be done with an eye toward collecting disaggregated data, if not now, in the future.

The development of standards to collect non-FFS payment data to measure primary care investment is likely to take several years, if the process to develop the HCPLAN framework is any indication. Some additional states may wish to begin collecting data about non-FFS payments before a standard can be determined. These states should consider the data collection efforts currently under way in the states discussed here to determine which model is most aligned with their needs.

## Next Steps

While this work has taken a first step toward defining what is needed to develop standards for reporting non-FFS payment data in the context of primary care, significant additional work will be needed to finalize these standards. The HCPLAN process for developing a framework for categorizing non-FFS payments was a multiyear process involving many stakeholders. A similar process of convening key stakeholders and building consensus around seminal features of non-FFS payment data collection definitions is needed. Such an effort would be well-timed at present, because the experience of early adopter states can concretely inform these discussions

and the decisions made by other states and APCDs that have not yet begun to develop their data collection. There remains an opportunity to implement common data collection structures moving forward. To facilitate comparable data across states and over time for calculation of primary care spending as a proportion of total health care spending as well as other potential use cases, stakeholder engagement efforts should aim to build consensus around the following key topics discussed above:

- a single structure approach for categorizing types of non-FFS payments
- a common approach for identifying what types of non-FFS payments and to which providers are considered primary care payments
- a uniform standard for which patients, payers, and lines of business are included in reporting
- a goal of disaggregated non-FFS payment data reporting.

In addition, such stakeholder engagement and consensus building may provide opportunities to share experiences and best practices with regard to the level of aggregation feasible for non-FFS payment data collection as well as mechanisms for validation of that data.

Future work in this area should also assess the data that are currently being collected by states to assess whether and how differences in states' current approaches for collection of non-FFS payment data and primary care spending data affect the resulting findings. Because most states are not currently releasing the findings from their non-FFS payment data collection, little is known about how variations in approaches to data collection affect the data that are ultimately received. Nor are the implications known for calculation of measures of primary care spending as a percentage of total health care spending or other spending metrics of interest to policymakers. Additional work is also needed to understand how measures of primary care spending, with and without inclusion of non-FFS spending, correlate with desired outcomes of care delivery. This is particularly important in an evolving health care landscape that is increasingly shaped by ongoing provider consolidations and increased prevalence of non-FFS payment. Future research will be needed to further assess these measures.

Future work to formalize standards for the collection of non-FFS payment data will also have implications for broader use cases outside the area of understanding primary care spending as a percentage of total health care spending. As non-FFS payment models grow in prevalence, there is also a need to understand what percent of total health care spending comes from non-FFS payment models. Moreover, as non-FFS payment models continue to grow, there is also a need to examine the relationship between provider organizations receipt of non-FFS payments and their performance on measures of utilization, quality, value, access, and patient experience. In addition, identifying ways to integrate non-FFS spending data into APCDs will open many future opportunities for research. As non-FFS payment data collection standards are developed and formalized, a broad set of potential use cases should be considered.

Future work to develop standards might be taken up by the National Association of Insurance Commissioners, which currently collects data on financial information from health plans as part of the Supplemental Health Care Exhibit; by the APCD Council, which represents state APCDs and their efforts to collect health care claims data; by foundations who seek to move the collection of these data forward at a more rapid pace; by federal agencies, who have greater ability to require submission of data for ERISA (Employee Retirement Income Security Act of 1974) plans; or by a new group that brings together stakeholders across these and other groups, including payers and states, to represent a broad set of interests and perspectives. This report provides a first step toward understanding the current landscape for whatever organization is best positioned to continue the effort in the future.

# Appendix

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## Interview Guides

### *APCDs and State Entities*

#### Introduction

Thank you for speaking with us. We are working on a project funded by the Milbank Memorial Fund to understand health care spending for primary care in the United States. To fully estimate primary care spending, it is necessary to account for all payments made to primary care providers (PCPs).

All-payer claims databases (APCDs) routinely capture fee-for-service (FFS) payments to providers but miss many other types of payments including capitation payments, alternative payment model payments (e.g., medical home payments, shared savings), and quality incentive payments. Several APCDs (and in some cases other entities within states) as well as Medicare have considered how to collect non-FFS payment data. Currently, there is no standardized method for defining and collecting these data.

The Milbank Memorial Fund asked RAND to conduct a series of interviews with stakeholders including APCDs and payers to explore how best to capture nonclaims payments in plan data submissions to APCDs, with an eye toward defining a common set of data elements and a data submission structure that APCDs could use when requiring plans to submit non-FFS payment data. We hope to learn how your organization has approached collecting non-FFS payment data.

Before we start, I would like to walk you through our human subjects' consent. (CONSENT) There are no right or wrong answers to the questions I will ask. We ask that you share your perspective based on your experience and knowledge. These interviews are confidential so that you can speak candidly. We will not identify any individual in any reports or articles that we may publish. You can decline to answer any question or quit the interview at any time. Do you have any questions before we begin?

Do you agree to participate? (YES/NO)

We would like to report which states we have talked to gather information. Is it acceptable to you for us to do that? (YES/NO)

As we mentioned in our email, we would like to record the interview to make sure that our notes are accurate. No one outside the RAND evaluation team will have access to the recording and as soon as the interview notes are complete, we will destroy the recording.

Do you agree for the interview to be recorded? (YES/NO)

## General Information About APCD (or Other Entity)

We understand that your APCD (or entity) collects provider payment data. We want to start by asking a few questions about how your APCD (or entity) collects provider payment data from payers (i.e., health plans).

1. What are guidelines for determining which payers and plans are required to submit data to the APCD?
  - a. Are there requirements based on the number of covered lives?
2. Does your APCD (or entity) collect data from self-insured lines of business? (YES/NO) (We know payers are not required by law to submit these data.)
  - a. (If YES) How many self-funded plans are submitting data in your state?
  - b. (If YES) What percent of all self-funded plans in your state would you estimate are submitting data?

## Other-Nonclaims Data

3. Do payers submit any information about carve-out payments or services? (YES/NO)
  - a. (If YES) For what types of carve-outs payments or services?
  - b. (If NO) Do carve out organizations submit data directly? (YES/NO)
4. Do you collect encounter data? (YES/NO)
  - a. (If YES) Are the encounter data available in the APCD? (YES/NO)
  - b. (IF NO) Or are they collected by a different organization within your state?

## Non-FFS Payments and Details

For the rest of the interview, we will talk about non-FFS payments.

5. Are non-FFS payment data stored within your state's APCD, or in some other data system?

## *Types of Payments Collected*

Prior to today's call, we sent you a list of types of non-FFS payments. It would be helpful if you could have this in front of you while we talk. When we say non-FFS payment data, we are referring to the following types of payments:

- Capitation (i.e., full, partial, or professional risk)
- Risk-based contracting payments (e.g., hospital gainsharing, shared savings)
- Bundled/episode-based payments
- Medical home payments
- Pay-for-performance
- Payments for infrastructure expenditures or investment (e.g., HIT incentives)
- Payments for workforce expenditures or investment (e.g., nurse care managers, community health workers)
- Other.

For each type of non-FFS payment, we'd like to capture a few details about the data payers are submitting.

6. Are there any documents that you are able to share that would convey some of the details about the types of non-FFS payment data that you collect (i.e., data submission guidelines or guidance, a table shell)?
7. As you look at the list, have we missed any type of non-FFS payments your APCD (or entity) collects?
8. Of the listed non-FFS payment types, which of these does your APCD (or entity) require plans to submit?

#### *Structure of Non-FFS Data*

I'd like to now focus on the structure of the data you collect and what the unit of reporting is for each type of non-FFS payment data type. By unit, we are referring to whether the payment data are reported at the level of the patient, an individual physician or provider, the medical group, hospital, or health system, or other level (such as in the aggregate by payer).

9. Could you help me to understand the structure of the data? What is a unit of observation?
10. Does the non-FFS data your APCD (or entity) collects include data collected for specific non-FFS payment types or does it only contain information about the aggregate overall amount spent by a payer on included non-FFS payments?
  - a. (If it contains specific payment types) Which types are included?
11. Does that include data about downside risk payments, withholds, financial penalties for poor performance? (YES/NO)
  - a. (If YES) For which types of payments?
12. Does the data collected include information about the amount of non-FFS payments of each type paid to specific providers? (YES/NO)
  - a. (If YES) Which payment types contain amounts paid to specific providers?
  - b. (If YES) Are payments to providers identified by a provider group (for example, by TIN), by a specific provider (for example, an NPI), or by some other mechanism?
  - c. (IF UNCLEAR) Could you provide an example?
13. In the non-FFS payment data collected, is payment data linked to specific patients or episodes of care?
  - a. (If YES) For which types of payments?

#### *Other Features of Non-FFS Data*

Now, we will ask for some additional details for each of the non-FFS payment types for which your APCD (or entity) collects data:

(For each payment type collected, ask questions 12–14)

14. For which payer populations, do you collect (non-FFS payment) data? Or, are there any populations or product types for which you do not collect non-FFS data?
  - a. Commercial PPO

- b. Commercial HMO
  - c. Self-insured
  - d. Medicaid
  - e. Medicare Advantage
  - f. Medicare FFS
  - g. Medicare Supplemental Insurance
  - h. TRICARE
  - i. Federal Employee Health Insurance
  - j. Other
  - k. (If YES) For which types of payments?
15. With what frequency do plans submit (non-FFS payment) data to your APCD (or entity): annually, quarterly, monthly, other?
- a. (If YES) Does this differ for some payment types? If so, which ones?
16. Is there a way to distinguish whether (non-FFS payment) are for primary care or nonprimary care?
- a. (If YES) How is that distinguished?
  - b. (If YES) Are there payment types for which it is a gray area?
  - c. (If YES) Can you give an example?

#### Interaction with Payers About Non-FFS Payment Data Submission

17. How did you work with the different payers submitting data to achieve a common data submission file layout for nonclaims payment data?
- a. What nonclaims payment information could the payers provide?
  - b. What limitations did payers face in providing nonclaims payment data?
18. Do you have any means to verify the accuracy and completeness of non-FFS payment data submitted by payers?
- a. (If YES) How is this accomplished?
19. What difficulties have payers experienced in submitting non-FFS payment data to your APCD?
- a. How common are these problems?
  - b. How have you resolved these problems?
20. How well do you think what your APCD (or entity) is asking payers to submit aligns with the data they already capture and maintain in their internal systems?
21. Have you made changes to your data collection requirements or process for non-FFS payments to make them work better for payers?
22. Reflecting on what you have learned about requesting plans submit non-FFS payment data and report it to your APCD (or entity), are there lessons for reporting nonclaims payment data in a standardized manner?

## *Payers*

### Introduction

Thank you for speaking with us. We are working on a project funded by the Milbank Memorial Fund to understand health care spending for primary care in the United States. To fully estimate primary care spending, it is necessary to account for all payments made to primary care providers.

All payer claims databases routinely capture fee-for-service payments to providers but miss many other types of payments including capitation payments, alternative payment model payments (e.g., medical home payments, shared savings), and quality incentive payments. Several APCDs as well as other state organizations and Medicare have considered how best to collect these data. Currently, there is no standardized method for defining and collecting these data.

The Milbank Memorial Fund asked RAND to conduct a series of interviews with stakeholders including APCDs and payers to explore how best to capture the nonclaims payments in plan data submissions to APCDs, with an eye toward defining a common set of data elements and data submission structure that APCDs could use. In this project, we hope to learn how your organization has approached collecting this type of information for internal purposes and for reporting it to state organizations such as APCDs.

I would like to walk you through our human subjects' consent. (CONSENT) There are no right or wrong answers to the questions I will ask. We ask that you share your perspective based on your experience and knowledge. These interviews are confidential so that you can speak candidly. We will not identify any individual or organization in any reports or articles that we may publish. You can decline to answer any question or quit the interview at any time. Do you have any questions before we begin?

Do you agree to participate? (YES/NO)

As we mentioned in our email, we would like to record the interview to make sure that our notes are accurate. No one outside of the RAND evaluation team will have access to the recording and as soon as the interview notes are complete, the recording will be destroyed.

Do you agree for the interview to be recorded? (YES/NO)

Prior to today's call we sent you a list of types of non-FFS payments and a table shell. It would be helpful if you could have both of these in front of you while we talk. When we say non-FFS payment data, we are referring to the following types of payments:

- Capitation (i.e., full, partial, or professional risk)
- Risk-based contracting payments (e.g., hospital gainsharing, shared savings)
- Bundled/episode-based payments
- Medical home payments
- Pay-for-performance
- Payments for infrastructure expenditures or investment (e.g., HIT incentives)
- Payments for workforce expenditures or investment (e.g., nurse care managers, community health workers)
- Other.

1. Can you describe the types of non-FFS payment arrangements that your organization has in place?
  - a. How have these arrangements evolved over the last 5 years?
2. Could you describe the non-FFS payment data that your organization currently tracks and maintains in its internal data systems?
  - a. (If any types mentioned in 1a are not accounted for confirm that this data is not maintained or collected)
3. Do you collect encounter data for patients covered by non-FFS contracts?

## Non-FFS Payments and Details

### *Types of Payments Collected*

For each type of non-FFS payment, we'd like to capture a few details about the data that your organization tracks.

4. Have we missed any type of non-FFS payments your organization tracks in your data system?
5. Of the listed non-FFS payment types, for which does your organization track in your data system?
6. Are there any documents that you are able to share that would convey some of the details about the types of non-FFS payment data that you track in your data system (i.e., a table shell, data dictionary)?

### *Structure of Non-FFS Data*

This next series of questions is about the data structure and the unit of observation for these data. We'd like to know if the data are tracked on a patient, individual provider, group, or some aggregate basis.

7. Could you help me to understand the structure of the data? What is a unit of observation?
8. Does the non-FFS data your organization tracks include information about specific non-FFS payment types or does it only contain information about the aggregate overall amount spent by a payer on included non-FFS payments?
  - a. (If data by payment type is tracked) Which payment types are specified?

(If data collected by specific payment type, we will work through the table asking each question first overall, and then separately for each payment type, if it does not contain specific payment types, we can still ask these questions, just about the aggregate amounts.)

Next, we are going to work through the table we previously provided you column by column, asking a number of questions about each type of non-FFS payments.

9. Does that include data about downside risk payments, withholds, or financial penalties for poor performance? (YES/NO)
  - a. (If YES) For which non-FFS payment types?

10. Does the data tracked include information about the amount of non-FFS payments paid to specific providers? (YES/NO)
  - a. (If YES) Does this include the total aggregate non-FFS payment amount paid to that provider?
  - b. (IF TOTAL AGGREGATE NON-FFS PAYMENTS) Are payments to providers identified by a provider group (for example, by TIN), by a specific provider (for example, an NPI), or by some other mechanism?
  - c. (If YES) Does that included data about specific non-FFS payment types to that provider?
  - d. (IF SPECIFIC PAYMENT TYPES) For which non-FFS payment types are specific provider-level payments tracked?
  - e. For (each payment type) are payments to providers identified by a provider group (for example, by TIN), by a specific provider (for example, an NPI), or by some other mechanism?
11. In the non-FFS payment data tracked, is payment data linked to specific patients or episodes of care?
  - a. (If YES) For which non-FFS payment types?

*Other Features of Non-FFS Data*

Now, we will ask for some additional details for each of the non-FFS payment types for which your entity tracks data. (For each payment type collected, ask questions 8–10.)

12. For which payer populations, do you track non-FFS payment data?
  - a. Commercial PPO
  - b. Commercial HMO
  - c. Self-insured
  - d. Medicare Advantage
  - e. Medicare Supplemental Insurance
  - f. Medicaid managed care
  - g. Federal employee health insurance
  - h. Other
  - i. Does this differ for different types of payments?
13. With what frequency does your organization track data for (non-FFS payment): annually, quarterly, monthly, other?
  - a. Does this differ for different types of payments?
14. For what provider types are those payments applicable: all, primary care, specialists, facilities, N/A?
  - a. Does this differ for different types of payments?

*Interaction with APCD About Non-FFS Payment Data Submission*

15. Do you submit non-FFS payment data to your state's APCD?
  - a. Do you submit to some other entity in your state?

16. What difficulties have you experienced in submitting non-FFS payment data to your APCD (or other entity)?
  - a. How common are these problems?
  - b. How have you resolved these problems?
17. How well do you think what your state is asking you to submit aligns with the data you already capture and maintain in your internal systems?
18. Did you work with the state to come to an agreed upon set of variables, definitions, and file format?
19. Have you made changes to your procedures or data tracking requirements surrounding non-FFS payments to make them align better with state requirements?
20. What do you do to ensure the data you submit to the state are complete and correct?
21. Reflecting on what you have learned about submitting non-FFS payment data and reporting it to your APCD (or another entity), are there lessons for reporting nonclaims payment data in a standardized manner?

## Specifications for Calculation of Primary Care Spending as a Percentage to Total Health Care Spending

**Table A.1. Overview of Specifications in Use for Calculation of Primary Care Spending as a Percentage to Total Health Care Spending**

State/Entity	Provider Types					Primary Care–Specific Procedure Codes	Data Source	Definition of Total Spending	Primary Care Spending Percentage
	Family Medicine, Internal Medicine, General Practice, Pediatric	Nurse Practitioner, Physician Assistant	Obstetrics and Gynecology	Behavioral Health	Other				
<b>Rhode Island</b>	X	X		If paid for primary care service on primary care fee schedule	Geriatric, osteopathic	X	APCD/claims, nonclaims-based payments, other payer reported payments	All payments to Rhode Island facilities and providers including pharmacy, behavioral health, laboratory, and imaging	Commercial 11.5% (2016)
<b>Oregon</b>	X	X	X	X	Naturopathic, homeopathic, geriatric, federally qualified health center, rural health clinic	X	APCD/claims, nonclaims-based payments	Total claims-based and nonclaims-based payments (includes specialty care, mental health care, and hospitalizations, excludes pharmacy)	Commercial 13.4% Medicaid Coordinated Care Organization 16.5% Medicare Advantage 10.6% Public employee and educators 12.2% (2017)
<b>Colorado</b>	X	X	X	X	Naturopathic, homeopathic, geriatric, federally qualified health center, rural health clinic	X	APCD/claims	Total claims-based payments, including payments for some capitation encounters, using carrier-reported FFS equivalents (excludes pharmacy)	Commercial 6.18% Medicaid 6.4% Medicare Advantage 4.86% Medicare FFS 2.6% (2018)
<b>Connecticut</b>	X	Nurse practitioner only	X	X	Geriatric	X	APCD/claims		State employee health plan 4.7% (2017)

Table A.1 (continued)

State/Entity	Provider Types					Primary Care–Specific Procedure Codes	Data Source	Definition of Total Spending	Primary Care Spending Percentage
	Family Medicine, Internal Medicine, General Practice, Pediatric	Nurse Practitioner, Physician Assistant	Obstetrics and Gynecology	Behavioral Health	Other				
Massachusetts	X					X			Commercial 6.6% (2015)
Vermont	X	X	X		Naturopathic, osteopathic, geriatrics	X	APCD/claims, nonclaims-based payments	Total ACO expenditures by payer	Claims-based Medicaid 13% Fully insured 5% Self-funded 6% Medicare 4% (2017)
Washington—narrow	X	X			Naturopathic, preventive medicine federally qualified health center, primary care clinic, rural health clinic	X			4.4% (2018)
Washington—broad	X	X	X	X	Narrow providers, plus family medicine and pediatric subspecialties, homeopathic, midwife, clinical nurse specialist, registered nurse	X	APCD/claims, nonclaims-based payments	All medical claims including inpatient hospitalizations and pharmacy claims (excludes Medicare and Medicaid FFS)	5.6% (2018)

Table A.1 (continued)

State/Entity	Provider Types					Primary Care–Specific Procedure Codes	Data Source	Definition of Total Spending	Primary Care Spending Percentage
	Family Medicine, Internal Medicine, General Practice, Pediatric	Nurse Practitioner, Physician Assistant	Obstetrics and Gynecology	Behavioral Health	Other				
Milbank— narrow	X				Other plan-designated primary care providers	X			4.5% PPO 4.3% HMO (2014)
Milbank— broad	X	X	X		Geriatric, adolescent medicine, other plan-designated primary care providers		Payer reported data	Total medical and pharmacy spending	7.1% PPO 7.6% HMO (2014)
Reid et al.— narrow	X					X	Medicare FFS claims	Total medical and pharmacy spending	2.12% (2015)
Reid et al.— broad	X	X	X		Geriatric				4.88% (2015)
PCPCC/Graham Center— narrow	X				Geriatric		Medical Expenditure Panel Survey	Sum of billed expenditures for office-based outpatient, hospitalizations, emergency department visits, pharmacy, vision, dental, home health, other medical category	5.6% (2011–2016)
PCPCC/Graham Center— broad	X	X	X	X	Nurses, geriatric				10.2% (2011–2016)

SOURCE: Adapted with some modification from the Maine Quality Forum, 2020.

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