

Recommendations for Collecting Payer Information on Plan Benefit Design and Payments to Providers for Non-Claims based Services

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Introduction

The current iteration of the Maryland Health Care Commission (MHCC)'s Medical Care Data Base (MCDB) supports the collection of post-adjudicated claims data for medical (institutional and professional), dental, and pharmacy claims, as well as member and provider information. This project seeks to identify ways for Maryland to receive information about two key areas that are not currently captured in the MCDB: plan benefit design and non-claims based payments.

Plan benefit design information is important to better understand the nature of health care service delivery (e.g., how service utilization differs as benefit coverage changes). MHCC (and other state APCDs) are interested in ways to get more information about plan benefit design into the APCD as a way to supplement the claims-based APCD information. In addition, the information from the APCD about cost and utilization can also supplement the information about plan benefits and rates that are part of the Health Insurance Exchange (HIX) and rate review processes. However, MHCC does not currently have a way to connect the eligibility/membership information in the MCDB to the plan benefit design or other supplemental data from these processes.

Another important issue for APCDs in the future is collecting information about financial arrangements that exist outside the standard claims-based transactions. APCDs typically capture charges, allowed amounts, payment amounts, and patient liabilities from claims data. However, carriers routinely have fiscal transactions, both debits and credits, between themselves and providers outside of claims processing for a multitude of purposes. Eligibility and claims files typically do not capture these transactions or their amounts, thus leaving state APCDs with an incomplete picture of total costs and pricing.

The primary task for this report is to summarize the work to develop a set of recommendations about the type of information that can be included in supplemental data submissions from the health insurance payers for inclusion in the MCDB, beginning with collection of 2014 data in 2015, and a mechanism for that collection process. The report includes:

- (1) How to include critical information on the benefit structure of the plans offered by the payers.
- (2) How to collect information about non-claims based payments made by the payers to providers for a variety of purposes, including capitation payments and payments to providers participating in shared savings arrangements.

Approach

Four primary activities were performed as part of the assessment process for both the plan benefit design report and the non-claims based payments report:

- (1) Examination of the specifications for the MCDB submissions, and research about whether organizations, such as the Maryland Insurance Administration (MIA), the National Association of Insurance Commissioners (NAIC), or the Centers for Medicare and Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) Federal Health Insurance

Oversight System (HIOS) have established standards for what information should be included in the reports.

- (2) Exploration of the level of current activity and future interest in existing APCD states to collect similar information about plan benefit design and/or non-claims based payments.
- (3) Interviews with carriers in Maryland to understand current practices for capture and storage of this information and the potential for submission of the information to the MCDB.
- (4) Synthesis of the above information to develop recommendation(s) for possible approaches MHCC could consider for receiving the supplemental information; (i.e., defining the reports, including the information to be collected in the report, if possible, and/or additional information MHCC might need to define the report.

Overview

Plan Benefit Design Information

Overall, the inclusion of plan benefit design information in APCD data submissions from carriers is a challenge. There are no national standards that codify the dimensions of a plan benefit design into a common coding system. For example, there are no standards that define a Health Maintenance Organization (HMO) with a \$100 deductible, \$10 office visit co-pay, and \$50 emergency department co-pay into a plan with a specific code type. Moreover, plans are created by health insurers to meet the specific market demands. For fully insured business, a carrier may require an employer to choose from a set number of product offerings, each of which has a set of plan benefit offerings. If employers choose among these offerings, a specific health benefit plan will have a defined set of benefits. In many instances, self-insured employers using a carrier as a Third-Party Administrator (TPA) will customize the plan benefit design to meet the unique requests of the employer. As a result, there are many—almost infinite—possible plan benefit design options.

Depending on the level of granularity used, health benefit plans differ in many ways. Plans can vary not only by whether they cover certain services, but also at what level a particular service is covered. For example, a plan can be designated as one type of plan if it covers chiropractor care in any way; or, plans can be differentiated into different plans if they cover a specific number of chiropractic care visits. As states have developed carrier reporting mechanisms to understand the scope of health benefit plans offered in their state, guidance from the state to the carrier for what dimensions differentiate one plan from another plan will be important. At this time, national standards to guide these reporting definitions are not available.

Since 2009, the APCD Council has been actively engaged with national Data Standard Maintenance Organizations (DSMOs) to develop standards for health care claims data reporting. Of the six DSMOs named in HIPAA legislation, ASC X12 (www.x12.org) and the National Council for Prescription Drug Programs (NCPDP, www.ncpdp.org) are responsible for developing and maintaining industry standards for insurance claims and member eligibility transactions. The DSMOs have formal ANSI-accredited

processes for maintaining standards and related implementation guides. These processes have addressed some aspects of APCD development.

In October 2011, NCPDP published the Uniform Healthcare Payer Data Standard Implementation Guide Version 1.0. The NCPDP guide provides direction for the submission of pharmacy claims data for APCDs. ASC X12 and the industry approved a set of three implementation guides: ASC X12 Version 005010 Post-Adjudicated Claims Data Reporting (PACDR): Professional (837) Technical Report Type 3; ASC X12 Version 005010 Post-adjudicated Claims Data Reporting: Institutional (837) Technical Report Type 3; and ASC X12 Version 005010 Post-adjudicated Claims Data Reporting: Dental (837) Technical Report Type 3. Thus, standards for dental, pharmacy, and medical claims have been developed.

Currently, the ASC X12 PACDR workgroup is reviewing member eligibility and enrollment standards in hopes of creating an implementation guide in 2014. However, specific levels of coverage in an individual plan (e.g., co-pay amount for office visits, coverage levels for physical therapy) are not part of the eligibility and enrollment files, and are not being addressed by the standards work.

Generally, each payer designs its benefit package for its employer groups within its claims processing system. The coding assigned to each employer group identifier is unique to each carrier; each carrier has a different internal coding system for co-pays, deductibles, co-insurances, etc.

In addition to the DSMOs, this project reviewed NAIC guidance to identify benefit information standards. While there is recognition of the importance of standardizing plan benefit design information as HIXs and rate review functions develop with the Affordable Care Act rollout, NAIC does not have a standard approach for use across states at this stage.

The development of the state-based Health Insurance Exchanges (HIX) and supplemental rate review processes across the country have expanded the amount of information being collected about plan benefit designs and rates. Benefit and other information is collected from carriers and reported to CCIIO and the MIA. However, except for the Qualified Health Plan (QHP) requirements from CMS, there is no uniform approach to these rate review processes; instead, states have developed tailored processes to meet their unique state needs. For example, variation exists across states on which carriers are required to submit information on which plans to state agencies, the definitions for what must be reported, and how the submitted information should be interpreted. This results in a lack of uniformity in the rate review information.

Non-Claims Payment Information

The following are examples of non-claims based fiscal transactions:

- Pay-for-performance (P4P) payments;
- Per member per month (PMPM) medical home payments;
- Capitation fees;
- Contractual settlement debits or credits supporting risk contracts.

There are no standards for collection of information about these transactions. Moreover, the contractual arrangements associated with these payments can differ in their design. The arrangements

can include per member per month standard amounts to providers based on an attributed population, a withheld payment amount that is paid out when targets are met, or shared savings arrangements in which the payer receives part of the “pool” of savings dollars if certain targets are met. This variability in payment mechanisms, as well as the tremendous variability in payer financial systems, makes it difficult to identify a uniform approach for capturing non-claims based payment information.

Review and Opportunities for Maryland

In reviewing the 2013 MCDB Data Submission Manual in conjunction with data available through the MIA and CCIIO, the most logical option for Maryland to receive plan benefit design and non-claims based payment information is to combine the data available through these two reporting mechanisms (MCDB and CCIIO reporting).

Availability of Plan Benefit Design Information

Like many other APCDs, the MCDB includes files for member eligibility, medical claims (including professional and institutional services), pharmacy claims, and provider data.

For assessing plan benefit design, the MCDB member eligibility file describes coverage information for the member by capturing Coverage Type and Product Type. Coverage Type indicates the type of insurance coverage (e.g., “Medicare Supplemental,” “Medicare Advantage Plan,” “Individual Market”), using a system that is specific to the Maryland market and codified in the Code of Maryland Regulations (COMAR). However, Coverage Type does not provide a granular representation of the plan benefit design. Similarly, Product Type (e.g., “Exclusive Provider Organization,” “Health Management Organization,” “Indemnity”) indicates the type of product classified by key product characteristics, such as scope of coverage, size of provider network, and coverage for out-of-network benefits. None of the fields in the eligibility file represent detail of the plan benefit design. Regarding the granular detail about the benefits available to the member, the eligibility file includes a flag for dental services and behavioral health services, but does not include any greater specificity about benefit level. In addition to the eligibility information, the claims data also includes fields that capture patient liability amounts (i.e., co-pay, co-insurance, and deductible), which provide some indication of plan benefit design. . In addition, carriers in Maryland are required to submit data reports for the purposes of documentation and control total verification. That is, control total reports provide the total number of enrollees and number of member months by product type and coverage type.

While the information coming in to MCDB about plan benefit design is limited, there is some information collected by the MIA that could be useful. As part of rate review filing, the carrier completes a standardized template (Part I Unified Rate Review Templateⁱ to be submitted via SERFFⁱⁱ) for each plan, along with a non-standardized filing that includes the required items numerated in a checklistⁱⁱⁱ provided by the MIA. The term “plan” in the context of rate review is defined as “a specific set of benefits and cost sharing values within a product that produce an actuarial value equal to one of the metal levels permitted under the ACA”. The filing checklist requires carriers to provide detail about the plan, including information about essential health benefits, cost-sharing requirements, exclusions, exchange-related standards, enrollment periods, or standard provisions. For example, the checklist

includes benefit design dimension, such as inpatient hospital services, outpatient hospital services, home health services, and chiropractor care. Research for this report indicated that the information submitted to MIA is limited to the plans offered on the Maryland Health Benefit Exchange. Submissions for fully insured plans in the individual and small group markets are made to CCIIO. An alternative solution for MHCC to collect plan benefit design information is to acquire the submissions directly from the MIA and CCIIO. Notably, no systematic reporting of large group market or self-insured plans currently exists; capturing information about those market segments will require a different approach.

Availability of Non-Claims based Payment Information

Some information about non-claims based payments in Maryland is available through MHCC's annual submission report "Professional Service File – Data Submission Documentation," which requires carriers to indicate what types of services in the data submission *do not* have payment information, because they are capitated or reimbursed through a global contract. The documentation allows the carrier to indicate for which types of service (e.g., primary care, specialty care) these capitated or global contract payments exist. However, information about the level of those payments or other non-claims based payments (e.g., shared savings) are not collected.

Additionally, the Unified Rate Review Template collected by the MIA includes reporting in a general category of "Capitation," which "Includes all services provided under one or more capitated arrangements." The data collected do not specify the types of capitated arrangements that are associated with the dollars reported by the carriers.

Current State APCD Activity

To date, fifteen (15) states have enacted legislation to create all-payer claims databases. Of those, eleven (11) states have constructed APCDs and have been collecting data from carriers. For the purpose of understanding current activity around the collection of benefit design information and non-claims based payments, state APCD submission manuals were reviewed. Interviews conducted with representatives of state APCDs indicated interest in capturing benefit design information and non-claims based payments; those state APCD conversations are summarized later in this report (See "State APCD Interest and Intent to Collect Plan Benefit Design and Non-Claims Based Payment Information"). Two (2) states have relevant state-specific experience in reporting from carriers that may inform the approach for Maryland: New Hampshire and Massachusetts. Those two states are described below. It is important to note that these processes were in place in these states in 2013 and will likely evolve as the HIOS reporting, and other efforts, evolve.

New Hampshire

New Hampshire does not collect detailed information about benefit design or non-claims based payments in its APCD. However, both types of information are captured to some extent in New Hampshire's "Supplemental Reporting" processes.

Plan Benefit Design

Through the supplemental reporting process^{iv}, the New Hampshire Insurance Department (NHID) collects information about the plans offered by each licensed carrier. Regarding the financial dimensions of the plans, the Supplemental Reports include: Deductible, Co-Insurance, Co-Pay, and Out-of-Pocket Maximum. In addition, several specific dimensions of covered services are included (as yes/no that the services are covered at some level): Ambulance Service, Audiology Screening for Newborns, Blood and Blood Products, Case Management Program, Chiropractic Services, DME, Emergency Room, Family Planning Services, Rehabilitative Services, Hearing Aids, Home Health Care, Hospice, Hospitalization, Infertility Services, Medical Food, Mental Health and Substance Abuse, Nutritional Services, Outpatient Hospital Services and Surgery, Outpatient Laboratory and Diagnostic Services, Outpatient Short-Term Rehabilitative Services, Pregnancy and Maternity, Rx, Preventive Services, Skilled Nursing Facility, Transplants, and Well Child and Immunization Benefits. It is important to note that New Hampshire's process does not require or create a unique plan ID that can link the plan benefit design to an individual member in the APCD.

New Hampshire also collects plan benefit design information in its rate review filing documents.^v The dimensions of the plans' offerings are captured as yes/no to a benefit, but more granular information is not provided. Unique Plan IDs that can be linked to the APCD are not created in the process.

Non-Claims Based Payment Information

Regarding non-claims based payments, the Supplemental Report includes a column for each plan to report "Other Payments and Credits," defined as "other payments made such as capitation, incentive payments, etc. which are included in medical expense as reported for the carrier's Statement of Revenue and Expenses, or its equivalent, which is a required component of the annual statement filing." The reporting does not require more granular explanation of the exact types of payments that make up the "other payments."

Massachusetts

Review of the Massachusetts APCD regulations and submission manual indicates that Massachusetts requires carriers to submit the following files to the MA APCD: eligibility data; medical (institutional and professional claims), dental, and pharmacy claims data; provider files; and health plan information to the Massachusetts APCD. In addition, Massachusetts has requested additional information from payers to inform the understanding of non-claims based payments (discussed in more detail below).

Plan Benefit Design

According to Massachusetts regulations^{vi}, the **health benefit plan** information submitted by private payers is to include but not be limited to:

- "1) individual and family plan premiums for a representative range of group sizes, and annual individual and family plan premiums for the lowest cost plan in each group size for every plan with at least 1,000 Massachusetts residents that meets the minimum standards and guidelines established by the Division of Insurance under section 8H of chapter 26, organized by product codes that also appear in the Member Eligibility File;
- 2) information supporting the actuarial assumptions that underlie the premiums for each plan;

- 3) summaries of the plan designs for each plan;
- 4) medical and administrative expenses by market sector, including medical loss ratios for each plan;
- 5) information regarding the payer's current level of reserves and surpluses; and
- 6) information on provider payment methods and levels, including but not limited to total amounts and specific capitated payments, risk sharing arrangements and settlements, and any other provider payments made outside the automated or manual claims payment system."

In order to meet this statutory requirement, Massachusetts carriers are required to submit a "Product File"^{vii} that provides the attributes of each product. The attributes for each product include "product benefit type" (e.g. medical only, pharmacy only), "insurance plan market code" (e.g. Group-GIC), "carrier license type" (e.g. pharmacy benefit manager, commercial carrier, third party administrator), and "product line of business model" (e.g. Point of Service, Accident Only, CHAMPUS). While the Product File does capture attributes of the plan, the "product benefit type" does not include specific detail about the benefit design (e.g. number of chiropractic services covered).

Non-Claims Based Payment Information

In August 2013, the Massachusetts Center for Health Information and Analysis (CHIA) released its first "Annual Report on the Massachusetts Health Care Market."^{viii} Within the report, there is the acknowledgement that, "This *Annual Report* is published pursuant to M.G.L. c. 12C, which requires the Center to report on health care payer and provider cost trends, provider price variation, and the prevalence of alternative payments methods in the Massachusetts health system, among other topics."^{ix} This is important, as it indicates the statutory obligation that Massachusetts has to collect and report alternative payment arrangements, and explains, in part, its thought-leading work in this area.

The report is based on requests for data from payers that allow for the calculation of "Total Medical Expenses (TME)," which "represents the full amount paid to providers for health care services delivered to a payer's covered enrollee population (payer and enrollee cost-sharing payments combined). TME covers all categories of medical expenses and all non-claims related payments to providers, including provider performance payments." Specific to the non-standard payments, the technical appendix to that report includes the following explanation of the TME data collection:

"In May 2013, the Center started to collect the data on alternative payment methods from the ten largest commercial payers for calendar year 2012 (Table TA 2). The information was collected at the member zip code level and the managing physician group level, similar to the TME data. In this report, only the member zip code level information was analyzed and presented. The reported payment information, especially the non-claims payments, could differ from the final payment amounts since quality and financial performance is normally part of the features of alternative payment methods. And these final settlements for quality and financial performance have not been completed at the time of APM data submission deadline, which was May 15th, 2013."

These data were reported by plan, across categories of payment types (e.g., global budget, bundled payment, etc.); the data are not associated at the individual level.

State APCD Interest and Intent to Collect Plan Benefit Design and Non-Claims Based Payment Information

The APCD Council convened two state calls to discuss current state practices and/or pending plans for collecting non-claims based information from carriers. The calls were held on May 8, 2014 and May 12, 2014, and included one or more representatives from the following states: Maryland, Vermont, Colorado, Oregon, Utah, and Massachusetts. The discussion guide is included in Appendix 1. Findings from these calls for each of the areas of interest (plan benefit design and non-claims based payments) are summarized below.

Plan Benefit Design Detail

Definitions for items to be collected regarding plan benefit design detail will be important. This is especially difficult when it comes to plan design, since the dimensions are almost infinite when all variations of product offerings and coverage options are considered. The market demands variation, but what are the most important factors for the APCD and for the state? While co-pays and co-insurance amounts can be found in the claims reported to the APCD and out-of-pocket maximums may be included in the member eligibility file, what is missing? For example, for deductibles, there are many types, including: Pharmacy, Medical/Pharmacy, Dental, Behavioral Health, and Vision. Lack of standard definitions will make data collection and comparisons across states difficult.

While most states do not collect this information today, Massachusetts receives a quarterly product file from their plans with actual levels of deductibles (annual per member, annual per family). Massachusetts is working to align/merge their APCD specifications with those required by the Department of Insurance as part of their Cycle III CMS CCIIO grant. Massachusetts worked closely with payers to submit additional information for purposes of risk adjustment for the Massachusetts Connector. These specifications can be used by other states as well (available at <http://www.mass.gov/chia/>).

Non-Claims Based Payment Information

Non-claims based payment fields are becoming more important for states with active APCDs, especially as payers move away from the Fee-for-Service (FFS) claims model. Not capturing other financial information results in the underestimation of cost growth rates. As medical home and Accountable Care Organization (ACO) arrangements expand, understanding the administrative costs versus service payments is becoming an important issue, and a challenge for those promoting managed care as a way to reduce administrative burden. For transparency purposes, lower priced providers may not be the lowest priced providers if they accept side payment arrangements with the payer—thus distorting the true price of payments. The lines between claims and non-claims based payments are getting fuzzy. It was agreed that, even if 100 percent of a state's market were capitated, states would still need cost/financial and utilization data. What is needed are consistent definitions; however, even with definitions, states may interpret them differently.

For the purposes of data collection and this discussion, states agreed that the definition of non-claims based payment practices include the following possible financial arrangements outside of the claims payment transactions:

- Capitated plans
- Global payments
- Carve-outs (Behavioral Health and Pharmacy)
- Managed Care (Medicaid and Commercial)
- Back-end settlements (retrospective adjustments)
- Pay for Performance (P4P)
- Case management fees
- Rebates
- Contingent premiums (employer-payer settlements)
- Payments to patients/incentives

Because states must focus on the business case and related information needs, states need to be strategic in what information they need and justify the purpose of collection of that information. Keeping the universe of supplemental financial information manageable (and useful) was a consensus position among the participants.

Some states want to use their APCD to identify who received the care, what care they received, who provided the care, and at what cost. Figuring out how to document the cost of alternate payment arrangements and attribute them back to the proper unit of analysis is not a trivial undertaking. To help states sort out the universe of possible fields and make the case for essential fields, it would be helpful to have a matrix of all inputs and outputs made to the various players, which states could use to identify priority fields and guide planning for potential future fields.

States collecting some of these fields report challenges to the collection and use of these data, including:

- Alternate payment methods may come in, not at the individual claims level, but as an annual or quarterly report from the carriers.
- Alternative financial information comes from a different payer account or system than the claims system.
- Payers within a state vary in how they collect and store this information.
- Linking aggregate and other non-claims data back to the member service level may not be possible, making it difficult to define and measure a unit of analysis.
- Patient attribution to match patients to capitation, especially given patient churn or enrollment turnover and PCP assignment, is difficult.
- Identification of the real cost of episodes of care is not straightforward. Because all services theoretically come into the APCD through the claims file, analysis can reveal those with fewer ancillary services (e.g., Magnetic Resonance Imaging) and identify efficiency. However, these bundled payments may not reveal the negotiated episode rate or bonus payments.

Some participants felt that the complexity and cost of collecting some of the fields would make it difficult to justify and, in some instances, even to use. For example, back-end settlements, in which a global payment arrangement is adjusted (“trued up”) at year end may be possible to collect, but what will the state do with it? Rebates, especially for Medicaid, are paid out of total negotiated rates and

may not be that helpful to states with APCDs; rebates may be a never-ending exercise in reconciling total cost numbers. On the other hand, for rate review, everything that contributes to the rate is essential information. The challenge is to recommend supplemental fields that are useful, i.e., those that add value to the APCD. The focus on actual payments and actual services should be the priority. For other types of payments, determining what state insurance departments already collect to see if existing information can inform the total cost of care equation is an important initial step.

Overall, there was general agreement that state APCDs must make the business case for collecting supplemental files and fields to justify the value of the information against the cost to collect (and use) these additional fields. Carrier input is key to this effort. States need to prioritize the questions and information of interest, and work with carriers to devise the best way(s) to capture the information. It may require separate data feeds, because this information is stored in different places within and across different carriers.

Maryland Carrier Experience with Capture and Storage of Plan Benefit Design and Non-Claims Based Payment Information

The APCD Council and MHCC staff conducted a series of phone interviews with insurance carriers that are currently submitting data to the MCDB to assess how carriers currently capture and store information related to plan benefit design and non-claims based payments. Interviews were conducted from February through May and included one or more representatives from: CareFirst, Aetna, Coventry, Cigna, Assurant, State Farm, and United Healthcare. The discussion guide is included in Appendix 2.

Plan Benefit Design Information

Carriers shared that the plan benefit design information varies among carriers, and across products and plans within the carriers. The information about plan benefit design is detailed and typically stored at the plan or group level, typically in systems that are for adjudicating eligible benefits, and not tied to the claims adjudication system in a way that would allow for reporting in a standardized way to state or federal agencies. The systems are often old, legacy systems. In one case, a carrier indicated that the systems are maintained on many platforms (from previous acquisitions). Occasionally, the information is paper-based.

When considering all the deductible amounts, service limits, and co-pay amounts, the number of different plan benefit design types becomes infinite; reporting on all of them is nearly impossible. Carriers have considered (and, in some cases, hoped) for limiting the design options, but the market does not allow for it. Carriers indicated that they are not aware of plans within their companies to update the plan benefit design systems that would allow them to support reporting plan benefit design detail in a systematic way.

When the information is required for reporting purposes, the effort is typically manual and time-intensive. To date, some general reporting of plan benefit design is done for HIOS and other state reporting efforts, as described in the review of state activity to date. Carriers consistently report that only broad-level reporting categories is possible.

- For states working on this issue, carriers consistently recommended meeting with that state's carriers to explore what is feasible and reasonable to report to the APCD. In general, carriers indicated that only broad categories of collection is likely feasible. Attempts to capture the service limits in detailed categories would lead to an infinite number of plan benefit designs, and an unwieldy data collection process. Some carriers think that the following reporting categories might be possible:
 - Annual deductible amount (e.g. individual level or family levels);
 - Co-pays in distinct, defined categories (e.g. PCP office visit, ER, admissions, specialist office visit);
 - Whether or not coverage (i.e., as a “yes” or “no”) exists for categories of service (e.g., physical therapy, occupational therapy, chiropractic care).

Non-Claims Based Payment Information

Interviews with carriers confirmed that the non-claims based payment information is often captured and managed by a division or an office within the carrier organization that is separate from the office responsible for reporting to the state-based APCD.

Carriers also consistently reported that there is tremendous variation in the implementation of non-claims based payments in the carrier community, with some having arrangements for payment outside of fee-for-service reimbursement. It is unclear how large a part of the health care market these payments are in Maryland. Carrier interviews indicated that, overall, non-claims based payments are a very small part of the Maryland health care market.

Types of payments include:

- Capitation
- Pay for performance
- Global payments
- Patient centered medical home payments
- Provider revenue/settlements
- Surcharge to providers
- Increased fee schedules

Of note, the concept of “increased fee schedules” is typically not part of the conversations with the state APCDs when considering non-claims based payments, because these are technically claims-based. However, one carrier noted that the incentive for Medical Home was an increased fee schedule, so this type of payment could be considered in tracking payment for all non-traditional service arrangements.

Other types of payments discussed during the carrier interviews included pay-for-performance targets and global payments, but it was unclear the extent to which those payments were being made in Maryland. The interviewees talked about the use of those payments arrangements for the industry, in general, but had little information about the specific extent of those arrangements in their own health plans.

The level at which payments are made can vary, and this is an important and complicated factor in collecting non-claims based payments. Payments can be at the provider level in concept, but are likely at the practice group, or at a broader organizational arrangement. With regard to plan benefit design, the systems to track these payments are distinct and do not tie into the claims adjudication systems. Moreover, because the payments have targets at the provider (or group, or organization) level, not at the member level, it is unlikely that an APCD would be able to associate these payments to the claims submissions.

Considerations and Recommendations

As with other types of non-claims based payment information, APCD systems must make trade-offs and compromise based on the capacity of carriers to report, and how useful the reported information is to stakeholders.

States working on these issues, and carriers responding to inquiries about this information, recommend that all states meet carriers within that state to explore what is feasible and reasonable to report to the APCD.

States should consider the following activities to guide the collection of these items of interest:

- To the degree that states can come up with common definitions, methods, and formats for collection of these fields, this will help reduce the plans' reporting burden and improve the utility of the information states collect.
- Monitor which states now (or will soon) collect plan benefit design and/or non-claims based payment information to leverage whatever reporting guidance and infrastructure exists.
- Start small. Keep the universe small enough so that the data have some analytic utility. States should initially focus on fields that are important to their APCD mission and to stakeholders.
- States may have to consider changes to the APCD data structure. That can be difficult, but may be needed in some fields to support linking APCD data to supplemental information about plan benefit design and/or non-claims based payments. The addition of a field that indicates a medical home/capitated arrangement or attribution to a provider group will facilitate the link of information collected at that level back to the member record. For other fields, such as back-end settlements, a separate submission mechanism (which will not link to the claim or member at all) that requires provider identification and attribution strategies may be needed.
- To facilitate the collection of plan benefit design information, it is important to know which plans the state Insurance Department regulates in order to understand which payers are required to submit data. Starting with a map or matrix of the possible plan configurations may be useful.
- For non-claims based payments, fields that can roll up to a total health care spend may be the most appropriate place to start for data collection efforts. Understanding what payment arrangements exist might be a good starting place for expanded financial reporting because it could begin to define the types of payment information a state might receive when collecting non-claims based payment data.

- Payments for episodes of care that are not tied to claims services directly, but tied to a set of services, pose both opportunities and challenges to the APCD. States can explore with payers how much bundled payments are included in the claims file, and what is paid outside of the claims transaction, in these instances.
- Physician attribution for analytics will be a challenge, but is important for the utility of the APCD, especially as payments become based on members at the group level. Specific experience from Massachusetts is summarized below.

Collecting PCP Assignment in Massachusetts

One example of how a state can approach the collection of supplemental information from plans is the collection of data from capitated plans in Massachusetts. Massachusetts found that monthly reporting Primary Care Physician (PCP) was too difficult and started with annual reporting of PCP assignment. Since per member per month (PMPM) management fees move with the patient, and patients change PCPs frequently, matching patients to the capitation was nearly impossible. Massachusetts came up with an approach:

Plans report patients assigned to a PCP at the end of the year--not throughout the year. This reduced the reporting burden and variation across plans, but raised a side issue of physician attribution. Therefore, they had to understand the hierarchy of doctors and registered groups. Massachusetts has a good taxonomy of medical groups, organization identifiers, and the APCD supplements this other data. While the PCP attribution is not precise and does not reflect claims-level experience, it is a starting place for PMPM analyses.

Collection of Plan Benefit Design Information: Implications for Maryland

Maryland (and other states) should identify business needs for the benefit information in order to determine the level of specificity for the capture of benefit information. There are mechanisms through the MIA and CCIIO that collect information at the plan level that describe benefit design: the Rate Review Filing (template and checklist response), and defining how to best leverage those efforts is a priority for Maryland. In the short term, identifying ways to link the MCDB to the rate review filing information is likely the most expedient way to get plan benefit design information into the MCDB. Table 1 summarizes the Maryland insurance market, and potential ways to get plan benefit design information about those market segments.

Table 1: Availability of Plan Benefit Design Information, by Size and Nature of Maryland Insurance Market¹

Market Segment	% in Maryland Market	Potential Source of Information
Fully-insured large group	27%	New data collection (e.g., via health plans)
Fully-insured small group	13%	CCIIO Reporting
Fully-insured individual	7%	CCIIO Reporting
Self-insured	53%	New data collection (e.g., via health plans)

As indicated in Table 1, while potential sources of information for some of the Maryland population exists, the majority of the covered lives are not included in existing reporting efforts; i.e., CCIIO or MIA, or otherwise. Gathering information about these populations will likely require new reporting efforts.

Even for those populations about which information is available through CCIIO reporting, more research is needed to determine whether or not the level of detail about plan benefit design available in the rate review filing is specific enough to meet the needs of MHCC. Maryland may benefit from analyzing available data, which will provide a “test” to better understand how these types of data could be used in the future. Reviewing the CCIIO data as a first approach would allow Maryland the opportunity to evaluate the cost-benefit question, informing the approach for how to systematically collect the data from carriers, particularly for populations with no alternative for data.

Alternatively, MHCC could require a carriers to submit a separate product file that includes plan benefit design information, reported at the level of the Plan ID from the Rate Review filing. This would require MHCC to provide specific dimensions and levels of detail required as part of the reporting. For example, MHCC would need to provide guidance about the broad categories of services, focusing on the dimensions of plan benefit design that impact the nature of the care received. If MHCC seeks additional detail about plan benefit design, it must work with carriers to develop this additional collection process.

According to an October 21, 2011 memo^x, the MIA announced its interest in establishing a Memorandum of Understanding (MOU) with the Health Services Cost Review Commission (HSCRC) and MHCC to share data from each agency in an effort to support MIA’s rate review process. Therefore, it is possible that data sharing may be covered by the existing MOU. However, because the data are not currently stored by the MIA in ways that allow for easy reporting, both an MOU for data sharing and also changes in MIA processes will be necessary to support the needs identified by MHCC.

Assuming MHCC determines that the data collected through the rate review filings or HIOS filings are sufficient for understanding plan benefit design, MHCC should consider the appropriate mechanism for collection of the data. This would include evaluating the potential linkage of the MCDB to plan characteristics captured in the MIA rate review process. Two options were considered for this project:

¹ Approximate % of Maryland population within the group, according to MHCC analysis of 2012 enrollment data.

1. Adding “Plan ID” to the member eligibility file. Discussions with carriers indicated that this option was not a feasible solution. There is no existing data system that links Plan ID to a set of characteristics of plan benefit design which is also linked to the member eligibility information that is the basis of the member eligibility file.
2. Require carriers to submit a separate file that includes a roster of MCDB Encrypted Member Identification numbers for each “Plan ID”. This option may be a feasible solution for carriers required to do HIOS reporting; however, this reporting process is likely to be manual.

Collection of Non-Claims Based Payment Information: Implications for Maryland

Maryland should determine the business needs for the payment information for non-claims based services; this will provide the framework for the inventory of the types of payment information that could be provided to the MCDB. In the interviews for this report, carriers indicated that these payments were a small part of the insurance market in Maryland, so MHCC needs to consider what level of information is necessary at this stage. The effort in Maryland could be considered more of an effort to track the nature of non-claims based payments and the dollar amounts in these arrangements, rather than the level of granularity in categories that are not currently well-defined or standardized.

Because non-claims based payments are not available at the member level, Maryland could potentially expand the MCDB report that captures non-claims based payments, (“Professional Service File – Data Submission Documentation”) to request more specific information about the types of payments being made. The broad categories might include:

1. Pay-for-performance (P4P) payments;
2. Per member per month (PMPM) medical home payments;
3. Capitation fees;
4. Contractual settlement debits or credits supporting risk contracts; and
5. Withholds (including detail about budget and capitation)

Maryland may want to monitor the Massachusetts experience. While it is a relatively new approach, Massachusetts is optimistic that annual reporting of non-claims based payments, PCP attribution, and the construction of a taxonomy will allow them to expand their reporting capabilities.

Next Steps

Following are a few general next steps as MHCC continues to pursue approaches to collect plan benefit design and non-claims based payment information:

- MHCC will continue to consider and define the business cases for collecting these data, and monitor other states that continue to develop these business cases.
- MHCC will consider CCIIO and other sources for plan benefit design information, focusing on the exchange plans and individual and small group markets from both CCIIO and the MIA. Using

these data from CCIIO will help MHCC understand the utility of the plan benefit design information in the MCDB.

- MHCC will continue to work with carriers to identify ways to obtain data for large group and self-insured markets.
- For non-claims based payments, MHCC will focus on tracking the types of these payments and the dollars associated with them. For example, United Healthcare may be able to provide data collection categories.

Conclusions

MHCC's interest in capturing more information about plan benefit design and non-claims based payments is echoed in APCD states across the country. While APCDs states have not developed standard mechanisms for collecting this information, many states are contemplating the feasibility and would look to the Maryland experience as guidance. For plan benefit design information, there is an opportunity for Maryland to leverage work being done by MIA/CCIIO by linking the information collected by MIA/CCIIO to the MCDB. For non-claims based payments, there are methods for collecting that information that will allow Maryland to understand the impact of those payments on the overall health market in Maryland; however, tying those results to individual members is unlikely.

The adoption of national standards for the codification of plan benefit design information and non-claims based payments would benefit all APCD states. However, that work is not on the immediate horizon, and the on-the-ground activity at the state-level (including Maryland) is likely to continue to inform this work.

Appendix 1: Questions for State Interviews

Non-Claims Based Payments and Plan Benefit Design Detail

Non-Claims Based Payments (NCBP)

1. What are NCBPs and how would you define NCBPs?
2. Do you see value in collecting NCBPs? If yes, what is the value of NCBPs?
3. Do you currently collect NCBP?

If yes...

4. What was the process for initiating the collection NCBP?
5. What about this process worked well?
6. What about this process was challenging?
7. How do you collect NCBP?
8. What NCBP do you collect?
9. Who do you collect NCBP from?
10. If you collect NCBP from multiple sources, are there any differences in the process?
11. How often to do collect NCBP?
12. What do you do with the NCBP that you collect?

If no...

13. Why don't you collect NCBP?
14. Do you have any plan to collect NCBP in the future?
15. If you did collect NCBP, what would you use it for?

Plan Benefit Design Detail (PBDD)

1. What is PBDD and how would you define PBDD?
2. Do you see value in collecting PBDD? If yes, what is the value of PBDD?
3. Do you currently collect PBDD?

If yes...

4. What was the process for initiating the collection PBDD?
5. What about this process worked well?
6. What about this process was challenging?
7. How do you collect PBDD?
8. What PBDD do you collect?
9. Who do you collect PBDD from?
10. If you collect PBDD from multiple sources, are there any differences in the process?
11. How often to do collect PBDD?
12. What do you do with the PBDD that you collect?

If no...

13. Why don't you collect PBDD?
14. Do you have any plan to collect PBDD in the future?
15. If you did collect PBDD, what would you use it for?

Appendix 2: Questions for Carrier Interviews

Total Medical Expenditure / Non-FFS Spending

- What would you define as payment to provider that is not claims-based?
For example:
 - Incentive payments
 - P4P
 - Shared Savings / FTP
 - Other?
- How is a non-claims-based payment negotiated with the provider? And subsequently, how is it contracted and paid? And how is the information stored?
- Reporting:
 - How would your organization report non-claims based payments?
 - What group(s) within your organization is (are) responsible for this area?
 - Logistics of reporting? What groups/teams need to be involved?
 - Cycle/Frequency:
 - What is the cycle/frequency of tracking/collection of this data?
 - What would be a reasonable frequency of reporting?

Plan Benefit Design

- What does “plan benefit design” mean to you? Is there a systematic approach to define a “new plan” versus a plan with variations?
- Where and in what format is this information stored? (e.g. Actuarial or Marketing databases vs. Analytics or Reporting databases)
- Other uses of plan benefit design:
 - How is this data linked for claims adjudication?
 - How is data provided for price transparency efforts with links to individual plan benefit details?
- Reporting:
 - How would you report plan benefit design?
 - Logistics of reporting? What groups/teams need to be involved?
 - Cycle/Frequency:
 - What is the cycle/frequency of tracking/collection of this data?
 - What would be a reasonable frequency of reporting?

ⁱ Maryland Rate Review Filing Template and Instructions can be accessed here:

<http://www.mdinsurance.state.md.us/sa/insurer/index.html>

ⁱⁱ SERFF is the System for Rate and Form Filing, maintained by NAIC. <http://www.serff.com/>

ⁱⁱⁱ Example of Checklist for filing by Small Employer Coverage Issued by Insurers:

<http://www.mdinsurance.state.md.us/sa/docs/documents/insurer/rates-and-forms/insurers-small-employer-non-grandfathered-1-1-2014.pdf>

^{iv} New Hampshire Insurance Department, Docket No.: INS No. 08-001-AB, Supplemental Reporting Bulletin, May 3, 2013. http://www.nh.gov/insurance/media/bulletins/2013/documents/suprpt_ins_08-001.pdf

^v http://www.nh.gov/insurance/lah/documents/ind_qhp_cklst.pdf

^{vi} Massachusetts Division of Health Care Finance and Policy, 114.5 CMR 21.00: Health Care Payers Claims Data Submissions (Adopted July 8, 2010). <http://www.mass.gov/chia/docs/g/chia-regs/114-5-21.pdf>

^{vii} Massachusetts All-Payer Claims Database Product File Submission Guide (June 7, 2013). <http://www.mass.gov/chia/docs/p/apcd/submission-guides/v3-1-apcd-product-file-submission-guide-2013-06.pdf>

^{viii} <http://www.mass.gov/chia/docs/r/pubs/13/ar-ma-health-care-market-2013.pdf>

^{ix} M.G.L. c. 12C, section 16 established under Section 19 of Chapter 224 of the Acts of 2012, [An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation.](#)

^x Memo from Maryland Insurance Administration about data sharing with MHCC and HSCRC (October 21, 2011). <http://www.mdinsurance.state.md.us/sa/docs/documents/home/reports/datasharingmhcc-hscrc.pdf>